



Institute for Child Health Policy at the University of Florida
Texas External Quality Review Organization

The Texas STAR+PLUS Program Member Survey Report

Fiscal Year 2012

Measurement Period:

September 1, 2011 through August 31, 2012

The Institute for Child Health Policy

University of Florida

**The External Quality Review Organization
for Texas Medicaid Managed Care and CHIP**

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Executive Summary

Introduction

The Institute for Child Health Policy serves as the External Quality Review Organization (EQRO) for Texas Medicaid managed care and annually evaluates STAR+PLUS members' health care experiences and satisfaction using a member telephone survey. This report provides results from the fiscal year (FY) 2012 STAR+PLUS Member Survey conducted for Medicaid-only members who were enrolled in one of the five STAR+PLUS managed care organizations (MCOs) between July 2011 and December 2011. Members enrolled in STAR+PLUS as a result of the expansion to the El Paso, Lubbock, and Hidalgo service areas, as well as to the Jefferson service area, did not meet the six-month enrollment criteria and were therefore not included in this report.

The purpose of the FY 2012 STAR+PLUS Member Survey is to:

- Describe the demographic, household, and health characteristics of adults enrolled in STAR+PLUS.
- Use CAHPS[®] composites, member ratings, and HHSC Performance Dashboard Indicators to assess members' experiences and satisfaction with their health care across the following domains:
 - Access to and timeliness of care;
 - Patient-centered medical home;
 - Service coordination; and
 - Health plan information and customer service.
- Identify disparities in member experiences and satisfaction of care across member characteristics, MCOs, and service areas (SAs).
- Assess factors associated with access to care, timeliness of care, and whether providers discussed health goals with members.

Methodology

Survey participants were selected from a stratified random sample of members enrolled in STAR+PLUS for six months or longer between July 2011 and December 2011. The EQRO set a target sample of 3,500 completed telephone interviews with members, representing 250 respondents for each of the 14 STAR+PLUS plan codes (MCO-SA groups) included in this study. The response rate for this survey was 55 percent and the cooperation rate was 81 percent.

The FY 2012 STAR+PLUS Member Survey included:

- The Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) Health Plan Survey 4.0 (Medicaid module), which asks respondents to relate their health care experiences and satisfaction in the six months prior to the survey.¹
- Items from the CAHPS[®] Clinician and Group Surveys.²

- Items from the RAND® 36-Item Health Survey that assess emotional health.³
- Items developed by ICHP pertaining to member demographic and household characteristics, and STAR+PLUS member experiences and satisfaction with service coordination.

Summary of Findings

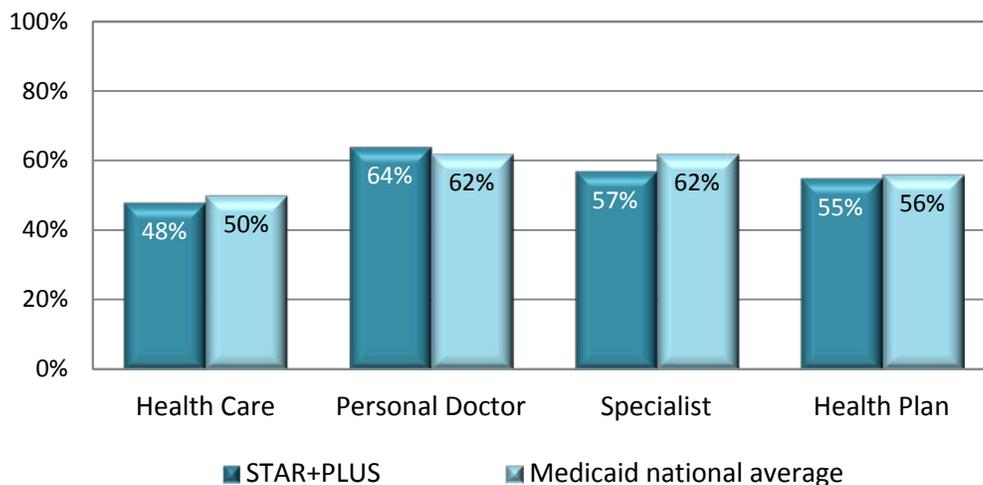
Profile of STAR+PLUS survey participants (members):

- The average age was 48 years old.
- Black, non-Hispanic members were the most common racial/ethnic group (36 percent), followed by Hispanic members (31 percent), and White, non-Hispanic members (25 percent).
- Forty-five percent of members did not complete high school.
- The most common marital status was 'single' (39 percent), followed by 'divorced' (21 percent), and 'married' (16 percent).
- Nearly one-third of members reported living alone (30 percent).

Positive findings

- *Member Ratings.* A majority of members provided high ratings of their health care, doctors, and health plan, indicated by a rating of 9 or 10 on a 10-point scale. These ratings were comparable to those published from Medicaid national data.

Percent of members rating their health services a "9" or "10"

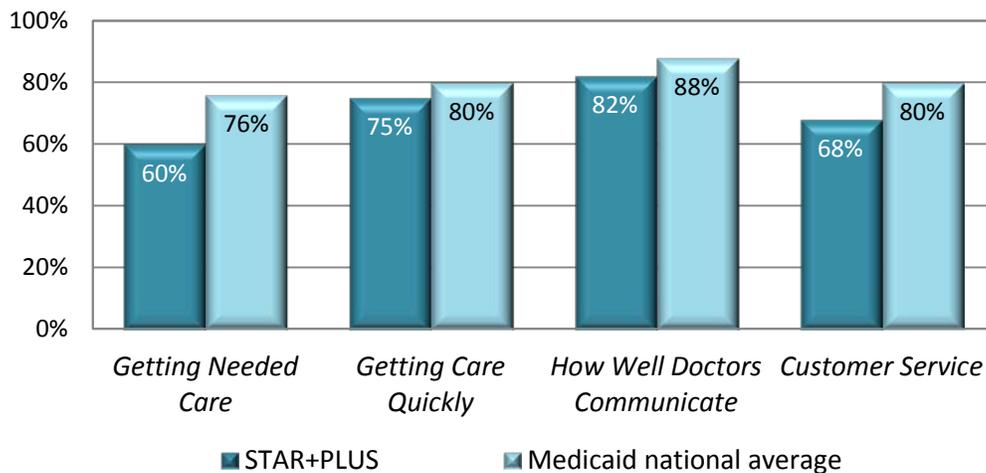


- *Access to Prescription Medicines.* Eighty-two percent of members who received prescription medication (new or refill) said it was “usually” or “always” easy to get prescription medications.
- *Preventive Care and Health Promotion.* Among members who reported that they smoke cigarettes, nearly three-quarters said that their doctor advised them to quit smoking during the last six months (69 percent), which is approximately equal to the HHSC Dashboard standard of 70 percent.
- *Shared Decision-Making.* A majority of members reported they “usually” or “always” were involved as much as they wanted in decisions about their health care (81 percent). Seventy-three percent of members reported that it was “usually” or “always” easy to get their doctors to agree on how to manage their health care problems.
- *Good Access to Service Coordination.* Among members who needed service coordination, 67 percent reported that they “usually” or “always” received service coordination as soon as they thought they needed it. This percentage exceeds the HHSC Dashboard standard of 63 percent for this indicator.
- *Satisfaction with Service Coordination.* Eighty-three percent of members who had a service coordinator said they were “satisfied” or “very satisfied” with their service coordinator.

Improvement areas

- *Good Access to Urgent Care.* Seventy-seven percent of members reported that they “usually” or “always” received urgent care as soon as they needed. Three MCO-SAs performed at or above the HHSC Dashboard standard of 81 percent for this indicator.
- *Good Access to Routine Care.* Approximately three in four members reported that they usually or always received an appointment for routine care as soon as it was needed (73 percent). Only one MCO-SA group met the HHSC Dashboard standard of 80 percent for this indicator.
- *Getting Needed Care.* Sixty percent of members “usually” or “always” had positive experiences on the CAHPS® composite *Getting Needed Care*, which is below the national Medicaid average (76 percent). Scores for *Getting Needed Care* were found to vary by service area, with the lowest scores in the Bexar and Dallas SAs.

Percent of members “usually” or “always” having positive experiences (CAHPS®)



- *Communication with Providers’ Office Personnel.* Slightly more than half of members reported that someone in their provider’s office spoke with them about specific goals for their health (58 percent). This aspect of patient-centered care was found to vary by service area, with rates in the Travis SA higher than the other SAs.
- *Awareness of Service Coordination.* Less than half of respondents were aware that their health plan offers service coordination to its members (46 percent), although it is a service available for all STAR+PLUS members who request it.
- *Having Service Coordination.* Only 31 percent of STAR+PLUS members reported that they have a service coordinator.
- *Involvement in Service Coordination.* Although members generally had high levels of satisfaction with their service coordinators, two-thirds (64 percent) said their service coordinator involved them in making decisions about their services.
- *Health Plan Information and Customer Service.* Sixty-eight percent of members said they “usually” or “always” had positive experiences on the CAHPS® composite *Health Plan Information and Customer Service*, which is below the national average of 80 percent.
- *Health Plan Approval.* Thirty-eight percent of members reported having no delays in health care while waiting for health plan approval, which is below the HHSC Dashboard standard of 57 percent. None of the MCO-SA groups met the HHSC Dashboard standard for this indicator.

HHSC Performance Dashboard Indicators	STAR+PLUS	HHSC Standard
<i>Good Access to Urgent Care</i>	77%	81%
<i>Good Access to Specialist Referral</i>	61%	73%
<i>Good Access to Routine Care</i>	73%	80%
<i>No Delays in Health Care while Waiting for Health Plan Approval</i>	38%	57%
<i>No Wait to be Taken to the Exam Room Greater than 15 Minutes</i>	28%	42%
<i>Good Access to Special Therapies</i>	52%	66%
<i>Good Access to Service Coordination</i>	67%	63%
<i>Advising Smokers to Quit</i>	69%	70%
<i>Good Access to Behavioral Health Treatment or Counseling</i>	59%	63%

Recommendations

The EQRO recommends the following strategies to Texas HHSC for improving the delivery and quality of care for adults in the STAR+PLUS program. These strategies are relevant to improving coordination of care for members with chronic conditions and reducing long-term nursing home admissions, which are HHSC’s overarching goals for STAR+PLUS MCOs for 2012.

Domain	Recommendations	Rationale
Patient-Centered Care	<ul style="list-style-type: none"> To improve communication between providers and members about members’ preferences—including health goals—STAR+PLUS health plans should ensure providers in their networks are following validated physician-patient communication models such as the SEGUE model.⁴ Health plans operating in the Travis SA are encouraged to assess factors associated with higher levels of member involvement in this service area. This information can be used to effectively target and improve interventions to increase member involvement in other areas of the state. 	<p>The percentage of members whose provider office personnel discussed health goals with them was low (58 percent). Controlling for member demographics, health status, and health plan membership, members in the Travis SA were more likely than members in other SAs to report having discussed their health goals.</p> <p>Among members who</p>

	<ul style="list-style-type: none"> To improve shared decision-making in service coordination, HHSC should encourage MCOs to ensure that members are involved more fully in the development of their service plans. 	<p>have a service coordinator, two-thirds said that their service coordinator “usually” or “always” involved them in making decisions about their services (64 percent).</p> <p>Research has found that models that emphasize patients’ agreement with their service plans were associated with lower rates of functional decline and higher satisfaction with services.⁵</p>
<i>Getting Needed Care</i>	<ul style="list-style-type: none"> To improve <i>Getting Needed Care</i> (getting appointments with specialists and getting treatment, tests, or needed care), MCOs may want to assess: (1) supply and demand of specialist providers to evaluate staffing needs in their provider networks; and (2) referral systems that prioritize access to needed care according to the urgency of the members’ needs. To better determine the reasons why <i>Getting Needed Care</i> was low and how it could be improved, future surveys should include questions that more specifically assess why members have difficulties getting the care they need. 	<p>The percentage of members with positive experiences of <i>Getting Needed Care</i> (60 percent) was lower than that of the national Medicaid population (76 percent).</p> <p>Implementation of referral systems that prioritize access to care according to members’ needs may help to reduce the wait time to see a specialist.⁶</p>
Health Plan Approval	<ul style="list-style-type: none"> STAR+PLUS MCOs should ensure that authorization processes for medical services follow recent recommendations made by the American Medical Association. These include: (1) implementing standardized prior authorization forms; (2) making 	<p>Only 38 percent of STAR+PLUS members reported having no delays for approval, and no MCO-SA group met the HHSC Dashboard standard for <i>No Delays in</i></p>

	<p>authorization requirements readily accessible; (3) making rules for authorization uniform across payers; (4) placing practical limits on medical record requests; (5) enforcing consistent response times for urgent and non-urgent circumstances; and (6) forming a consensus in the health care industry regarding operating rules and standard transactions. These practices could reduce the amount of time spent waiting for approval and could make the process easier for patients and providers.⁷</p>	<p><i>Health Care while Waiting for Health Plan Approval</i> (57 percent).</p>
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Introduction and Purpose

The STAR+PLUS Program is a Texas Medicaid managed care program that offers integrated acute and long-term health care services to members who are elderly and have a disability. STAR+PLUS members receive acute primary and specialist care, long-term services including adult day care services, and service coordination for members with complex medical conditions. Service coordination is also offered at the request of the STAR+PLUS member. Service coordinators help customize health care plans for members to ensure that their needs are met.

Studies suggest that members' experiences and satisfaction ratings are good indicators of the quality of care they receive, can highlight areas for care improvement, and are often associated with health outcomes and compliance with treatment regimens.^{8,9} Because disabled and chronically ill Medicaid members face several challenges to health and health care access, it is particularly important to assess their experiences to evaluate whether the care they receive is addressing and meeting their needs.¹⁰

As part of external quality review activities for the State of Texas, the Institute for Child Health Policy—which serves as the External Quality Review Organization (EQRO) for Texas Medicaid managed care—collected data from adult STAR+PLUS members by telephone survey. As of March 2012, STAR+PLUS expanded to the El Paso and Lubbock service areas (SAs), as well as the new Hidalgo SA, and now operates in 90 counties.¹¹ This report presents data for enrolled Medicaid-only members served through the 14 managed care organization service areas (MCO-SA) operating in STAR+PLUS during calendar year (CY) 2011, prior to the expansion to the El Paso, Lubbock, and Hidalgo service areas, and excluding the Jefferson service area.

The purpose of the FY 2012 STAR+PLUS Member Survey is to:

- Describe the demographic and household characteristics of adults enrolled in STAR+PLUS.
- Document the health status of adult members—including overall health, mental health, and body mass index (BMI).
- Document members' experiences and satisfaction with their health care.
- Use CAHPS[®] composites, member ratings, and HHSC Performance Dashboard Indicators to evaluate the STAR+PLUS program and health plan performance across the following domains:
 - Access to and timeliness of care;
 - Patient-centered medical home;
 - Service coordination; and
 - Health plan information and customer service.
- Identify disparities in member experiences and satisfaction of care across member characteristics, MCOs, and service areas.

- Assess factors associated with access to care, timeliness of care, and whether providers discussed health goals with members.

Methodology

This section provides a brief overview of the methodology used to generate this report. Detailed descriptions of sample selection procedures, survey instruments, data collection, and data analyses are provided in **Appendix A**.

Sample Selection Procedures

The EQRO selected survey participants from a stratified random sample of adults 18 to 64 years old who were enrolled in the same STAR+PLUS MCO in Texas for six months or longer between July 2011 and December 2011. Members having no more than one 30-day break in enrollment during this period were included in the sample. Dual-eligible members, who are eligible for both Medicaid and Medicare benefits, were excluded from the sample.¹²

A target sample of 3,500 completed telephone interviews was set, representing 250 respondents for each of the 14 MCO-SA groups participating in STAR+PLUS during calendar year (CY) 2011:¹³

• Amerigroup – Bexar	• Molina – Harris
• Amerigroup – Harris	• Superior – Bexar
• Amerigroup – Tarrant	• Superior – Dallas
• Amerigroup – Travis	• Superior – Nueces
• HealthSpring – Tarrant	• UnitedHealthcare – Harris
• Molina – Bexar	• UnitedHealthcare – Nueces
• Molina – Dallas	• UnitedHealthcare – Travis

Survey Instruments

The FY 2012 STAR+PLUS Member Survey is comprised of:

- The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 4.0 (Medicaid module).¹⁴
- Items from the CAHPS® Clinician and Group Surveys.¹⁵
- Items from the RAND® 36-Item Health Survey, Version 1.0 that assess emotional health.¹⁶
- Items developed by ICHP pertaining to member demographic and household characteristics, and member experiences and satisfaction with STAR+PLUS service coordination.

The CAHPS[®] Health Plan Survey is a widely used instrument for measuring and reporting consumers' experiences with their health plan and providers. The STAR+PLUS Member Survey uses the Medicaid module of the CAHPS[®] survey and includes both the core questionnaire and supplemental items. The CAHPS[®] survey allows for the calculation and reporting of health care composites, which are scores that combine results for closely related survey items.

For adults, CAHPS[®] composite scores are calculated in the following four domains: (1) *Getting Needed Care*; (2) *Getting Care Quickly*; (3) *How Well Doctors Communicate*; and (4) *Health Plan Information and Customer Service*. Scores for composite measures were calculated using both Agency for Healthcare Research and Quality (AHRQ) and National Committee for Quality Assurance (NCQA) specifications.

Nine survey questions function as indicators of health plan performance for adult STAR+PLUS members, as listed on HHSC's Performance Indicator Dashboard for CY 2012.¹⁷ These include: (1) *Good Access to Urgent Care*; (2) *Good Access to Specialist Referral*; (3) *Good Access to Routine Care*; (4) *No Delays in Health Care while Waiting for Health Plan Approval*; (5) *No Wait to be Taken to the Exam Room Greater than 15 Minutes*; (6) *Good Access to Special Therapies*; (7) *Good Access to Service Coordination*; (8) *Advising Smokers to Quit*; and (9) *Good Access to Behavioral Health Treatment or Counseling*.

Respondents were also asked to report their height and weight. These questions allow for calculation of the member's body mass index (BMI), a common population-level indicator of overweight and obesity.

Data Collection

The EQRO sent letters written in English and Spanish to 18,803 sampled STAR+PLUS members, requesting their participation in the survey. Of the advance letters sent, 68 were returned undeliverable.

The Survey Research Center (SRC) at the University of Florida conducted the survey using computer-assisted telephone interviewing (CATI) between May 2012 and September 2012. The SRC telephoned STAR+PLUS members seven days a week between 10 a.m. and 9 p.m. Central Time. Of 3,432 completed interviews, 71 (2 percent) were conducted in Spanish. On average 7.6 calls per phone number were made in the STAR+PLUS member survey sample.

Forty-seven percent of members could not be located. Among those located, two percent indicated that they were not enrolled in STAR+PLUS and nine percent refused to participate. The response rate was 55 percent and the cooperation rate was 81 percent.

Data Analysis

Descriptive statistics and statistical tests were performed using SPSS 19.0 and focused on the CAHPS® composite measures and HHSC Performance Dashboard indicators. Statistical tests of differences were conducted among members of the 14 MCO-SA groups, and among relevant demographic sub-groups of the sample. Multivariate analyses were also conducted to examine the influence of service area and health plan membership on self-reported access to care (CAHPS® *Getting Needed Care* and *Getting Care Quickly*) and patient-centered encounters, controlling for member demographics and health status.

Frequencies and means in this report were weighted to account for differences in plan code population size, permitting a greater degree of accuracy when making inferences to the STAR+PLUS member population. To prevent overestimation of statistical significance resulting from sample size inflation, statistical tests were conducted on unweighted data. Therefore some differences may be noted between results calculated for population inferences and results calculated for statistical tests.

Survey Results

This section presents survey findings for adults in STAR+PLUS regarding: (1) Demographic characteristics; (2) Health status; (3) Access to and timeliness of care; (4) Presence of a usual source of care and patient-centered medical home; (5) Service coordination; and (6) Experiences and satisfaction with STAR+PLUS health plans.

Demographic Characteristics

Nearly two-thirds of survey respondents were female (61 percent), and the mean age was 48 years old. Black, non-Hispanics represented the largest racial/ethnic group in the sample (36 percent), followed by Hispanics (31 percent) and White, non-Hispanics (25 percent). Nine percent of survey respondents reported that they were of Other, non-Hispanic race/ethnicity.

Most members were born in the United States (92 percent); however, eight percent of members were born in a country other than the United States. The average amount of time that non-native members lived in the United States was 30 years.

When respondents were asked what language they speak at home, a vast majority reported that they speak mainly English at home (88

	STAR+PLUS Members
Mean Age (years)	47.9 (SD = 12.10)
Sex	
Female	61%
Male	39%
Race/Ethnicity	
Hispanic	31%
Black, non-Hispanic	36%
White, non-Hispanic	25%
Other, non-Hispanic	9%
Native Country	
United States	92%
Mexico	3%
Other	5%

percent). Ten percent of respondents reported that they speak mainly Spanish at home.

Regarding educational status, nearly half of survey respondents had less than a high school education (45 percent). Thirty-six percent of respondents had a high school degree or equivalent, and 20 percent had some college or a college degree.

When asked about their marital status, greater than one-third of respondents reported that they were single (39 percent). Twenty-one percent of respondents were divorced, and only 16 percent of respondents were married.

Respondents also answered questions about their household. Nearly one-third of respondents reported that they live alone (30 percent). In addition, half of respondents reported that they live in a single-parent household (50 percent). When asked to indicate what their primary type of housing or residence was, greater than half of respondents reported that they live in rented housing (53 percent). Only 18 percent of respondents indicated that they own their home, and 11 percent of respondents indicated that they live in public or subsidized housing.

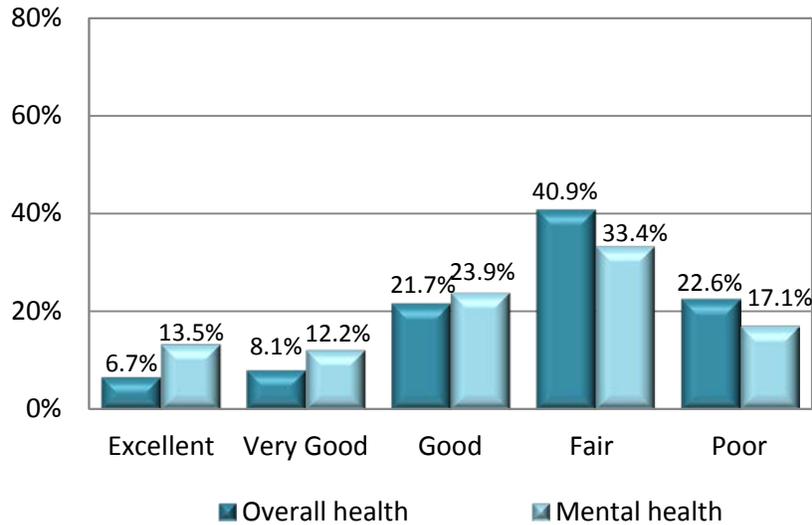
Health Status

Overall and Mental Health

Respondents were asked to rate their overall health and mental health. Overall, health ratings were low (**Figure 1**). However, this is expected in the STAR+PLUS population, which has higher rates of chronic illness and disability than the general Medicaid population.

- Only 15 percent of respondents rated their overall health as “excellent” or “very good”. In contrast, 64 percent of respondents rated their health as “fair” or “poor”.
- Twenty-six percent of respondents rated their mental health as “excellent” or “very good”, which is higher than their ratings for overall health. However, approximately half of respondents rated their mental health as “fair” or “poor” (51 percent).

Figure 1. Member Ratings of Their Overall Health and Mental Health



The mental health of members was also assessed using the *Emotional Well-Being* scale of the RAND® 36-Item Health Survey, Version 1.0. The RAND®-36 scores range from 0 to 100, with higher scores indicating better health status. The scale is comprised of questions that assess how often during the past four weeks members experienced negative emotions, including feeling “nervous”, “downhearted”, or “blue”. In addition, the scale also contains questions that assess how often members felt positive emotions, including feeling “calm”, “peaceful”, or “happy”. The average score for *Emotional Well-Being* among respondents was 57.1 out of 100, indicating that STAR+PLUS members in general have low emotional health status.

Body Mass Index

Figure 2 provides the body mass index (BMI) results for STAR+PLUS members, which is based on respondents’ self-reported weight and height data. Half of members were classified as obese (50 percent), and one-quarter were classified as overweight (25 percent). STAR+PLUS members had a substantially higher rate of obesity compared to the national rate for adults (36 percent) and the rate for the Texas population (29 percent), as reported by the Centers for Disease Control and Prevention in 2012.¹⁸

Obesity Prevalence in the U.S. by Sex and Race/Ethnicity^a	
	% obese in population
Men	36%
Women	36%
Hispanic	38%

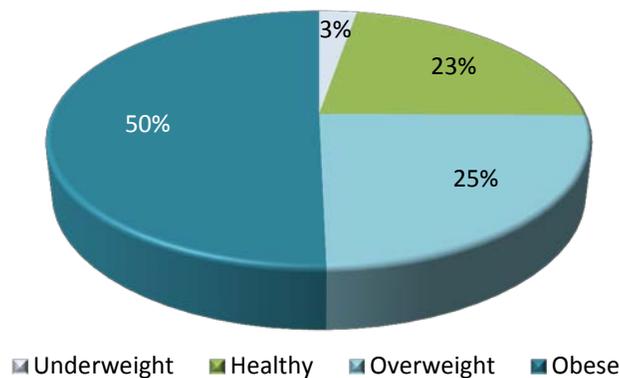
- Female members had a higher rate of obesity than male members (57 percent vs. 40 percent).²⁰ The gender difference among STAR+PLUS members was greater than that observed for the U.S. adult population, which has no difference in obesity rates by gender.

Non-Hispanic Black	50%
Non-Hispanic White	35%

^a Based on the National Health Examination and Nutrition Survey, 2009-2010 ¹⁹

- Obesity rates were different among the racial/ethnic groups in STAR+PLUS. Hispanic members had the highest rate of obesity (57 percent), followed by Black, non-Hispanic members (50 percent). White, non-Hispanic members had the lowest rate of obesity (46 percent).²¹ Compared with the U.S. adult population, Hispanic and White, non-Hispanic members had higher rates of obesity, whereas Black, non-Hispanic members had an obesity rate that is equal to the national average.
- Obesity rates by MCO-SA group varied from 44 percent in Superior-Dallas to 59 percent in Superior-Bexar, as shown in **Table B1** in **Appendix B**. The obesity rate for each MCO-SA was above the national average of 36 percent.

Figure 2. Body Mass Index Classification from Member-Reported Height and Weight



Activities of Daily Living

Activities of daily living are an important component of health status for individuals who are older and chronically ill. Functional limitations with routine and personal care needs, for instance, could suggest disability and dependence on others.

- Nearly two-thirds of survey respondents indicated they have a physical or medical condition that seriously interferes with their independence, participation in the community, or quality of life (65 percent).
- Over half of survey respondents indicated they needed help with their routine needs, including everyday household chores, shopping, or getting around for other purposes (52 percent).

- Approximately one-third of survey respondents indicated they needed the help of others with their personal care needs, including eating, dressing, or getting around the house (33 percent).

Pain and Mobility

Members were asked questions about functional limitations caused by pain or fatigue. Pain and fatigue are important indicators of health status because they put an individual at increased risk of disability.

- Nearly half of surveyed members reported that pain “usually” or “always” limited their ability to do the things they need to do (49 percent).
- Forty-two percent of members reported that fatigue “usually” or “always” limited their ability to do the things they need to do.

Members were also asked questions about their mobility limitations, which are physical conditions that interfere with an individual’s ability to function in his or her environment.

- Thirty-nine percent of members reported that they needed mobility equipment, including items such as a wheelchair, scooter, or cane, to move around their home or community.
- Only one-third of members reported that they were able to walk a quarter mile (32 percent). Among these members, 22 percent reported that they needed assistance to walk a quarter mile.

The findings regarding activities of daily living, pain, and mobility indicate that a majority of STAR+PLUS members have conditions that interfere with their ability to participate in daily life. This is of particular relevance for the STAR+PLUS program, given that nearly one in three members reported that they live alone.

Access to and Timeliness of Care

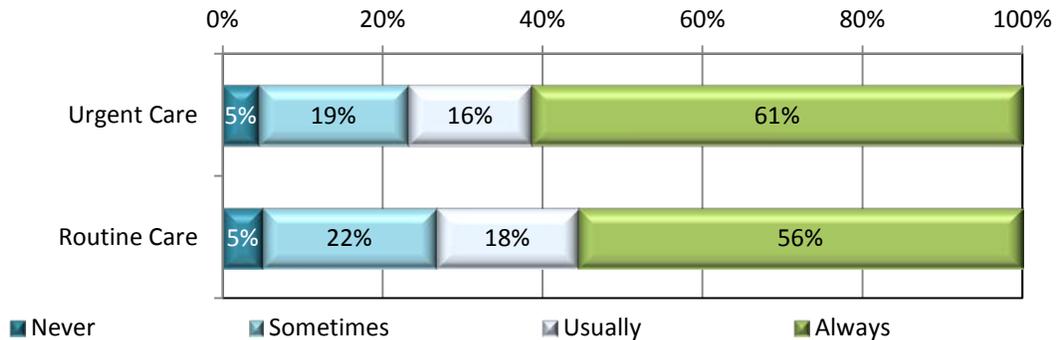
This section provides members’ reports of access to and timeliness of health services delivered through their STAR+PLUS MCOs and providers, including urgent and routine care, specialist care, specialized services, and prescription medicines.

Urgent and Routine Care

Members reported using both urgent and routine care services in the last six months. Half of members said they had an illness, injury, or condition that required urgent medical care (52 percent), and three out of four members said they made appointments for their health care at a doctor’s office or clinic (77 percent).

Figure 3 shows member satisfaction with two aspects of timeliness of care: (1) how often members who needed care right away got care as soon as they thought they needed; and (2) how often members who did not need care right away got an appointment for health care at their doctor’s office or clinic as soon as they thought they needed.

Figure 3. Percent of STAR+PLUS Members Who Said They Got Urgent and Routine Care As Soon As They Thought They Needed



These two survey items are HHSC Performance Dashboard indicators. (See **Table B6** in **Appendix B** for individual MCO-SA group performance on these and other dashboard indicators.)

- Good Access to Urgent Care.* Seventy-seven percent of members who needed care right away for an illness, injury, or condition reported that they “usually” or “always” received care as soon as they thought they needed. This percentage is lower than the HHSC Dashboard standard of 81 percent. The percentage of STAR+PLUS members with good access to urgent care ranged from 71 percent in Molina-Bexar to 83 percent in Amerigroup-Travis, although differences across MCO-SA groups were not statistically significant. Three of the 14 MCO-SA groups performed at or above the HHSC Dashboard standard for *Good Access to Urgent Care*.
- Good Access to Routine Care.* Seventy-three percent of members reported that they “usually” or “always” were able to make a routine appointment as soon as they thought they needed. This percentage is lower than the HHSC Dashboard standard of 80 percent. The percentage of members with good access to routine care ranged from 69 percent in Molina-Dallas to 80 percent in Molina-Harris, although differences across MCO-SA groups were not statistically significant. Only Molina-Harris met the HHSC Dashboard standard for *Good Access to Routine Care*.

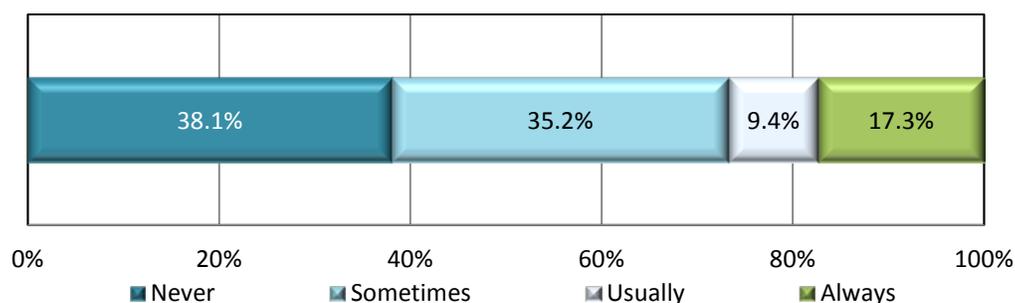
The above indicators also represent the individual items that comprise the CAHPS® composite *Getting Care Quickly*. Three out of four members reported “usually” or “always” having positive experiences with *Getting Care Quickly* (75 percent), which is below the 80 percent reported for this composite measure in Medicaid plans nationally.

Getting Care Quickly was also calculated on a 3-point scale following NCQA specifications. The mean score for this CAHPS® composite was 2.3 (SD = 0.80). Differences among MCO-SA groups on this composite were neither statistically nor meaningfully significant. (Refer to **Table B2** in **Appendix B** for these and other composite score means across MCO-SA groups.)

Members reported the number of days they usually had to wait between making an appointment for routine care and actually seeing a health provider. About half of members said they were able to get an appointment with a health provider within three days (48 percent), whereas one-third of members said they had to wait longer than one week to get an appointment (33 percent).

For some members, access to providers was hindered by provider hours and availability (see **Figure 4**). When asked how often they had to wait for an appointment because their provider worked limited hours or had few appointment slots available, about one-third of members said they “never” had to wait for an appointment (38 percent), another third said they “sometimes” had to wait for an appointment (35 percent), and the remaining 27 percent said they “usually” or “always” had to wait.

Figure 4. How Often Members Waited for a Routine Appointment Because Provider Worked Limited Hours or Had Few Available Appointments



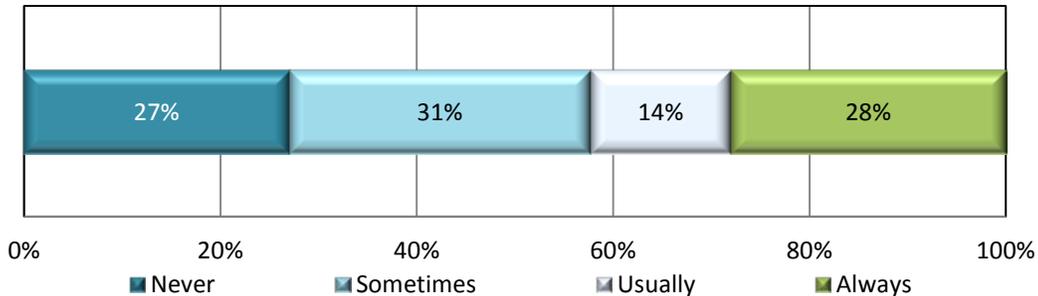
Members were also asked about their experiences seeking after-hours care. Seventeen percent of members said they needed to visit a doctor’s office or clinic for after-hours care. Among these members, less than half said it was “usually” or “always” easy to get after-hours care (45 percent).

Lastly, members were asked how often they were seen within 15 minutes of their appointment time in the past six months (**Figure 5**). This question is an HHSC Dashboard indicator for the STAR+PLUS program, as shown on **Table B6** in **Appendix B**.

- *No Wait to be Taken to the Exam Room Greater than 15 Minutes.* Overall, 28 percent of members reported having no wait greater than 15 minutes before being taken to the exam room, which is lower than the HHSC Dashboard standard of 42 percent. The percentage of members who reported waiting no longer than 15 minutes ranged from 23 percent in Superior-Bexar to 34 percent in Amerigroup-Travis, although differences

across MCO-SA groups were not statistically significant. None of the MCO-SA groups met the HHSC Dashboard standard for this measure.

Figure 5. How Often Members Waited 15 Minutes or Less to be Taken to the Exam Room



Members were also asked about their use of emergency room services. Nearly half of the survey respondents said they had visited the emergency room at least once to get care in the last six months (49 percent), and a third of respondents reported visiting the emergency room on multiple occasions (32 percent).

Of members who visited the emergency room at least once, only one-third said that they had contacted their personal doctor before going to the emergency room (32 percent). More than a third of members reported that they used emergency room services because they could not get an appointment with their doctor in a timely manner (39 percent), which suggests that at least some of these visits could have been prevented with increased access to ambulatory care providers.

Members who said that they had visited the emergency room were asked to rate their emergency room care on a scale of 0 to 10. Half of those members gave a rating of 9 or 10 (50 percent). The mean emergency room care rating was 7.6 (SD = 2.88).

Specialist Care

Almost half of members reported that they tried to make an appointment to see a specialist in the last six months (46 percent). Among these members, 61 percent indicated that it was “usually” or “always” easy to get a specialist appointment. Members were also asked about their access to specialist referrals. This question is an HHSC Performance Dashboard indicator.

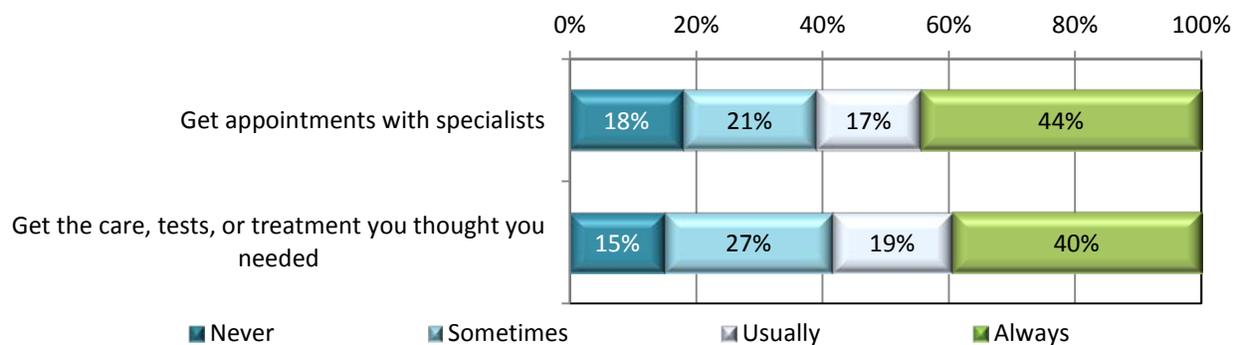
- Good Access to Specialist Referrals.* Sixty-one percent of members reported it was “usually” or “always” easy to get a referral to a specialist they needed to see. This percentage is lower than the HHSC Dashboard standard of 73 percent for this indicator. The percentage of STAR+PLUS members who had good access to specialist referrals differed among the MCO-SA groups and ranged from 44 percent in Superior-Dallas to 70 percent in Amerigroup-Harris (**Table B6 in Appendix B**). None of the 14 MCO-SA groups performed at or above the HHSC Dashboard standard for this item.

When asked to rate their specialist on a scale of 0 to 10, 57 percent of members gave a rating of 9 or 10. This percentage is lower than the 62 percent of the national Medicaid population who gave their specialist a rating of 9 or 10. The mean specialist rating in STAR+PLUS was 7.9 (SD = 2.97). The percent of STAR+PLUS members who gave their specialist a rating of 9 or 10 differed among the MCO-SA groups.²²

Figure 6 shows member satisfaction with two aspects of access to needed care: (1) how often it was easy to get appointments with specialists; and (2) how often it was easy to get the care, tests, or treatment they thought they needed through their health plan. These items comprise the CAHPS® composite *Getting Needed Care*. Combining responses to both questions, 60 percent of members “usually” or “always” had positive experiences with *Getting Needed Care*, a percentage lower than that of the national Medicaid population (76 percent).

Getting Needed Care was also calculated on a three point scale following NCQA specifications. The mean score for this CAHPS® composite was 2.0 (SD = 0.85). Averages for this composite differed among MCO-SA groups (see **Table B2** in **Appendix B**).²³

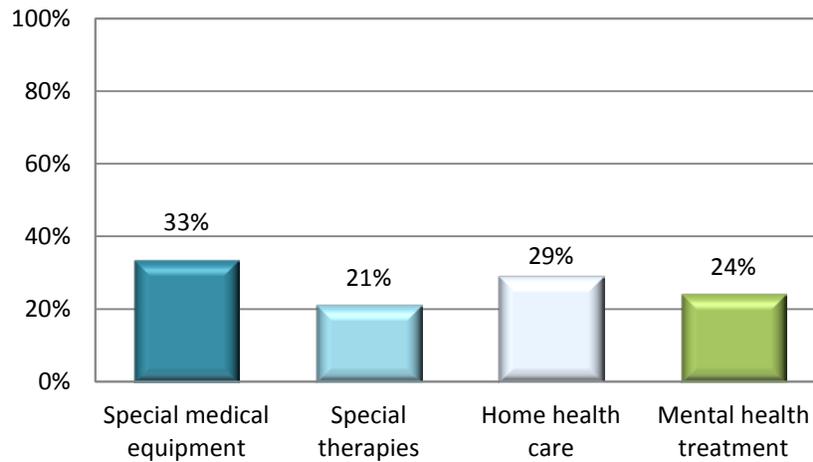
Figure 6. Percent of STAR+PLUS Members Reporting How Often It Was Easy To Get Appointments with Specialists or Get Care, Tests, or Treatment



Specialized Services

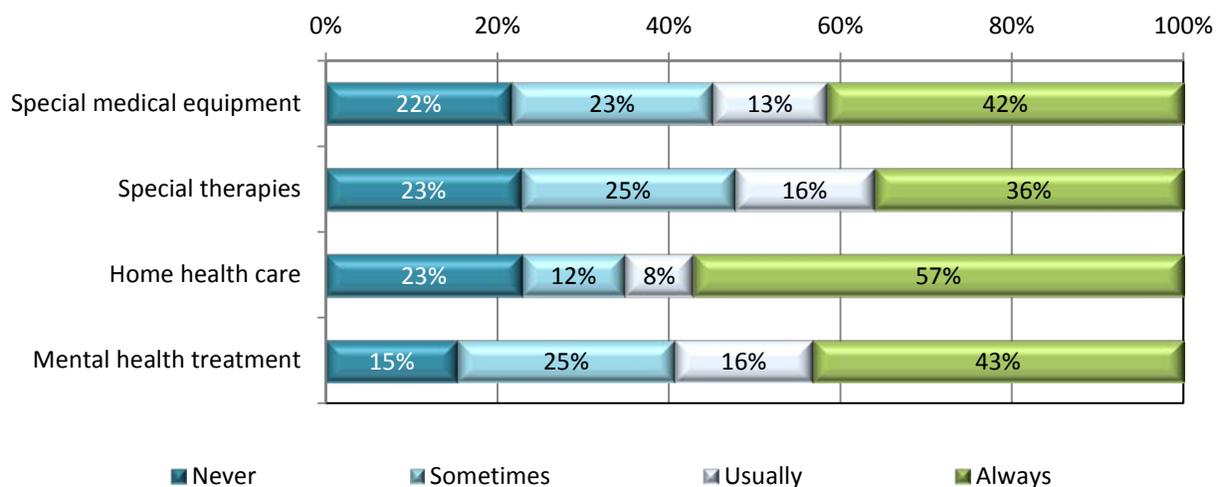
Figure 7 shows the percentage of STAR+PLUS members who needed specialized services. The most-utilized specialized services were medical equipment (such as a cane, a wheelchair, or oxygen equipment) (33 percent), and home health care or assistance (29 percent). Fewer members required special therapies (21 percent) or mental health treatment (24 percent).

Figure 7. The Percentage of STAR+PLUS Members Needing Specialized Services



- Members who said that they used specialized services reported how easy it was to get the specialized services they needed (**Figure 8**). Good access to specialized services – defined as a response of “usually” or “always” – was highest for home health care (65 percent), followed by mental health treatment (59 percent) and special medical equipment (55 percent).

Figure 8. STAR+PLUS Member Responses for How Easy It Was to Get Specialized Services



Two of these survey items are HHSC Performance Dashboard indicators for STAR+PLUS. (See **Table B6** in **Appendix B** for individual MCO-SA group performance on these and other HHSC Dashboard indicators.) At the plan code level, denominators for these measures met the minimum criterion for reporting (n=30), but were low compared to other HHSC Dashboard

indicators (all less than 100). The estimates for these measures therefore have lower reliability when making inferences to the population.

- *Good Access to Special Therapies.* Fifty-two percent of STAR+PLUS members needing special therapies said it was “usually” or “always” easy to get this therapy. This percentage is lower than the HHSC Dashboard standard of 66 percent for this indicator. The percentage of STAR+PLUS members who had good access to special therapies ranged from 33 percent in Molina-Dallas to 63 percent in Superior-Nueces. None of the 14 MCO-SA groups met the HHSC Dashboard standard for this survey item.
- *Good Access to Behavioral Health Treatment or Counseling.* Fifty-nine percent of STAR+PLUS members needing behavioral health treatment or counseling said it was “usually” or “always” easy to get this service. This percentage is lower than the HHSC Dashboard standard of 63 percent for this indicator. The percentage of STAR+PLUS members who had good access to behavioral health treatment or counseling ranged from 47 percent in Amerigroup-Tarrant to 76 percent in HealthSpring-Tarrant. Seven of the 14 MCO-SA groups met the HHSC Dashboard standard for this survey item.

Prescription Medicines

Seventy-nine percent of STAR+PLUS members said they got new prescription medicines or refilled a medication during the past six months. Among these members, 82 percent said it was “usually” or “always” easy to get prescription medicine from their health plan.

Members’ Overall Satisfaction with Their Health Care

When asked to rate all their health care in the past six months on a scale of 0 to 10, 48 percent of members gave a rating of 9 or 10. This is comparable to the 50 percent of the national Medicaid population who gave their health care a rating of 9 or 10. The mean rating for all the health care members received in STAR+PLUS was 7.9 (SD = 2.46).

Patient-Centered Medical Home

This section examines STAR+PLUS member experiences with receiving care from a patient-centered medical home model. In a joint statement released in 2007, the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Physicians, and the American Osteopathic Association identified seven principles of the medical home model:²⁴

- Personal physician
- Physician-directed medical practice
- Whole person orientation
- Care that is coordinated and/or integrated across settings and providers
- Quality and safety
- Enhanced access (e.g., open scheduling, extended hours)

- Payment

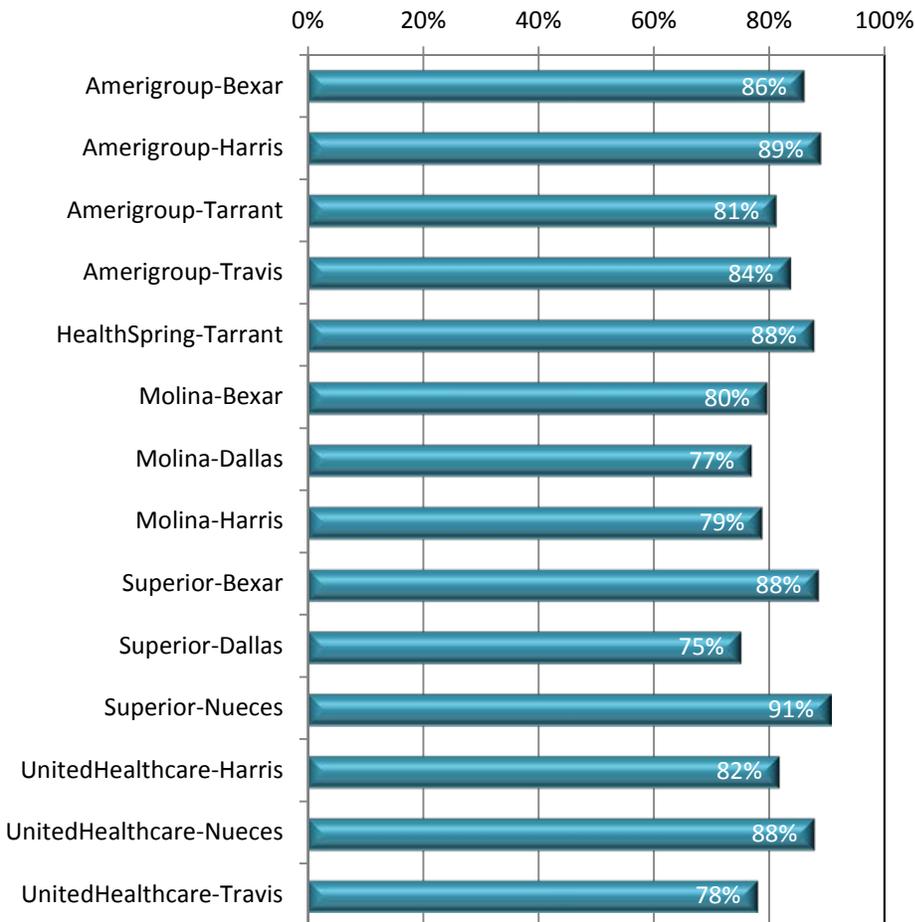
This survey addressed different components of the medical home model, including having an ongoing relationship with a personal doctor, having access to advice and care during and after regular business hours, and receiving high-quality, patient-centered, and compassionate care from their personal doctors and office staff.

Presence of a Usual Source of Care

Approximately four out of five members reported having a personal doctor (82 percent), indicating a usual source of care. **Figure 9** presents the percentage of STAR+PLUS members who reported having a personal doctor for each MCO-SA.²⁵ There was a significant difference among the MCO-SA groups, with the percentage of members who had a personal doctor ranging from 75 percent in Superior-Dallas to 91 percent in Superior-Nueces.²⁶

Among members who reported having a personal doctor, 59 percent reported that they have been going to their personal doctor for two or more years, indicating the presence of a continuous, long-term relationship with their provider. However, greater than half of members said that they did not have the same personal doctor that they had before they joined their STAR+PLUS health plan (59 percent). These findings indicate that the majority of STAR+PLUS members were not able to maintain a usual source of care while enrolling in their present health plan.

Figure 9. The Percentage of STAR+PLUS Members Who Reported Having a Personal Doctor by MCO-SA



STAR+PLUS members who had a personal doctor answered some additional questions regarding seeking help and advice from their doctor's office:

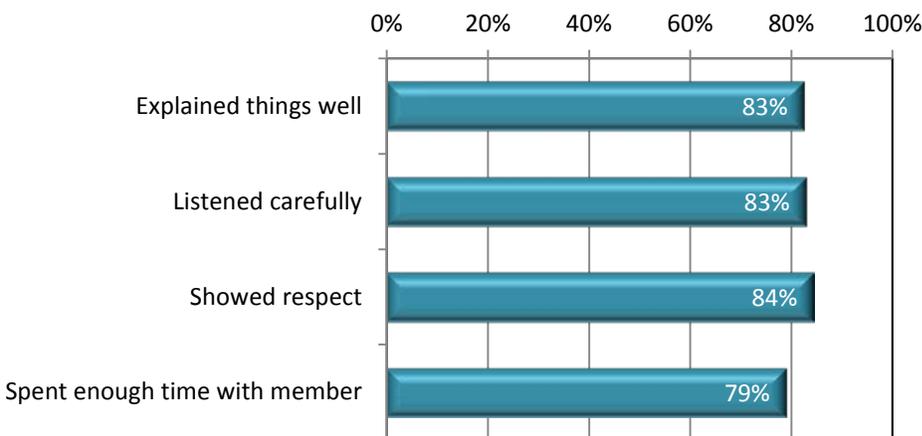
- Nearly two out of three members reported that they phoned their personal doctor's office during regular office hours to get help or advice (63 percent), and most of these members said they "usually" or "always" got the help or advice they needed (72 percent).
- Twenty-two percent of members reported that they phoned their personal doctor's office after regular office hours to get help or advice. Sixty-six percent of these members said they "usually" or "always" got the help or advice they needed.

Satisfaction with Doctors' Communication

This section reports members' satisfaction with their personal doctor, which is assessed by the four CAHPS® survey questions that comprise the composite *How Well Doctors Communicate*. This composite assesses how often a member's personal doctor explains things well, listens carefully, shows respect, and spends enough time with the member. Results are based on the percentage of members who reported that they "usually" or "always" had positive communication experiences with their personal doctor (**Figure 10**).

Combining responses to all four questions, 82 percent of STAR+PLUS members "usually" or "always" had positive experiences with *How Well Doctors Communicate*. This is lower than the Medicaid national average of 88 percent.

Figure 10. How Well Doctors Communicate – The Percentage of Members Who Reported Their Personal Doctor "Usually" or "Always" Explained Things Well, Listened Carefully, Showed Respect, and Spent Enough Time with Them

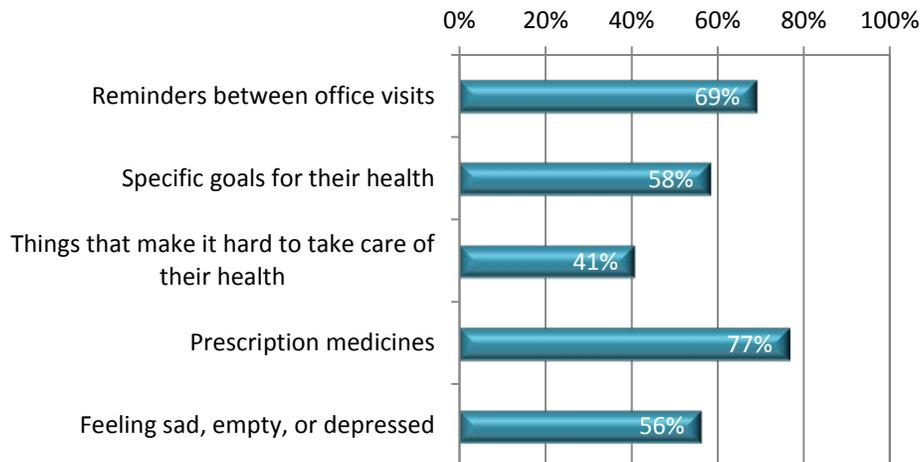


How Well Doctors Communicate was also calculated on a 3-point scale following NCQA specifications. Following NCQA specifications, the mean score for *How Well Doctors Communicate* was 2.54 (SD = 0.63) out of 3.00. Differences among the MCO-SA groups on this measure were statistically significant (**Table B2 in Appendix B**).

Communication with Provider Office Personnel

Members were asked questions that indicate whether personnel at their personal doctor's office communicated with them about appointments, prescription medicines, and issues regarding their health (**Figure 11**). Office personnel include any employees who interact with patients, such as doctors, nurses, physician assistants, and office staff.

Figure 11. The Percentage of Members Who Reported Their Providers' Office Communicated with them Regarding Different Aspects of their Health and Health Care



Approximately three in four members reported that:

- Someone in their provider's office spoke with them at each visit about the prescription medicines they were taking (77 percent).
- They received reminders from their provider's office between visits (69 percent).

Slightly more than half of members reported that:

- Someone in their provider's office spoke with them about specific goals for their health (58 percent).
- Someone at their provider's office asked them if there was a period of time when they felt "sad", "empty", or "depressed" (56 percent).

Less than half of members reported that:

- Someone in their provider's office asked them if there were things that made it hard for them to take care of their health (41 percent).

Preventive Care and Health Promotion

Members were asked several questions regarding preventive health care. STAR+PLUS members were asked how long it had been since they last visited a doctor for a routine checkup. The majority of members reported having had a routine checkup within the past year (70 percent).

Forty-two percent of respondents said they smoked cigarettes or used tobacco. The percentage of members who were advised to quit smoking by a doctor or other health provider at least once during the past six months is an HHSC Performance Dashboard indicator for STAR+PLUS.

- *Advising Smokers to Quit.* Sixty-nine percent of the members who reported they smoke said that they had been advised to quit smoking by a doctor or other health provider at least once during the past six months. This percentage is approximately equal to the HHSC Dashboard standard of 70 percent. The percentage of STAR+PLUS members who were advised to quit smoking ranged from 60 percent in Amerigroup-Bexar and Superior-Dallas to 76 percent in Molina-Harris, although MCO-SA group differences were not statistically significant (**Table B6** in **Appendix B**). Seven of the 14 MCO-SA groups met the HHSC Dashboard standard for this survey item.

Respondents who smoke were also asked to indicate the number of visits where their doctor recommended medication or specific strategies to assist them in quitting smoking.

Approximately one-third of respondents said that their doctor recommended medication to help them quit smoking on at least one occasion (37 percent). Forty-two percent of respondents said that their doctor recommended or discussed strategies other than medication to help them quit smoking.

Shared Decision-Making

Approximately half of STAR+PLUS members said they received care from a doctor or other health provider besides their personal doctor (55 percent). Among these members, the majority said their personal doctor “usually” or “always” seemed informed and up-to-date about the care they received from these other providers (68 percent).

About two-thirds of STAR+PLUS members said that decisions were made about their health care in the last six months (62 percent). Among these members, 81 percent said they “usually” or “always” were involved as much as they wanted in decisions about their health care, and 73 percent said it “usually” or “always” was easy to get their doctors to agree with them on the best way to manage their health problems.

Members’ Satisfaction with Their Personal Doctor

Sixty-four percent of members rated their personal doctor a 9 or 10 on a scale from 0 to 10, with 0 representing the worst personal doctor possible and 10 representing the best personal doctor possible. This is comparable to the 62 percent of the national Medicaid population who gave their personal doctor a rating of 9 or 10. The mean personal doctor rating in STAR+PLUS was 8.5 (SD = 2.26).

***Service Coordination*¹**

Having Service Coordination

¹ In October 2012, HHSC began a process to revise service coordination requirements in a manner expected to address many of the concerns identified in this survey. This process was completed and the changes were implemented October 1, 2013.

Awareness of service coordination. Less than half of respondents were aware that their health plan offers service coordination to its members (46 percent). However, all STAR+PLUS members have the option to be assigned a service coordinator upon request. Members who were aware of service coordination were asked how they heard about their health plan's service coordination.

- Forty-one percent reported that they received a letter in the mail from their health plan explaining service coordination.
- Nearly one in five members reported that they received a call from a service coordinator (19 percent).
- Seventeen percent reported that they read about it in the health plan's handbook or other materials.
- Five percent reported that they received a visit from a service coordinator.
- The remaining 18 percent said that they found out about service coordination another way.

Having a service coordinator. Approximately one in three STAR+PLUS members reported that they had a service coordinator (31 percent). Among these members, 74 percent had been contacted by their service coordinator in the last six months.

Members with a service coordinator were also asked if they needed service coordination in the past six months. Greater than half said that they needed such services in the past six months (54 percent). The percent of members who “usually” or “always” received service coordination help as soon as they thought it was needed is an HHSC Performance Dashboard indicator for STAR+PLUS:

- *Good Access to Service Coordination.* Sixty-seven percent of STAR+PLUS members who needed service coordination in the past six months said they “usually” or “always” received service coordination as soon as they thought they needed it. This rate is higher than the HHSC Dashboard standard of 63 percent for this indicator. The percentage of STAR+PLUS members with good access to service coordination ranged from 44 percent in Molina-Bexar to 74 percent in UnitedHealthcare-Travis (**Table B6 in Appendix B**). Eleven of the 14 MCO-SA groups met the HHSC Dashboard standard for this survey item. Members eligible for this measure represent a small sub-group of the STAR+PLUS population (16 percent). Denominators at the plan code level are relatively small compared to other HHSC Dashboard indicators (less than 100) and therefore result in less reliable population estimates.

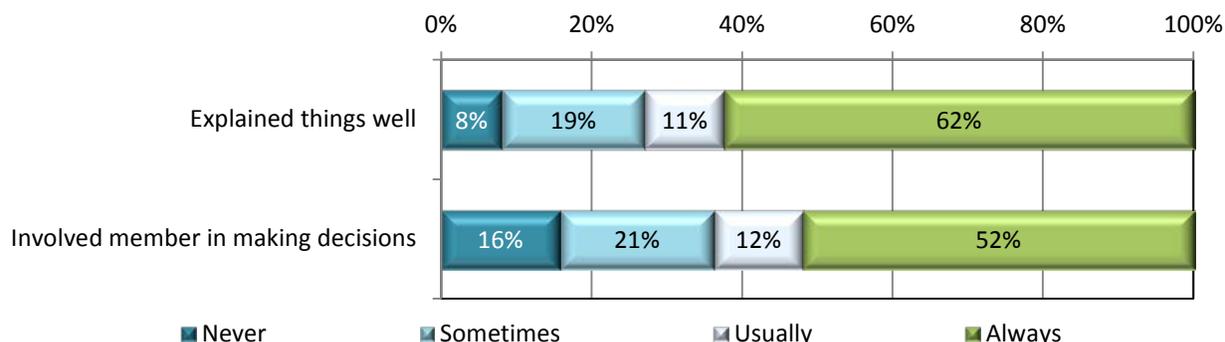
Among members without a service coordinator, 17 percent reported that someone other than a service coordinator from their STAR+PLUS health plan helped to arrange services for them. Help was most commonly received from a family member or friend (41 percent).

Members without a service coordinator were also asked if they would like a service coordinator from their STAR+PLUS health plan to help arrange services for them. Greater than half reported that they would like a service coordinator to help with such services (58 percent).

Satisfaction with Service Coordination

Figure 12 shows members’ experiences with two aspects of their service coordination that are relevant to the patient-centered medical home – having a service coordinator who explains things in a way they can understand, and having a service coordinator who involves them in making decisions about their services. These items were asked specifically to members who have a service coordinator. Approximately three in four members said their service coordinator “usually” or “always” explained things well (73 percent). Sixty-four percent of members said their service coordinator “usually” or “always” involved them in making decisions about their services.

Figure 12. Percentage of STAR+PLUS Members Who Said Their Service Coordinator Explained Things Well and Involved Them in Making Decisions



Members were asked to indicate how satisfied they were with the help they received from their service coordinator. Eighty-three percent of members reported that they were “satisfied” or “very satisfied” with their service coordinator. A significant difference in satisfaction was found by education level:²⁷

- Ninety percent of members with less than a high school education were “satisfied” or “very satisfied” with their service coordinator.
- Eighty-one percent of members with a high school education or equivalent were “satisfied” or “very satisfied” with their service coordinator.
- Seventy-two percent of members with some college or a college degree were “satisfied” or “very satisfied” with their service coordinator.

Health Plan

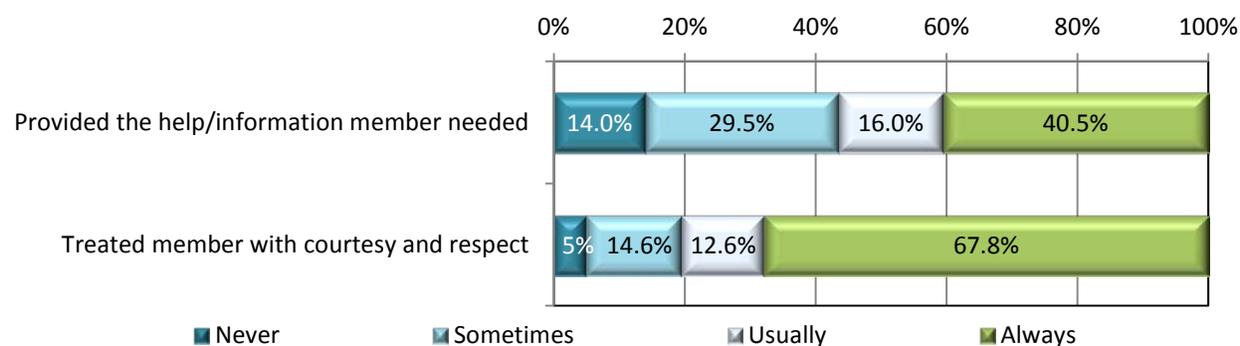
The survey assessed members' experiences and satisfaction with various aspects of their health plan, including health plan information and customer service; approval for care, tests, or treatment; and transportation services.

Health Plan Information and Customer Service

One out of three members said they tried to get help or information from their health plan's customer service in the past six months (36 percent). Of members who said they called customer service, one in four members said it took them only one call to get the help or information they wanted (26 percent), half of members said it took them two or more calls to get the help or information they wanted (50 percent), and one in four members said they were still waiting for help (23 percent).

Figure 13 shows member satisfaction with two aspects of STAR+PLUS health plan customer service: (1) how often customer service gave members the help or information they needed; and (2) how often customer service treated members with courtesy and respect. Over half of members said they "usually" or "always" got the help or information they needed from customer service (57 percent), and 14 percent said that they "never" got the information they needed. Members were satisfied with how they were treated by customer service, with 80 percent reporting that customer service "usually" or "always" treated them with courtesy and respect.

Figure 13. Percentage of STAR+PLUS Members Who Said Their Health Plan's Customer Service Provided Help/Information and Treated Them with Courtesy and Respect



The above items comprise the CAHPS[®] composite *Health Plan Information and Customer Service*. Combining responses to both questions, 68 percent of STAR+PLUS members "usually" or "always" had positive experiences with *Health Plan Information and Customer Service*, which is below the 80 percent reported for Medicaid plans nationally.

Health Plan Information and Customer Service was also calculated on a 3-point scale following NCQA specifications. The mean score for this CAHPS[®] composite was 2.2 (SD = 0.73). Averages for this composite differed among MCO-SA groups²⁸ (see **Table B2** in **Appendix B**).

Health Plan Approval

Half of members said they tried to get care, tests, or treatment through their STAR+PLUS health plan in the past six months (51 percent). Among these members, 58 percent said it was “usually” or “always” easy to get the care, tests, or treatment they needed through their health plan. The percentage of members who had no delays for health plan approval is an HHSC Performance Dashboard Indicator for STAR+PLUS:

- *No Delays in Health Care while Waiting for Health Plan Approval:* Thirty-eight percent of STAR+PLUS members reported having no delays in their health care while waiting for approval from their health plan. This percentage is below the HHSC Dashboard standard of 57 percent for this indicator. The percentage of STAR+PLUS members who had no delays for an approval ranged from 27 percent in Amerigroup-Bexar to 43 percent in Amerigroup-Travis and Molina-Dallas, although differences across MCO-SA groups were not statistically significant (see **Table B6** in **Appendix B**). None of the 14 MCO-SA groups met the HHSC Dashboard standard for this survey item.

Transportation

A third of members said that they phoned their STAR+PLUS health plan to get help with transportation in the last six months (31 percent). Among those who made calls for such assistance, 67 percent said they “usually” or “always” received the transportation services they needed.

Members’ Satisfaction with their STAR+PLUS Health Plan

When asked to rate their STAR+PLUS health plan on a scale of 0 to 10, 55 percent of members gave a rating of 9 or 10. This percentage is comparable to the percent of the national Medicaid population who gave their health plan a rating of 9 or 10 (56 percent). The mean health plan rating in STAR+PLUS was 8.1 (SD = 2.53). The percent of STAR+PLUS members who gave their health plan a rating of 9 or 10 differed among the MCO-SA groups.²⁹

Disparities in CAHPS® Composites and Ratings by MCO-SA Group

This section elaborates on findings of important MCO-SA group differences for several CAHPS® composites and member ratings (as reported in **Tables B2** and **B7** in **Appendix B**).

CAHPS® Composites. Of the four core CAHPS® composites calculated, three (all but *Getting Care Quickly*) differed by MCO-SA group.

- *Getting Needed Care* composite means ranged from 1.86 in Molina-Dallas to 2.18 in UnitedHealthcare-Harris on a 3-point scale. Post hoc analyses revealed 11 statistically significant and meaningful pairwise comparisons (Cohen’s $d > 0.30$). (See **Table B3** of **Appendix B** for effect sizes of meaningful comparisons for each composite.) The largest effect sizes were $d = 0.38$ for the comparison between UnitedHealthcare-Harris and Molina-Dallas and between UnitedHealthcare-Harris and Superior-Dallas.

- *How Well Doctors Communicate* composite means ranged from 2.41 in Molina-Dallas to 2.63 in Molina-Harris on a 3-point scale. Post hoc analyses revealed three significant and meaningful pairwise comparisons (Cohen's $d > 0.30$). (See **Table B3** in **Appendix B**.) The largest effect size was $d = 0.34$ for the comparison between Molina-Harris and Molina-Dallas.
- *Health Plan Information and Customer Service* composite means ranged from 2.04 in Amerigroup-Tarrant to 2.39 in Superior-Nueces on a 3-point scale. Post hoc analyses revealed 13 significant and meaningful pairwise comparisons (Cohen's $d > 0.30$). (See **Table B3** in **Appendix B**.) The largest effect size was $d = 0.52$ for the comparison between Superior-Nueces and Amerigroup-Tarrant.

CAHPS® Ratings. Of the four core ratings calculated, three ratings (all but *Overall Health Care Rating*) differed by MCO-SA group.

- *Personal Doctor Rating.* Members giving a rating of 9 or 10 ranged from 55 percent in Molina-Dallas to 71 percent in Superior-Nueces.³⁰
- *Specialist Rating.* Members giving a rating of 9 or 10 ranged from 43 percent in Superior-Dallas to 67 percent in UnitedHealthcare-Harris.³¹
- *Health Plan Rating.* Members giving a rating of 9 or 10 ranged from 41 percent in HealthSpring-Tarrant to 66 percent in Superior-Nueces.³²

Furthermore, the MCO-SA groups varied with regard to how many ratings met or surpassed those of the national Medicaid population.

- The groups with the fewest ratings meeting the national averages were: HealthSpring-Tarrant, Molina-Dallas, Superior-Dallas, Amerigroup-Tarrant, and Molina-Bexar.
- The groups with the most ratings meeting or surpassing the national averages were Amerigroup-Harris, Amerigroup-Travis, UnitedHealthcare-Harris, Superior-Bexar, and Superior-Nueces.

Trends across the differences in CAHPS® composites and ratings reported here show that Molina-Dallas, Superior-Dallas, and Amerigroup-Tarrant performed consistently among the lowest, whereas UnitedHealthcare-Harris, Superior-Nueces, and Amerigroup-Harris performed consistently among the highest. The number and magnitude of the differences across the MCO-SA groups, however, suggests a need to ensure consistency in the quality of health care delivered to members across all MCO-SA groups.

Summary Points and Recommendations

This report provides results from the FY 2012 STAR+PLUS Member Survey regarding: (1) demographic and household characteristics of STAR+PLUS members; (2) the health status of STAR+PLUS members, including physical and mental health, body mass index, and activities of daily living; and (3) member experiences and satisfaction with the access and timeliness of their routine, urgent, and specialized care; elements of the patient-centered medical home, such as a usual source of care, providers' communication, preventive care and health promotion, and shared decision-making; access to and utilization of service coordination; and experiences with their health plan, including health plan information, customer service, and transportation.

Demographic and household characteristics

- **Member demographics.** A majority of the members were female (61 percent). The mean age among members was 48 years old. Black, non-Hispanic members represented the largest racial/ethnic group (36 percent), followed by Hispanics (31 percent), and White, non-Hispanics (25 percent). Nine percent of members were of Other, non-Hispanic race/ethnicity.
- A vast majority of members were born in the United States (92 percent). Among non-native members, the average number of years that they have lived in the United States was 30 years.
- A majority of members also reported that they spoke mainly English at home (88 percent). However, 10 percent of members reported that they spoke mainly Spanish at home.
- Nearly half of members reported that they did not have a high school education (45 percent). Approximately one-third had a high school degree (36 percent), and the remaining 20 percent had some college or a college degree.
- Respondents most commonly reported their marital status as single (39 percent), followed by divorced (21 percent). Married individuals represented 16 percent of the sample.
- **Member household characteristics.** Approximately one-third of members reported that they lived alone (30 percent). In addition, half of members reported that they lived in a single-parent household (50 percent). Rented housing was reported as the most common type of housing (53 percent).

Health status

- **Overall health and mental health.** Health ratings in STAR+PLUS were very low. Two-thirds of members rated their overall health as "fair" or "poor" (64 percent). Approximately half of members rated their mental health as "fair" or "poor" (51 percent). In addition, the average score among respondents for the *Emotional Well-Being* scale was 57.1 out of 100, indicating a low mental health status.

- **Body mass index.** Half of members were classified as obese (50 percent). Reported obesity rates were higher than national averages and greater for women (57 percent) than men (40 percent). Hispanic members had the highest rate of obesity (57 percent).
- **Activities of daily living.** Approximately two-thirds of members reported having a physical or mental condition that interfered with their independence (65 percent). Half of members needed help with their routine needs (52 percent), and one-third of members needed help with their personal care needs (33 percent).
- **Pain.** Approximately half of respondents indicated that pain usually or always limited their ability to do the things they need to do (49 percent), and 42 percent indicated that fatigue limited their ability to do the things they need to do.
- **Mobility.** Thirty-nine percent of members needed mobility equipment, such as a wheelchair or cane, to move around their home or community. Only one-third of respondents reported that they were able to walk a quarter mile (32 percent).

Access to and timeliness of care

- **Getting care quickly.** Three out of four members “usually” or “always” had positive experiences on the CAHPS® composite *Getting Care Quickly* (75 percent); this percentage falls short of the national Medicaid average (80 percent).
- **Good access to urgent care.** About three out of four members reported they “usually” or “always” received urgent care as soon as they needed (77 percent). Three MCO-SAs performed at or above the HHSC Dashboard standard of 81 percent for this indicator.
- **Good access to routine care.** About three out of four members reported they were “usually” or “always” able to make a routine appointment (73 percent). Only one MCO-SA group met the HHSC Dashboard standard of 80 percent for this indicator.
- **Appointment availability and provider hours.** About half of the members reported getting an appointment within three days (48 percent), whereas a third of members said they had to wait longer than one week to get an appointment (33 percent). Thirty-eight percent of members reported “never” having appointment delays caused by limited hours or few appointments, 35 percent reported “sometimes” waiting, and 27 percent reported “usually” or “always” waiting for an appointment.
- **Office wait.** Only about one in four members reported waiting less than 15 minutes to be taken to the exam room (28 percent), which is well below the HHSC Dashboard standard of 42 percent. None of the MCO-SA groups met the HHSC Dashboard standard for this indicator.
- **Emergency room care.** Nearly half of members said that they had visited the emergency room to get care in the last six months (49 percent). More than a third of members said that they used the emergency room because they were unable to make an appointment with their doctor (39 percent). On a scale from 0 to 10, half of members gave their emergency room care a rating of 9 or 10, with an average of 7.6 (SD = 2.88).

- **Access to specialist care.** About half of members reported making an appointment with a specialist (46 percent). Most of these members said it was “usually” or “always” easy to make a specialist appointment (61 percent). Members rated their specialist on a scale from 0 to 10, with an average rating of 7.9 (SD = 2.97). Over half of members gave their specialist a rating of 9 or 10 (57 percent), which is comparable to the national Medicaid average of 62 percent.
- **Good access to specialist referral.** A majority of the members reported that it was “usually” or “always” easy to receive a referral for a specialist (61 percent), which is lower than the HHSC Dashboard standard for this indicator (73 percent). No MCO-SA group met the HHSC Dashboard standard for this item.
- **Getting needed care.** Sixty percent of members “usually” or “always” had positive experiences on the CAHPS® composite *Getting Needed Care*, which is below the national Medicaid average (76 percent). Access to needed care varied among the MCO-SA groups.
- **Access to specialized services.** Need for various specialized services was highest for special medical equipment (33 percent), followed by home health care or assistance (29 percent), mental health treatment (24 percent), and special therapies (21 percent). Good access to these services was highest for home health care (65 percent) and mental health treatment (59 percent).
- **Good access to special therapies.** About half of the members needing special therapy reported that it was “usually” or “always” easy to get this therapy (52 percent). This percentage is lower than the HHSC Dashboard standard of 66 percent.
- **Good access to behavioral health treatment or counseling.** Fifty-nine percent of STAR+PLUS members needing behavioral health treatment or counseling said it was “usually” or “always” easy to get this service. This percentage is lower than the HHSC Dashboard standard of 63 percent for this indicator.
- **Access to prescription medicines.** A large majority of the members who received prescription medication (new or refill) said it was “usually” or “always” easy to get prescription medications (82 percent).
- **Members’ rating of all their health care.** Members rated their overall health care in the past six months on a scale from 0 to 10, with an average rating of 7.9 (SD = 2.46). Forty-eight percent of the members gave a rating of 9 or 10, which is comparable to the national Medicaid average of 50 percent.

Patient-centered medical home

- **Presence of a usual source of care.** Approximately four in five respondents reported having a personal doctor (82 percent). Among these members, 59 percent reported having that doctor for at least two years.

- **Seeking help and advice.** Nearly two in three members phoned their doctor's office during regular office hours for help or advice (63 percent). Among these members, 72 percent reported "usually" or "always" receiving help. Twenty-two percent of members phoned their doctor's office after regular office hours for help or advice. Two-thirds of these members reported "usually" or "always" receiving help (66 percent).
- **Satisfaction with doctors' communication.** A majority of members reported "usually" or "always" having positive experiences on the CAHPS® composite *How Well Doctors Communicate* (82 percent). This percentage is lower than the national Medicaid average of 88 percent.
- **Communication with providers' office personnel.** About three in four members reported that someone in their provider's office spoke with them at each visit about the prescription medicines they are taking (77 percent), or sent them reminders between visits (69 percent). Slightly more than half of members reported that someone spoke with them about specific goals for their health (58 percent), or asked them if they felt "sad", "empty", or "depressed" (56 percent). Less than half of members said that someone asked them about things that make it hard for them to take care of their health (41 percent).
- **Preventive care and health promotion.** A majority of the participants reported having a routine checkup in the last year (70 percent). Forty-two percent of members in STAR+PLUS reported that they smoke cigarettes. Among these members, 69 percent reported that a doctor advised them to quit within the last six months. This percentage is approximately equal to the HHSC Dashboard standard of 70 percent.
- **Shared decision-making.** Approximately four in five members reported they "usually" or "always" were involved as much as they wanted in decisions about their health care (81 percent). Seventy-three percent of members reported that it was "usually" or "always" easy to get their doctors to agree on how to manage their health care problems.
- **Members' rating of their personal doctor.** Members gave their personal doctor an average rating of 8.5, on a scale from 0 to 10. Sixty-four percent of the members gave a rating of 9 or 10, which is comparable to the national Medicaid average of 62 percent.

Service coordination

- **Awareness of service coordination.** Only half of members were aware that their health plan offers service coordination (46 percent). Among members who were aware of service coordination, the most common way that they heard about such services was by receiving a letter in the mail from their health plan (41 percent).
- **Having service coordination.** Nearly one-third of members reported that they have a service coordinator (31 percent). Among these members, 74 percent had been contacted by their service coordinator in the past six months.

- **Good access to service coordination.** More than half of members reported they needed service coordination in the past six months (54 percent). Among these members, 67 percent reported that they had good access to service coordination.
- **Satisfaction with service coordination.** Nearly three-quarters of members reported that their service coordinator “usually” or “always” explained things well (73 percent). In addition, 64 percent of members reported that their service coordinator involved them in making decisions about their services. Eighty-three percent of members reported that they were “satisfied” or “very satisfied” with their service coordinator.

Health plan

- **Health plan information and customer service.** About two-thirds of members “usually” or “always” had positive experiences on the CAHPS® composite *Health Plan Information and Customer Service* (68 percent), which is below the national average of 80 percent. Satisfaction varied among the MCO-SA groups. Among members who called their health plan’s customer service, only one in four said they received all the information they needed in one call (26 percent), and one in four said they were still waiting for help after several calls (23 percent). The large majority of members said that customer service treated them with courtesy and respect (80 percent).
- **Health plan approval.** Thirty-eight percent of members reported having no delays in health care while waiting for health plan approval of services, which is below the HHSC Dashboard standard of 57 percent. None of the MCO-SA groups met the HHSC Dashboard standard for this indicator.
- **Transportation.** One in three members requested transportation assistance (31 percent); of these members, two-thirds said they got the services they needed (67 percent).
- **Members’ rating of their health plan.** On a scale from 0 to 10, 55 percent of members gave their STAR+PLUS health plan a rating of 9 or 10, with a mean rating of 8.1 (SD = 2.53). The percent of STAR+PLUS members who gave their health plan a rating of 9 or 10 differed among the MCO-SA groups.

Disparities in CAHPS® Composites and Ratings by MCO-SA

- **CAHPS® composites.** Three of the four CAHPS® composites differed by MCO-SA. *Getting Needed Care* composite averages ranged from 1.86 in Molina-Dallas to 2.18 in UnitedHealthcare-Harris. *How Well Doctors Communicate* scores ranged from 2.41 in Molina-Dallas to 2.63 in Molina-Harris. *Health Plan Information and Customer Service* scores ranged from 2.04 in Amerigroup-Tarrant to 2.39 in Superior-Nueces.
- **Ratings.** Three of the four core ratings differed by MCO-SA. For the *Personal Doctor Rating*, the percent of members with ratings of 9 or 10 ranged from 55 percent in Molina-Dallas to 71 percent in Superior-Nueces. For the *Specialist Rating*, the percent of members with ratings of 9 or 10 ranged from 43 percent in Superior-Dallas to 67 percent

in UnitedHealthcare-Harris. For the *Health Plan Rating*, the percent of members with ratings of 9 or 10 ranged from 41 percent in HealthSpring-Tarrant to 66 percent in Superior-Nueces.

- **Trends.** Trends across the differences in CAHPS® composites and ratings reported here show that Molina-Dallas, Superior-Dallas, and Amerigroup-Tarrant performed consistently among the lowest, whereas UnitedHealthcare-Harris, Superior-Nueces, and Amerigroup-Harris performed consistently among the highest. The sizeable differences in some of the domains suggest that quality of health care may need improvement in certain MCO-SA groups.

Recommendations

The EQRO recommends the following strategies to Texas HHSC for improving the delivery and quality of care for adults in the STAR+PLUS program. These strategies are relevant to improving coordination of care for members with chronic conditions and reducing long-term nursing home admissions, which are the HHSC's overarching goals for STAR+PLUS MCOs.

Patient-centered care. The percentage of members whose provider office personnel discussed health goals with them was low (58 percent). Controlling for member demographics, health status, and health plan membership, members in the Travis SA were more likely than members in other SAs to report having discussed their health goals. Furthermore, two-thirds of members who had a service coordinator said that their service coordinator “usually” or “always” involved them in making decisions about their services (64 percent).

To improve communication between providers and members about members' preferences – including health goals – STAR+PLUS health plans should ensure that providers in their networks are following validated physician-patient communication models such as the SEGUE model.³³ In addition, to improve shared decision-making in service coordination, HHSC should encourage MCOs to ensure that members are involved more fully in the development of their service plans. Research has found that models that emphasize patients' agreement with their service plans are associated with lower rates of functional decline and higher satisfaction with services.³⁴

Getting needed care. The percentage of members with positive experiences on the CAHPS® composite *Getting Needed Care* (60 percent) – which includes getting appointments with specialists and getting treatment, tests, or needed care – was lower than that of the national Medicaid population (78 percent). To improve scores on *Getting Needed Care*, STAR+PLUS MCOs should assess: (1) supply and demand of specialist providers to evaluate staffing needs; and (2) the urgency of the members' need to prioritize access to needed care.³⁵ To better determine the reasons why *Getting Needed Care* was low and how it could be improved, future surveys should include questions that more specifically assess why members have difficulties getting the care they need.

Health plan approval of services. Only 38 percent of STAR+PLUS members reported having no delays for approval, and no MCO-SA group met the HHSC Dashboard standard for *No Delays in Health Care while Waiting for Health Plan Approval* (57 percent). The American Medical Association recommends streamlining the authorization process for medical services by: (1) implementing standardized prior authorization forms; (2) making authorization requirements readily accessible; (3) making rules for authorization uniform across payers; (4) placing practical limits on medical record requests; (5) enforcing consistent response times for urgent and non-urgent circumstances; and (6) forming a consensus in the health care industry regarding operating rules and standard transactions. These practices could reduce the amount of time spent waiting for approval and could make the process easier for patients and providers.³⁶

Appendix A. Detailed Methodology

Sample selection procedures

The EQRO selected survey participants from a stratified random sample of adults 18 to 64 years old who were enrolled in the same STAR+PLUS MCO in Texas for six months or longer between July 2011 and December 2011. Following CAHPS[®] specifications, members having no more than one 30-day break in enrollment during this period were included in the sample. These criteria ensured that members would have sufficient experience with the program to respond to the survey questions.

Dual-eligible members, who are eligible for both Medicaid and Medicare benefits, were excluded from the sample. Based on EQRO findings from FY 2010 data, half of all STAR+PLUS members (53 percent) are dual-eligible in both Medicaid and Medicare. The FY 2012 STAR+PLUS Member Survey therefore represents the half of the program population that is Medicaid-only (47 percent), younger than 65 years old, and who meet other criteria for eligibility in STAR+PLUS. Members who had participated in the prior year's survey (FY 2011) were also excluded from the sample.

A target sample of 3,500 completed telephone interviews was set, representing 250 respondents for each of the 14 MCO-SA groups participating in STAR+PLUS during CY 2011:³⁷

• Amerigroup – Bexar	• Molina – Harris
• Amerigroup – Harris	• Superior – Bexar
• Amerigroup – Tarrant	• Superior – Dallas
• Amerigroup – Travis	• Superior – Nueces
• HealthSpring – Tarrant	• UnitedHealthcare – Harris
• Molina – Bexar	• UnitedHealthcare – Nueces
• Molina – Dallas	• UnitedHealthcare – Travis

This sample size was selected to: (1) provide a reasonable confidence interval for the survey responses; and (2) ensure there was a sufficient sample size to allow for comparisons among MCO-SA groups. **Table A1** presents the stratification strategy by MCO-SA group, showing both the number of targeted interviews (N = 3,500) and the number of completed interviews (N = 3,432). The number of targeted interviews was met in all quotas except for HealthSpring-Tarrant, for which 178 interviews were collected. This was due to a considerably smaller sampling frame in HealthSpring-Tarrant, where only 740 members met the study inclusion criteria.

Table A1. STAR+PLUS Member Survey Sampling Strategy

MCO-SA group	Targeted Interviews	Completed Interviews
Amerigroup – Bexar	250	250
Amerigroup – Harris	250	250
Amerigroup – Tarrant	250	250
Amerigroup – Travis	250	250
HealthSpring – Tarrant	250	178
Molina – Bexar	250	250
Molina – Dallas	250	250
Molina – Harris	250	250
Superior – Bexar	250	250
Superior – Dallas	250	251
Superior – Nueces	250	250
UnitedHealthcare – Harris	250	251
UnitedHealthcare – Nueces	250	252
UnitedHealthcare – Travis	250	250

Using a 95 percent confidence interval, the responses provided in the tables and figures are within ± 1.6 percentage points of the “true” responses in the STAR+PLUS adult Medicaid-only population. At the MCO-SA level, the margin of error ranged from ± 5.8 percentage points in Amerigroup-Bexar, Molina-Bexar, UnitedHealthcare-Nueces, and UnitedHealthcare-Travis to ± 6.4 percentage points in HealthSpring-Tarrant.

Enrollment data were used to identify the members who met the sample selection criteria and to obtain their contact information. Member names, mailing addresses, and telephone contact information for 18,803 eligible STAR+PLUS members were collected and provided to interviewers. For households with multiple adults enrolled in STAR+PLUS, one member from the household was randomly chosen to be included in the sample. Member age, sex, and race/ethnicity were also collected from the enrollment data to allow for comparisons between respondents and non-respondents and to identify any participation biases in the final sample.

Survey instruments

The FY 2012 STAR+PLUS Member Survey is comprised of:

- The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 4.0 (Medicaid module).³⁸
- Items from the CAHPS® Clinician and Group Surveys.³⁹

- Items from the RAND[®] 36-Item Health Survey, Version 1.0 that assess emotional health.⁴⁰
- Items developed by ICHP pertaining to member demographic and household characteristics, and member experiences and satisfaction with service coordination.

The CAHPS[®] Health Plan Survey is a widely used instrument for measuring and reporting consumers' experiences with their health plan and providers. The STAR+PLUS Member Survey uses the Medicaid module of the CAHPS[®] survey and includes both the core questionnaire and supplemental items. The core survey instrument is divided into sections that assess health care experiences within the past six months specific to urgent and routine care, personal doctors, specialist care, and the member's health plan. Questions from the supplemental item set include those dealing with chronic conditions, measures of health status, communication, mobility impairments, prescription medicines, after-hours care, care coordination, transportation, and health promotion.

The CAHPS[®] survey allows for the calculation and reporting of health care composites, which are scores that combine results for closely related survey items. Composites provide a comprehensive yet concise summary of results for multiple survey questions. For adults, CAHPS[®] composite scores are calculated in the following four domains:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Health Plan Information and Customer Service*

Scores for composite measures were calculated using both AHRQ and NCQA specifications. Specifications by AHRQ produce scores that represent the percentage of members who had positive experiences in the given domain. These percentage-based scores can be compared with Medicaid national data available through the NCQA Quality Compass.⁴¹ Composite scores were calculated following AHRQ specifications for all four domains.

Specifications by NCQA produce scaled scores ranging from 1 to 3, rather than percentage-based scores. It should be noted that analyses comparing CAHPS[®] composite scores across different demographic groups and MCO-SA groups used a modified version of NCQA specifications. In order to permit statistical comparisons, a separate score was calculated for each member, and then averaged. This differs from NCQA specifications, in which means are calculated by averaging the aggregate scores on a composite's individual items. As a result, individual item responses in the means calculated for statistical comparison are weighted according to their frequency, and overall scores may vary slightly from those presented on **Table B2** in **Appendix B**.

In addition, supplemental items from the CAHPS[®] Clinician and Groups Surveys were included in the STAR+PLUS Member Survey. The selected items assess members' experiences with receiving information about care and appointments and self-management support in the context

of the patient-centered medical home. It should be noted that these items were slightly modified to fit the format and six-month time frame of the CAHPS® Health Plan Survey 4.0.

The RAND® 36-Item Health Survey was developed to assess health status in the Medical Outcomes Study. This instrument was designed for use in health policy evaluations and general population surveys. The RAND®-36 assesses eight separate health domains: (1) Physical functioning; (2) Role limitations due to physical health; (3) Role limitations due to emotional problems; (4) Energy/fatigue; (5) Emotional well-being; (6) Social functioning; (7) Pain; and (8) General health.

The FY 2012 STAR+PLUS Member Survey included five items from the RAND®-36 used to calculate the *Emotional Well-Being* scale. Research has found that the five items used in this scale correlate significantly with the presence of major depression among functionally impaired, community-dwelling elderly patients.⁴² Using composite scoring methods, ICHP researchers calculated a mean score ranging from 0 to 100 for the *Emotional Well-Being* scale. Higher composite scores indicate better health status and/or functioning.

Nine survey questions function as indicators of health plan performance for adult STAR+PLUS members, as listed on HHSC's Performance Indicator Dashboard for CY 2012.⁴³ These include: (1) *Good Access to Urgent Care*; (2) *Good Access to Specialist Referral*; (3) *Good Access to Routine Care*; (4) *No Delays in Health Care while Waiting for Health Plan Approval*; (5) *No Wait to be Taken to the Exam Room Greater than 15 Minutes*; (6) *Good Access to Special Therapies*; (7) *Good Access to Service Coordination*; (8) *Advising Smokers to Quit*; and (9) *Good Access to Behavioral Health Treatment or Counseling*.

The survey also includes questions regarding the demographic and household characteristics of adult STAR+PLUS members. These questions were developed by ICHP and have been used in surveys with more than 25,000 Medicaid and CHIP members in Texas and Florida. The items were adapted from questions used in the National Health Interview Survey, the Current Population Survey and the National Survey of America's Families.^{44,45,46}

Respondents were also asked to report their height and weight. These questions allow for calculation of the member's body mass index (BMI), a common population-level indicator of overweight and obesity.

Lastly, the survey included nine questions from the Depression Stigma Scale (DSS), used to calculate the DSS-Personal score – a measure of an individual's personal attitudes toward the condition of depression.⁴⁷ This tool was added to inform future studies of depression in the STAR+PLUS population, including studies of racial/ethnic disparities in diagnosis and treatment of depression. Results for these items are presented only in the technical appendix that accompanies this report.

Survey data collection

The EQRO sent letters written in English and Spanish to 18,803 sampled STAR+PLUS members, requesting their participation in the survey. Of the advance letters sent, 72 were returned undeliverable.

The Survey Research Center (SRC) at the University of Florida conducted the survey using computer-assisted telephone interviewing (CATI) between May 2012 and September 2012. The SRC telephoned STAR+PLUS members seven days a week between 10 a.m. and 9 p.m. Central Time. The Sawtooth Software System was used to rotate calls in the morning, afternoon, and evening to maximize the likelihood of reaching potential survey respondents. If a respondent was unable to complete the interview in English, SRC rescheduled the interview at a later date and time with a Spanish-speaking interviewer. Of 3,432 completed interviews, 71 (2 percent) were conducted in Spanish. On average 7.6 calls per phone number were made in the STAR+PLUS member survey sample.

Up to 30 attempts were made to reach a member, and if the member was not reached after that time, the software selected the next individual on the list. No financial incentives were offered to participate in the surveys. Forty-seven percent of members could not be located. Among those located, two percent indicated that they were not enrolled in STAR+PLUS and nine percent refused to participate. The response rate was 55 percent and the cooperation rate was 81 percent.

To test for participation bias, the distributions of members' age, sex, and race/ethnicity were collected from the enrollment data and compared between members who responded to the survey and members who did not participate. Among members who could be contacted by SRC, the participation rate was higher among women than among men (59 percent vs. 49 percent).⁴⁸ Participants were also on average older than non-participants (48 years vs. 44 years).⁴⁹ Results for program-level frequencies and means were weighted to account for participation bias by member biological sex and age, as shown on **Table A2**, below.

For most survey items, members had the option of stating they did not know the answer to a question. They also were given the choice to refuse to answer a particular question. If a respondent refused to answer an individual question or series of questions but completed the interview, their responses were used in the analyses. If the respondent ended the interview before all questions had been asked, her or his responses were not included in the analyses.

Data Analysis

Descriptive statistics and statistical tests were performed using SPSS 19.0 (Chicago, IL: SPSS, Inc.) and focused on the CAHPS[®] composite measures and HHSC Performance Dashboard indicators. Frequency tables showing descriptive results for each survey question are provided in a separate technical appendix. The statistics presented in this report exclude "do not know" and "refused" responses. Percentages shown in most figures and tables are rounded to the nearest whole number; therefore, percentages may not add up to 100 percent.

To facilitate inferences from the survey results to the STAR+PLUS Medicaid-only population, results were weighted to the full set of eligible beneficiaries in the enrollment dataset. Because sampling for STAR+PLUS was stratified by MCO-SA group, a separate weight was calculated for each MCO-SA, in which frequencies were multiplied by the inverse probability of inclusion in the sample (the total number of eligible MCO-SA members in the population divided by the number of MCO-SA members with completed surveys). The MCO-SA weighting factor was then multiplied by a second weighting factor to account for differences in participation rates by member sex, and a third weighting factor to account for differences in participation rates by member age. **Table A2** provides the weights for each of the 14 MCO-SA groups, men and women, and five age categories of members in the survey. The frequencies and means presented in this report and the technical appendix that accompanies this report incorporate survey weights.

Table A2. Survey Weighting Strategy

MCO-SA group	Eligible members (N)	Completed surveys (n)	Weight
Amerigroup – Bexar	2,149	250	8.60
Amerigroup – Harris	12,547	250	50.19
Amerigroup – Tarrant	9,042	250	36.17
Amerigroup – Travis	3,679	250	14.72
HealthSpring – Tarrant	740	178	4.16
Molina – Bexar	1,846	250	7.38
Molina – Dallas	10,429	250	41.72
Molina – Harris	2,938	250	11.75
Superior – Bexar	10,379	250	41.52
Superior – Dallas	7,503	251	29.89
Superior – Nueces	3,150	250	12.60
UnitedHealthcare – Harris	12,352	251	49.21
UnitedHealthcare – Nueces	2,058	252	8.17
UnitedHealthcare – Travis	2,041	250	8.16
Member sex	Eligible members (%)	Completed surveys (%)	Weight
Male	40.0%	37.1%	1.08
Female	60.0%	62.9%	0.95
Member age group	Eligible members (%)	Completed surveys (%)	Weight
33 years or younger	19.5%	15.3%	1.27
34 – 46 years old	20.6%	20.2%	1.02
47 – 53 years old	20.8%	22.6%	0.92
54 – 58 years old	20.1%	22.1%	0.91
59 years or older	19.0%	19.8%	0.96

Analysis of differences in frequencies used the Pearson Chi-square test of independence, and analysis of differences in means used t-tests and analysis of variance (ANOVA). To prevent overestimation of statistical significance resulting from sample size inflation, all tests were performed without weighting. These tests allowed comparisons of frequencies and means among members of the 14 MCO-SA groups, and among relevant demographic sub-groups of the sample. Differences were considered to be statistically significant at $p < 0.05$.

When significant omnibus tests revealed between-groups differences by MCO-SA or demographic sub-groups that had more than two groups (e.g. race/ethnicity), post-hoc analyses (specifically, LSD pairwise comparisons) were conducted to determine which groups differed. For demographic sub-groups that had only two groups (e.g. gender), independent sample t-tests were performed. Cohen's d was then used to assess the effect size (i.e. magnitude) of each observed significant mean difference. A list of significant post hoc analyses for comparisons of CAHPS[®] composite scores by MCO-SA appears in **Table B3**. The magnitude of significant (omnibus) chi-square analyses was assessed by its Phi coefficient (Cramer's V) – a measure of effect size of the relationship between two binary variables.

Body mass index (BMI) was calculated by dividing the member's weight in kilograms by their height in meters squared. BMI could be calculated for 3,285 members in the sample (96 percent) for whom height and weight data were complete. Height data were missing for 70 members (2 percent), and weight data were missing for 99 members (3 percent). Survey respondents were classified into one of four clinically relevant BMI categories, which are recognized by the Centers for Disease Control and Prevention.⁵⁰

- 1) Underweight – less than 18.5
- 2) Healthy weight – 18.5 to 24.9
- 3) Overweight – 25.0 to 29.9
- 4) Obese – 30.0 or greater

These standardized BMI categories for adults may be used for comparison with national and state averages. Excluded from these analyses were 25 members whose BMI was considered biologically implausible and likely the result of errors in data collection.

Lastly, the EQRO conducted a set of multivariate analyses to examine the influence of service area and health plan membership on self-reported access to care (CAHPS[®] *Getting Needed Care* and *Getting Care Quickly*) and patient-centered encounters, controlling for member demographics and health status. The detailed methodology and results for these analyses can be found in **Appendix C** of this report.

Appendix B. Supplementary Tables and Figures

Table B1. STAR+PLUS Member Obesity Rates by MCO/Service Area

MCO-SA	Obesity rate (% of members in survey sample) *
Amerigroup-Bexar	50.6%
Amerigroup-Harris	49.4%
Amerigroup-Tarrant	56.2%
Amerigroup-Travis	49.2%
Amerigroup total	51.3%
Molina-Bexar	54.7%
Molina-Dallas	48.3%
Molina-Harris	47.6%
Molina total	50.2%
Superior-Bexar	58.6%
Superior-Dallas	44.1%
Superior-Nueces	56.1%
Superior total	52.9%
UnitedHealthcare-Harris	49.6%
UnitedHealthcare-Nueces	49.6%
UnitedHealthcare-Travis	45.3%
UnitedHealthcare total	48.2%
*HealthSpring-Tarrant	53.9%
Note: This survey assesses one service area in the STAR+PLUS HealthSpring MCO (Tarrant); thus, an overall total is not provided for this MCO.	
X ² test for significant differences **	22.570 (p = 0.05)

* Obesity defined as BMI \geq 30.

** Test for differences is reported for MCO-SA comparison only. The test for differences among MCOs (all SA's combined) was not statistically significant.

Table B2. CAHPS® Health Plan Survey Core Composite Scores by STAR+PLUS MCO-SA

MCO-SA	<i>Getting Needed Care</i>	<i>Getting Care Quickly</i>	<i>How Well Doctors Communicate</i>	<i>Health Plan Information and Customer Service</i>
STAR+PLUS overall *	2.02	2.30	2.55	2.24
Amerigroup-Bexar	1.93	2.26	2.51	2.28
Amerigroup-Harris	2.13	2.35	2.60	2.31
Amerigroup-Tarrant	1.90	2.26	2.51	2.04
Amerigroup-Travis	2.07	2.36	2.60	2.24
HealthSpring-Tarrant	1.91	2.28	2.54	2.33
Molina-Bexar	1.91	2.27	2.53	2.14
Molina-Dallas	1.86	2.21	2.41	2.09
Molina-Harris	2.07	2.41	2.63	2.30
Superior-Bexar	2.06	2.26	2.56	2.26
Superior-Dallas	1.87	2.28	2.49	2.10
Superior-Nueces	2.17	2.30	2.59	2.39
UnitedHealthcare-Harris	2.18	2.38	2.62	2.33
UnitedHealthcare-Nueces	2.15	2.26	2.52	2.32
UnitedHealthcare-Travis	2.05	2.34	2.54	2.29
F significance **	< 0.001	N.S.	= 0.04	= 0.02

* The method of calculation follows NCQA specifications, with the exception that a separate score is calculated for each member and then averaged. As a result, individual item responses are weighted according to their frequency and overall scores may vary slightly from those presented in the narrative. This method of scoring permits statistical comparisons.

** Analyses performed on unweighted data. In the case of a significant F, post hoc pairwise comparisons were performed.

Table B3. Largest Effect Sizes for CAHPS® Composite Disparities Between MCO-SA Groups

<i>Getting Needed Care</i>	Cohen's <i>d</i>
UnitedHealthcare-Harris > Molina-Dallas	0.38
Superior-Nueces > Molina-Dallas	0.36
UnitedHealthcare-Nueces > Molina-Dallas	0.34
Amerigroup-Harris > Molina-Dallas	0.31
UnitedHealthcare-Harris > Superior-Dallas	0.38
Superior-Nueces > Superior-Dallas	0.35
UnitedHealthcare-Nueces > Superior-Dallas	0.33
Amerigroup-Harris > Superior-Dallas	0.31
UnitedHealthcare-Harris > Amerigroup-Tarrant	0.34
Superior-Nueces > Amerigroup-Tarrant	0.32
UnitedHealthcare-Nueces > Amerigroup-Tarrant	0.30
<i>How Well Doctors Communicate</i>	Cohen's <i>d</i>
Molina-Harris > Molina-Dallas	0.34
UnitedHealthcare-Harris > Molina-Dallas	0.33
Amerigroup-Travis > Molina-Dallas	0.30
<i>Health Plan Information and Customer Service</i>	Cohen's <i>d</i>
Superior-Nueces > Amerigroup-Tarrant	0.52
UnitedHealthcare-Harris > Amerigroup-Tarrant	0.40
HealthSpring-Tarrant > Amerigroup-Tarrant	0.41
UnitedHealthcare-Nueces > Amerigroup-Tarrant	0.38
Amerigroup-Harris > Amerigroup-Tarrant	0.37
Molina-Harris > Amerigroup-Tarrant	0.36
UnitedHealthcare-Travis > Amerigroup-Tarrant	0.34
Amerigroup-Bexar > Amerigroup-Tarrant	0.33
Superior-Nueces > Molina-Dallas	0.43
UnitedHealthcare-Harris > Molina-Dallas	0.32
HealthSpring-Tarrant > Molina-Dallas	0.33
UnitedHealthcare-Nueces > Molina-Dallas	0.30
Amerigroup-Harris > Molina-Dallas	0.30

Table B4. CAHPS® Composite Scores by STAR+PLUS Member Race/Ethnicity, Education, and Sex

	<i>Getting Needed Care</i>	<i>Getting Care Quickly</i>	<i>How Well Doctors Communicate</i>	<i>Health Plan Information and Customer Service</i>
Race/Ethnicity				
Hispanic	2.11 ^a	2.27 ^a	2.58 ^a	2.32 ^a
White, non-Hispanic	1.99 ^b	2.35 ^b	2.51 ^b	2.25 ^{ab}
Black, non-Hispanic	1.98 ^b	2.32 ^{ab}	2.57 ^a	2.20 ^b
F significance *	< 0.01 ^{**}	= 0.07 ^{***}	= 0.03 [†]	= 0.07 ^{††}
Education				
Less than high school degree	2.09 ^a	2.31	2.56	2.29
High school degree or GED	1.96 ^b	2.29	2.56	2.23
Some college or college degree	2.00 ^{ab}	2.31	2.51	2.20
F significance *	< 0.01 ^{†††}	N.S.	N.S.	N.S.
Member Sex				
Male	2.00	2.28	2.56	2.21
Female	2.04	2.31	2.54	2.26
T-test significance *	N.S.	N.S.	N.S.	N.S.
Cohen's d	-	-	-	-

* Analyses performed on unweighted data. In the case of a significant F, post hoc pairwise comparisons were performed. Superscripts denote statistical significance of these comparisons. Means within a column that share a common superscript do not significantly differ from one another; means within a column that have different superscripts significantly differ from one another.

** Hispanic vs. White, $p < 0.01$, $d = 0.15$; Hispanic vs. Black, $p < 0.01$, $d = 0.15$

*** Hispanic vs. White, $p = 0.02$, $d = 0.11$

† White vs. Hispanic, $p = 0.02$, $d = 0.11$; White vs. Black, $p = 0.03$, $d = 0.11$

†† Hispanic vs. Black, $p = 0.02$, $d = 0.16$

††† Less than high school degree vs. High school degree or GED, $p < 0.01$, $d = 0.15$

Table B5. CAHPS® Composite Scores by STAR+PLUS Member Age and Health Status

	<i>Getting Needed Care</i>	<i>Getting Care Quickly</i>	<i>How Well Doctors Communicate</i>	<i>Health Plan Information and Customer Service</i>
Age				
Age 46 and younger	1.91 ^a	2.22 ^a	2.46 ^a	2.19
Age 47-56	2.04 ^b	2.34 ^b	2.57 ^b	2.27
Age 57 and older	2.11 ^b	2.34 ^b	2.61 ^b	2.27
F significance *	< 0.001**	= 0.001***	< 0.001 [†]	N.S.
Health Status ^{††}				
Healthy	2.11	2.30	2.61	2.38
Unhealthy	1.98	2.30	2.52	2.18
T-test significance *	= 0.001	N.S.	< 0.001	< 0.001
Cohen's d	0.16	-	0.14	0.28

* Analyses performed on unweighted data. In the case of a significant F, post hoc pairwise comparisons were performed. Superscripts denote statistical significance of these comparisons. Means within a column that share a common superscript do not significantly differ from one another; means within a column that have different superscripts significantly differ from one another.

** Age 46 and younger vs. Age 47-56, $p < 0.01$, $d = 0.15$; Age 46 and younger vs. Age 57 and older, $p < 0.001$, $d = 0.24$

*** Age 46 and younger vs. Age 47-56, $p = 0.001$, $d = 0.15$; Age 46 and younger vs. Age 57 and older, $p < 0.01$, $d = 0.14$

† Age 46 and younger vs. Age 47-56, $p < 0.001$, $d = 0.17$; Age 46 and younger vs. Age 57 and older, $p < 0.001$, $d = 0.24$

†† Health status categories were created by grouping member self-reported health status categories.

- Healthy ("Excellent", "Very good", or "Good")
- Unhealthy ("Fair" or "Poor")

Table B6. HHSC Performance Indicator Results by STAR+PLUS MCO-SA

MCO-SA	1	2	3	4	5	6	7	8	9	# ≥ Std.
Amerigroup-Bexar	81%	60%	70%	27%	25%	57%	NR**	60%	66%	2
Amerigroup-Harris	78%	70%	75%	38%	31%	55%	57%	71%	64%	2
Amerigroup-Tarrant	78%	58%	71%	38%	26%	42%	NR**	73%	47%	2
Amerigroup-Travis	83%	63%	78%	43%	34%	57%	65%	75%	64%	4
HealthSpring-Tarrant	77%	57%	73%	33%	25%	49%	68%	64%	76%	2
Molina-Bexar	71%	58%	72%	36%	29%	58%	NR**	67%	57%	0
Molina-Dallas	73%	48%	69%	43%	29%	33%	64%	68%	50%	1
Molina-Harris	82%	63%	80%	34%	28%	54%	67%	76%	61%	4
Superior-Bexar	74%	67%	72%	40%	23%	62%	73%	72%	58%	2
Superior-Dallas	74%	44%	73%	41%	24%	42%	70%	60%	51%	1
Superior-Nueces	79%	67%	70%	29%	30%	63%	70%	70%	69%	3
UHC-Harris	80%	68%	79%	35%	32%	59%	72%	72%	67%	3
UHC-Nueces	75%	64%	72%	37%	24%	57%	67%	66%	69%	2
UHC-Travis	80%	66%	76%	40%	30%	49%	74%	66%	61%	1
HHSC Standard	81%	73%	80%	57%	42%	66%	63%	70%	63%	-
# MCO/SAs ≥ Standard	3	0	1	0	0	0	11	7	7	-
X ² significance *	N.S.	< 0.01	N.S.	-						

Percentage of members who...

1. Had good access to urgent care
2. Had good access to specialist referral
3. Had good access to routine care
4. Had no delays for an approval
5. Had no wait to be taken to the exam room greater than 15 minutes
6. Had good access to special therapies
7. Had good access to Service Coordination
8. Were advised to quit smoking in at least one office visit
9. Had good access to behavioral health treatment or counseling

* Analyses performed on unweighted data.

** NR – Results not reported for plan codes with fewer than 30 members in the denominator.

Table B7. Ratings Results by STAR+PLUS MCO-SA

MCO-SA	1	2	3*	4	5	6	# ≥ Nat'l Population
Amerigroup-Bexar	49%	59%	50%	62%	55%	56%	2
Amerigroup-Harris	51%	46%	49%	64%	62%	57%	4
Amerigroup-Tarrant	46%	55%	46%	62%	48%	54%	1
Amerigroup-Travis	50%	56%	46%	64%	65%	52%	3
HealthSpring-Tarrant	43%	48%	38%	57%	54%	41%	0
Molina-Bexar	43%	54%	48%	65%	55%	50%	1
Molina-Dallas	40%	49%	30%	55%	49%	48%	0
Molina-Harris	51%	47%	42%	63%	56%	53%	2
Superior-Bexar	51%	54%	50%	69%	59%	62%	3
Superior-Dallas	45%	50%	32%	61%	43%	51%	0
Superior-Nueces	52%	53%	70%	71%	61%	66%	3
UnitedHealthcare-Harris	52%	51%	53%	68%	67%	59%	4
UnitedHealthcare-Nueces	49%	47%	46%	69%	60%	56%	2
UnitedHealthcare-Travis	49%	47%	38%	63%	60%	52%	1
National Medicaid Population	50%	-	-	62%	62%	56%	-
# MCOs ≥ National Pop.	6	-	-	11	3	6	-
X ² significance **	N.S.	N.S.	= 0.01	= 0.04	= 0.02	< 0.001	-
Phi/Cramer's V	-	-	0.19	0.09	0.13	0.12	

Percentage of members who gave a rating of 9 or 10 for...

1. Health Care
2. Emergency Room Care
3. Counseling
4. Personal Doctor
5. Specialist
6. Health Plan

* Plan code level denominators for this measure met the minimum criterion for reporting (n=30), but were relatively small compared to other ratings measures (less than 100). These estimates are therefore less reliable for making inferences to the population.

** Analyses performed on unweighted data. In the case of a significant F, post hoc pairwise comparisons were performed.

Table B8. Ratings by STAR+PLUS Member Race/Ethnicity, Education, and Sex

	Health Care Rating	Emergency Room Rating	Counseling Rating	Personal Doctor Rating	Specialist Rating	Health Plan Rating
Race/Ethnicity						
Hispanic	53%	54%	50%	69%	59%	61%
White, non-Hispanic	42%	46%	41%	57%	57%	44%
Black, non-Hispanic	50%	53%	46%	65%	55%	57%
Chi square significance *	< 0.001	= 0.02	N.S.	< 0.001	N.S.	< 0.001
Phi	0.09	0.07	-	0.10	-	0.14
Education						
Less than high school degree	52%	56%	50%	68%	60%	61%
High school degree or GED	47%	49%	42%	63%	56%	53%
Some college or college degree	39%	43%	44%	57%	54%	42%
Chi square significance *	< 0.001	< 0.001	N.S.	< 0.001	N.S.	< 0.001
Phi	0.10	0.10	-	0.09	-	0.14
Member Sex						
Male	44%	52%	39%	63%	52%	51%
Female	50%	51%	49%	65%	61%	56%
Chi square significance *	= 0.001	N.S.	= 0.02	N.S.	= 0.001	< 0.01
Phi	0.06	-	0.08	-	0.09	0.05

* Analyses performed on unweighted data. In the case of a significant F, post hoc pairwise comparisons were performed.

Table B9. Ratings by STAR+PLUS Member Age and Health Status

	Health Care Rating	Emergency Room Rating	Counseling Rating	Personal Doctor Rating	Specialist Rating	Health Plan Rating
Age						
Age 46 and younger	45%	42%	39%	59%	50%	51%
Age 47-56	50%	56%	50%	66%	58%	55%
Age 57 and older	49%	57%	53%	68%	64%	57%
Chi square significance *	= 0.07	< 0.001	< 0.01	< 0.001	< 0.001	< 0.01
Phi	0.04	0.14	0.12	0.08	0.12	0.06
Health Status**						
Healthy	57%	56%	54%	70%	65%	63%
Unhealthy	43%	49%	42%	61%	55%	49%
Chi square significance *	< 0.001	< 0.01	< 0.01	< 0.001	< 0.001	< 0.001
Phi	0.14	0.07	0.11	0.09	0.10	0.13

* Analyses performed on unweighted data. In the case of a significant F, post hoc pairwise comparisons were performed.

** Health status categories were created by grouping member self-reported health status categories.

- Healthy ("Excellent", "Very good", or "Good")
- Unhealthy ("Fair" or "Poor")

Appendix C. Multivariate Analysis – Influence of Health Plan Membership and Service Area on Experiences with Care

Patients' experiences and satisfaction with the quality of the health care they receive may be influenced by a number of factors – including aspects of health care structure and process that are within the control of health plans and providers, as well as demographic and health status factors that are more closely connected to individual patients and the areas in which they live. Using results from the FY 2012 STAR+PLUS Member Survey, the EQRO conducted a set of multivariate analyses to determine the relative influence of health plan membership and service area on STAR+PLUS members' experiences with their health care, controlling for demographic and health status factors.

The multivariate analyses tested the likelihood that a member would report:

- 1) Positive experiences with access to care, measured using the CAHPS® *Getting Needed Care* composite;
- 2) Positive experiences with timeliness of care, measured using the CAHPS® *Getting Care Quickly* composite; and
- 3) Whether providers talked with them about their specific health goals in the past six months – an important aspect of shared decision-making in the patient-centered medical home (PCMH).

Estimates of the effects of health plan membership and service area on the three outcomes controlled for the member's racial/ethnic group, age, biological sex, education, overall health status, and mental health status.

Methodology

The multivariate analysis was conducted using unconditional logistic regression, with the outcomes dichotomized – coded as 1 for members who had positive health care experiences, and 0 for members who did not have positive health care experiences. Based on analysis of the quartiles of distribution of scores for *Getting Needed Care* and *Getting Care Quickly* (which range from 1 to 3 following NCQA specifications), a score of 3 was chosen as an appropriate cutoff point for defining "positive" health care experiences for these two outcomes. The PCMH outcome was based on a yes/no question – coded as 1 for members who reported their providers talked with them about their health goals, and 0 for members who reported their providers did not talk with them about their health goals.

The following demographic and health status covariates were used in all three logistic regression models:

- 1) *Race/ethnicity*. Members were categorized as White, non-Hispanic; Black, non-Hispanic; or Hispanic. The reference group was White, non-Hispanic members. Due to the small number of survey respondents classified as Other, non-Hispanic, these members were excluded from the models.

- 2) *Age*. Based on the distribution of age in the survey sample, members were grouped into four age categories – 40 years old and younger, 41 to 50 years old, 51 to 60 years old, and 61 years old and older. Members 40 years old and younger were the reference group.
- 3) *Biological sex*. Members were categorized as male or female, with males as the reference group.
- 4) *Education*. Members were categorized as having less than a high school education or having a high school diploma or greater. Members with less than a high school education comprised the reference group.
- 5) *Overall health status*. The health status of members was categorized using the CAHPS® item on self-reported overall health status. Members were categorized into three overall health groups: (1) “Excellent”, “Very good”, or “Good”; (2) “Fair”; or (3) “Poor”. Members in the first category comprised the reference group.
- 6) *Mental health status*. The mental health status of members was categorized using the CAHPS® item on self-reported mental health status. Members were categorized into three mental health groups: (1) “Excellent”, “Very good”, or “Good”; (2) “Fair”; or (3) “Poor”. Members in the first category comprised the reference group.

Within each model, the service area with the highest rate on the outcome was selected as the reference group against which the other service areas were compared.

- Nueces had the highest percentage of members with a score of 3.00 for *Getting Needed Care* (45.8 percent).
- Harris had the highest percentage of members with a score of 3.00 for *Getting Care Quickly* (54.7 percent).
- Travis had the highest percentage of members who reported their providers talked with them about their specific health goals (66.3 percent).

Lastly, within each model, the health plan with the highest rate on the outcome was selected as the reference group against which the other health plans were compared. For all three models, UnitedHealthcare-Texas had the highest rates – at 41.1 percent for *Getting Needed Care*, 50.8 percent for *Getting Care Quickly*, and 62.4 percent for discussion of health goals.

Results

Results of the multivariate analysis are presented in **Tables C1** through **C3** as odds ratios. The odds ratios represent the likelihood of a member having positive experiences on the outcome, compared to members in the reference group. For any particular test variable or covariate, an odds ratio above 1.00 suggests that members in the specified category were more likely to have had positive experiences than members in the reference group. Conversely, an odds ratio below 1.00 suggests that members in the specified category were less likely to have positive experiences than members in the reference group.

The tables also provide 95 percent confidence intervals for the odds ratios, which function as an indicator of statistical significance. An odds ratio with a confidence interval that includes 1.00 in its range is not considered statistically significant at $p < 0.05$.

Across the three models, member's age and service area were the most consistent predictors of positive health care experiences, with some outcomes also showing significant effects for race/ethnicity, education, overall health, and mental health. Member's biological sex or health plan membership were not associated with outcomes in any of the models. Specific findings for each of the three models are described below:

Getting Needed Care

- Having a score of 3.00 on *Getting Needed Care* was more likely among Hispanic members compared to White, non-Hispanic members (1.4 times), and among members 51 to 60 years old compared to members 40 years of age and younger (1.7 times).
- Access to care was lower for members in lower health status categories. Compared to members in excellent, very good, or good overall health, members in fair health and poor health were less likely to have a score of 3.00 on *Getting Needed Care* (by 28 percent and 41 percent, respectively). Likewise, compared to members in excellent, very good, or good mental health, members in fair mental health were 23 percent less likely to have a score of 3.00.
- Compared to members in Nueces SA, a lower likelihood of positive experiences with *Getting Needed Care* was observed for members in Bexar SA (by 50 percent) and Dallas SA (by 38 percent).
- Although the percentage of members with a score of 3.00 on *Getting Needed Care* varied widely by health plan, from 29 percent in HealthSpring to 41 percent in UnitedHealthcare, no significant differences in the likelihood of positive experiences were observed after controlling for demographics, health status, and service area.

Getting Care Quickly

- Members in older age categories were more likely than members 40 years old and younger to have a score of 3.00 on *Getting Care Quickly* – from 1.3 times greater among members 61 years old and older to 1.6 times greater among members 51 to 60 years old.
- Compared to members with less than high school education, members with a high school diploma or greater were 15 percent less likely to have a score of 3.00 on *Getting Care Quickly*. This finding may reflect differing expectations, rather than actual differences in the timeliness of care by educational status.
- Compared to members in Harris SA, a lower likelihood of positive experiences with *Getting Care Quickly* was observed for members in Bexar SA (by 27 percent), Dallas SA (by 33 percent), and Tarrant SA (by 32 percent).

PCMH – Discussing Specific Health Goals

- Compared to White, non-Hispanic members, Black, non-Hispanic members were 1.9 times more likely to report their providers talked with them about their specific health goals.
- Members in older age categories were more likely than members 40 years of age and younger to report their providers talked with them about their specific health goals – from 1.3 times greater among members 51 to 60 years old to 1.6 times greater among members 61 years of age and older.
- Compared to members in Travis SA, a lower likelihood of discussing specific health goals was observed for members in Bexar SA (by 38 percent), Dallas SA (by 50 percent), and Harris SA (by 34 percent).

Model fit statistics

For each of the three models, the EQRO used the likelihood-ratio test to determine the predictive value of each set of covariates, which were added to the models in three steps:

- 1) Model 1, including only demographic factors (race/ethnicity, age, biological sex, and education);
- 2) Model 2, including demographic factors and health status (overall and mental health); and
- 3) Model 3, including demographic factors, health status, and service factors (service area and health plan).

Model fit statistics for Model 2 were compared to model fit statistics for Model 1 to determine the predictive value of adding health status variables. Model fit statistics for Model 3 were compared to model fit statistics for Model 2 to determine the predictive value of adding service factor variables. Results of the likelihood-ratio tests are shown in the tables below.

Outcome	Comparison of Model 1 and 2			p-value
	Model 2 (χ^2 , df)	Model 1 (χ^2 , df)	Difference (χ^2 , df)	
CAHPS® <i>Getting Needed Care</i>	60.688, df = 11	37.573, df = 7	23.115, df = 4	< 0.0005
CAHPS® <i>Getting Care Quickly</i>	30.762, df = 11	28.296, df = 7	2.466, df = 4	Not significant
PCMH – Discussing Specific Health Goals	49.953, df = 11	43.472, df = 7	6.481, df = 4	Not significant
Outcome	Comparison of Model 2 and 3			p-value
	Model 3 (χ^2 , df)	Model 2 (χ^2 , df)	Difference (χ^2 , df)	
CAHPS® <i>Getting</i>	88.473, df = 20	60.688, df = 11	27.785, df = 9	< 0.0025

<i>Needed Care</i>				
CAHPS® <i>Getting Care Quickly</i>	43.148, df = 20	30.762, df = 11	12.386, df = 9	Not significant
PCMH – Discussing Specific Health Goals	75.259, df = 20	49.953, df = 11	25.306, df = 9	< 0.0050

Findings from this report’s bivariate analyses showed a number of significant differences in CAHPS® scores – particularly for *Getting Needed Care* – by MCO-SA group. The multivariate analysis presented in this section separates the influence of health plan and service area, showing that service area has a greater influence on variability in scores for this domain. For all three outcomes, health care experiences were worse in the Bexar and Dallas service areas.

Of particular concern is the finding that members in lower health status categories were less likely to have reported positive experiences with *Getting Needed Care*. Access to care is particularly important for the STAR+PLUS population, which has a greater need for specialist care and specialized services than the general Texas Medicaid population. It is possible that the observed association is the result of reduced availability of specialist care or low density of specialists in provider networks.

Lastly, findings from the likelihood-ratio tests show that the addition of service factors (in particular, service area) significantly increased the predictive value of the models for both *Getting Needed Care* and discussing specific health goals. Compared to demographics and health status, service factors are under greater control by the programs and health plans that administer health services. This finding suggests that both access to and patient-centeredness of care can be improved through efforts by health plans to address deficiencies in the structure and delivery of care at the service area level.

Table C1. Getting Needed Care – Multivariate Analysis

Factor	% With GNC score = 3	Odds Ratio	95% CI
Race/Ethnicity			
White, non-Hispanic	32.8%	REF	-
Black, non-Hispanic	34.7%	1.10	(0.85 - 1.44)
Hispanic	39.8%	1.36	(1.05 - 1.76)
Member Age			
40 years old and younger	30.5%	REF	-
41 to 50 years old	32.9%	1.18	(0.87 - 1.61)
51 to 60 years old	40.6%	1.72	(1.31 - 2.25)
61 years old and older	35.8%	1.33	(0.93 - 1.88)
Member Sex			
Male	35.3%	REF	-
Female	36.5%	1.08	(0.88 - 1.33)
Education			
Less than high school	41.1%	REF	-
High school diploma or greater	32.2%	0.70	(0.57 - 0.86)
Overall Health			
Excellent, very good, or good	42.5%	REF	-
Fair	34.2%	0.72	(0.57 - 0.92)
Poor	31.6%	0.59	(0.44 - 0.79)
Mental Health			
Excellent, very good, or good	39.6%	REF	-
Fair	32.1%	0.77	(0.61 - 0.97)
Poor	34.9%	0.90	(0.67 - 1.21)
Service Area			
Bexar	30.0%	0.50	(0.35 - 0.72)
Dallas	32.3%	0.62	(0.40 - 0.96)
Harris	41.5%	0.95	(0.65 - 1.39)
Nueces	45.8%	REF	-
Tarrant	31.5%	0.76	(0.44 - 1.31)
Travis	35.2%	0.73	(0.49 - 1.09)
Health Plan			
Amerigroup	34.7%	0.96	(0.70 - 1.32)
HealthSpring	28.7%	0.76	(0.39 - 1.50)
Molina	34.3%	1.01	(0.71 - 1.44)
Superior	36.3%	1.07	(0.76 - 1.52)
UnitedHealthcare	41.1%	REF	-

Table C2. Getting Care Quickly – Multivariate Analysis

Factor	% With GCQ score = 3	Odds Ratio	95% CI
Race/Ethnicity			
White, non-Hispanic	49.1%	REF	-
Black, non-Hispanic	51.2%	1.06	(0.85 - 1.31)
Hispanic	47.4%	0.93	(0.75 - 1.15)
Member Age			
40 years old and younger	40.8%	REF	-
41 to 50 years old	51.3%	1.53	(1.20 - 1.95)
51 to 60 years old	52.5%	1.64	(1.32 - 2.03)
61 years old and older	47.7%	1.33	(1.00 - 1.76)
Member Sex			
Male	48.3%	REF	-
Female	49.4%	1.08	(0.91 - 1.29)
Education			
Less than high school	51.1%	REF	-
High school diploma or greater	47.2%	0.85	(0.72 - 1.00)
Overall Health			
Excellent, very good, or good	49.8%	REF	-
Fair	49.0%	0.92	(0.76 - 1.13)
Poor	48.1%	0.85	(0.67 - 1.08)
Mental Health			
Excellent, very good, or good	49.4%	REF	-
Fair	47.5%	0.94	(0.78 - 1.13)
Poor	51.0%	1.08	(0.84 - 1.37)
Service Area			
Bexar	46.6%	0.73	(0.55 - 0.97)
Dallas	46.0%	0.67	(0.49 - 0.91)
Harris	54.7%	REF	-
Nueces	47.0%	0.74	(0.54 - 1.01)
Tarrant	46.5%	0.68	(0.47 - 0.99)
Travis	52.2%	0.94	(0.70 - 1.26)
Health Plan			
Amerigroup	49.7%	1.02	(0.79 - 1.33)
HealthSpring	48.1%	1.24	(0.73 - 2.10)
Molina	47.4%	0.98	(0.73 - 1.31)
Superior	48.2%	1.13	(0.85 - 1.51)
UnitedHealthcare	50.8%	REF	-

Table C3. Discussing Specific Health Goals – Multivariate Analysis

Factor	% whose providers talked with them about specific health goals	Odds Ratio	95% CI
Race/Ethnicity			
White, non-Hispanic	52.5%	REF	-
Black, non-Hispanic	66.1%	1.94	(1.55 - 2.42)
Hispanic	56.9%	1.17	(0.94 - 1.45)
Member Age			
40 years old and younger	52.5%	REF	-
41 to 50 years old	60.5%	1.40	(1.10 - 1.78)
51 to 60 years old	58.5%	1.34	(1.07 - 1.66)
61 years old and older	62.4%	1.55	(1.16 - 2.07)
Member Sex			
Male	57.6%	REF	-
Female	58.5%	1.09	(0.91 - 1.30)
Education			
Less than high school	59.8%	REF	-
High school diploma or greater	56.8%	0.89	(0.75 - 1.05)
Overall Health			
Excellent, very good, or good	60.2%	REF	-
Fair	56.5%	0.86	(0.70 - 1.05)
Poor	58.2%	0.93	(0.73 - 1.19)
Mental Health			
Excellent, very good, or good	59.7%	REF	-
Fair	55.3%	0.85	(0.70 - 1.03)
Poor	59.6%	0.95	(0.74 - 1.22)
Service Area			
Bexar	54.8%	0.62	(0.45 - 0.85)
Dallas	54.3%	0.50	(0.34 - 0.73)
Harris	59.3%	0.66	(0.49 - 0.90)
Nueces	59.7%	0.75	(0.53 - 1.06)
Tarrant	56.0%	0.72	(0.48 - 1.08)
Travis	66.3%	REF	-
Health Plan			
Amerigroup	59.5%	0.94	(0.72 - 1.24)
HealthSpring	52.3%	0.79	(0.46 - 1.36)
Molina	53.4%	0.89	(0.66 - 1.21)
Superior	58.2%	1.07	(0.80 - 1.43)
UnitedHealthcare	62.4%	REF	-

Endnotes

- ¹ CAHPS® (Consumer Assessment of Healthcare Providers and Systems). 2012a. "CAHPS Health Plan Survey 4.0. Adult Medicaid Questionnaire."
- ² CAHPS® 2012b. "CAHPS Clinician and Group Surveys." Available at https://cahps.ahrq.gov/clinician_group/.
- ³ Rand Health. 2009. "Medical Outcomes Study: 36-Item Short Form Survey." Available at http://www.rand.org/health/surveys_tools/mos/mos_core_36item.html.
- ⁴ Makoul, G. 2001. "The SEGUE Framework for teaching and assessing communication skills." *Patient Education and Counseling*, 45: 23-34.
- ⁵ Hebert, R., M. Raiche, M.F. Dubois, N.R. Gueye, N. Dubuc, M. Tousignant, and The PRISMA Group. 2010. "Impact of PRISMA, a coordination-type integrated service delivery system for frail older people in Quebec (Canada): A quasi-experimental study." *Journal of Gerontology*, 65: 107-118.
- ⁶ Stainkey, L.A., I.A. Seidl, A.J. Johnson, G.E. Tulloch, and T. Pain. 2010. "The challenge of long waiting lists: How we implemented a GP referral system for non-urgent specialist' appointments at an Australian public hospital." *BMC Health Services Research*, 10:303-307.
- ⁷ AMA (American Medical Association). 2011. *Standardization of prior authorization process for medical services white paper*. Available at <http://www.ama-assn.org/resources/doc/psa/standardization-prior-auth-whitepaper.pdf>.
- ⁸ Pascoe, G.C. 1983. "Patient Satisfaction in Primary Health Care: A Literature Review and Analysis." *Evaluation and Program Planning* 6: 185-210.
- ⁹ Shaul, J.A., S.V. Eisen, V.L. Stringfellow, B.R. Clarridge, R.C. Hermann, D. Nelson. E. Anderson, A.I. Kubrin, H.S. Leff, and P.D. Cleary. 2001. "Use of consumer ratings for quality improvement in behavioral health insurance plans." *The Joint Commission Journal on Quality Improvement*, 27(4): 216-219.
- ¹⁰ Coughlin, T.A., S.K. Long, and S. Kendall. 2002. "Health Care Access, Use, and Satisfaction Among Disabled Medicaid Beneficiaries." *Health Care Financing Review* 24 (2): 115-136.
- ¹¹ HHSC (Texas Health and Human Services Commission). 2012a. Medicaid Managed Care Initiatives. Available at <http://www.hhsc.state.tx.us/medicaid/MMC.shtml>.
- ¹² Half of all STAR+PLUS members (53 percent) are dual-eligible in both Medicaid and Medicare. The FY 2012 STAR+PLUS Member Survey represents the half of the program population (47 percent) younger than 65 years old, and who meet other criteria for eligibility in STAR+PLUS.
- ¹³ Members who were part of the STAR+PLUS expansion into Jefferson SA on September 1, 2011 did not meet the eligibility criteria for the survey.
- ¹⁴ CAHPS® 2012a.
- ¹⁵ CAHPS® 2012b.
- ¹⁶ Rand Health. 2009.

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- ¹⁷ HHSC. 2012b. CY 2012 HHSC MCO Quality Performance Indicators. Available at: http://www.hhsc.state.tx.us/medicaid/umcm/Chp10/10_1_7.pdf.
- ¹⁸ CDC (Centers for Disease Control and Prevention). 2012. U.S. Obesity Trends. Available at: <http://www.cdc.gov/obesity/data/trends.html>.
- ¹⁹ Ogden, C.L., M.D. Carroll, B.K. Kit, K.M. Flegal. 2012. "Prevalence and trends in obesity among U.S. adults, 2009 – 2010." Available at <http://www.cdc.gov/nchs/data/databriefs/db82.pdf>.
- ²⁰ Chi-square = 87.09, $p < 0.001$.
- ²¹ Chi-square = 25.65, $p < 0.001$.
- ²² Chi-square = 25.13, $p = 0.02$, $\phi = 0.13$
- ²³ $F = 2.94$, $p < 0.001$.
- ²⁴ ACP (American College of Physicians). 2007. *Joint Principles of the Patient-Centered Medical Home*. Available at: http://www.acponline.org/running_practice/pcmh/demonstrations/jointprinc_05_17.pdf.
- ²⁵ To permit statistical comparisons among the MCO-SA groups, percentages in this figure are not weighted.
- ²⁶ Chi-square = 58.45, $p < 0.001$.
- ²⁷ Chi-square = 21.12, $p < 0.001$.
- ²⁸ $F = 1.96$, $p = 0.02$.
- ²⁹ Chi-square = 44.68, $p < 0.001$, $\phi = 0.12$
- ³⁰ Chi-square = 23.01, $p < 0.05$, $\phi = 0.09$
- ³¹ Chi-square = 25.13, $p = 0.02$, $\phi = 0.13$
- ³² Chi-square = 44.68, $p < 0.001$, $\phi = 0.12$
- ³³ Makoul, G. 2001.
- ³⁴ Hebert, R., et al. 2010.
- ³⁵ Stainkey, L.A., et al. 2010.
- ³⁶ AMA. 2011.
- ³⁷ Members who were part of the STAR+PLUS expansion into Jefferson SA on September 1, 2011 did not meet the eligibility criteria for the survey.
- ³⁸ CAHPS® 2012a.
- ³⁹ CAHPS® 2012b.

⁴⁰ Rand Health. 2009.

⁴¹ NCQA (National Committee for Quality Assurance). 2012. [Quality Compass](http://www.ncqa.org/tabid/177/default.aspx). Available at: <http://www.ncqa.org/tabid/177/default.aspx>.

⁴² Friedman, B., M. Heisel, R. Delavan. 2005. "Validity of the SF-36 five-item Mental Health Index for major depression in functionally impaired, community-dwelling elderly patients." *Journal of the American Geriatric Society* 53(11): 1978-1985.

⁴³ HHSC. 2012b.

⁴⁴ National Center for Health Statistics. 2008. *National Health Interview Survey*. Available at: <http://www.cdc.gov/nchs/nhis.htm>.

⁴⁵ U.S. Census Bureau. 2008. *Current Population Survey*. Available at: <http://www.census.gov/cps>.

⁴⁶ Urban Institute. 2008. *National Survey of America's Families*. Available at: <http://www.urban.org/center/anf/nsaf.cfm>.

⁴⁷ Griffiths, K.M., H. Christensen, A.F. Jorm, K. Evans, C. Groves. 2004. "Effect of web-based depression literacy and cognitive-behavioural therapy interventions on stigmatising attitudes to depression: Randomised controlled trial." *The British Journal of Psychiatry* 185: 342-349.

⁴⁸ Chi-square = 57.608, $p < 0.001$.

⁴⁹ T-test = -14.067, $p < 0.001$.

⁵⁰ CDC, 2012.