



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

The Texas STAR+PLUS Program Adult Member Survey Report

Fiscal Year 2011

Measurement Period:

September 1, 2010 through August 31, 2011

**The Institute for Child Health Policy
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**The External Quality Review Organization
for Texas Medicaid Managed Care and CHIP**

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Executive Summary

Introduction

This report provides results from the fiscal year 2011 STAR+PLUS Adult Member Survey for the State of Texas, prepared by the Institute for Child Health Policy (ICHP) at the University of Florida. In fiscal year 2011, the STAR+PLUS program was administered through four managed care organizations (MCOs), providing services in four geographic service areas (SAs) of Texas. The Texas Health and Human Services Commission (HHSC) contracts with ICHP to evaluate members' experiences and satisfaction with their health care while enrolled in the STAR+PLUS program.

The purpose of the fiscal year 2011 STAR+PLUS Adult Member Survey is to:

- Describe the demographic and household characteristics of members.
- Assess the health status of the population, including body mass index (BMI) and activities of daily living.
- Document member experiences and general satisfaction with the care they receive through STAR+PLUS across four domains of care:
 - Access to and timeliness of care
 - Patient-centered medical home
 - Service coordination
 - Health plan information and customer service
- Test the influence of domains of care on member understanding of service coordination, controlling for demographic, health status, and health services delivery variables.

Methodology

Survey participants were selected from a stratified random sample of members enrolled in STAR+PLUS for nine months or longer between December 2009 and November 2010. The EQRO set a target sample of 3,000 completed telephone interviews with members, representing 300 respondents for each of the 10 MCO/SA groups in STAR+PLUS. The response rate for this survey was 53 percent and the cooperation rate was 75 percent.

The fiscal year 2011 STAR+PLUS Adult Member Survey included:

- The Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) Health Plan Survey 4.0 (Medicaid module).
- Items developed by ICHP pertaining to member demographic and household characteristics, and member experiences and satisfaction with service coordination.

Summary of Findings

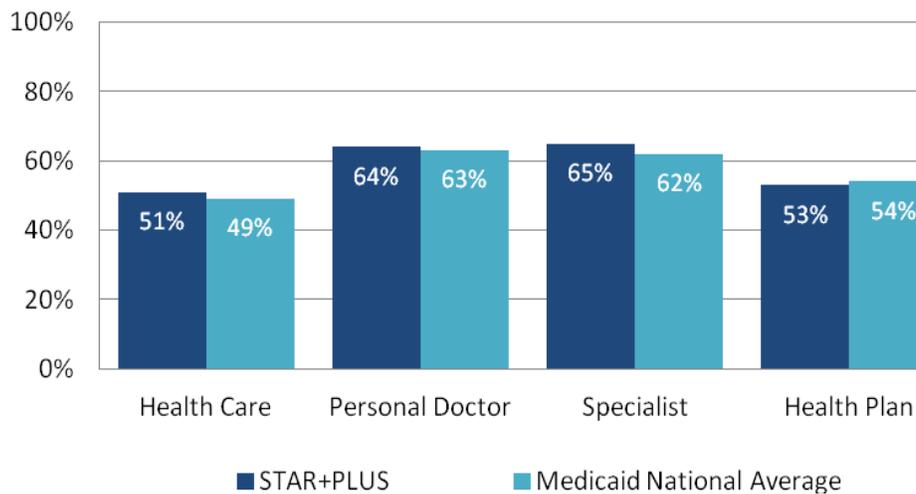
Profile of STAR+PLUS survey participants (members):

- The average age was 50 years old.
- Hispanic members were the most common racial/ethnic group (38 percent), followed by Black, non-Hispanic members (31 percent), and White, non-Hispanic members (27 percent).
- Forty-two percent of members did not complete high school.
- Ninety-five percent of members were unemployed.
- One-third of members were single (36 percent), one-quarter of members were divorced (24 percent), and 16 percent were married.

Positive findings

- *Member Ratings.* The 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”

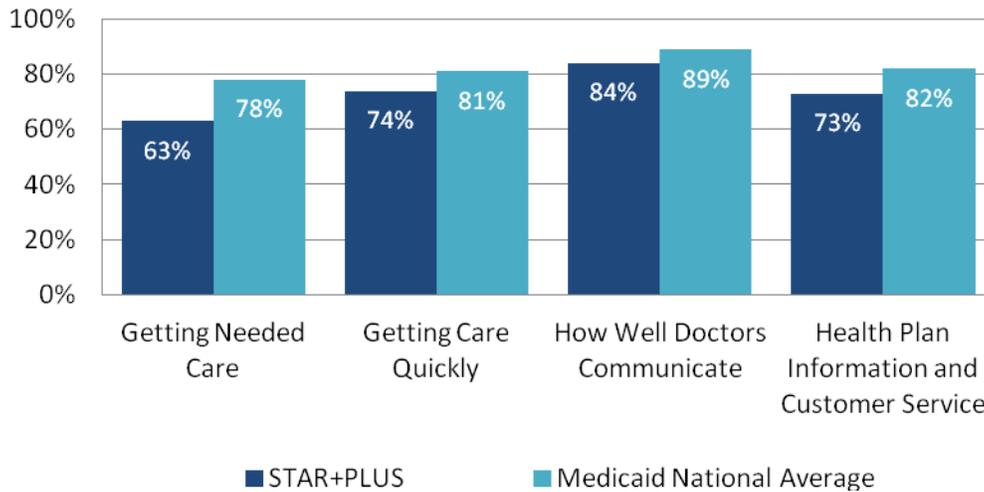


- *Access to Specialist Referral.* The majority of members reported that it was usually or always easy to get a referral to see a specialist (64 percent). Eight of the 10 MCO/SA groups met the HHSC Dashboard standard of 62 percent for good access to specialist referrals.
- *Access to Specialized Services.* The majority of members needing specialized services said it was usually or always easy to get specialized services, such as home health care and assistance (70 percent), mental health treatment (67 percent), and special therapies (54 percent). Eight of the 10 MCO/SA groups met the HHSC Dashboard standard of 47 percent for good access to special therapies.
- *Access to Prescription Medicines.* A large majority of members reported it was usually or always easy to get the prescription medicines they needed (83 percent).
- *Presence of a Usual Source of Care.* A large majority of members reported having a personal doctor (85 percent).
- *Preventive Care.* Among members who said they smoked cigarettes, 68 percent said their doctor advised them to quit smoking on at least one office visit in the last six months. All 10 MCO/SA groups met the HHSC Dashboard standard of 28 percent for advice on quitting smoking.
- *Shared Decision-Making.* A large majority of members said they usually or always were involved as much as they wanted in decisions about their health care (84 percent).

Improvement areas

- *Body Mass Index.* Rates of obesity in STAR+PLUS were considerably higher than state and national averages, at 54 percent for women and 40 percent for men.
- *Getting Needed Care.* Sixty-three percent of STAR+PLUS members usually or always had positive experiences with *Getting Needed Care*, compared to the 78 percent reporting for Medicaid plans nationally.
- *Good Access to Urgent Care.* Seventy-six percent of STAR+PLUS members said they usually or always received urgent care as soon as it was needed. Only five of the 10 MCO/SAs performed at or above the HHSC Dashboard standard of 76 percent for good access to urgent care.
- *Good Access to Routine Care.* Seventy-three percent of STAR+PLUS members said they usually or always received an appointment for routine care as soon as it was needed. None of the 10 MCO/SAs met the HHSC Dashboard standard of 78 percent for good access to routine care.
- *Office Wait.* Only 28 percent of members reported waiting less than 15 minutes to be taken to the exam room. None of the 10 MCO/SAs met the HHSC Dashboard standard of 42 percent for this indicator.

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



- *Service Coordination.* Only 24 percent of members reported having a service coordinator, suggesting a low level of understanding of service coordination benefits. Among the majority of members who said they did not have a service coordinator, 46 percent said they would like someone from their STAR+PLUS health plan to arrange services for them.
- *Health Plan Information and Customer Service.* Seventy-three percent of STAR+PLUS members usually or always had positive experiences with *Health Plan Information and Customer Service*, compared to the 81 percent reporting for Medicaid plans nationally.
- *Health Plan Approval.* Only 39 percent of members reported having no delays in health care while waiting for health plan approval. None of the 10 MCO/SAs met the HHSC Dashboard standard of 57 percent for this indicator.

HHSC Performance Dashboard Indicators	STAR+PLUS	HHSC Standard
<i>Good access to urgent care</i>	76%	76%
<i>Good access to specialist referral</i>	64%	62%
<i>Good access to routine care</i>	73%	78%
<i>No delays for an approval</i>	39%	57%
<i>No exam room wait greater than 15 minutes</i>	28%	42%
<i>Good access to special therapies</i>	54%	47%
<i>Good access to service coordination</i>	69%	-
<i>Advising smokers to quit</i>	68%	28%

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 member understanding of service coordination, which is one of HHSC's overarching goals for STAR+PLUS MCOs.

Domain	Recommendations	Rationale	HHSC Response
Member understanding of service coordination in STAR+PLUS	<ul style="list-style-type: none"> • To improve member understanding of service coordination, MCOs should focus their performance improvement projects on members who do not have a usual source of care. These members have the greatest need for resources relevant to service coordination. • STAR+PLUS MCOs with lower scores on <i>Health Plan Information and Customer Service</i> should consider interventions to improve the accuracy of information provided to members and/or the responsiveness of customer service representatives. • STAR+PLUS service coordinators should stay up-to-date on successful innovations implemented by disability care coordination 	<p>Only one in four STAR+PLUS members reported having a service coordinator, suggesting an overall low level of awareness of this important program benefit.</p> <p>Members who had a personal doctor were twice as likely to say they had a service coordinator.</p> <p>Members who had high scores on the CAHPS® <i>Health Plan Information and Customer Service</i> composite were also twice as likely to say they had a service coordinator.</p>	<p>One of HHSC's overarching goals for STAR+PLUS in 2012 is to improve members' understanding and utilization of service coordination. The STAR+PLUS MCO's developed performance improvement projects that focus on the need for improving service coordination. The EQRO will review the Performance Improvement Projects and provide HHSC a mid-year analysis.</p>

	organizations (DCCOs), which include directly linking medical and behavioral health providers in the clinical setting and at the point of provider-patient contact. ¹		
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Introduction and Purpose

The STAR+PLUS Program is a Texas Medicaid Managed Care program designed to integrate the delivery of acute and long-term services and supports for low-income aged and disabled members.² Members in STAR+PLUS receive acute primary and specialist care, long-term services such as attendant care and adult day health care, and service coordination to address complex medical conditions. Service coordinators are responsible for developing a care plan with members, their families, and providers to ensure that members' health care needs are met.

Studies have demonstrated that low-income aged and disabled Medicaid members experience barriers to health care access and report low satisfaction with health care services.^{3,4,5} Patients' rating of satisfaction with health care is an indicator of quality of care, and has been associated with positive health-related behaviors, such as compliance with treatment regimens.^{6,7} The assessment of health care satisfaction among the low-income aged and disabled is an essential component for evaluating the quality of care for this unique population.

This report presents findings from the Texas STAR+PLUS Adult Member Survey conducted by the Institute for Child Health Policy – the External Quality Review Organization (EQRO) for Texas Medicaid managed care – evaluating members' experiences and satisfaction with the care they receive through STAR+PLUS managed care organizations (MCOs). At the beginning of fiscal year 2011, the STAR+PLUS program operated in 29 counties in the Travis, Bexar, Nueces, and Harris Service Areas.⁸ In February 2011, STAR+PLUS expanded to the Dallas and Tarrant Service Areas and now operates in 42 counties. This report presents data collected from members who were in STAR+PLUS before the expansion.

The purpose of the fiscal year 2011 STAR+PLUS Adult Member Survey is to:

- Describe the demographic and household characteristics of adult members.
- Assess the health status of the population, including overall health ratings, BMI/obesity, and activities of daily living.
- Document member experiences and general satisfaction with the care they receive through STAR+PLUS MCOs across four domains of care:
 - Access to and timeliness of care
 - Patient-centered medical home
 - Service coordination
 - Health plan information and customer service
- Test the influence of domains of care on member understanding and utilization of service coordination, controlling for demographics, health status, and MCO membership.

In addition, this report presents findings on a separate survey of the STAR+PLUS dual-eligible population, comparing member experience and satisfaction between fiscal year 2010 and 2011.

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 used a stratified sampling strategy to permit comparison of survey responses across the following ten MCO-Service Area (SA) groups operating in STAR+PLUS in fiscal year 2011:

- AMERIGROUP – Bexar
- AMERIGROUP – Harris
- AMERIGROUP – Travis
- Evercare – Harris
- Evercare – Nueces
- Evercare – Travis
- Molina – Bexar
- Molina – Harris
- Superior – Bexar
- Superior – Nueces

A stratified random sample of adult STAR+PLUS members was selected, with a target of 3,000 completed telephone interviews (representing 300 respondents per MCO/SA). STAR+PLUS members 18 to 64 years old were considered for inclusion in the survey sample if they were continuously enrolled in a STAR+PLUS MCO for at least nine months between December 2009 and November 2010. Members who were eligible for both Medicaid and Medicare (dual-eligibles) and members who participated in the prior year's survey (FY 2010) were excluded.

Survey Instruments

The fiscal year 2011 STAR+PLUS Adult Member Survey includes:

- The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 4.0 (Medicaid module).⁹
- Items developed by ICHP pertaining to member demographic and household characteristics, and member experiences and satisfaction with service coordination.

The CAHPS® Health Plan Survey (Version 4.0) is a widely used instrument for measuring and reporting consumer experiences with their health plan and providers. It 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. The EQRO calculated CAHPS® composite scores in the following four domains:

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

Where applicable, STAR+PLUS results for CAHPS® composites and specific CAHPS® items are compared to national Medicaid averages reported by the Agency for Healthcare Research and Quality

(AHRQ).¹⁰ National Medicaid averages are based on survey results for the general Medicaid population reported by state agencies. Differences are expected on most measures between the national averages and STAR+PLUS, which is intended for members with chronic illness and disability.

The survey includes eight questions that function as indicators of health plan performance for adult STAR+PLUS members, as listed on HHSC's Performance Indicator Dashboard for fiscal year 2010.¹¹ 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 exam room wait greater than 15 minutes; (6) Good access to special therapies; (7) Good access to service coordination; and (8) Advising smokers to quit.

Survey Data Collection Techniques

The EQRO sent letters written in English and Spanish to 16,311 sampled STAR+PLUS members, requesting their participation in the survey. Of the advance letters sent, 27 were returned undeliverable.

The Survey Research Center (SRC) at the University of Florida conducted the survey using computer-assisted telephone interviewing (CATI) between February 2011 and November 2011. The SRC telephoned STAR+PLUS members seven days a week between 10 a.m. and 9 p.m. Central Time. Of 2,936 completed interviews, 106 (4 percent) were conducted in Spanish. On average, 7.1 calls per phone number were made in the STAR+PLUS member sample.

Forty-nine percent of members could not be located. Among those located, two percent indicated that they were not enrolled in STAR+PLUS at the time of the survey (and were excluded from participation), and 12 percent refused to participate. The response rate was 53 percent and the cooperation rate was 75 percent.

Data Analysis

The EQRO conducted descriptive statistics and statistical tests using SPSS 17.0 (Chicago, IL: SPSS, Inc.). Frequency tables showing descriptive results for each survey question are provided in a separate Technical Appendix.¹² Supplementary tables of results are provided in **Appendix B**. 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.

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). These tests allowed for comparison of frequencies and means among the different MCO-SA groups and among the demographic sub-groups within the sample.

In addition, researchers conducted a multivariate analysis to examine the effects of demographic, health status, and health delivery factors on STAR+PLUS members' awareness of service coordination offered by the program. A more detailed description of this analysis is presented in **Appendix C**.

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

The majority of survey respondents were female (64 percent), and the mean age among all respondents was 50 years old. Hispanic members represented the largest racial/ethnic group (38 percent), followed by Black, non-Hispanic members (31 percent) and White, non-Hispanic members (27 percent). However, 84 percent of respondents stated the language spoken in their home was English. Five percent of surveyed members were of “Other” race/ethnicity, which included American Indian/Alaskan Native (2.5 percent) and Asian/Pacific Islander (1.0 percent).

Overall, STAR+PLUS members had low educational and employment status, were more likely to be single or divorced than to be married, and were more likely to live in a single-parent household and in rented housing.

	STAR+PLUS Members
Mean Age (years)	49.8 (SD = 11.0)
Sex	
Female	64%
Male	36%
Race/Ethnicity	
Hispanic	38%
Black, Non-Hispanic	31%
White, Non-Hispanic	27%
Other	5%

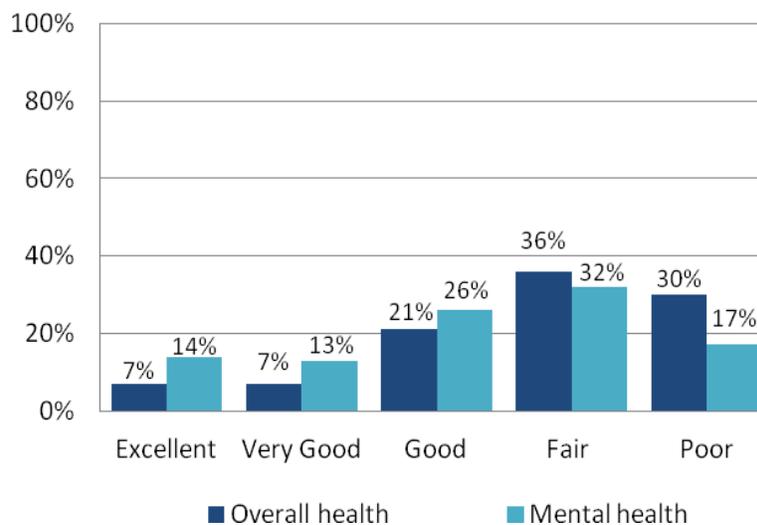
- Forty-two percent of respondents had not attained a high school diploma, while more than half had a high school diploma or equivalent (54 percent), and five percent of the respondents had attained a college degree.
- The vast majority of respondents said they were not employed at the time of the survey (95 percent).
- One-third of respondents reported they were single (36 percent), which was the most common marital status in the sample. Married individuals represented 16 percent of the sample, and divorced individuals represented 24 percent of the sample.
- Greater than half of respondents lived in a single-parent household (52 percent). One out of four reported they were not a parent (26 percent), indicating that no children lived in the household.
- The most common type of housing reported by respondents was rented housing (45 percent). One in four reported they owned their home (24 percent). Eleven percent lived in public or subsidized housing.

Health Status

Self-reported health status was generally low for both overall and mental health (**Figure 1**). This is expected in the STAR+PLUS population, which has higher rates of chronic illness and disability than the general Medicaid population.

- Two-thirds of respondents rated their overall health as fair or poor (66 percent), while only 14 percent rated their health as excellent or very good. STAR+PLUS members had considerably lower self-reported health status than the national Medicaid population, in which 32 percent of members rated their health as fair or poor.
- Mental health ratings were slightly higher, with nearly half of respondents rating their mental health as fair or poor (48 percent), and greater than one in four respondents rating their mental health as excellent or very good (26 percent).

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



Body Mass Index

Figure 2 provides the Body Mass Index (BMI) results for STAR+PLUS members in the sample. Based on their weight and height data, nearly half of members were classified as obese (49 percent), and one-quarter were classified as overweight (26 percent). The obesity rate was considerably greater among STAR+PLUS members than among adults in the national population (34 percent) or the Texas population (31 percent), as reported by the Centers for Disease Control and Prevention in 2010.¹³

Obesity Prevalence in the U.S. by Sex and Race/Ethnicity ^a	
	% obese in population
Men	32%

- Female members had a significantly higher rate of obesity than male members (54 percent vs. 40 percent).¹⁵ The gender difference in STAR+PLUS was greater than that observed for the U.S. adult population.
- Obesity rates were significantly higher among Hispanic members (55 percent) and Black, non-Hispanic members (52 percent) than among White, non-Hispanic members (41 percent).¹⁶

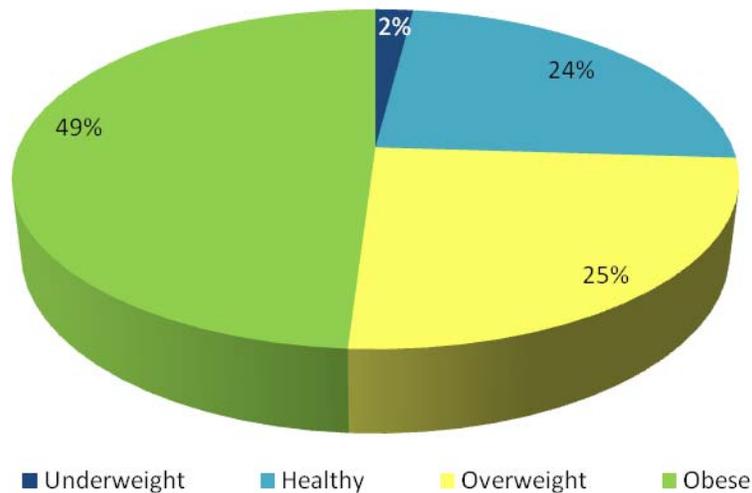
Women	36%
Hispanic	38%
Non-Hispanic Black	44%
Non-Hispanic White	33%

Based on the National Health Examination and Nutrition Survey, 2007-2008¹⁴

The racial-ethnic difference in STAR+PLUS was similar to that observed for the U.S. adult population, although in STAR+PLUS, Hispanic members had the highest rate of obesity.

- Obesity rates also varied considerably by MCO-SA group, as shown on **Table B1** in Appendix B. Obesity in STAR+PLUS was consistently above the national average for all MCOs, ranging from 45 percent in AMERIGROUP-Harris and AMERIGROUP-Travis to 55 percent in Superior-Nueces.

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



Activities of Daily Living

An important component of health status involves a person's independence and ability to perform specific tasks of daily living, in which low levels of functioning indicate disability and dependence on others.

- 72 percent of respondents reported having a physical or medical condition that seriously interferes with their independence, participation in the community, or quality of life.
- 51 percent of respondents reported they needed help with their routine needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes.
- 32 percent of respondents reported they needed help with their personal care needs, such as eating, dressing, or getting around the house.

These findings indicate that a large majority of STAR+PLUS members are in need of assistance with personal care and daily tasks. This is of particular relevance for the STAR+PLUS program, given that the majority of respondents reported they were single, divorced, and/or living in a single-parent household (as discussed above).

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

Greater than half of respondents said they had an illness, injury, or condition for which they needed urgent medical care in the past six months (52 percent). Three out of four respondents said they made appointments for their health care at a doctor's office or clinic in the past six months (79 percent), indicating a need for routine care.

Two CAHPS[®] survey questions comprise the composite *Getting Care Quickly*, assessing how often members were able to get routine and urgent care. Overall, 74 percent of members "usually" or "always" had positive experiences with *Getting Care Quickly*. This is below the 81 percent reported for this composite measure in Medicaid plans nationally.

The mean score for the CAHPS[®] composite *Getting Care Quickly* was 2.35 out of 3.00, following NCQA specifications. Differences between MCO/SA groups on this composite were not statistically or meaningfully significant (**Table B2** in Appendix B).

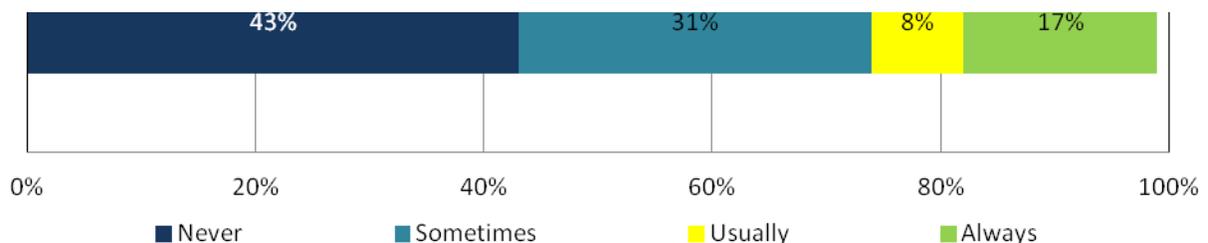
The two survey items that make up the *Getting Care Quickly* composite are also HHSC Performance Dashboard Indicators (**Table B3** in Appendix B).

- *Good Access to Urgent Care.* Seventy-six percent of members who needed care right away for an illness, injury, or condition reported they usually or always received care as soon as needed. This percentage meets the HHSC Dashboard standard of 76 percent. The percentage of STAR+PLUS members with good access to urgent care ranged from 68 percent in Evercare-Travis to 81 percent in Molina-Harris. Five MCO/SAs performed at or above the 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 78 percent. The percentage of members with good access to routine care ranged from 71 percent in AMERIGROUP-Bexar, AMERIGROUP-Travis, Evercare-Travis, Superior-Bexar, and Superior-Nueces to 76 percent in Molina-Harris. None of the MCO/SAs met the Dashboard standard for good access to routine care.

Members were also asked how many days they usually had to wait between making an appointment for routine care and actually seeing a health provider. Slightly greater than half of members said they were able to get an appointment with a health provider within three days (52 percent). Thirty percent of members said they had to wait longer than one week to get an appointment.

For some members, access to providers was hampered by provider hours and availability (see **Figure 3**). When asked how often they had to wait for an appointment because their provider worked limited hours or had few appointment slots available, 43 percent of members said they never had to wait for an appointment, 31 percent said they sometimes had to wait for an appointment, and 25 percent said they usually or always had to wait.

Figure 3. How Often Member Waited for a Routine Appointment Because Provider Worked Limited Hours or Had Few Available Appointments

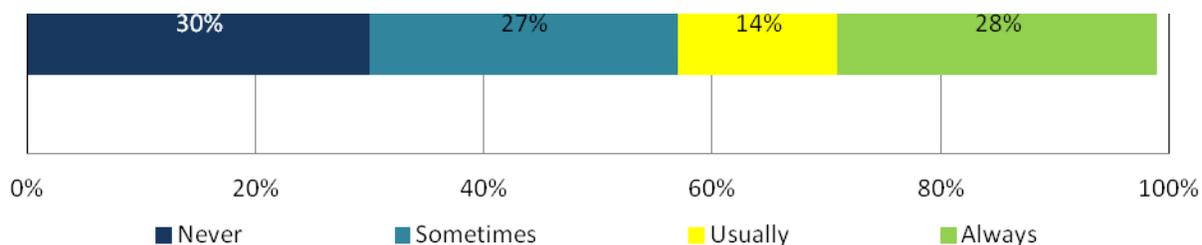


Members were also asked about their experiences seeking after-hours care. Sixteen percent of members said they needed to visit a doctor’s office or clinic for after-hours care. Among these members, 50 percent said it was usually or always easy to get after-hours care, and 50 percent said it was sometimes or never easy to get after-hours care.

Lastly, members were asked how often they were seen within 15 minutes of their appointment time in the past six months (**Figure 4**). This question is an HHSC Dashboard Indicator for the STAR+PLUS program, as shown on **Table B3** in Appendix B.

- *No Exam Room Wait 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 considerably lower than the HHSC Dashboard standard of 42 percent. The percentage of members who reported waiting no longer than 15 minutes ranged from 21 percent in Superior-Nueces to 36 percent in AMERIGROUP-Travis, and differences among the MCO/SA groups were statistically significant. None of the MCO/SA groups met the HHSC Dashboard standard for this measure.

Figure 4. How Often Members Waited 15 Minutes or Less to be Taken to the Exam Room



Specialist Care

Forty-six percent of members reported that they tried to make an appointment to see a specialist in the last six months. Among these members, 63 percent indicated that it was usually or always easy to get a specialist appointment. Having good access to specialist referrals is an HHSC Performance Dashboard Indicator.

- *Good Access to Specialist Referrals.* Sixty-four percent of members reported it was usually or always easy to get a referral to a specialist they needed to see. This percentage meets the HHSC Dashboard standard of 62 percent for this indicator. The percentage of STAR+PLUS members who had good access to specialist referrals ranged from 59 percent in Molina-Harris to 68 percent in Evercare-Nueces (**Table B3** in Appendix B). Eight of the ten MCO/SA groups met the Dashboard standard for this survey item.

When asked to rate their specialist on a scale of 0 to 10, 65 percent of members gave a rating of 9 or 10. This is comparable to the 62 percent of the national Medicaid population who gave their specialist a rating of 9 or 10. The mean specialist rating was 8.5 (SD = 2.3).

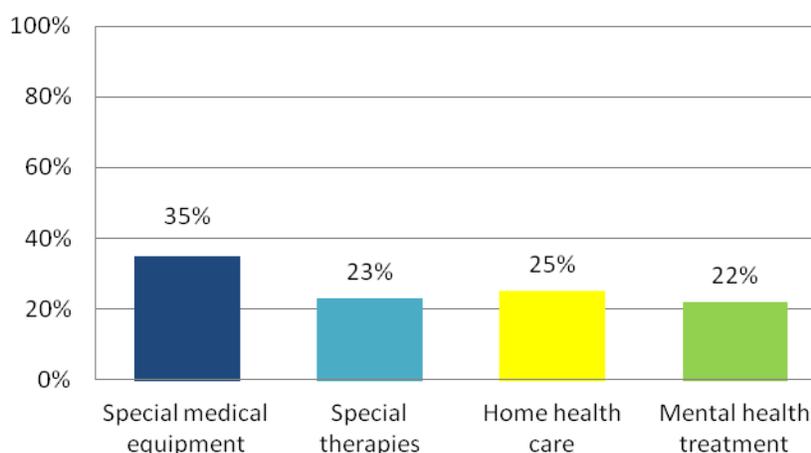
The CAHPS® composite *Getting Needed Care* is based on two survey items that assess: (1) How often it was easy for members to get appointments with specialists, and (2) How often it was easy for members to get the care, tests and treatment they needed through their health plan. Sixty-three percent of members “usually” or “always” had positive experiences with *Getting Needed Care*, compared to the 78 percent in the national Medicaid population. The mean score for the CAHPS® composite *Getting Needed Care* was

2.11 out of 3.00, following NCQA specifications. Differences between MCO/SA groups on this composite were not statistically significant (**Table B2** in Appendix B).

Specialized Services

Figure 5 shows the percentage of STAR+PLUS members who needed specialized services, such as special medical equipment or devices, special therapies, home health care or assistance, and mental health services. Greater than one-third of members needed special medical equipment, such as a cane, a wheelchair, or oxygen equipment (35 percent). About one in four members needed home health care or assistance (25 percent), special therapies (23 percent), or mental health treatment (22 percent).

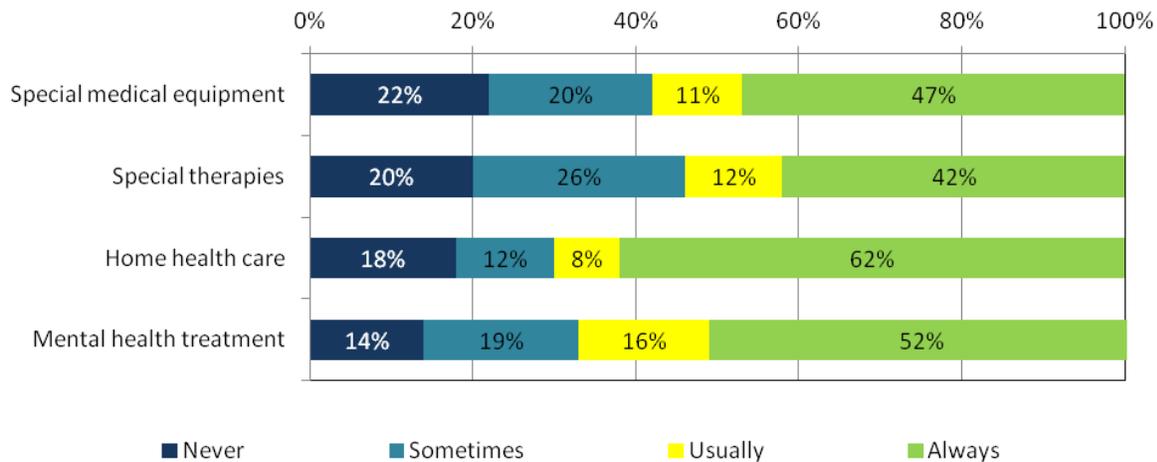
Figure 5. The Percentage of STAR+PLUS Members Needing Specialized Services



These members were asked how often it was easy to get the specialized services they needed (**Figure 6**). Good access to specialized services – defined as a response of “usually” or “always” – was highest for home health care (70 percent), followed by mental health treatment (67 percent). Having good access to special therapies is an HHSC Performance Dashboard Indicator for STAR+PLUS.

- *Good Access to Special Therapies.* Fifty-four percent of STAR+PLUS members needing special therapies said it was “usually” or “always” easy to get this therapy. This percentage meets the HHSC Dashboard standard of 47 percent for this indicator. The percentage of STAR+PLUS members who had good access to special therapies ranged from 39 percent in AMERIGROUP-Travis to 66 percent in Evercare-Harris (**Table B3** in Appendix B). Eight of the ten MCO/SA groups met the Dashboard standard for this survey item.

Figure 6. STAR+PLUS Member Responses for How Easy It Was to Get Specialized Services



Prescription Medicines

Eighty-one percent of STAR+PLUS members said they got new prescription medicines or refilled a medication during the past six months. Among these members, 83 percent said it was “usually” or “always” easy to get prescription medicine from their health plan. Most members reported taking medications for chronic conditions. Ninety-four percent of those who took or needed prescription medication said the medication was to treat a condition that has lasted for at least three months.

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, 51 percent of members gave a rating of 9 or 10. This is comparable to the 49 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 = 2.5).

Patient-Centered Medical Home

This section examines STAR+PLUS member experiences 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:¹⁷

- 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

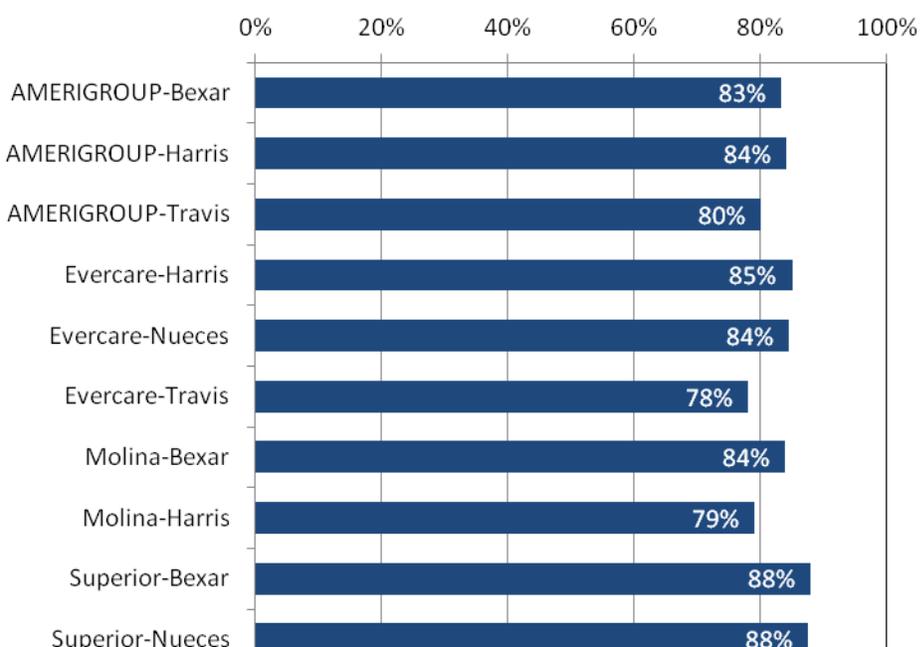
This survey addressed different components of the medical home model, specifically whether members have an ongoing relationship with a personal doctor, have access to advice and care during and after regular business hours, and receive high-quality, patient-centered, and compassionate care from their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

Presence of a Usual Source of Care

Overall, 85 percent of STAR+PLUS members reported having a personal doctor. **Figure 7** presents the percentage of STAR+PLUS members who had a personal doctor in each MCO/SA group.¹⁸ Differences among the MCO/SA groups were statistically significant, with the percentage of members with a personal doctor ranging from 78 percent in Evercare-Travis to 88 percent in Superior-Bexar and Superior-Nueces.¹⁹ These findings are comparable to the 79 percent of Medicaid members nationally who had a personal doctor.

Two-thirds of members who had a personal doctor had been going to their personal doctor for two or more years (66 percent), which suggests the presence of a continuous, long-term relationship with a usual source of care. However, 60 percent of members said that they did not have the same personal doctor before they joined their STAR+PLUS health plan. These findings suggest that, although continuity of care is good for STAR+PLUS members currently enrolled, a large percentage of STAR+PLUS members may experience disruption in the continuity of care at the time of enrollment.

Figure 7. The Percentage of STAR+PLUS Members with a Personal Doctor by MCO/SA



Among STAR+PLUS members who had a personal doctor:

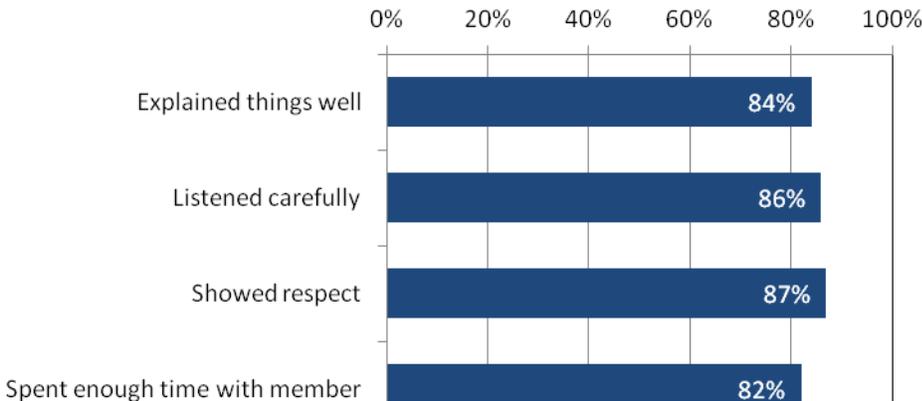
- Two-thirds said they phoned their personal doctor's office during regular office hours to get help or advice (64 percent). Seventy-four percent of these members said they usually or always got the help or advice they needed.
- Nearly one in four said they phone their personal doctor's office after regular office hours to get help or advice (22 percent). Sixty-five percent of these members said they usually or always got the help or advice they needed.

Satisfaction with Doctors' Communication

Four CAHPS® survey questions 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 they usually or always had positive communication experiences with their personal doctor (**Figure 8**).

The majority of members were highly satisfied with the quality of communication they had with their personal doctor. Combining responses to all four questions, 84 percent of STAR+PLUS members usually or always had positive experiences with *How Well Doctors Communicate*. This percentage is slightly lower than the 89 percent reported for Medicaid members nationally. Following NCQA specifications, the mean score for *How Well Doctors Communicate* was 2.59 out of 3.00. Differences among the MCO/SA groups on this measure were not statistically significant (**Table B2** in Appendix B).

Figure 8. How Well Doctors Communicate – The Percentage of Members Who Reported Their Personal Doctor Usually or Always...



Preventive Care and Health Promotion

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 (71 percent). Five percent of members said their last routine checkup was five or more years ago. Seven percent reported never having had a routine checkup.

One-third of the survey sample said they smoked cigarettes or used tobacco (35 percent). The percentage of these 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-eight percent of STAR+PLUS members who smoked reported they had been advised to quit smoking by a doctor or other health provider at least once during the past six months. This percentage greatly exceeds the HHSC Dashboard standard of 28 percent for this indicator. The percentage of STAR+PLUS members who were advised to quit smoking ranged from 55 percent in Molina-Bexar to 73 percent in Evercare-Harris (**Table B3** in Appendix B). All of the ten MCO/SA groups met the Dashboard standard for this survey item. Hispanic members were significantly less likely to have been advised to quit smoking (61 percent) compared to White, non-Hispanic members (70 percent) and Black, non-Hispanic members (68 percent).²⁰ Male members were less likely than female members to have been advised to quit smoking (60 percent vs. 71 percent).²¹

In addition, smokers in the STAR+PLUS survey sample were asked on how many visits their doctor recommended specific strategies to quit smoking. Forty-three percent of these members said their doctor recommended or discussed medication to assist them in quitting on at least one visit. Forty-two percent said their doctor recommended or discussed methods and strategies other than medication to assist them in quitting on at least one visit.

Shared Decision-Making

Fifty-nine percent of STAR+PLUS members said they received care from a doctor or other health provider besides their personal doctor. Among these members, 75 percent said their personal doctor usually or always seemed informed and up-to-date about the care they received from these other providers.

Sixty-one percent of STAR+PLUS members said that decisions were made about their health care in the last six months. Among these members 84 percent said they usually or always were involved as much as they wanted in decisions about their health care, and 78 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

When asked to rate their personal doctor on a scale of 0 to 10, 64 percent of members gave a rating of 9 or 10. This is comparable to the 63 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 = 2.3).

Service Coordination

Survey respondents were also asked a series of questions regarding the service coordination they receive through the STAR+PLUS program. Only 24 percent of members said they had a service coordinator from their STAR+PLUS health plan who helps arrange services for them like doctor visits, transportation, or meals. However, all STAR+PLUS members are assigned a service coordinator upon enrollment.

These findings suggest that the majority of STAR+PLUS members – greater than 75 percent – are not aware that they have a service coordinator. Furthermore, among the majority of members who said they did not have a service coordinator, 46 percent said they would like someone from their STAR+PLUS health plan to arrange services for them.

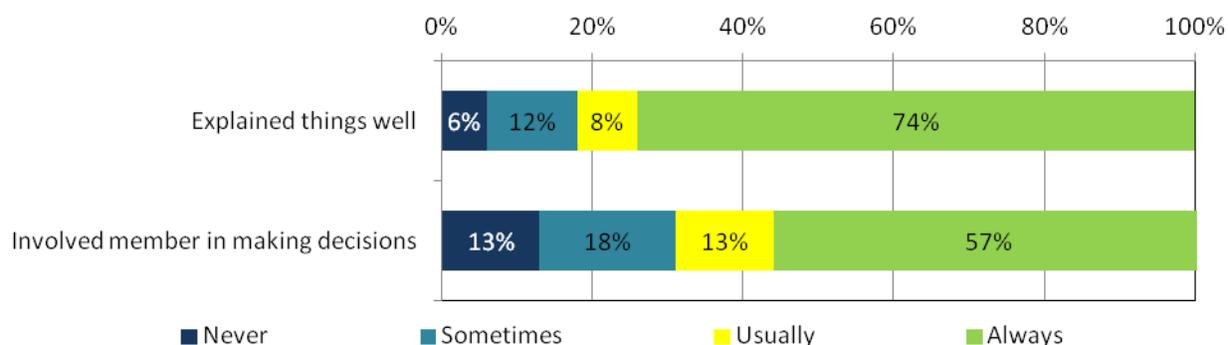
Among members who reported having a service coordinator, about half said they needed service coordination in the past six months (49 percent). The percent of members who usually or always received service coordination help as soon as they thought it was needed is an HHSC Performance Dashboard Indicator for STAR+PLUS:

- *Good Access to Service Coordination.* Sixty-nine 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 it was needed. The percentage of STAR+PLUS members with good access to service coordination ranged from 60 percent in Evercare-Travis and Molina-Harris to 75 percent in Molina-Bexar (**Table B3** in Appendix B).²²

Among members who reported having a service coordinator, 79 percent utilized service coordination in the six months prior to the survey. Utilization was high overall, with 22 percent of members reporting they had received help 5 to 9 times, and 22 percent reporting they had received help 10 times or more.

Figure 9 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. Eighty-two percent of members said their service coordinator usually or always explained things well. Seventy percent of members said their service coordinator involved them in making decisions about their services.

Figure 9. Percentage of STAR+PLUS Members Who Said Their Service Coordinator...



Multivariate Analysis – Member Understanding of Service Coordination

Appendix C presents the methodology and findings of a multivariate analysis, testing the relative influence of health service delivery factors on the likelihood of member awareness of service coordination, controlling for demographic factors, health status, and MCO/SA membership. This analysis found significant associations between the likelihood of member awareness of service coordination and the following factors:

- *Member's age.* Members 51 years of age and older were approximately 1.5 times more likely than members 18 to 30 years of age to say they had a service coordinator.
- *Member's MCO/SA.* Compared with members of Evercare-Travis (who were the most likely to report they had a service coordinator), members of AMERIGROUP-Harris, Molina-Bexar, Molina-Harris, and Superior-Nueces were about half as likely to say they had a service coordinator.
- *Presence of a usual source of care.* Members who had a personal doctor were twice as likely as those who did not have a personal doctor to say they had a service coordinator.
- *CAHPS® Health Plan Information and Customer Service.* Members with high scores on the CAHPS® composite *Health Plan Information and Customer Service* (score = 3.00)

were twice as likely as members with low scores on this composite to say they had a service coordinator.

These findings suggest that having a continuous relationship with a usual source of care, and having positive experiences with health plan information and customer service, can help to improve member understanding of the service coordination benefits they receive through the STAR+PLUS program.

Health Plan

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

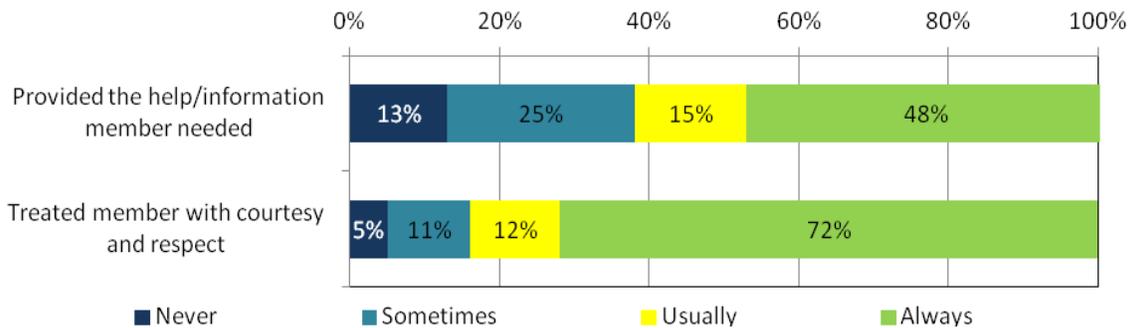
Health Plan Information and Customer Service

Slightly more than half of members said they received information from their STAR+PLUS health plan before they signed up for it (54 percent). Among these members, 57 percent said that all of the information they were given was correct, and 28 percent said that most of the information was correct.

Sixteen percent of members said they looked for information in written materials or on the Internet about how their health plan works. Among these members, 56 percent said they usually or always got the information they needed.

One-third of members said they tried to get help or information from their health plan's customer service in the past six months (32 percent). **Figure 10** 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. Forty-eight percent of members said they always got the help or information they needed from customer service, leaving more than half who had some degree of difficulty getting help or information (52 percent). Member satisfaction with how customer service treated them was high, with 84 percent reporting that customer service usually or always treated them with courtesy and respect.

Figure 10. Percentage of STAR+PLUS Members Who Said Their Health Plan’s Customer Service...



The above items comprise the CAHPS® composite *Health Plan Information and Customer Service*. Combining responses to both questions, 73 percent of STAR+PLUS members “usually” or “always” had positive experiences with *Health Plan Information and Customer Service*, which is below the 81 percent reported for Medicaid plans nationally. Following NCQA specifications, the mean score for this composite was 2.33 out of 3.00. Differences among the MCO/SA groups on this measure were not significant (**Table B2** in Appendix B).

About one-third of members who said they called customer service said it took them only one call to get the help or information they wanted (30 percent). One in four members said it took them two calls to get the help or information they wanted (23 percent). Fourteen percent said they were still waiting for help.

Health Plan Approval

Half of survey respondents 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, 64 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 for an Approval:* Thirty-nine percent of STAR+PLUS members reported having no delays in their health care while waiting for approval from their health plan. This percentage is considerably 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 33 percent in Molina-Bexar to 43 percent in Evercare-Harris and Evercare-Travis (**Table B3** in Appendix B). None of the ten MCO/SA groups met the Dashboard standard for this survey item.

Transportation

One in four members reported phoning their STAR+PLUS health plan to get help with transportation (24 percent). Among those who needed help with transportation, 69 percent said they usually or always received the transportation services they needed from their health plan. When asked whether the transportation met their needs, 78 percent indicated these needs were usually or always met by the health plan.

Members' Satisfaction with Their STAR+PLUS Health Plan

When asked to rate their STAR+PLUS health plan on a scale of 0 to 10, 53 percent of members gave a rating of 9 or 10. This is comparable to the 54 percent of the national Medicaid population who gave their health plan a rating of 9 or 10. The mean health plan rating in STAR+PLUS was 8.0 (SD = 2.5).

Summary Points and Recommendations

This report provides results from the fiscal year 2011 STAR+PLUS Adult Member Survey regarding: (1) Demographic and household characteristics of STAR+PLUS members; (2) the health status of STAR+PLUS members, including 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 having a usual source of care, doctor's communication, preventive care, 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 (64 percent) with a mean age of 50 years old. Hispanic members represented the largest ethnic group (38 percent), followed by Black, non-Hispanic (31 percent), White, non-Hispanic (27 percent), and Other, non-Hispanic (5 percent). Members reported high rates of unemployment (95 percent) and 42 percent of the members did not receive a high school diploma.
- **Member household characteristics.** A majority of the members reported living in a single-parent household (52 percent), and about one quarter (26 percent) indicated no children lived in the home. Rented housing was reported as the most common type of housing (45 percent). One in four members reported owning their own home (24 percent). Eleven percent lived in subsidized housing.

Health status

- **Overall health and mental health.** Two-thirds of members rated their overall health as fair or poor (66 percent). Half of members rated their mental health as fair or poor (48 percent). These findings are expected, as this population has higher rates of chronic illness and disability as compared to other Medicaid programs.

- **Body mass index.** Reported obesity rates were higher than national averages and greater for women (54 percent) than men (40 percent). Hispanic members reported higher rates of obesity (55 percent), followed by Black, non-Hispanic members (52 percent), and White non-Hispanic members (41 percent).
- **Activities of daily living.** A large percentage of members reported needing help with routine needs (51 percent) and personal care needs (32 percent). Nearly three-quarters of the participants indicated having a physical or medical condition which interferes with their independence (72 percent).

Access to and timeliness of care

- **Getting care quickly.** About three-quarters of the members usually or always had positive experiences on the CAHPS® composite *Getting Care Quickly* (74 percent), which is below the national Medicaid average of 81 percent.
- **Good access to urgent care.** Three-quarters of the members reported receiving urgent care when needed (76 percent). Only five MCO/SAs performed at or above the HHSC Dashboard standard of 76 percent for this indicator.
- **Good access to routine care.** About three-quarters of members reported usually or always being able to make a routine appointment (73 percent). Performance on this measure across MCO/SA groups ranged from 71 to 76 percent, with none of the MCO/SA groups meeting the HHSC Dashboard standard of 78 percent for this indicator.
- **Appointment availability and provider hours.** About half of the members reported getting an appointment within three days (52 percent) and about one-third of the participants had to wait longer than one week to get an appointment (30 percent). Forty-three percent of members reported never having appointment delays caused by limited hours or few appointments. Thirty-one percent reported sometimes waiting, and 25 percent reported usually or always waiting for an appointment.
- **Office wait.** Only 28 percent of members reported waiting less than 15 minutes to be taken to the exam room, which is well below the HHSC Dashboard standard of 42 percent for this indicator. While MCO/SA groups differed significantly for this measure, none met the Dashboard standard.
- **Access to specialist care.** Forty-six percent of the members reported making an appointment for a specialist, and a majority of these members said it was usually or always easy to make a specialist appointment (63 percent). Members rated their specialist on a scale from 0 to 10, with an average rating of 8.5. Sixty-five percent gave their specialist a rating of 9 or 10, 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 (64 percent), which is above the HHSC Dashboard standard for this indicator (62 percent). Eight of the 10 MCO/SA groups met the Dashboard standard for this item.

- **Getting needed care.** About two-thirds of members usually or always had positive experiences on the CAHPS® composite *Getting Needed Care* (63 percent), which is below the national Medicaid average (78 percent).
- **Access to specialized services.** Between one-quarter and one-third of members indicated needing specialized services, such as special medical equipment (35 percent), home health care or assistance (25 percent), special therapies (23 percent), and mental health treatment (22 percent). The majority of these members had good access to home health care (70 percent) and mental health treatment (67 percent).
- **Good access to special therapies.** Over half of the members needing special therapy reported that it is “usually” or “always” easy to get this therapy (54 percent). This percentage meets the HHSC Dashboard standard of 47 percent. Eight of the 10 MCO/SA groups met the Dashboard standard for this indicator.
- **Access to prescription medicines.** Over three-quarters of the members reported it was usually or always easy to get prescription medications (83 percent). Most of these members were taking these medications to treat chronic conditions (94 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. Fifty-one percent of the members gave a rating of 9 or 10, which is comparable to the national Medicaid average of 49 percent.

Patient-centered medical home

- **Presence of a usual source of care.** A large majority of members reported having a personal doctor (85 percent) and two-thirds of these members reported having that doctor for at least two years (66 percent).
- **Seeking help and advice.** Sixty-four percent of members phoned their doctor’s office during regular office hours for help or advice. Among these members, 74 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. Among these members, 65 percent reported usually or always receiving help.
- **Satisfaction with doctors’ communication.** A majority of members reported usually or always having positive experiences on the CAHPS® composite *How Well Doctors Communicate* (84 percent). This percentage is slightly below the national Medicaid average of 89 percent.
- **Preventive care and health promotion.** A majority of the participants reported having a routine check-up in the last year (71 percent), with only five percent of the members indicating they had not had a routine check-up in over five years. Thirty-five percent of members in STAR+PLUS reported smoking cigarettes, and 68 percent of these members reported that a doctor advised them to quit within the last six months. This percentage exceeds the HHSC Dashboard standard of 28 percent.

- **Shared decision-making.** The majority of members said they usually or always were involved as much as they wanted in decisions about their health care (84 percent), and that it was usually or always easy to get their doctors to agree on how to manage their health care problems (78 percent).
- **Members' rating of their personal doctor.** Members rated their personal doctor on a scale from 0 to 10, with an average rating of 8.5. Sixty-four percent of the members gave a rating of 9 or 10, which is comparable to the national Medicaid average of 63 percent.

Service coordination

- **Good access to service coordination.** Only one in four members reported having a service coordinator (24 percent), although all STAR+PLUS members are assigned a service coordinator upon enrollment. Among these members, half said they utilized those services in the last six months (49 percent). Sixty-nine percent of members who needed service coordination indicated usually or always receiving service coordination as soon as they thought it was needed.
- **Member awareness of service coordination.** The multivariate analysis, which controlled for member demographics, health status, and MCO/SA, found that members who had a usual source of care and members with high scores on the CAHPS® composite *Health Plan Information and Customer Service* were twice as likely to have knowledge of their service coordinator than members who did not have a personal doctor and members with low scores on the composite, respectively.

Health plan

- **Health plan information and customer service.** Three-quarters of members usually or always had positive experiences on the CAHPS® composite *Health Plan Information and Customer Service* (73 percent), which is below the national average of 81 percent. Among members who called their health plan's customer service, only one-third said they received all the information they needed in one call (30 percent), and one-quarter said they needed to make two calls to get the information they needed (23 percent).
- **Health plan approval.** Thirty-nine 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 Dashboard standard for this indicator.
- **Transportation.** One in four members requested transportation assistance, and of these members, 69 percent were usually or always provided with this transportation. Over three-fourths of these members said the transportation they received met their needs (78 percent).
- **Members' rating of their health plan.** Members rated their STAR+PLUS health plan on a scale from 0 to 10, with an average rating of 8.0. Fifty-three percent of the members gave a rating of 9 or 10, which is comparable to the national Medicaid average of 54 percent.

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 member understanding of service coordination, which is one of HHSC's overarching goals for STAR+PLUS MCOs.

Domain	Recommendations	Rationale	HHSC Response
<p>Member understanding of service coordination in STAR+PLUS</p>	<ul style="list-style-type: none"> Findings suggest that personal doctors in STAR+PLUS MCO networks are facilitating the connection between members and their service coordinators. To improve member understanding of service coordination, MCOs should focus their performance improvement projects on members who do not have a usual source of care. These members are the most likely to report not having a service coordinator, and therefore have the greatest need for resources relevant to service coordination. STAR+PLUS MCOs with lower scores on <i>Health Plan Information and Customer</i> 	<p>Only one in four STAR+PLUS members reported having a service coordinator, although all STAR+PLUS members must be provided with a service coordinator upon request. This finding indicates an overall low level of awareness of this important program benefit on the part of STAR+PLUS members.</p> <p>Members who had a personal doctor were twice as likely to say they had a service coordinator. Having a usual source of care was the most influential factor in predicting member awareness of service coordination.</p> <p>Members who had high scores on the CAHPS® <i>Health Plan Information and Customer Service</i> composite were also twice as likely to say they had a service</p>	<p>One of HHSC's overarching goals for STAR+PLUS in 2012 is to improve members' understanding and utilization of service coordination. The STAR+PLUS MCO's developed performance improvement projects that focus on the need for improving service coordination. The EQRO will review the Performance Improvement Projects and provide HHSC a mid-year analysis.</p>

	<p>Service should also consider interventions to improve the accuracy of information provided to members and/or the responsiveness of customer service representatives. To determine the effectiveness of these strategies, measurements of member awareness of service coordination should be taken before, during, and after the intervention.</p> <ul style="list-style-type: none"> • STAR+PLUS service coordinators should stay up-to-date on successful innovations implemented by disability care coordination organizations (DCCOs), which include directly linking medical and behavioral health providers in the clinical setting and at the point of provider-patient contact.²³ 	<p>coordinator.</p>	
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The EQRO also recommends that HHSC and STAR+PLUS MCOs monitor the following areas, based on findings of low member satisfaction in domains that do not directly address the overarching goals. Continued issues with quality of care in these domains may warrant additional studies and their eventual inclusion in MCO performance improvement projects.

- *Obesity.* Rates of obesity in STAR+PLUS are considerably higher than national and state averages, with about half of all STAR+PLUS members being classified as obese. This finding suggests there is a considerable burden of obesity-related illness and disability in the STAR+PLUS population. Successful interventions to reduce obesity among these members can improve the overall health of the STAR+PLUS membership and reduce health care costs.
- *Office wait.* Results for the HHSC Dashboard Indicator – *No Exam Room Wait Greater Than 15 Minutes* – were particularly low, with only 28 percent of STAR+PLUS members saying they were always taken to the exam room within 15 minutes of their appointment. Successful interventions to improve the timeliness of care in the clinical setting can lead to higher member satisfaction with their providers, a greater likelihood that members will keep their routine appointments, and improved patient-provider relationships.
- *Health plan approval.* Results for the HHSC Dashboard Indicator – *No Delays for Health Plan Approval* – were particularly low, with only 39 percent of STAR+PLUS members saying they never had delays in their health care while waiting for approval from their health plan.

Appendix A. Detailed Methodology

Sample selection procedures

The EQRO used a stratified sampling strategy to permit comparison of survey responses across the following ten MCO-Service Area (SA) groups operating in STAR+PLUS in fiscal year 2011:

- AMERIGROUP – Bexar
- AMERIGROUP – Harris
- AMERIGROUP – Travis
- Evercare – Harris
- Evercare – Nueces
- Evercare – Travis
- Molina – Bexar
- Molina – Harris
- Superior – Bexar
- Superior – Nueces

STAR+PLUS members 18 to 64 years old were considered for inclusion in the survey sample if they were continuously enrolled in a STAR+PLUS MCO for at least nine months between December 2009 and November 2010. These criteria ensured that members would have sufficient experience in the program to respond to the survey questions. Members who were eligible for both Medicaid and Medicare (dual-eligibles) and members who participated in the prior year's survey (FY 2010) were excluded.

A stratified random sample of adult STAR+PLUS members was selected, with a target of 3,000 completed telephone interviews (representing 300 respondents per MCO/SA). 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, showing both the number of targeted interviews (N = 3,000) and the number of completed interviews (N = 2,936).

Table A1. STAR+PLUS Survey Sampling Strategy

MCO/SA	Targeted Interviews	Completed Interviews
AMERIGROUP-Bexar	300	283
AMERIGROUP-Harris	300	300
AMERIGROUP-Travis	300	300
Evercare-Harris	300	300
Evercare-Nueces	300	300
Evercare-Travis	300	300
Molina-Bexar	300	253
Molina-Harris	300	300

Superior-Bexar	300	300
Superior-Nueces	300	300

Using a 95 percent confidence interval, the responses provided in the tables and figures are within ± 1.8 percentage points of the “true” responses in the STAR+PLUS member population and ± 5.6 percentage points of the “true” responses at the MCO/SA level.

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 16,311 eligible STAR+PLUS members were collected and provided to interviewers. For households with multiple members enrolled in STAR+PLUS, one member from the household was randomly chosen as the member to respond to the survey. Member age, sex, and race/ethnicity were also collected for the enrollment data to allow for comparisons between respondents and non-respondents and identify any participation biases in the final sample.

Survey instruments

The fiscal year 2011 STAR+PLUS Adult Member Survey is comprised of:

- The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 4.0 (Medicaid module).²⁴
- Items developed by ICHP pertaining to member demographic and household characteristics, and member experiences and satisfaction with service coordination.

The CAHPS® Health Plan Survey (Version 4.0) is a widely used instrument for measuring and reporting consumer experiences with their health plan and providers. The STAR+PLUS Adult Survey uses the Medicaid module of the CAHPS® survey and includes both the core questionnaire and supplemental items. The survey instrument is divided into sections that assess health care experiences within the past six months specific to a member’s health care, personal doctor, specialist care, and health plan.

The CAHPS® Health Plan 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 the present survey, the EQRO calculated CAHPS® composite scores in the following four domains:

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

Scores for the composites were calculated using both AHRQ and NCQA specifications. Specifications by AHRQ produce scores that represent the percentage of members who “usually” or “always” had positive experiences in the given domain. These percentage-based scores can be compared with Medicaid national data found in the CAHPS® Benchmarking Database.²⁵

Specifications by NCQA produce scaled scores that range 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 B4** in Appendix B.

The EQRO also calculated CAHPS® composites on the 100-point scale used in prior years' survey reports. Results of CAHPS® composites on the 100-point scale are shown in **Table B4** in Appendix B, for the purpose of comparison with the other two scoring methods. Scores range from 0 to 100, with higher scores indicating more positive health care experiences. A score of 75 or higher generally indicates that member experiences were usually or always positive.

The survey includes eight questions that function as indicators of health plan performance for adult STAR+PLUS members, as listed on HHSC's Performance Indicator Dashboard for fiscal year 2010.²⁶ 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 exam room wait greater than 15 minutes; (6) Good access to special therapies; (7) Good access to service coordination; and (8) Advising smokers to quit.

The survey also includes questions regarding the demographic and household characteristics of 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.^{27, 28, 29}

Survey data collection

The EQRO sent letters written in English and Spanish to 16,311 sampled STAR+PLUS members, requesting their participation in the survey. Of the advance letters sent, 27 were returned undeliverable.

The Survey Research Center (SRC) at the University of Florida conducted the survey using computer-assisted telephone interviewing (CATI) between February 2011 and November 2011. The SRC telephoned STAR+PLUS members seven days a week between 10 a.m. and 9 p.m. Central Time. 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. 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 2,936 completed interviews, 106 (4 percent) were conducted in Spanish. On average, 7.1 calls per phone number were made in the STAR+PLUS member sample.

Forty-nine percent of members could not be located. Among those located, two percent indicated that they were not enrolled in STAR+PLUS at the time of the survey (and were excluded from participation), and 12 percent refused to participate. The response rate was 53 percent and the cooperation rate was 75 percent.

To test for participation bias, the distributions of member 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. Compared with members who responded to the survey, members who did not

participate were significantly younger (49.5 vs. 45.2 years).³⁰ Thirty-eight percent of members who participated were male, while 42 percent of members who did not participate were male.³¹ Members who participated were significantly more likely than those who did not participate to be White, non-Hispanic (34 percent vs. 28 percent), and were significantly less likely than those who did not participate to be Black, non-Hispanic (24 percent vs. 27 percent).³² While the actual differences in member age, sex, and race/ethnicity between respondents and non-respondents were small, statistical tests suggest that a participation bias may be present in the survey data. When interpreting results of this report, it should be taken into account that those who participated were more likely to be older, female, and White, non-Hispanic.

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

The EQRO conducted descriptive statistics and statistical tests using SPSS 17.0 (Chicago, IL: SPSS, Inc.). Frequency tables showing descriptive results for each survey question are provided in a separate Technical Appendix. Supplementary tables of results are provided in **Appendix B**. 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 member 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, 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 dataset divided by the number of MCO/SA members with completed surveys). **Table A2** provides the weights for each of the 10 MCO/SA groups. The frequencies and means presented in this report and the technical appendix that accompanies this report incorporate survey weights.

Table A2. Survey Quota Weighting Strategy

MCO/SA	Population of eligible members (N)	Number of completed surveys (n)	Weight
AMERIGROUP-Bexar	1,912	283	6.76
AMERIGROUP-Harris	10,370	300	34.57
AMERIGROUP-Travis	3,271	300	10.90
Evercare-Harris	10,023	300	33.41
Evercare-Nueces	1,837	300	6.12
Evercare-Travis	1,557	300	5.19

Molina-Bexar	1,535	253	6.07
Molina-Harris	2,241	300	7.47
Superior-Bexar	9,238	300	30.79
Superior-Nueces	2,975	300	9.92

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, all tests were performed without weighting. These tests allowed for comparison of frequencies and means among the different MCO-SA groups and among the demographic sub-groups within the sample.

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 2,770 members in the sample (94 percent) for whom height and weight data were complete. Height data were missing for 73 members (2 percent), and weight data were missing for 108 members (4 percent).

Survey respondents were classified into one of four clinically relevant BMI categories, which are recognized by the Centers for Disease Control and Prevention.³³

- 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

In addition, researchers conducted a multivariate analysis to examine the effects of demographic, health status, and health delivery factors on STAR+PLUS members' awareness of service coordination offered by the program. Specifically, models were tested to assess the influence of: (1) having a usual source of care, and (2) having a high score on the CAHPS® *Health Plan Information and Customer Service* composite on members' awareness of having a service coordinator, controlling for member's age, sex, race/ethnicity, and MCO/SA membership. A more detailed description of this analysis is presented in **Appendix C**.

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) ^a
AMERIGROUP-Bexar	50.4%
AMERIGROUP-Harris	45.4%
AMERIGROUP-Travis	44.7%

AMERIGROUP total	46.8%
Evercare-Harris	48.9%
Evercare-Nueces	51.1%
Evercare-Travis	45.8%
Evercare total	48.6%
Molina-Bexar	50.6%
Molina-Harris	46.6%
Molina total	48.6%
Superior-Bexar	53.4%
Superior-Nueces	54.5%
Superior total	54.0%
X ² test for significant differences ^b	38.316 (p = 0.07)

^a Obesity defined as BMI \geq 30.

^b 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 and Service Area

Health Plan	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
STAR+PLUS overall ^a	2.11	2.30	2.60	2.31
AMERIGROUP-Bexar	2.08	2.28	2.69	2.34
AMERIGROUP-Harris	2.16	2.36	2.65	2.40

AMERIGROUP-Travis	2.07	2.30	2.55	2.26
Evercare-Harris	2.17	2.29	2.55	2.36
Evercare-Nueces	2.16	2.30	2.56	2.30
Evercare-Travis	2.14	2.22	2.65	2.32
Molina-Bexar	2.04	2.29	2.65	2.30
Molina-Harris	2.00	2.38	2.59	2.31
Superior-Bexar	2.09	2.30	2.56	2.28
Superior-Nueces	2.13	2.27	2.58	2.27
F significance ^b	N.S	N.S.	= 0.095	N.S.

^a 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.

^b Analyses performed on unweighted data.

Table B3. HHSC Performance Indicator Results by STAR+PLUS MCO and Service Area

MCO/SA	1	2	3	4	5	6	7	8	# ≥ Std.
STAR+PLUS overall	76%	64%	73%	39%	29%	52%	68%	68%	4
AMERIGROUP-Bexar	77%	64%	71%	35%	32%	47%	73%	60%	4
AMERIGROUP-Harris	79%	61%	75%	36%	34%	45%	72%	64%	2
AMERIGROUP-Travis	75%	65%	71%	35%	36%	39%	68%	70%	2
Evercare-Harris	73%	67%	74%	43%	25%	66%	68%	73%	3
Evercare-Nueces	78%	68%	73%	41%	29%	48%	65%	60%	4
Evercare-Travis	68%	64%	71%	43%	31%	60%	60%	66%	3
Molina-Bexar	77%	62%	73%	33%	28%	61%	75%	55%	4
Molina-Harris	81%	59%	76%	38%	26%	47%	60%	68%	3
Superior-Bexar	76%	63%	71%	42%	25%	60%	71%	71%	3
Superior-Nueces	74%	66%	71%	37%	21%	53%	68%	67%	3
HHSC Standard	76%	62%	78%	57%	42%	47%	N/A	28%	-
# MCO/SAs ≥ Standard	6	8	0	0	0	8	N/A	10	-
X ² significance ^b	N.S.	N.S.	N.S.	N.S.	= 0.008	= 0.040	N.S.	N.S.	-

^a 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 exam room wait 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

^b Analyses performed on unweighted data.

Table B4. Comparison of CAHPS® Composite Scoring Methods

CAHPS® Composite	Global proportion ^a	3-point mean ^b	100-point mean ^c
Getting Needed Care	63%	2.11	65.8
Getting Care Quickly	74%	2.35	75.0
How Well Doctors Communicate	84%	2.59	84.6
Health Plan Information and Customer Service	73%	2.33	74.3

^a The percentage of respondents who “usually” or “always” had positive health care experiences, following AHRQ specifications.

^b Mean ranging from 0 to 3, following NCQA specifications. Means differ slightly from those on Table B2 because they follow strict NCQA specifications, calculated by averaging the aggregate scores on a composite’s individual items.

^c Mean ranging from 0 to 100, developed and used by the EQRO in prior year survey reports.

Appendix C. Multivariate Analysis – Member Awareness of Service Coordination

Improving member understanding of service coordination is one of HHSC's overarching goals for STAR+PLUS MCOs in the design and implementation of performance improvement projects. All STAR+PLUS members are assigned a service coordinator through their health plan who helps to arrange services like doctor visits, transportation, or meals. However, when asked whether they had a service coordinator, only 24 percent of respondents in the fiscal year 2011 STAR+PLUS Adult Member Survey said they did, suggesting a low level of member awareness of this important program benefit. To assess the influence of health service delivery factors on STAR+PLUS member understanding of service coordination, the EQRO conducted a multivariate analysis using this question as an outcome. Controlling for demographic factors, health status, and MCO/SA membership, this analysis tests whether member awareness of service coordination is associated with: (1) having a usual source of care; and (2) having positive experiences with health plan information and customer service.

Methodology

The multivariate analysis was conducted using unconditional logistic regression, with the outcome dichotomized – coded as 1 for members who said they had a service coordinator, and 0 for members who said they did not have a service coordinator. The EQRO tested two models to predict the odds of a member knowing they have a service coordinator, controlling for member age, sex, race/ethnicity, health status, and MCO/SA:

- 1) Presence of a usual source of care. The model testing the influence of having a usual source of care – the most basic element of the patient-centered medical home – compared members who said they had a personal doctor with members who said they did not have a personal doctor.
- 2) CAHPS® *Health Plan Information and Customer Service*. This composite score combines responses to two questions about members' experiences with their health plan. Specifically, members were asked how often they received needed help or information from their health plan, and how often their health plan's customer service treated them with courtesy and respect. Using modified NCQA scoring (1- to 3-point scale), this composite was dichotomized with a score of 3.00 as the threshold – with members having a *Health Plan Information and Customer Service* score of 3.00 coded as 1 (indicating positive member experiences), and members having a score less than 3.00 coded as 0.

The EQRO used the following covariates in both logistic regression models:

- Age – categorized into five age cohorts: 18 to 30 years old, 31 to 40 years old, 41 to 50 years old, 51 to 60 years old, and 61 years and older. The reference group was members 18 to 30 years old.
- Sex, with male members as the reference group.

- Race/ethnicity – categorized as White, non-Hispanic; Hispanic; Black, non-Hispanic; or Other, non-Hispanic. The reference group was White, non-Hispanic members.
- Self-reported health status – categorized into two groups: (1) Excellent, very good, or good; and (2) Fair or poor. The reference group was members who said they were in fair or poor health.
- MCO/SA -- among the 10 STAR+PLUS MCO/SA groups, the reference group was Evercare-Travis, chosen because it had the highest percentage of members who said they had a service coordinator (32 percent) and was therefore the best-performing MCO/SA on the outcome measure.

Results

Results of the multivariate analysis are presented in **Table C1** and **Table C2** as odds ratios. The odds ratios represent the likelihood of a member reporting they had a service coordinator, compared to members who said they did not have a service coordinator. For any particular test variable or covariate, an odds ratio above 1.0 suggests that members in the specified category were more likely to have said they had a service coordinator than members in the reference group. Conversely, an odds ratio below 1.0 suggests that members in the specified category were less likely to have said they had a service coordinator 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 $p < 0.05$.

In either model, the only demographic or health status covariate that was significantly associated with the likelihood of member awareness of service coordination was age. In the overall sample, 27 percent of members age 61 or older reported having a service coordinator, compared to 17 percent of members age 18 to 30 years old. In the first model (testing for usual source of care), members in the oldest two age groups were 1.5 times and 1.7 times more likely, respectively, than members in the youngest age group to have been aware of their service coordinator. In the second model (testing for health plan information and customer service), a similar trend was observed, although odds ratios were not statistically significant.

Members in a number of MCO/SA groups were significantly less likely to say they had a service coordinator, compared to the Evercare-Travis reference group. Controlling for other covariates, the likelihood of member awareness of service coordination was reduced by about half in both models for STAR+PLUS members in AMERIGROUP-Harris, Molina-Bexar, Molina-Harris, and Superior-Nueces.

Both test factors were significantly associated with the likelihood of member awareness of service coordination.

- *Usual Source of Care (Model 1)*. In the overall sample, 25 percent of members with a personal doctor reported having a service coordinator. Controlling for demographic factors, health status, and MCO/SA membership, members who had a personal doctor were 2.1 times more likely than those who did not have a personal doctor to know they had a service coordinator.
- *Health Plan Information and Customer Service (Model 2)*. The percentage of STAR+PLUS members who said they had a service coordinator was higher overall in Model 2 than in Model 1.

Forty percent of members who had a score of 3.00 on the CAHPS® composite *Health Plan Information and Customer Service* reported having a service coordinator, compared to 25 percent of members who had a score less than 3.00. This suggests that simply seeking out health plan information or contacting customer service is associated with member awareness of service coordination. Nevertheless, controlling for demographic factors, health status, and MCO/SA membership, members with high ratings on this composite were 2.1 times more likely than those with lower ratings to know they had a service coordinator.

The EQRO used the likelihood-ratio test to determine the relative fit of both models, and identify which model had the greatest predictive value with regard to the outcome of member awareness of service coordination. For both models, model fit statistics were compared to a simpler model, which contained only demographic factors, health status, and MCO/SA membership. This test permits an assessment of the increase in predictive value due to the addition of a test factor. Results of the likelihood-ratio tests are shown in the table below.

Test factor	Model Type			p-value
	Full (χ^2 , df)	Simple (χ^2 , df)	Difference (χ^2 , df)	
Having a usual source of care	60.78, df = 19	32.89, df = 18	27.89, df = 1	< 0.001
CAHPS® <i>Health Plan Information and Customer Service</i>	39.37, df = 19	32.89, df = 18	6.48, df = 1	= 0.011

Having a usual source of care and having good health plan information and customer service were both significantly associated with member awareness of service coordination. However, the increase in predictive value was considerably greater for having a usual source of care. These findings suggest that personal doctors in STAR+PLUS MCO networks are facilitating the connection between members and their service coordinators, which increases member awareness and utilization of service coordination.³⁴ Interventions to improve member understanding of service coordination should focus on those STAR+PLUS members who do not have a relationship with a personal doctor, and those members who are less likely to use, or to have positive experiences using, health plan information and customer service.

Table C1. Multivariate Analysis Model 1 – Influence of Having a Usual Source of Care on Member Awareness of Service Coordination

Factor	Percent aware of service coordination	Odds Ratio	95% CI
Age (years)			
18 to 30	17%	REF	-
31 to 40	21%	1.25	(0.81- 1.95)
41 to 50	23%	1.42	(0.96 - 2.09)
51 to 60	25%	1.53	(1.06 – 2.22)
61 and older	27%	1.73	(1.15 – 2.61)
Sex			
Male	24%	REF	-
Female	24%	0.97	(0.80 – 1.16)
Race/Ethnicity			
White, non-Hispanic	23%	REF	-
Hispanic	23%	1.12	(0.89 – 1.40)
Black, non-Hispanic	25%	1.15	(0.89 – 1.49)
Other, non-Hispanic	24%	1.13	(0.73 – 1.76)
Health Status			
Fair or poor	24%	REF	-
Excellent, very good, or good	23%	1.00	(0.82 – 1.21)
MCO/SA			
AMERIGROUP-Bexar	22%	0.58	(0.39 – 0.85)
AMERIGROUP-Harris	23%	0.59	(0.40 – 0.87)
AMERIGROUP-Travis	25%	0.70	(0.48 – 1.02)
Evercare-Harris	26%	0.68	(0.47- 1.00)
Evercare-Nueces	26%	0.70	(0.48 – 1.02)
Evercare-Travis	32%	REF	-
Molina-Bexar	19%	0.48	(0.32 – 0.74)
Molina-Harris	20%	0.52	(0.35 – 0.77)
Superior-Bexar	23%	0.58	(0.39 – 0.85)
Superior-Nueces	19%	0.44	(0.29 – 0.66)
Member has personal doctor			
No	14%	REF	-

Yes	25%	2.06	(1.55 – 2.74)
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Table C2. Multivariate Analysis Model 2 – Influence of Good Health Plan Information and Customer Service on Member Awareness of Service Coordination

Factor	Percent aware of service coordination	Odds Ratio	95% CI
Age (years)			
18 to 30	24%	REF	-
31 to 40	29%	1.34	(0.64- 2.82)
41 to 50	30%	1.40	(0.73 - 2.70)
51 to 60	34%	1.71	(0.92 – 3.17)
61 and older	38%	2.03	(0.99 – 4.17)
Sex			
Male	35%	REF	-
Female	31%	0.89	(0.64 – 1.23)
Race/Ethnicity			
White, non-Hispanic	32%	REF	-
Hispanic	33%	0.96	(0.65 – 1.42)
Black, non-Hispanic	33%	1.04	(0.67 – 1.63)
Other, non-Hispanic	23%	0.59	(0.28 – 1.25)
Health Status			
Fair or poor	31%	REF	-
Excellent, very good, or good	34%	1.11	(0.79 – 1.56)
MCO/SA			
AMERIGROUP-Bexar	35%	0.65	(0.35 – 1.23)
AMERIGROUP-Harris	29%	0.47	(0.24 – 0.92)
AMERIGROUP-Travis	29%	0.51	(0.28 – 0.94)
Evercare-Harris	33%	0.56	(0.29- 1.06)
Evercare-Nueces	31%	0.56	(0.29 – 1.10)
Evercare-Travis	44%	REF	-
Molina-Bexar	27%	0.46	(0.23 – 0.90)
Molina-Harris	27%	0.46	(0.24 – 0.89)
Superior-Bexar	34%	0.69	(0.35 – 1.38)
Superior-Nueces	28%	0.48	(0.24 – 0.98)
Good Information/Customer Service			
No	25%	REF	-

Yes	40%	2.05	(1.49 – 2.80)
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Appendix D. STAR+PLUS Dual-Eligible Survey Results

A large percentage of members in STAR+PLUS are dual-eligibles – members who receive health insurance coverage from both Medicaid and Medicare.³⁵ Research has found that over half (58 percent) of dual eligibles report unmet health care needs, specifically for long-term care services.³⁶ This section presents findings on a separate survey of the STAR+PLUS dual-eligible population, showing comparisons on member experience and satisfaction measures between fiscal year 2010 and 2011.

Methodology

The EQRO selected a simple random sample of dual-eligible STAR+PLUS members 18 to 64 years of age who were enrolled in the same STAR+PLUS health plan for nine continuous months between April 2010 and March 2011. The EQRO excluded members who were enrolled only in Medicaid, members who participated in the fiscal year 2010 STAR+PLUS Adult Member Survey, and members selected for the fiscal year 2011 Long-term Care Focus Study.

A target of 300 telephone interviews was set, and a total of 254 telephone interviews were completed. Using a 95 percent confidence interval, the responses provided in this summary are within ± 6.1 percentage points of the “true” responses in the STAR+PLUS dual-eligible member population.

Enrollment data were used to identify members who met the sample selection criteria and to obtain their contact information. Member names, mailing addresses, and telephone contact information for 1,556 STAR+PLUS dual-eligible members were collected and provided to interviewers. The Survey Research Center (SRC) at the University of Florida conducted the survey using computer-assisted telephone interviewing (CATI) between October 2011 and December 2011. Of 254 completed interviews, seven (2.8 percent) were completed in Spanish. The response rate was 51 percent and the cooperation rate was 78 percent.

This survey was comprised of the same survey instruments used in the fiscal year 2011 STAR+PLUS Adult Member Survey, as described in Appendix A of this report. The summary of results focuses on the following survey measures: (1) CAHPS[®] composite scores; (2) CAHPS[®] ratings; (3) HHSC Performance Dashboard Indicators for STAR+PLUS; and (4) Selected additional items related to specialized services, usual source of care, and service coordination. For the CAHPS[®] composite scores and ratings, results from the national Medicaid and Medicare populations are provided for comparison.³⁷

To assess two-year trends in survey experience and satisfaction measures for this population, results were compared to a random sample of 300 completed surveys collected in the fiscal year 2010 STAR+PLUS Adult Member Survey, which was comprised primarily of STAR+PLUS dual-eligible members due to changes in the survey eligibility criteria.

Results

Figure D1 shows the percentage of STAR+PLUS dual-eligible members who “usually” or “always” had positive experiences with each of the four CAHPS® composite domains. For most domains, member satisfaction among STAR+PLUS dual-eligible members was lower than both the national Medicaid population and the national Medicare population. The highest-scoring domain was *How Well Doctors Communicate*, for which 90 percent of STAR+PLUS dual-eligible members usually or always had positive experiences.

Figure D1. STAR+PLUS Dual-Eligibles – CAHPS® Composite Results, 2011

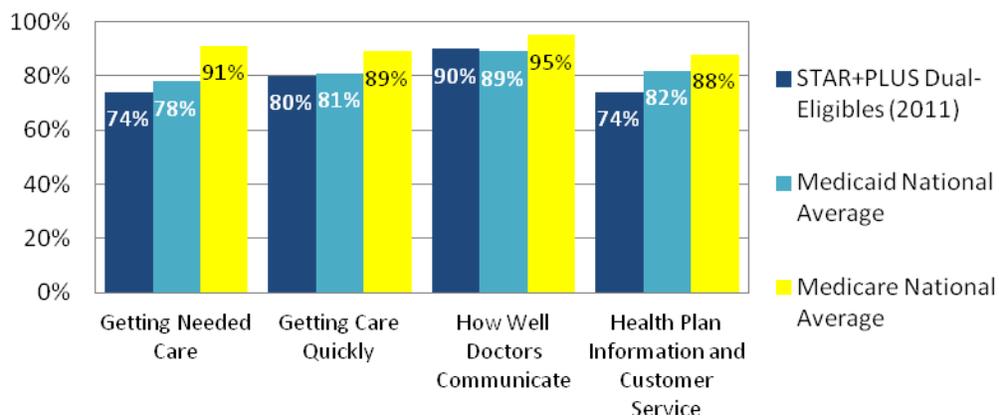


Figure D2 shows the percentage of STAR+PLUS dual-eligible members who gave ratings of 9 or 10 for their health care, personal doctor, specialist, and health plan. Overall, member satisfaction among STAR+PLUS dual-eligible members was slightly higher than in the national Medicaid population, and slightly lower than in the national Medicare population. The highest rating was for personal doctor, for which 73 percent of STAR+PLUS dual-eligible members gave a rating of 9 or 10.

Figure D2. STAR+PLUS Dual-Eligibles – CAHPS® Ratings, 2011

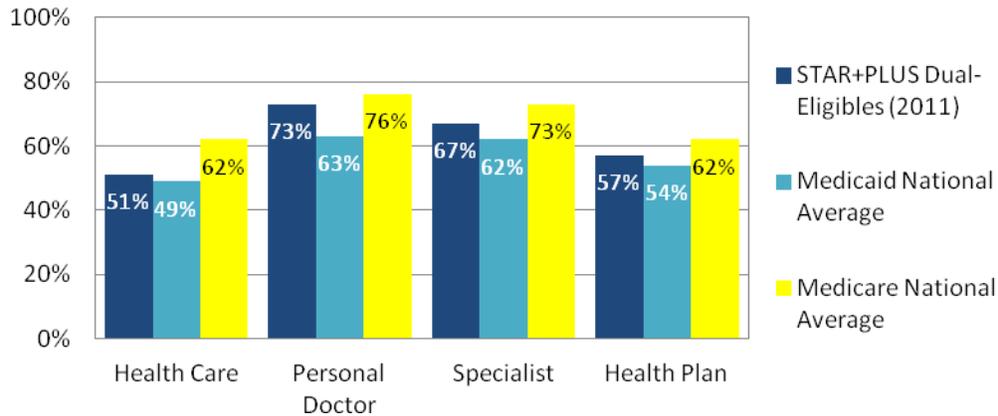


Table D1 shows results for the HHSC Performance Dashboard Indicators for STAR+PLUS dual-eligible members, comparing findings from 2010 and 2011. In both years, results for STAR+PLUS dual-eligible members met or exceeded HHSC Dashboard standards for all indicators except *No Delays for an Approval* and *No Exam Room Wait Greater than 15 Minutes*. The percentage of STAR+PLUS dual-eligible members who had good access to special therapies decreased significantly between 2010 (74 percent) and 2011 (53 percent).³⁸ However, access to special therapies in 2011 was still greater than the HHSC Dashboard standard.

Table D1. STAR+PLUS Dual-Eligibles – HHSC Dashboard Indicators, 2010-2011

HHSC Dashboard Indicator	2010 STAR+PLUS Dual-Eligibles	2011 STAR+PLUS Dual-Eligibles	HHSC Dashboard Standard
Good access to urgent care	84%	81%	76%
Good access to specialist referral	75%	78%	62%
Good access to routine care	80%	80%	78%
No delays for health plan approval	49%	49%	57%
No exam room wait greater than 15 minutes	31%	33%	42%
Good access to special therapies	74%	53%	47%
Good access to service coordination ^a	LD	LD	-
Advising smokers to quit	61%	66%	28%

^a The number of members who reported needing service coordination was too low in 2010 (n = 36) and in 2011 (n = 26) to permit a reliable estimate for *Good Access to Service Coordination*.

Table D2 shows scaled results for the CAHPS® composite domains (following modified NCQA specifications) and ratings for STAR+PLUS dual-eligible members, comparing findings from 2010 and 2011. None of the differences between the years were statistically significant.

Table D2. STAR+PLUS Dual-Eligibles – CAHPS® Composites and Ratings, 2010-2011

	2010 STAR+PLUS Dual-Eligibles	2011 STAR+PLUS Dual-Eligibles
CAHPS® Composite (3-point scale)		
<i>Getting Needed Care</i>	2.25	2.31
<i>Getting Care Quickly</i>	2.44	2.42
<i>How Well Doctors Communicate</i>	2.70	2.71
<i>Health Plan Information and Customer Service</i>	2.29	2.31
CAHPS® Rating (10-point scale)		
Health Care	8.1	8.0
Personal Doctor	8.8	9.1
Specialist	8.7	8.8
Health Plan	8.2	8.2

Table D3 shows results for survey items dealing with need for specialized services, presence of a usual source of care, and presence of a service coordinator for STAR+PLUS dual-eligible members, comparing findings from 2010 and 2011. The percentage of members who had the same personal doctor before enrolling in their STAR+PLUS health plan decreased significantly between 2010 (59 percent) and 2011 (42 percent).³⁹ Only one in five members in both years said they had a service coordinator (20 percent).

Table D3. STAR+PLUS Dual-Eligibles – Other Survey Items, 2010-2011

	2010 STAR+PLUS Dual-Eligibles	2011 STAR+PLUS Dual-Eligibles
Need for specialized services		
Special medical equipment and devices	37%	42%
Special therapies	29%	27%
Home health care	38%	37%
Personal doctors		
Member has personal doctor	90%	85%
Member visited personal doctor \geq 1x in past six months	94%	88%
Member has been seeing personal doctor for \geq 2 years	74%	65%
Member had same personal doctor before enrolling	59%	42%
Service coordination		
Member has service coordinator	20%	20%

Endnotes

- ¹ Mastal, M.F., M.E. Reardon, M. English. 2007. "Innovations in Disability Care Coordination Organizations: Integrating Primary Care and Behavioral Health Clinical Systems." *Professional Case Management*, 12(1): 27-36.
- ² HHSC (Texas Health and Human Services Commission). 2011a. *Texas Medicaid in Perspective, Eighth Edition*. "Chapter 6: Medicaid Managed Care." Available at <http://www.hhsc.state.tx.us/Medicaid/reports/PB8/PinkBookTOC.html>.
- ³ Niefeld, M.R., and Kasper, J.D. 2005. "Access to Ambulatory Medical and Long-Term Care Services Among Elderly Medicare and Medicaid Beneficiaries: Organizational, Financial, and Geographic Barriers." *Medical Care Research and Review* 62: 300-319.
- ⁴ Burns, M.E. 2009. "Medicaid Managed Care and Health Care Access for Adult Beneficiaries with Disabilities." *Health Research and Educational Trust* 44 (5): 1521-1541.
- ⁵ Coughlin, T.A., S.K. Long, and Kendall, S. 2002. "Health Care Access, Use, and Satisfaction Among Disabled Medicaid Beneficiaries." *Health Care Financing Review* 24 (2): 115-136.
- ⁶ Pascoe, G.C. 1983. "Patient Satisfaction in Primary Health Care: A Literature Review and Analysis." *Evaluation and Program Planning* 6: 185-210.
- ⁷ Hall, J.A., Roter, D.L., and Katz, N.R. 1988. "Meta-analysis of Correlates of Provider Behavior in Medical Encounters." *Medical Care* 26 (7): 657-675.
- ⁸ HHSC. 2011b. "STAR+PLUS Overview." Available at <http://www.hhsc.state.tx.us/starplus/Overview.htm>
- ⁹ CAHPS® (Consumer Assessment of Healthcare Providers and Systems). 2011. "CAHPS® Health Plan Survey 4.0, Adult Medicaid Questionnaire." Available at: <https://www.cahps.ahrq.gov/Surveys-Guidance/HP.aspx>.
- ¹⁰ AHRQ (Agency for Healthcare Research and Quality). 2011. CAHPS® Comparative Data. Available at: <https://www.cahps.ahrq.gov/CAHPS-Database/Comparative-Data.aspx>.
- ¹¹ HHSC. 2010. "Performance Indicator Dashboard for Administrative and Financial Measures." Available at: http://www.hhsc.state.tx.us/Medicaid/UMCM/Chp10/10_1_1.pdf.
- ¹² Frequencies in the Technical Appendix are weighted to the probability of inclusion in the sample by MCO-SA group.
- ¹³ CDC (Centers for Disease Control and Prevention). 2011. U.S. Obesity Trends. Available at: <http://www.cdc.gov/obesity/data/trends.html>.
- ¹⁴ Flegal, K.M., M.D. Carroll, C.L. Ogden, L.R. Curtin. 2010. "Prevalence and trends in obesity among U.S. adults, 1999 – 2008." *Journal of the American Medical Association* 303: 235-241.
- ¹⁵ Chi-square = 54.211, p < 0.001.
- ¹⁶ Chi-square = 60.924, p < 0.001.

¹⁷ ACP (American College of Physicians). 2007. *Joint Principals of the Patient-Centered Medical Home*. Available at: http://www.acponline.org/running_practice/pcmh/demonstrations/jointprinc_05_17.pdf.

¹⁸ To permit statistical comparisons among the MCO/SA groups, percentages in this figure are not weighted.

¹⁹ Chi-square = 21.58, p = 0.010.

²⁰ Chi-square = 8.82, p = 0.032.

²¹ Chi-square = 12.21, p < 0.001.

²² This indicator does not have an HHSC Dashboard standard.

²³ Mastal, M.F., et al. 2007.

²⁴ CAHPS®. 2011.

²⁵ AHRQ. 2011.

²⁶ HHSC. 2010.

²⁷ NCHS (National Center for Health Statistics). 2008. *National Health Interview Survey*. Available at: <http://www.cdc.gov/nchs/nhis.htm>.

²⁸ U.S. Census Bureau. 2008. *Current Population Survey*. Available at: <http://www.census.gov/cps>.

²⁹ Urban Institute. 2008. *National Survey of America's Families*. Available at: <http://www.urban.org/center/anf/nsaf.cfm>.

³⁰ T-test = -16.83, p < 0.001.

³¹ Chi-square = 16.86, p < 0.001.

³² Chi-square = 56.26, p < 0.001.

³³ CDC. 2011

³⁴ Improving member utilization of service coordination is also one of HHSC's overarching goals for STAR+PLUS MCOs in SFY 2012. However, the number of survey respondents who reported using service coordination in the past six months was too small to permit a multivariate analysis on utilization.

³⁵ HHSC. 2011b.

³⁶ Komisar, H.L., Feder, J., & Kasper, J.D. 2005. Unmet Long-Term Care Needs: An Analysis of Medicare-Medicaid Dual Eligibles. *Inquiry* 42: 171-182.

³⁷ AHRQ. 2011.

³⁸ Chi-square = 6.98, p = 0.008.

³⁹ Chi-square = 12.78, $p < 0.001$.