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

The Texas Medicaid Managed Care and Children's Health Insurance Program

Physical Health Provider Office Survey Report

Fiscal Year 2010

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Executive Summary

Purpose

This report summarizes findings from the fiscal year 2010 Physical Health Provider Office Survey, conducted with health care providers participating in Texas Medicaid Managed Care and the Children's Health Insurance Program (CHIP). The Institute for Child Health Policy (ICHP) at the University of Florida conducted the survey as the External Quality Review Organization (EQRO) for the State of Texas. The survey assesses compliance of managed care organizations (MCOs) with specific requirements for Texas Medicaid and CHIP, as defined by the Texas Health and Human Services Commission (HHSC).

Methods

Surveys assessed provider office characteristics and operations, office staff and provider perceptions of MCO practices, and overall provider satisfaction with the MCO. Surveys were mailed to 2,489 providers in STAR, STAR+PLUS, and CHIP, with 51 returned by the Postal Service as not deliverable. Using a follow-up period of five weeks and up to two mailings of reminder postcards, a total of 549 completed surveys were collected. Specifically, 236 completed surveys were collected for STAR, 84 for STAR+PLUS, and 229 for CHIP. The response rate was 24 percent for STAR, 24 percent for STAR+PLUS, and 21 percent for CHIP.

Summary of Major Findings

- *Provider office characteristics*. The majority of surveyed providers had individual practices (67 to 73 percent), treated patients in the identified health plan in one office location (85 to 89 percent), and had been in the identified health plan's network for greater than five years (55 to 66 percent).
- *Provider office operations*. In all three programs, greater than 90 percent of provider offices were open Monday through Friday. Saturday hours were reported in 22 to 28 percent of offices, and Sunday hours were reported in 1 to 3 percent of offices. Between 25 and 34 percent of providers offered extended office hours for patients in the identified health plan.
- *Provider satisfaction*. Greater than half of providers in STAR (56 percent), STAR+PLUS (59 percent), and CHIP (58 percent) reported they were highly satisfied with the selected health plan.
- *Office staff training*. The majority of office managers and staff (65 to 73 percent) reported they had received training from the health plan that allowed them to: (1) access appropriate MCO contacts to address office or patient issues; (2) submit accurate claims for payment; (3) understand requirements for authorization of services; and (4) stay informed about available benefits and services for their patients. All types of office staff training assessed in this study were associated with provider satisfaction.
- *Provider training*. Overall, providers reported receiving adequate training on the required elements for Texas Health Steps medical check-ups (64 to 78 percent) and Texas Health Steps benefits (60 to 71 percent). However, fewer than half of providers reported receiving training on the health plan's referral process to behavioral health providers (33 to 43 percent), new models of behavioral health interventions (21 to 40 percent), and how to screen for and identify behavioral health disorders (24 to 44 percent). All types of provider training assessed in this study were associated with provider satisfaction.
- *Communication with health plans*. All health plans have provider representatives who are available for assistance, training, and orientation. Overall, office managers reported a high rate of

visits from health plan representatives, with 80 percent in STAR, 74 percent in STAR+PLUS, and 70 percent in CHIP having received a representative visit in the past year.

  - Aspects of MCO-provider communication that were rated positively by provider offices included: (1) having the health plan's telephone hotline staffed with knowledgeable personnel (85 to 89 percent); (2) receiving timely information when needed from the health plan (83 to 89 percent); and (3) receiving information related to Texas Health Steps periodicity schedules.
  - Other aspects of MCO-provider communication were rated negatively by provider offices, including: (1) only half of providers "usually" or "always" having a wait time of less than two minutes to speak with a health plan representative on the hotline (44 to 56 percent);[1] and (2) nearly one-quarter of providers "never" having the opportunity to provide feedback to the health plan in order to improve the quality of care for their patients (21 to 25 percent).
  - All aspects of communication with health plans were associated with provider satisfaction, in particular the opportunity to provide feedback to the health plan.

- *Care coordination*. The percent of providers reporting they "usually" or "always" received notification that preventive care was due/overdue for their patients was 71 percent in STAR, 61 percent in STAR+PLUS, and 58 percent in CHIP.
  - Provider responses indicated a greater need for information-sharing in the coordination of care for behavioral health patients. Few providers stated the health plan "usually" or "always": (1) sent them regular reports on the BH health status of patients who received BH care from a different provider (23 to 35 percent); (2) informed them about changes in the health status of their patients participating in disease management programs (37 to 41 percent); or (3) assisted them in linking with allied health and social service agencies to facilitate implementation of their patients' plans of care (29 to 32 percent).
  - Greater than half of providers reported that the health plan had given them information about inappropriate use of the emergency department by their patients in the past year – 64 percent in STAR, 61 percent in STAR+PLUS, and 56 percent in CHIP.
  - All aspects of health plan care coordination were associated with provider satisfaction, in particular the inclusion of providers in the care coordination process.
- *Eligibility verification, authorization, and payment*. Overall, providers had positive experiences with the health plan with regard to these practices. Greater than 80 percent of providers in all three programs reported easy eligibility verification, timely payment of claims, and accurate payment of claims. The vast majority of providers also reported they could submit and receive claims through electronic data interchange (EDI) (86 to 92 percent). All items in this category were associated with provider satisfaction except for the option to submit/receive claims through EDI.
- *Open-ended responses*. Among providers who included open-ended comments in their surveys, approximately one-quarter (21 to 25 percent) raised issues related to: (1) problems with MCO staff/representatives; (2) problems with payments, claims, denials, or eligibility; and (3) problems with access to specialists for their patients.

EQRO Recommendations

This study's low response and completion rates limited the EQRO's ability to make strong conclusions regarding the state of MCO-provider relations in Texas Medicaid and CHIP. Key recommendations from this report address improvements to future provider office surveys, and secondary recommendations

focus on aspects of health plan training, communication, and the provision of information to providers that are likely in need of improvement.

Key recommendations:

1. Improve response rates for future provider office survey studies by using a combination of web-based and mail-based approaches. Revising provider office survey methodology with the aim of improving response rates will allow the EQRO to make stronger conclusions and more directed recommendations in future surveys.
2. Improve completion rates for future provider office survey studies by reducing the number of exclusions in the survey sample pool. To improve competion rates, the EQRO recommends: (1) focusing provider office surveys on a single program or group of programs each year, alternating Medicaid and CHIP provider surveys; and (2) allowing more than one provider per group practice to be eligible for inclusion in the sample.

Secondary recommendations

1. Health plans participating in STAR, STAR+PLUS, and CHIP should make provider manuals, webinar training, and provider representatives more accessible to provider offices, particularly with regard to the delivery of behavioral health care. Fewer than half of the respondents said the MCO had provided training on the referral process to behavioral health providers, new models of behavioral health interventions, and screening/identifying behavioral health disorders in the past year. Health plans are contractually required to provide this training to network providers, as stated in Section 8.1.15.4 of the Uniform Managed Care Contract. Additionally, the EQRO recommends that HHSC request copies of provider training sign-in sheets in order to assess provider participation.
2. Health plans should develop or improve upon systems for providers to offer feedback on issues of importance to the quality of care for Texas Medicaid and CHIP patients. One-fifth (21 percent) of STAR and STAR+PLUS providers and one-quarter (25 percent) of CHIP providers in this survey reported never having the opportunity to provide feedback to the health plan.
3. Health plans should improve upon the provision of information that providers need to deliver quality care to Texas Medicaid and CHIP members. Fewer than half of respondents in all three programs indicated that the MCO “usually” or “always” provided them with information about changes in the health status of their patients participating in disease management programs, and with information on the behavioral health status of patients receiving BH care from a different provider. Fewer than one-third of respondents reported that the MCO “usually” or “always” assisted them in linking with allied health and social service agencies to facilitate implementation of their patients’ plans of care. The effective and timely provision of this information to providers is essential to ensure that members are receiving the care coordination they need. Health plans are contractually required to provide this information and coordination to network providers, as stated in Sections 8.1.11, 8.1.14.1, 8.1.15.4, 8.2.10, and 8.2.11 of the Uniform Managed Care Contract.

HHSC Recommendations/Strategies

HHSC intends to implement the following strategies to address the EQRO recommendations:

1. Conduct future physical health provider office surveys using a combination of web-based and mail based approaches.

2. Re-structure the focus of physical health provider office surveys to include a single program or a group of programs, alternating Medicaid and CHIP provider surveys each year.

3. Established Quality Forums twice per year to provide training to MCO and staff. The agenda for the Quality Forum is based on issues/trends identified by HHSC and the EQRO. Future agendas will include a topic which addresses best practices for dissemination of information to providers on the delivery of quality care to Texas Medicaid and CHIP members.

Introduction and Purpose

This report summarizes findings from the fiscal year 2010 Physical Health Provider Office Survey, conducted with health care providers participating in Texas Medicaid Managed Care and the Children's Health Insurance Program (CHIP). The Institute for Child Health Policy (ICHP) at the University of Florida conducted this survey as the Texas Medicaid Managed Care and CHIP External Quality Review Organization (EQRO).The provider office survey assesses compliance of managed care organizations (MCOs) with specific requirements for Texas Medicaid and CHIP, as defined by the Texas Health and Human Services Commission (HHSC). Additionally, the survey examines the extent providers were satisfied with their relationship between MCOs and providers medical clinic/office.

Background

Investigating the attitudes, beliefs, behaviors, and concerns of physicians via survey is important given their role in the provision of health care and shaping the health care system. Health care service quality should not be evaluated exclusively by customers (i.e. patients, their relatives and citizens) and given the complexity and heterogeneity of health care services, providers can be a valuable resource for assessment. Understanding the relationship and perceptions of providers can lead to more efficient and satisfactory relationships with MCOs and patients.[2]

The survey included all MCOs participating in STAR, STAR+PLUS, and CHIP as of April 1, 2010. Eighteen MCOs were represented altogether, including 14 participating in STAR, 4 participating in STAR+PLUS, and 17 participating in CHIP (**Table 1**).

Table 1. STAR, STAR+PLUS, and CHIP MCOs

MCO	STAR	STAR+PLUS	CHIP
Aetna	✓		✓
AMERIGROUP	✓	✓	✓
Community First	✓		✓
Community Health Choice	✓		✓
Cook Children's	✓		✓
Driscoll	✓		✓
El Paso First	✓		✓
Evercare		✓	
FirstCare	✓		✓
Molina	✓	✓	✓
Parkland Community	✓		✓
Seton			✓
Superior	✓	✓	✓
Superior EPO			✓
Texas Children's	✓		✓
Unicare	✓		✓
UnitedHealthcare – Texas	✓		✓

The MCOs participating in Texas Medicaid and CHIP contract with physical health providers throughout the state to provide covered benefits to enrolled members. Requirements in the MCO contracts with HHSC define specific standards for processes to support the care and services physicians provide to members. Below is a list of these standards, along with other practices determined by HHSC and ICHP to be relevant for MCO relations with participating providers.

MCO Process Standards for Provider Support

- Training of physical health provider office staff regarding:
    - Available services/benefits for patients
    - Requirements for authorization of services
    - Submitting accurate claims for payment, and
    - Accessing appropriate MCO contacts to address office or patient issues;
- Ensuring the ease of obtaining eligibility verification for members in the health plan;
- Timely authorization of services when needed;
- Notification from the MCO when preventive care is due/overdue to patients;
- Accurate and timely payment of claims;
- Timely provision of information when needed from the MCO;
- At least one personal visit from a provider representative from the time a provider joins the MCO's network;
- Provision of information to providers with regard to:
    - Disease management programs available for patients
    - Changes in clinical practice guidelines, protocols, or medical policies
    - THSteps periodicity schedules
    - Timeliness of setting appointments for THSteps and other services
    - Case management services available for patients, and
    - Inappropriate use of the emergency room by patients;
- Documentation of the specialty services, including behavioral/mental health, provided to patients outside the provider's office setting;
- Notification when patients are treated in a hospital emergency department;
- Documentation of the care provided to patients in the emergency department;
- Care coordination for patients;
- Opportunities for patients to participate in disease management programs if needed;
- Opportunities for providers to offer feedback to the MCO to improve the quality of care for their patients.

The EQRO developed this Physical Health Provider Survey in an effort to assess providers' perceptions of MCOs' effectiveness at implementing these processes, as well their overall level of satisfaction as participating providers in the MCO's network.

Methodology

Instrument development

The EQRO developed the survey tools after review of MCO contract requirements and with input from HHSC's Quality Assurance and Program Improvement staff in Medicaid Managed Care and CHIP Operations. The survey tool consisted of two mail-based, self-administered questionnaires sent to stratified random samples of STAR, STAR+PLUS, and CHIP provider offices, to be completed by office managers and providers, respectively.

The office manager survey consisted of two pages (double-sided), organized into three discrete sections:

(1) Physical health provider office characteristics and operational components;

(2) Agreement statements regarding the selected MCO's training practices for participating providers;

(3) Questions regarding how often the selected MCO was compliant with various practices, including MCO hotline staffing, eligibility verification, provision of information, and payment.

The provider survey consisted of two pages (double-sided), organized into three discrete sections:

(1) Agreement statements regarding the selected MCO's compliance with training practices and provision of information;

(2) Questions regarding how often the selected MCO was compliant with various practices, including authorization, care coordination, and documentation of care;

(3) Questions regarding the provider's satisfaction with the selected MCO, including an overall satisfaction rating and an open-ended question soliciting suggestions for improvement.

While all questions on the survey were the same across program/MCO groups, each questionnaire indicated the program/MCO for which the provider was selected. Providers were given instructions to respond to the questions as they specifically pertained to their participation in the listed program/MCO.

Sampling

The STAR, CHIP, and STAR+PLUS surveys focused on providers designated as primary care practitioners (PCPs) in the P92 (STAR, STAR+PLUS) and A020 (CHIP) files.

The EQRO's sampling goal was to enable HHSC to assess provider responses across a health plan's network, as well as to compare performance among those plans where appropriate. Sampling was done by MCO within each program, so as to obtain plan-specific results at a 95% confidence level, with responses to individual questions within 10 percent of actual responses in the corresponding provider population. As shown in **Table 1** above, a total of 34 sampling groups were represented.

The EQRO used the appropriate P92 and A020 files to determine the population counts of unique providers within each program/MCO. These counts were used to determine the target number of completed surveys per program/MCO, to a maximum of 96 completed surveys in each group. Random samples of providers were then drawn within each program/MCO group at three times the target sample, resulting in an oversampling ratio of 3-to-1.

To minimize provider burden and avoid confounding of responses by a provider serving multiple MCOs, sampling specifications for the Physical Health Provider Office Survey required that a single provider could only be sampled once within each program. A single provider could still be sampled once in STAR, once in CHIP, and once in STAR+PLUS, receiving a maximum of three different survey mailings.

To ensure this specification did not limit the sample size drawn for any particular program/MCO group, providers were sampled in an order dictated by MCO population size – proceeding from the smallest to the largest MCO population. Within each program, providers in the MCO with the smallest population size were sampled first, and providers in the MCO with the largest population size were sampled last.

Samples were further de-duplicated by provider phone number and address, ensuring that for group practices, only one office was sampled per program. This procedure was conducted for two reasons, first to provide an equal chance of study inclusion between individual physician practices and larger group practices and second, to reduce the burden on office managers who may work with multiple physicians.

After de-duplication of provider addresses, the actual number of sampled providers within each program/MCO group was less than three times the targeted number. **Appendix A** provides the sampling strategy used for this survey, showing the population of unique providers, the number of targeted completes, and the number of providers sampled in each program/MCO group.

Data Collection

Data collection followed a modified Dillman approach. The Dillman approach includes five elements to enhance participant response rates: 1) A respondent-friendly questionnaire; 2) Personalized correspondence; 3) Four points of contact by first-class mail with an additional "special" contact (e.g., telephone call); 4) Return first-class mail envelopes; and 5) Financial incentives.[3, 4] In an effort to improve response rates, which typically have been very low for the Provider Office Surveys, the FISCAL YEAR 2010 Provider Office Surveys incorporated the first four of the above elements.

Specifically, the EQRO adopted the following strategies for FISCAL YEAR 2010: (1) The survey tools were redesigned to facilitate ease of completion; (2) The cover letter was personalized to include the provider's name; and (3) For the "special" point of contact, the EQRO's survey vendor (BEBR) telephoned all sampled providers prior to survey mailing to confirm their mailing address and encourage participation in the survey.

Data collection consisted of three primary phases:

1) *Pre-mailing telephone calls*. The EQRO provided BEBR with a pre-mailing contact script to standardize telephone calls to providers. BEBR contacted 2,669 physical health providers by telephone over the course of 15 weeks. Periodically, BEBR then provided the EQRO with a verified list of addresses for providers who had agreed to participate in the survey.

2) *Survey mailing.* The EQRO mailed surveys to providers over the course of 21 weeks as it received verified provider lists from BEBR. The first-class mailings included both the Office Manager and Provider survey tools, instructions for completing the tools, and a first-class stamped return envelope.

3) *Follow-up contact.* Each provider was assigned a unique tracking code, which enabled the EQRO to follow up with providers who did not return their survey within three weeks after the initial mailing. The provider postcard reminder included contact information for the EQRO in the event that provider offices had misplaced the surveys. A second postcard reminder was sent two weeks later to those providers who still had not completed the survey.

Analysis and Reporting

Completed survey tools were entered into a Microsoft Excel database as they were received, and the EQRO staff periodically performed quality checks on entered data.

Following completion of the data collection, analyses were performed using SPSS 19 (Chicago, IL: SPSS, Inc.). For all items, non-responses were not considered in overall percentages presented in the body of this report. Percentages reported in tables and figures may not add up to 100 percent due to rounding.

Responses were tabulated by item for each program overall (STAR, CHIP, and STAR+PLUS) and for each individual MCO.[5] Analysis focused on providers' satisfaction with the MCO for which they were selected, and the characteristics (both of the provider and office) most associated with MCO contract compliance.

Results

Response Rates [6]

STAR: Of the 1,009 surveys mailed to STAR providers, 18 (1.8 percent) were returned due to incorrect or outdated addresses. Of the remaining 991 surveys mailed, ICHP obtained completed surveys from 236 providers – producing a response rate of 23.9 percent and a completion rate of 21.3 percent.

STAR+PLUS: Of the 351 surveys mailed to STAR+PLUS providers, 3 (1.0 percent) were returned due to incorrect or outdated addresses. Of the remaining 348 surveys mailed, ICHP obtained completed surveys from 84 providers – producing a response rate of 24.3 percent and a completion rate of 43.8 percent.

CHIP: Of the 1,129 surveys mailed to CHIP providers, 30 (2.7 percent) were returned due to incorrect or outdated addresses. Of the remaining 1,099 surveys mailed, ICHP obtained completed surveys from 229 providers – producing a response rate of 21.0 percent and a completion rate of 16.2 percent.

Provider Office Characteristics

Table 2 shows provider office characteristics by program, including practice type, practice specialty, the number of office locations where the provider treats patients in the identified MCO, use of physician extenders, and the length of time the provider has been in the identified MCO network.

Table 2. Provider Office Characteristics by Program

	STAR	STAR+PLUS	CHIP
Practice Type			
Individual	69%	73%	67%
Group	31%	27%	34%
Practice Specialty [a]			
Pediatrics	51%	32%	39%
Family practice	28%	33%	27%
General practice	5%	6%	4%
OB/Gyn	6%	8%	16%
Internal medicine	10%	19%	7%
Other	1%	1%	6%
Number of locations			
One	89%	85%	87%
2 to 3	10%	14%	13%
4 to 5	1%	1%	1%
Over 5	1%	0%	0%
Physician extenders [a]			
Nurse practitioner	23%	33%	23%
Nurse midwife	1%	1%	1%
Physician assistant	17%	24%	20%
None	66%	57%	64%
Duration in MCO network [b]			
Less than 1 year	1%	0%	1%
1 to 2 years	10%	5%	16%
3 to 4 years	19%	29%	17%
5 or more years	66%	55%	56%

[a] Percentages exceed 100% because providers could select more than one response.
[b] Percentages may not equal 100% due to excluding "Don't know" responses from the table.

In all three programs, the majority of providers had individual practices (67 to 73 percent), treated patients in the identified MCO in one office location (85 to 89 percent), and had been in the identified MCO's network for greater than five years (55 to 66 percent). Approximately two-thirds of providers in each program worked in a group practice.

The most common practice specialties in STAR and CHIP were pediatrics (51 and 39 percent, respectively), while the most common practice specialty in STAR+PLUS was family practice (33 percent).

Between 34 and 43 percent of providers used physician extenders in their offices. Nurse practitioners were the most common physician extenders in all three programs (23 to 33 percent), followed by physician assistants (17 to 24 percent).

Provider Office Operations

Table 3 provides operational components of provider offices regarding the days per week provider offices are open, and the number of days with extended hours.

In all three programs, greater than 90 percent of provider offices were open Monday through Friday; on average, offices were open five days per week. Saturday hours were reported in 22 to 28 percent of offices, and Sunday hours were reported in one to three percent of offices. The percentage of offices that were open all seven days of the week was five percent in STAR, four percent in STAR+PLUS, and seven percent in CHIP.

Table 3. Provider Office Operations by Program

	STAR	STAR+PLUS	CHIP
Office is open on…			
Monday	99%	99%	100%
Tuesday	100%	99%	100%
Wednesday	98%	97%	98%
Thursday	98%	94%	98%
Friday	99%	99%	97%
Saturday	28%	22%	24%
Sunday	2%	1%	3%
Number of days with extended hours			
None	67%	74%	76%
One	7%	7%	7%
Two	5%	3%	4%
Three	5%	4%	2%
Four	4%	1%	4%
Five	7%	6%	5%
Six	5%	3%	2%
Seven	1%	1%	1%

Between 25 and 34 percent of providers in the three programs offered extended office hours for patients in the identified MCO. In all three programs, only one percent of providers offered extended hours all seven days of the week.

Perceptions of MCO Practices and Overall Satisfaction

The FISCAL YEAR 2010 Provider Office Survey contained questions for both the office manager and the provider to answer. An overview of the results is discussed in the following section, however a comprehensive listing of results can be found in the accompanying technical appendix. Items contained two different response sets. The first response set required the respondent to select "Yes," "No," or "Don't Know," while the second response set asked respondents to select "Always," "Usually," "Sometimes," "Never," or "Don't Know." Responses of "Don't Know" were combined with missing responses and not accounted for in the overall percentages. Totals may not equal 100 percent due to rounding.

Providers were asked to rate their satisfaction with the health plan, on a scale of 1 (not satisfied) to 5 (highly satisfied). Provider's satisfaction level by program is shown in **Figure 1**. A provider who gave a satisfaction rating of 4 or 5 was considered to be "highly satisfied" as a participating provider with their health plan. A provider who rated their satisfaction as a 1 or 2 was considered to be "not satisfied" as a participating provider. A satisfaction rating of 3 indicated a "neutral" level of satisfaction. Overall, more than 50 percent of providers in STAR, STAR+PLUS, and CHIP reported that they were satisfied as a participating provider with their MCO.

Figure 1. Provider Satisfaction Level with STAR, STAR+PLUS, and CHIP

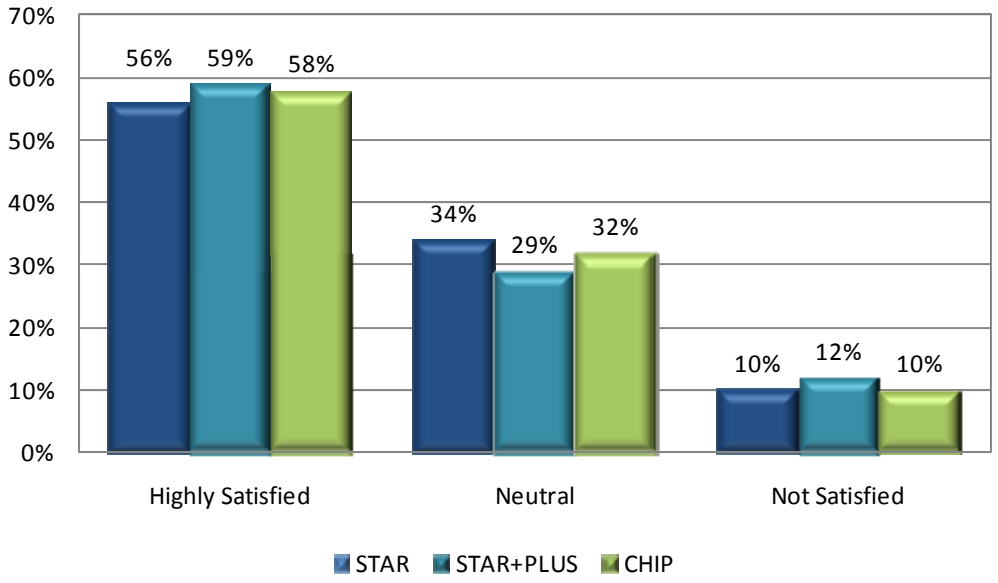
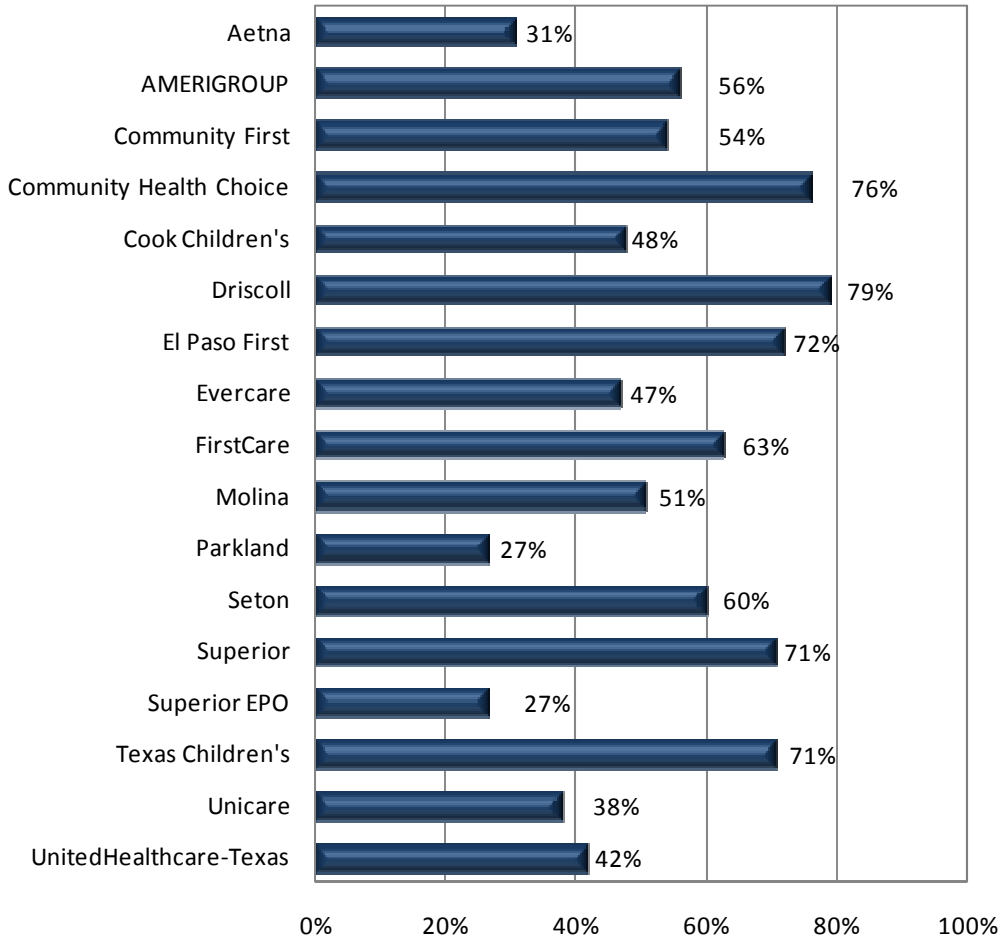


Figure 2 shows the percentage of providers who rated they were highly satisfied with their specific MCO. Driscoll (79 percent), Community Health choice (76 percent), Texas Children's (71 percent) and Superior (71 percent) were among the highest rated MCOs. In addition, high provider satisfaction was at 50 percent or greater in 10 out of 17 MCOs. Among medical specialties, providers specializing in OBGyn reported the highest satisfaction (64 percent) with MCOs, while pediatricians reported the lowest satisfaction (56 percent). However, it should be noted that over half of providers reported high satisfaction regardless of medical specialty, program type, or health plan.

Figure 2. Percent of Providers Reporting High Satisfaction Ratings with their Health Plan [a]



[a] Interpretation of these percentages should be made with caution. Only Molina, Superior, and Texas Children's had sample sizes large enough to reasonably estimate the actual percentages in their provider populations.[7]

Training

The EQRO probed both office managers' and providers' assessments of MCO training obligations for the provider's clinical practice over the past year. **Figure 3** shows that the majority of *office managers or staff* participating in STAR, STAR+PLUS, and CHIP programs had received training from the MCO that allowed them to: (1) access appropriate MCO contacts to address office or patient issues (65 to 74 percent); (2) submit accurate claims for payment (69 to 72 percent); (3) understand requirements for authorization of services (66 to 73 percent); and (4) stay informed about available benefits and services for their patients (65 to 72 percent). STAR MCOs were able to complete more training scenarios for office managers and clinic staff than MCOs in either STAR+PLUS or CHIP.

Figure 3. Percent of Provider Office Staff Who Received Training in the Past Year

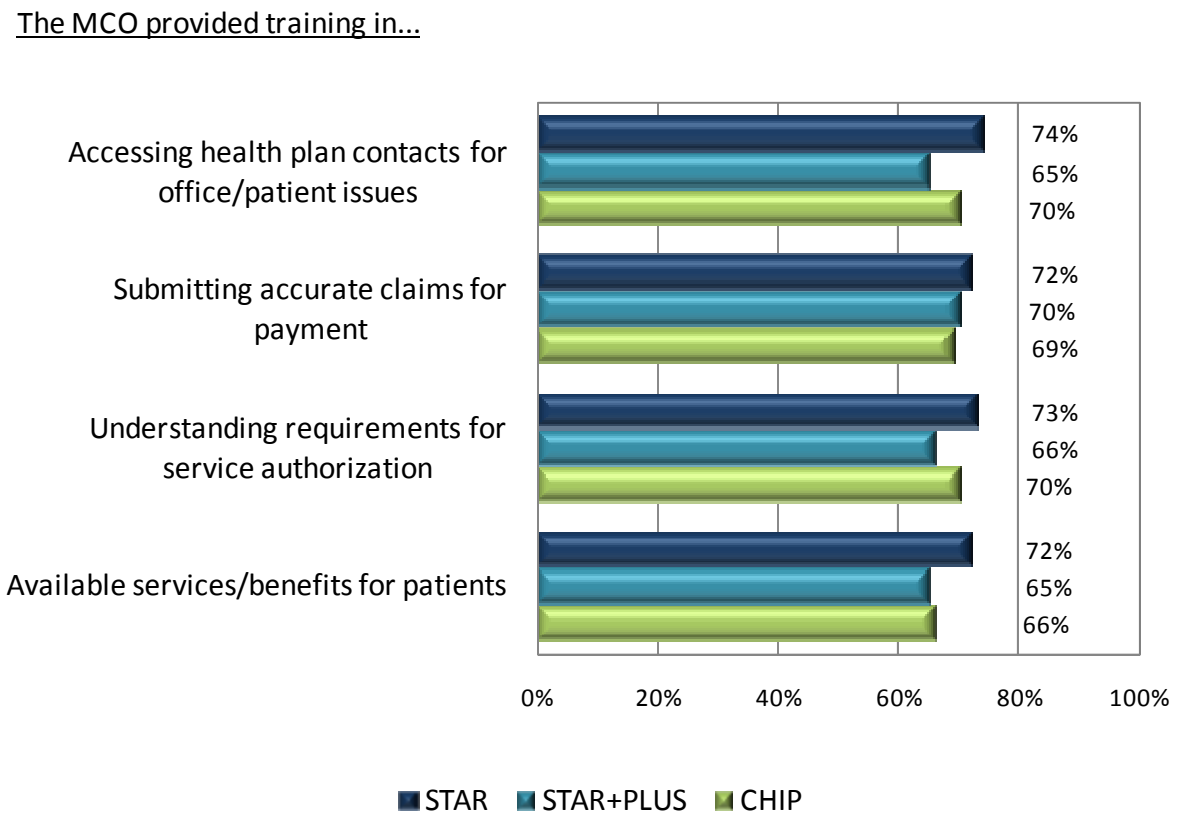


Figure 4 provides the percentage of *providers* who received training in the past year in six categories: (1) required lab screenings and Comprehensive Care Program services under the Texas Health Steps Program, (2) required elements of Texas Health Steps medical check-ups, (3) Texas Health Steps benefits, (4) the health plan's referral process to behavioral health providers, (5) new models of behavioral health interventions, and (6) how to screen for and identify behavioral health disorders.

Fifty-eight percent of providers in STAR, 57 percent in STAR+PLUS, and 55 percent in CHIP indicated that their health plans offered training about the required lab screenings and Comprehensive Care Program services under the Texas Health Steps Program. Seventy-eight percent of providers in the STAR Program agreed that their health plans had provided training about Texas Health Steps medical check-ups requirements, compared with 69 percent in STAR+PLUS and 64 percent in CHIP. Seventy-one percent of STAR and STAR+PLUS providers reported that their health plans provided training on Texas Health Steps (EPSDT) benefits, compared to 60 percent of CHIP providers.

Overall, training regarding behavioral health issues or procedures was low in all three programs, reported by less than 45 percent of providers. Specifically, 43 percent of providers in STAR, 41 percent in STAR+PLUS and 33 percent in CHIP said that their health plans offered training regarding the referral process to a behavioral health provider. Forty percent of STAR+PLUS providers stated that their health plans provided training on new models of behavioral health interventions, compared to 36 percent in STAR and 21 percent in CHIP. Forty-four percent of providers in STAR+PLUS reported that their health plans offered training on screening for and identifying behavioral health disorders, compared to 36 percent in STAR and 24 percent in CHIP.

Figure 4. Percent of Providers Who Received Training in the Past Year

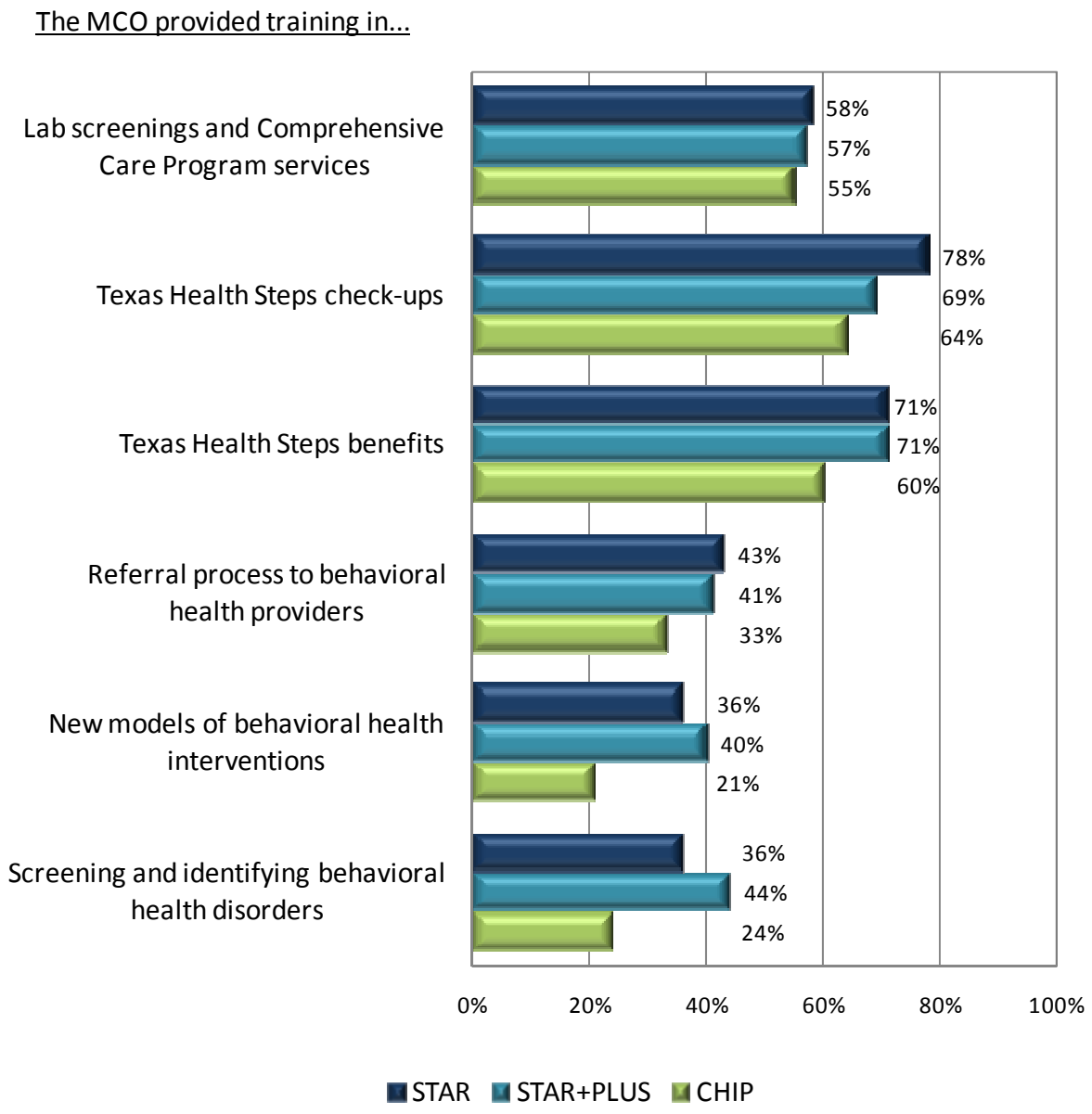


Table 4 reports the influence of MCO training on provider satisfaction levels. Results showed that training is significantly associated with provider satisfaction. Providers who reported that training did not occur were more likely to also report lower satisfaction ratings with their managed care organization. These associations were strongest for training on the referral process to BH providers, and training on required lab screenings and comprehensive care program services under Texas Health Steps.[8]

Table 4. Influence of Health Plan Training on Provider Satisfaction

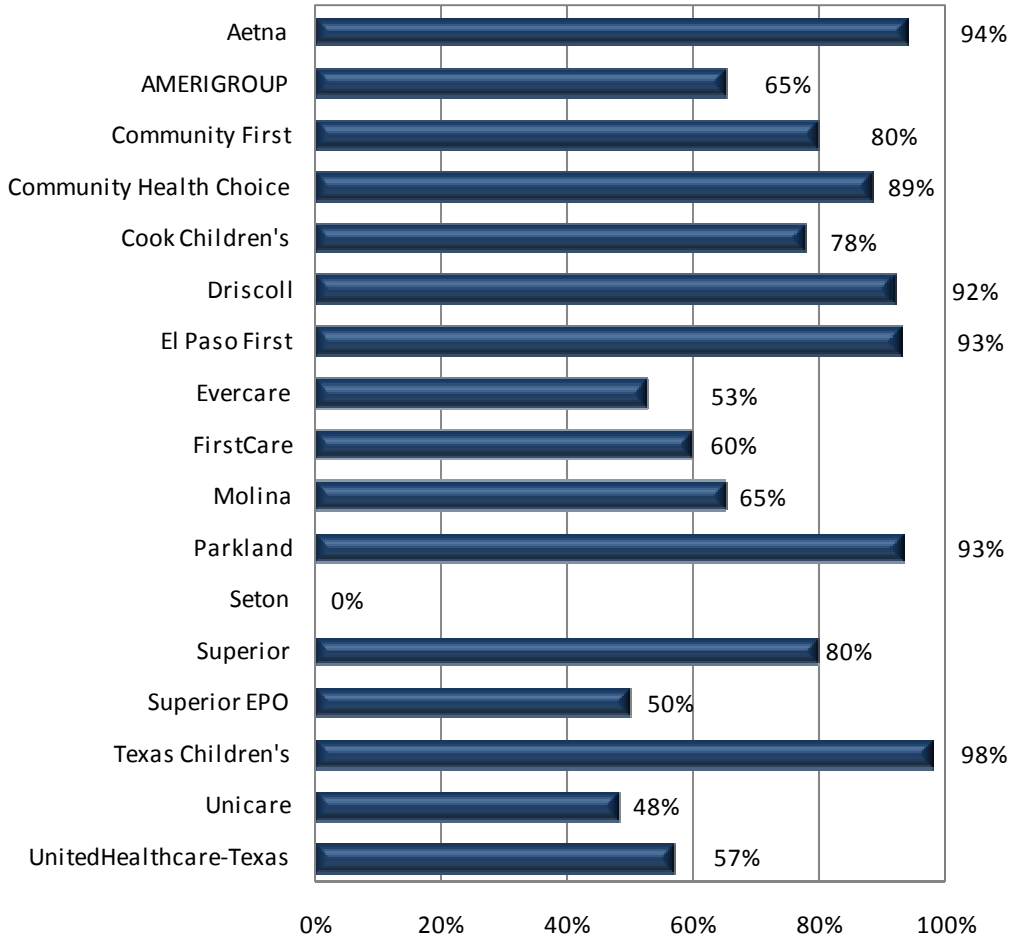
In the past year, has the health plan provided you or your staff with training on…	N	Not Highly Satisfied	Highly Satisfied [a]
Available services/benefits for patients?			
No	130	70%	30%
Yes	286	30%	70%
Understanding requirements for authorization of services?			
No	125	70%	30%
Yes	298	32%	68%
Submitting accurate claims for payment?			
No	120	69%	31%
Yes	285	31%	69%
Accessing health plan contacts to address office/patient issues?			
No	121	70%	30%
Yes	293	31%	69%
Referral process to behavioral health providers?			
No	216	62%	38%
Yes	138	17%	83%
Providing for all required lab screenings and Comprehensive Care program services under the Texas Health Steps program?			
No	148	71%	29%
Yes	193	27%	73%

[a] Chi-square tests for differences of proportions reported a p-value less than 0.001 for each measure.

Communication with health plans

The EQRO asked providers and office managers various questions about the thoroughness and frequency of their correspondence with MCOs. Eighty percent of office managers participating in the STAR program reported that their office received a personal visit from a health plan provider representative in the past year, compared to 74 percent in the STAR+PLUS program and 70 percent in CHIP. **Figure 5** shows the percent of office managers reporting a visit from a health plan representative in the past year, by health plan.

Figure 5. Percent of Office Managers Reporting Their Office Received a Visit from an MCO Provider Representative



[a] Interpretation of these percentages should be made with caution. Only Aetna, AMERIGROUP, Community Health Choice, Driscoll, El Paso First, Molina, Parkland, Superior, and Texas Children's had sample sizes large enough to reasonably estimate the actual percentages in their provider populations.[9]

Certain aspects of MCO-provider communication were rated positively by provider offices and varied little across programs.

- 85 to 89 percent of office managers usually or always felt the health plan's telephone hotline was staffed with personnel who are knowledgeable about covered services.
- 83 to 89 percent of office managers reported usually or always receiving timely information when needed from their health plan.
- 75 to 82 percent of office managers reported receiving information related to Texas Health Steps periodicity schedules.

Provider offices did not respond as favorably when asked about the availability of MCO hotline staff, or the receptiveness of the health plan to feedback regarding quality of care.

- 55 percent of office managers in STAR, 44 percent in STAR+PLUS, and 56 percent in CHIP reported that, when calling the health plan's hotline, the wait time to speak to a health plan representative was "usually" or "always" less than two minutes.

- 21 percent of STAR and STAR+PLUS providers and 25 percent of CHIP providers reported *never* having the opportunity to provide feedback to the health plan in order to improve the quality of care for their patients.

- 27 percent of providers in STAR, 33 percent in STAR+PLUS, and 30 percent in CHIP reported *sometimes* having the opportunity to provide feedback to the health plan.

The degree to which an MCO facilitates communication with its providers is associated with provider satisfaction, as shown in **Table 5**. For all questions related to MCO-provider communication, low ratings (responses of "No" or "Never") were significantly associated with low provider satisfaction. These associations were strongest for questions dealing with contact from health plan representatives, the provision of timely information, opportunities for providers to give feedback to MCOs, and information about Texas Health Steps periodicity schedules, the availability of case management, the availability of disease management, and changes to clinical practice guidelines.[10] In particular, low satisfaction was reported by:

- 78 percent of providers who were not given information about Texas Health Steps periodicity schedules

- 75 percent of providers who were not given information about disease management programs available to their patients

- 75 percent of providers who were not given information about case management services available to their patients

- 74 percent of providers who were never given the opportunity to provide feedback to the health plan to improve the quality of care for their patients

Table 5. Influence of Health Plan Communication on Provider Satisfaction

	N	Not Highly Satisfied	Highly Satisfied [a]
In the past year, did the health plan provide you with information related to…			
…changes in clinical practice guidelines, protocols, or medical policy?			
No	83	76%	24%
Yes	307	32%	68%
…Texas Health Steps periodicity schedules?			
No	82	78%	22%
Yes	310	31%	69%

Table 5 (continued). Influence of Health Plan Communication on Provider Satisfaction

	N	Not Highly Satisfied	Highly Satisfied [a]
In the past year, did the health plan provide you with information related to…			
…disease management program(s) available for your patients?			
No	98	75%	26%
Yes	286	30%	70%
…case management services available for your patients?			
No	97	75%	25%
Yes	283	30%	70%
In the past year, did you receive a personal visit from a health plan provider representative?			
No	111	71%	29%
Yes	344	33%	67%
In the past year, how often has your office received timely information when needed from the health plan?			
Never	8	75%	25%
Sometimes	64	78%	20%
Usually or Always	360	33%	67%
When you call the health plan's hotline, how often is hotline staffed with personnel who are *knowledgeable* about covered services?			
Never	4	50%	50%
Sometimes	54	70%	30%
Usually or Always	352	38%	63%
When you call the health plan's hotline, how often is the wait time to speak to a representative less than two minutes?			
Never	58	71%	29%
Sometimes	139	50%	50%
Usually or Always	229	31%	69%
How often are you given the opportunity to provide feedback to the health plan to improve the quality of care for your patients?			
Never	85	74%	26%
Sometimes	112	56%	44%
Usually or Always	192	20%	80%

[a] Chi-square tests for differences of proportions reported a p-value less than 0.001 for each measure.

Care Coordination

A key element of managed care involves the coordination of health care across different providers and services, and the delivery of appropriate, integrated care that is focused on the needs of individual cases or specific populations. The Agency for Healthcare Research and Quality (AHRQ) defines *care coordination* as "the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services."[11] Care coordination is integral to the timeliness, effectiveness, and efficiency of health services delivered through MCOs, and consequently to the health of an MCO's membership

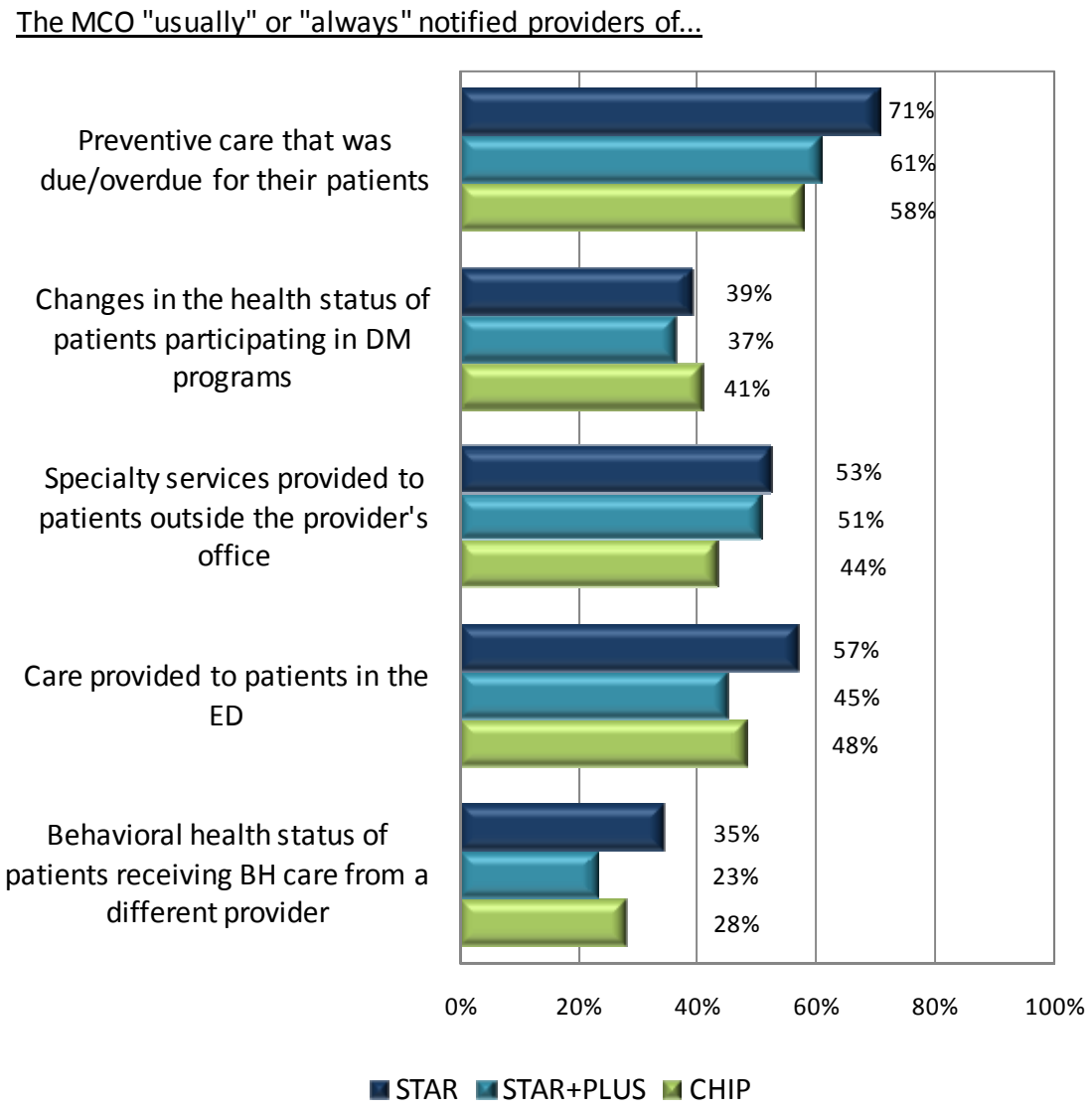
This survey asked providers about their experiences with the health plan's coordination of care for their patients. These included the following:

- receiving notification when preventive care is due/overdue for their patients
- receiving information about changes in the health status of their patients participating in DM programs
- receiving documentation of specialty services provided to their patients outside the office
- receiving documentation of the care provided to their patients in the emergency department (ED)
- receiving regular reports on the behavioral health (BH) status of patients who have a different provider for BH services
- being included by the health plan in the care coordination process
- having opportunities for their patients to participate in disease management programs
- receiving assistance in linking with allied health and social service agencies
- receiving information related to inappropriate ED use by their patients

Figure 6 shows the percent of providers who stated they "usually" or "always" received notifications, reports, or other forms of information from the health plan that are necessary for the coordination of care for their patients. All of these notifications are at the member/patient level, and refer to services rendered to particular patients, or to the health status of particular patients. Overall, information related to services rendered was provided more often than information related to patient health. The most frequent type of notification was that preventive care was due or overdue for a patient, reported by 71 percent of providers in STAR, 61 percent in STAR+PLUS, and 58 percent in CHIP. This was the only type of care coordination information for which differences among the programs were statistically significant.[12]

Provider responses indicate a greater need for information-sharing in the coordination of care for behavioral health patients. For patients in the health plan who received BH services from another provider, health plans sent regular reports on the BH health status of these patients to 35 percent of providers in STAR, 23 percent in STAR+PLUS, and 28 percent in CHIP. Texas Medicaid and CHIP members receive BH services through one of two delivery models: (1) "in-house" BH delivery, where the health plan provides BH services directly; and (2) "BHO" delivery, where members receive BH services through a behavioral health organization contracted with the MCO. To address the possibility that behavioral health delivery model might influence provider responses to questions on BH care coordination, ICHP repeated the analysis by delivery model. Overall, 34 percent of providers in health plans with an "in-house" model said they "usually" or "always" received reports on the BH status of their patients, compared with 31 percent of providers in health plans with a "BHO" model. These differences were not statistically significant.

Figure 6. Percent of Providers Receiving Information Necessary for Care Coordination



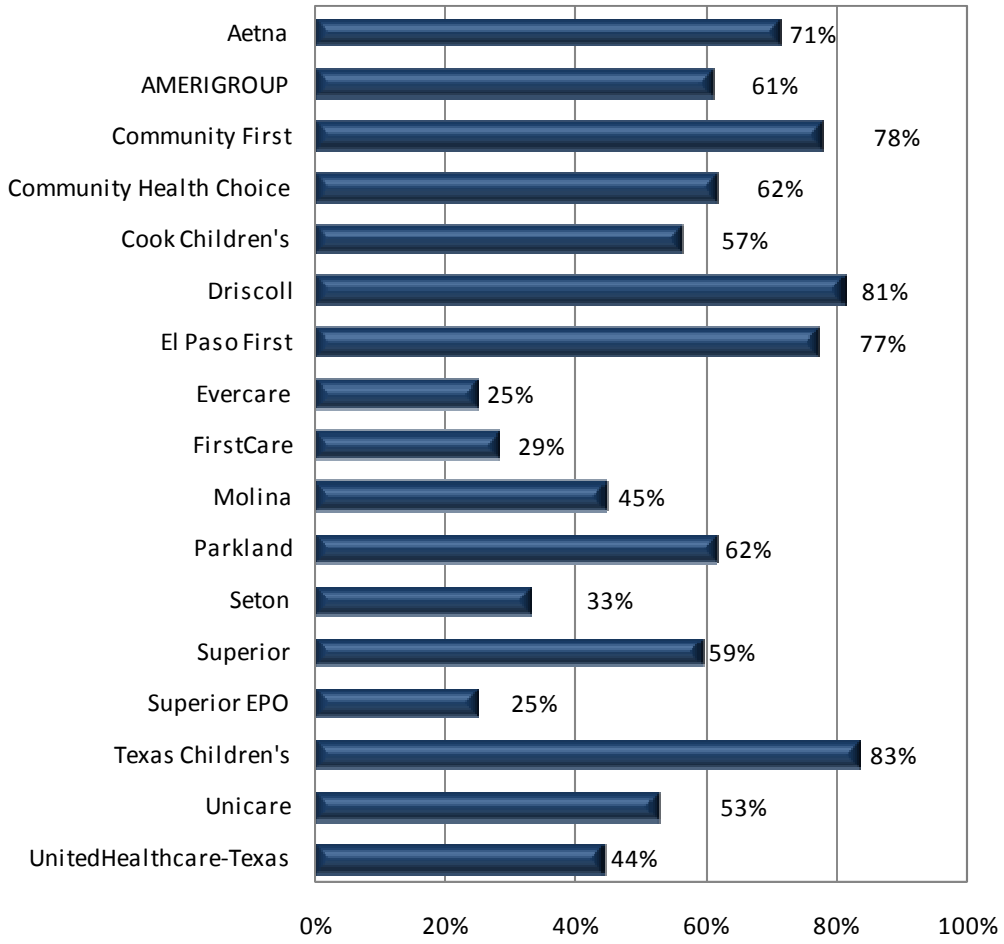
The majority of providers reported the health plan “usually” or “always”:

- included them in the care coordination process, reported by 60 percent of providers in STAR, 61 percent in STAR+PLUS, and 51 percent in CHIP.
- gave their patients opportunities to participate in disease management programs, reported by 65 percent of providers in STAR 68 percent in STAR+PLUS, and 58 percent in CHIP.

However, less than one third of providers reported the health plan “usually” or “always” assisted them in linking with allied health and social service agencies to facilitate implementation of their patients’ plans of care – at 32 percent in STAR, 29 percent in STAR+PLUS, and 29 percent in CHIP.

An important component of care coordination is ensuring appropriate use of the emergency department (ED). It is critical for both the quality and cost of care that health plans and providers regularly share information on patient use of the ED, with special attention to potentially avoidable ED admissions. This survey asked providers whether the health plan had given them information about inappropriate use of the ED by their patients in the past year. Sixty-four percent of providers in STAR, 61 percent in STAR+PLUS, and 56 percent in CHIP said they had received such information. **Figure 7** shows the percentage of providers who received information on inappropriate ED use by health plan.

Figure 7. Percent of Providers Who Received Information on Patients with Inappropriate ED Use [a]



[a] Interpretation of these percentages should be made with caution. Only Texas Children's had a sample size large enough to reasonably estimate the actual percentage in its provider population.[13]

Table 6 shows differences in provider satisfaction for each of the health plan care coordination items in the survey. For all questions related to health plan care coordination, low ratings (responses of "No" or "Never") were significantly associated with low provider satisfaction. These associations were strongest for questions regarding inclusion of the provider in care coordination, communicating changes in the health status of patients in DM programs, and assistance in linking with allied health and social service agencies.[14] The strongest association was observed for the health plan's inclusion of providers in care coordination, with low satisfaction reported in 84 percent of providers who said they were "never" included.

Table 6. Influence of Health Plan Care Coordination on Provider Satisfaction

	N	Not Highly Satisfied	Highly Satisfied [a]
In the past year, how often did your office receive notification from the health plan when preventive care was due/overdue for your patients?			
Never	62	69%	31%
Sometimes	84	55%	45%
Usually or Always	259	31%	69%
How often do you receive information from the health plan concerning changes in the health status of patients participating in DM programs?			
Never	85	71%	29%
Sometimes	131	51%	49%
Usually or Always	142	22%	78%
How often do you receive documentation of specialty services, including BH/MH, provided to patients outside your office?			
Never	80	66%	34%
Sometimes	102	48%	52%
Usually or Always	176	26%	74%
How often do you receive documentation of the care provided to patients when they visit an emergency department?			
Never	93	66%	34%
Sometimes	103	52%	49%
Usually or Always	211	28%	72%
How often do you receive regular reports from the health plan on the behavioral health status of patients who receive BH services from another provider?			
Never	123	55%	45%
Sometimes	119	52%	48%
Usually or Always	107	19%	81%
How often does the health plan include you in care coordination for your patients?			
Never	56	84%	16%
Sometimes	114	61%	39%
Usually or Always	224	24%	76%
How often does the health plan give your patients opportunities to participate in disease management programs if needed?			
Never	26	58%	42%
Sometimes	93	65%	36%
Usually or Always	208	28%	72%

[a] Chi-square tests for differences of proportions reported a p-value less than 0.001 for each measure.

Table 6 (continued). Influence of Health Plan Care Coordination on Provider Satisfaction

	N	Not Highly Satisfied	Highly Satisfied [a]
How often has the health plan assisted you in linking with allied health and social service agencies to facilitate implementation of your patients' plans of care?			
Never	115	67%	33%
Sometimes	115	47%	53%
Usually or Always	102	17%	83%
In the past year, did the health plan provide you with information related to inappropriate use of the emergency department by your patients?			
No	141	65%	35%
Yes	219	30%	70%

[a] Chi-square tests for differences of proportions reported a p-value less than 0.001 for each measure.

Eligibility verification, authorization, and payment

Four survey questions addressed the office manager's experiences with eligibility verification, claims submission and payment by the health plan. One survey question addressed the provider's experiences with authorization or prior authorization by the health plan. **Figure 8** shows the percentage of provider offices in STAR, STAR+PLUS, and CHIP who reported they "usually" or "always" received: (1) easy eligibility verification for patients in the health plan; (2) timely authorization or prior authorization of services; (3) timely payment of claims (within 30 days); and (4) accurate payment of claims.

Overall, providers had positive experiences with the health plan with regard to these practices. Greater than 80 percent of providers in all three programs reported easy eligibility verification, timely payment of claims, and accurate payment of claims. The most variation among the programs was observed for timely authorization or prior authorization of services, reported by 84 percent of providers in STAR, 69 percent in STAR+PLUS, and 78 percent in CHIP. However, these differences were not statistically significant.

The survey also asked office managers whether they had the option of submitting and receiving claims through electronic data interchange (EDI). The use of electronic information (both clinical and administrative) by health care providers is an important step toward ensuring that delivery of services is appropriate, adequate, and efficient, and can contribute to improvement in the quality of care.[15] Overall, the vast majority of providers reported they could submit and receive claims through EDI, including 86 percent of providers in STAR, and 92 percent of providers in both STAR+PLUS and CHIP.

Figure 8. Percent of Offices Reporting Adequate Health Plan Processes for Eligibility Verification, Authorization, and Payment

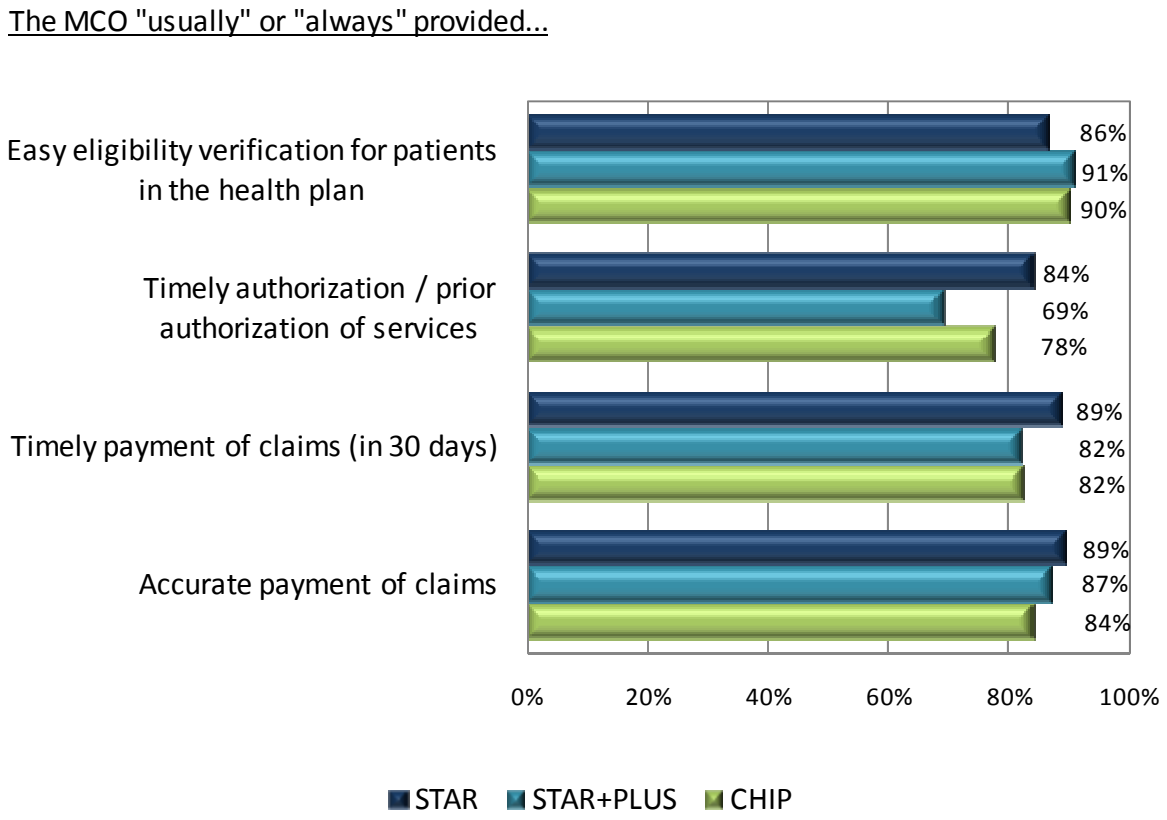
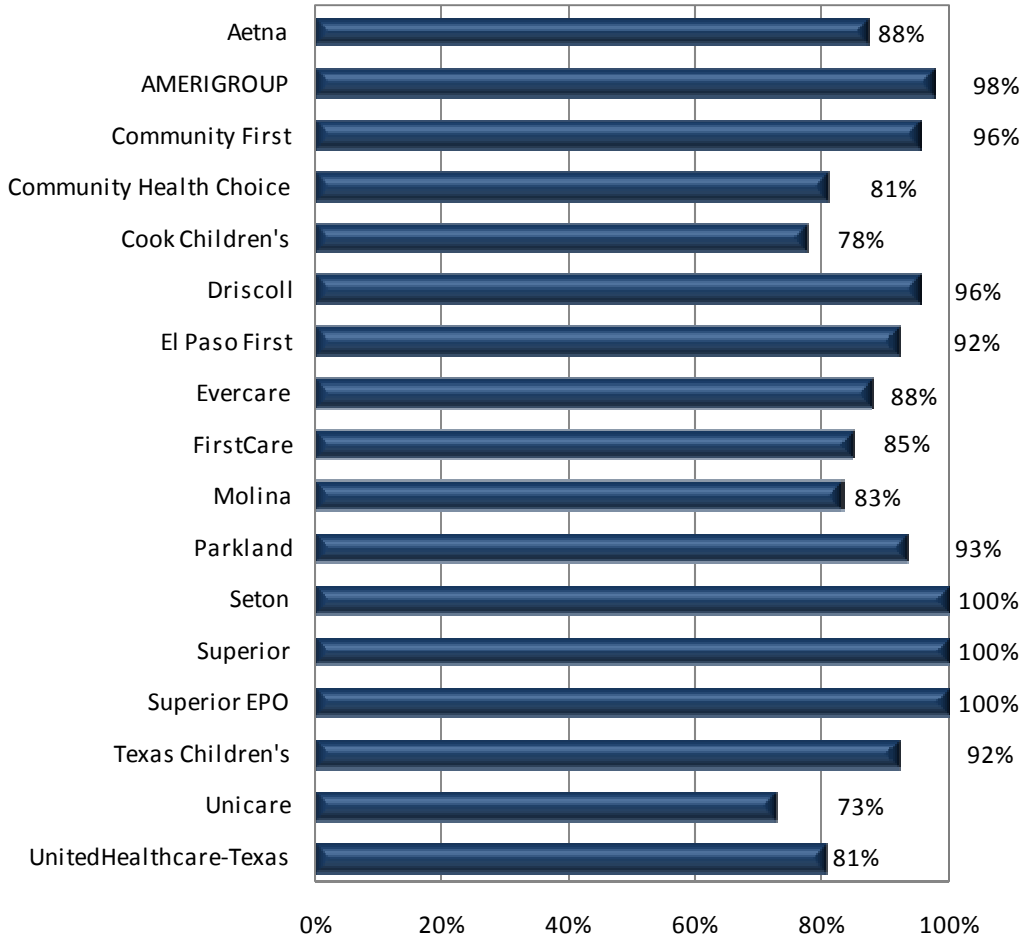


Figure 9 shows the distribution of provider offices reporting they had the option to submit/receive claims through EDI, by health plan. The highest percentages were observed in Superior (100 percent) and AMERIGROUP (98 percent). While 100 percent of office managers in Seton and Superior EPO also reported having the option for EDI, the sample sizes in these health plans were too small to produce reliable estimates. The lowest percentages of offices with the option for EDI were observed in Community Health Choice (81 percent) and Molina (83 percent). Although lower percentages were observed in Cook Children's (78 percent) and Unicare (73 percent), these health plans also had sample sizes too low for reliable estimation of proportions in the population.

Figure 9. Percent of Provider Offices with the Option to Submit/Receive Claims through Electronic Data Interchange [a]



[a] Interpretation of these percentages should be made with caution. Only AMERIGROUP, Community First, Community Health Choice, Driscoll, El Paso First, Molina, Superior, Texas Children's, and UnitedHealthcare-Texas had sample sizes large enough to reasonably estimate the actual percentages in their provider populations.[16]

Table 7 shows differences in provider satisfaction for each of the survey items dealing with health plan eligibility verification, authorization, and payment. For questions related to eligibility verification and authorization, low ratings (responses of "Never") were significantly associated with low provider satisfaction. Low ratings for the timeliness and accuracy of claims payments were also significantly associated with low provider satisfaction. While statistically significant, these associations were not as strong as those for training, information, and care coordination.[17] No association was observed between the option for EDI and provider satisfaction, as rates of high satisfaction were relatively equal between providers with EDI (58 percent) and without EDI (54 percent).

Table 7. Influence of Health Plan Eligibility Verification, Authorization, and Payment on Provider Satisfaction

	N	Not Highly Satisfied	Highly Satisfied [a]
In the past year…			
How often was eligibility verification for members in this health plan easy to obtain?			
Never	7	71%	29%
Sometimes	43	74%	26%
Usually or Always	392	38%	63%
How often did the health plan pay your claims in a timely manner (within 30 days)?			
Never	8	88%	13%
Sometimes	56	71%	29%
Usually or Always	348	36%	64%
How often did the health plan pay your claims accurately?			
Never	3	100%	0%
Sometimes	52	77%	23%
Usually or Always	362	37%	64%
How often does your office receive timely authorization / prior authorization of services from the health plan?			
Never	6	83%	17%
Sometimes	80	71%	29%
Usually or Always	327	34%	66%
With this health plan, do you have the option of submitting and receiving claims through electronic data interchange (EDI)?			
No	46	46%	54%
Yes	395	42%	58%

[a] Chi-square tests for differences of proportions reported a p-value less than 0.001 for all measures except submitting/receiving claims through EDI.

Open-ended Responses

Open-ended findings are valuable for understanding the impact of deficiencies in health care and health care management on the personal lives of members, and for identifying issues that may not have been captured in the closed-response survey items. A total of 122 providers provided responses to the open-ended question at the end of the survey, which asked: "What suggestions do you have for improving your office's relationship with this health plan?"

Table 8 provides the frequencies of respondent comments in five categories and 14 subcategories. Respondent comments were retained if they could be classified and if they were directly related to the selected health plan. Percentages for categories/subcategories are calculated out of all respondents who provided comments (n = 122).

Table 8. Open-ended Responses

Issue raised	N	% of open-ends [a]
Problems with MCO staff/representatives	**31**	**25%**
Need more visits from representative	18	15%
Poor communication	12	10%
Representative is unknowledgeable about the plan	3	3%
Representative is rude or uncooperative	3	3%
Problems with payments, claims, denials, eligibility	**30**	**25%**
Miscellaneous complaints regarding payments	9	7%
Authorizations	8	7%
Denials	6	5%
Claims assistance/process	5	4%
Enrollment issues	3	3%
Problems with access to specialists	**25**	**21%**
General lack of availability	22	18%
Behavioral and mental health specialists	8	7%
Dermatologists	3	3%
Orthopedic specialists	2	2%
General communication problems	**20**	**16%**
Noncompliance / patient education	**5**	**4%**

[a] Total exceeds 100 percent because some respondents discussed multiple issues.

Problems with MCO staff and representatives

Of the 31 open-ended responses that dealt with MCO staff and representatives, 18 providers explicitly mentioned that they desired a greater number of visits from their representatives. In some cases, providers stated that they had never actually met their representatives.

> *"Hardly ever see representative. And when she does come by she is always pushing me to open my panel. Other health plan representatives come by every month."*

Nearly half of all complaints in this category (7 of 18) pertained to Molina. Other MCOs receiving multiple comments about insufficient visitation were AMERIGROUP (3), Community Health Choice (2), Superior (2), and Unicare (2).

A total of 12 responses were coded as "poor communication." This subcategory included general complaints about lack of access to staff and representatives, along with specific statements that staff and representatives communicated poorly or infrequently.

> *"I need someone to contact our office for some issues that no one ever returns calls about."*

The MCO with the greatest number of responses in this subcategory was Molina (3), followed by two each for AMERIGROUP, Texas Children's, and Unicare.

Problems with payments, claims, denials, and eligibility

Thirty providers expressed various problems related to compensation. In addition to general complaints about low fees and the timeliness of payments, this category also included issues related to authorizations, denials, claims processing, and enrollment. Cook Children's received the most comments in this category (5), followed by AMERIGROUP (4), Molina (4), Superior (3), and Unicare (3).

Problems with authorizations were most common in Molina, problems with claims assistance were most common in AMERIGROUP, and problems with enrollment were most common in Cook Children's. No single health plan received more than one comment in the miscellaneous or denial subcategories.

Problems with access to care/specialists

Altogether, 25 providers had complaints regarding the lack of access to specialists for their patients. Providers in AMERIGROUP were the most likely to report complaints in this category, with a total of nine negative responses pertaining to a lack of specialty care. Other health plans receiving several negative comments were Superior (5) and Texas Children's (4).

General communication problems

Twenty providers gave open-ended responses that were coded as "general communication problems." These included problems with communication necessary for the coordination of their patients' care (such as monthly lists of patients due for their preventive care visit), with the health plan's website, and with training workshops held by the health plan to inform providers of updates and changes.

> *"It would be ideal to have training programs/lunches to inform us of any changes closer to our office. Houston is just too far and takes too long to go and come back; each employee is needed in the office during clinic."*

The distribution of comments regarding general communication was roughly equal among the following health plans: Three providers in AMERIGROUP made comments in this category, followed by two providers in Driscoll, El Paso First, Parkland, Superior, and UnitedHealthcare-Texas.

Noncompliance / patient education

Five providers made comments regarding the health plan's response (or lack of response) to patient noncompliance and education. Comments in this category dealt with the parents' role in keeping their child's appointments and a need for better health information for their patients.

> *"Train your parents to call and cancel when they no show. They are very lax and have a big non-compliant rate. We call and educate them in the process. The health plan needs to also do it!"*

> *"Help parents understand the importance of keeping their child's appointment for THSteps. If not, teach them to call and cancel. Very non-compliant."*

All complaints in this category were either from STAR or STAR+PLUS providers.

Conclusion and Recommendations

This survey had an overall response rate of 20.8 percent and an overall completion rate of 19.1 percent. Using new data collection methodologies based on a modified Dillman approach, the EQRO increased this survey's response rate over those reported in prior years (12.3 percent in fiscal year 2009, 8.8 percent in fiscal year 2008), which improves the reliability of results in estimating experiences and perceptions of the actual provider population. However, a response rate of 20.8 percent is still low, which may have been due to factors leading to participation bias.

Furthermore, this year's data collection methodology involved the delivery of fewer survey requests than in fiscal year 2009, and consequently produced a much lower completion rate (19.1 percent, vs. 49.8 percent in fiscal year 2009). Completion rates were not met for any of the program/MCO quotas, precluding any meaningful analysis by program/MCO, and precluding most analyses by MCO alone. For certain results in this report presented by health plan, the EQRO has indicated which health plans had sample sizes large enough to reasonably estimate population percentages within a 15 percentage point margin of error.

This study targeted 2,871 completed surveys overall, which would have produced estimates within 1.8 percent of actual proportions in the population. Targeted margins of error were 3.0 percent in STAR, 5.3 percent in STAR+PLUS, and 2.6 percent in CHIP. The actual number of completes produced estimates within 4.2 percent of actual proportions in the population. Actual margins of error were 6.4 percent in STAR, 10.7 percent in STAR+PLUS, and 6.5 percent in CHIP.[18] Most results in this report therefore focus on the three programs, for which reasonable population estimates could be made.

The low response and completion rates of this study should be taken into consideration when making conclusions and recommendations from the survey data. Given these limitations, the key recommendations for this study address areas of improvement for future EQRO surveys of STAR, STAR+PLUS, and CHIP providers. The secondary recommendations address areas of improvement for Texas Medicaid and CHIP MCO practices related to their relationships with providers; however, these are based on responses received in this survey and may not be indicative of issues or concerns of the larger provider pool.

Key recommendations

1. Improve response rates for future provider office survey studies by using a combination of web-based and mail-based approaches. Using a modified Dillman approach and telephone-based recruitment, the present survey had higher response rates than in prior years. Research has found that using a mixed-methods approach – combining web-based and mail-based data collection – can also improve response rates in surveys with clinicians.[19,20] Revising provider office survey methodology with the aim of improving response rates will allow the EQRO to make stronger conclusions and more directed recommendations in future surveys.
2. Improve completion rates for future provider office survey studies by reducing the number of exclusions in the survey sample pool. This year's study had strict sampling specifications that resulted in the exclusion of over half of the sampled providers. To improve competion rates, the EQRO recommends: (1) focusing provider office surveys on a single program or group of programs each year, alternating Medicaid and CHIP provider surveys; and (2) allowing more than one provider per group practice to be eligible for inclusion in the sample.

Secondary recommendations

1. Health plans participating in STAR, STAR+PLUS, and CHIP should make provider manuals, webinar training, and provider representatives more accessible to provider offices. The

percentage of provider offices reporting they had received training for patients with behavioral health problems was particularly low in this study. Fewer than half of the respondents said the MCO had provided training on the referral process to behavioral health providers, new models of behavioral health interventions, and screening/identifying behavioral health disorders in the past year. Training on the referral process to behavioral health providers is particularly relevant, as this study shows it is strongly associated with provider satisfaction with the health plan. Open-ended comments in this study also suggest that the lack of specialty care for their patients – in particular, BH/MH services – is an issue of concern to many providers. Health plans are contractually required to provide this training to network providers, as stated in Section 8.1.15.4 of the Uniform Managed Care Contract. Additionally, the EQRO recommends that HHSC request copies of provider training sign-in sheets in order to assess provider participation.

2. Health plans should develop or improve upon systems for providers to offer feedback on issues of importance to the quality of care for Texas Medicaid and CHIP patients. One-fifth (21 percent) of STAR and STAR+PLUS providers and one-quarter (25 percent) of CHIP providers in this survey reported never having the opportunity to provide feedback to the health plan. The opportunity to provide feedback was also strongly associated with provider satisfaction with the health plan.

3. Health plans should improve upon the provision of information that providers need to deliver quality care to Texas Medicaid and CHIP members. Fewer than half of respondents in all three programs indicated that the MCO "usually" or "always" provided them with information about changes in the health status of their patients participating in disease management programs, and with information on the behavioral health status of patients receiving BH care from a different provider. Fewer than one-third of respondents reported that the MCO "usually" or "always" assisted them in linking with allied health and social service agencies to facilitate implementation of their patients' plans of care. The effective and timely provision of this information to providers is essential to ensure that members are receiving the care coordination they need. Health plans are contractually required to provide this information and coordination to network providers, as stated in Sections 8.1.11, 8.1.14.1, 8.1.15.4, 8.2.10, and 8.2.11 of the Uniform Managed Care Contract.

   Health plans may refer to strategies for improving managed care information systems outlined by the Center for Applied Research.[21] In particular is an emphasis on standardization of health care information systems and reduction of system complexity. Provision of necessary information to providers can be simplified by: (1) establishing a protocol that can negotiate the various information technology systems used by different providers; and (2) reducing the number of steps involved in the provision of information.

Appendix A. Target Samples, Completion Rates and Response Rates by Program/MCO

Table 9. Target Samples, Completion Rates and Response Rates by Program/MCO

	Unique provider population	Targeted Completes	Random sample	Number Mailed	Number Completed	Completion Rate (%)	Response Rate (%) [a]
STAR							
Aetna	601	83	249	87	13	15.7	15.7
AMERIGROUP	2028	92	276	90	16	17.4	18.6
Community First	468	80	240	78	20	25.0	26.0
Community Health Choice	1110	88	264	85	23	26.1	27.4
Cook Children's	353	76	228	71	15	19.7	21.1
Driscoll	168	61	183[a]	57	10	16.4	17.5
El Paso First	183	63	189[a]	67	20	31.7	30.3
FirstCare	207	66	198	49	15	22.7	31.3
Molina	723	85	255	78	19	22.4	24.4
Parkland Community	436	79	237	59	15	19.0	26.3
Superior	1758	91	273	67	7	7.7	10.8
Texas Children's	840	86	258	95	31	36.0	31.9
UniCare	279	72	216	66	17	23.6	26.6
UnitedHealthcare-Texas	636	84	252	60	16	19.0	27.1
Total	**9790**	**1106**	**3318**	**1009**	**236**	**21.3**	**23.9**
CHIP							
Aetna	1972	92	276	70	11	12.0	16.4
AMERIGROUP	4671	94	282	76	16	17.0	21.6
Community First	450	79	237	55	6	7.5	12.0
Community Health Choice	2489	93	279	79	17	18.3	22.4
Cook Children's	827	86	258	86	13	15.1	15.5
Driscoll	430	79	237	83	16	20.3	20.5
El Paso First	433	79	237	53	14	16.5	27.5
FirstCare	968	87	261	59	11	12.6	20.0
Molina	2109	92	276	88	24	26.1	27.3
Parkland Community	1742	91	273	57	12	13.2	22.2
Seton	1067	88	264	60	6	6.8	10.3
Superior	5072	94	282	62	15	16.0	25.4
Superior EPO	4712	94	282	64	16	17.0	25.8
Texas Children's	2260	92	276	95	22	23.9	23.4
UniCare	715	85	255	74	12	14.1	16.9
UnitedHealthcare-Texas	1654	91	273	68	18	19.8	26.5
Total	**31571**	**1416**	**4248**	**1129**	**229**	**16.2**	**21.0**
STAR+PLUS							
AMERIGROUP	1385	90	270	87	25	27.8	28.7
Evercare	1189	89	267	80	17	20.2	21.8
Molina	810	86	258	88	18	20.9	20.9
Superior	693	84	252	96	24	29.8	25.3
Total	**4077**	**349**	**1047**	**351**	**84**	**24.1**	**24.3**

[a] Response rate calculations exclude undeliverable surveys from the denominator.

Endnotes

[1] Health plans are contractually required to ensure that provider hotline hold times are less than two minutes. (See HHSC Uniform Managed Care Manual – Chapter 10.1.1.) Health plan managers should take the independent, program-level rates provided in this report into consideration when monitoring health plan hotlines for compliance.

[2] Eiriz, V., & Figueiredo, J. A. 2005. Quality evaluation in health care services based on customer-provider relationships. *International journal of health care quality assurance incorporating Leadership in health services*, 18(6-7): 404-12.

[3] Dillman, D. A. 2007. *Mail and Internet Surveys: The Tailored Design, Second Edition—2007 Update.* Hoboken, NJ: John Wiley.

[4] Dillman, D. A. 1978. *Mail and Telephone Surveys: The Total Design Method.* New York: Wiley-Interscience.

[5] In most analyses by MCO, sample sizes were not large enough to produce reliable estimates of proportions in their provider populations, using a 95 percent confidence level and a 15-percent margin of error. Tables and graphs showing results by MCO will include footnotes to indicate which MCOs had reliable estimates. See the technical appendix that accompanies this report for more details.

[6] Using a 95-percent confidence level, responses for the STAR and CHIP programs are within 7 percent of actual percentages in their provider populations, and responses for STAR+PLUS are within 11 percent of actual percentages in its provider population.

[7] Required sample sizes for estimates of proportions were calculated with a 95 percent confidence level and a 15-percent margin of error.

[8] For these questions, the chi-square statistic was greater than 60 (df = 1).

[9] Required sample sizes for estimates of proportions were calculated with a 95 percent confidence level and a 15-percent margin of error.

[10] For these questions, the chi-square statistic was greater than 50 (df = 1 or 2).

[11] AHRQ (Agency for Healthcare Research and Quality). 2007. *Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies: Volume 7 – Care Coordination*. Available at: http://www.ahrq.gov/clinic/tp/caregaptp.htm.

[12] X =11.15, df = 4, p = 0.025

[13] Required sample sizes for estimates of proportions were calculated with a 95 percent confidence level and a 15-percent margin of error.

[14] For these questions, the chi-square statistic was greater than 50 (df = 1 or 2).

[15] IOM (Institute of Medicine). 2001. *Crossing the Quality Chasm: A New Health System for the 20th Century*. Washington, D.C.: National Academy Press.

[16] Required sample sizes for estimates of proportions were calculated with a 95 percent confidence level and a 15-percent margin of error.

[17] All chi-square values were less than 50 (df = 1 or 2).

[18] All confidence interval calculations assumed a confidence level of 95 percent and a proportion estimate of 50 percent (the most restrictive).

[19] Kroth, P.J., L. McPherson, R. Leverence, W. Pace, E. Daniels, R.L. Rhyne, and R.L. Williams. 2009. "Combining Web-Based and Mail Surveys Improves Response Rates: A PBRN Study From PRIME Net." *Annals of Family Medicine* 7(3): 245-248.

[20] Beebe, T.J., G.R. Locke III, S.A. Barnes, M.E. Davern, and K.J. Anderson. 2007. "Mixing Web and Mail Methods in a Survey of Physicians." *Health Services Research* 42(3): 1219-1234.

[21] Center for Applied Research. 2002. *Briefing Notes: Improving MCO Information Systems to Enhance Clinical Management*. Available at http://www.cfar.com/Documents/MCO_info.pdf.