



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

The Texas Medicaid STAR+PLUS Program

Adult Member Survey Report

Fiscal Year 2010

Institute for Child Health Policy

University of Florida

January 14, 2011

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Executive Summary

Purpose

This report provides results from the fiscal year 2010 STAR+PLUS Adult Member Survey for the State of Texas, prepared by the Institute for Child Health Policy (ICHP) at the University of Florida. The purpose of this survey is to gather information about the health care experiences of adults in the STAR+PLUS program. The survey provides a demographic and health profile of STAR+PLUS adult members, and a greater understanding of their experiences and satisfaction with different facets of their health care, such as communication with their personal doctor, specialist care, care coordination, and their health plan's customer service.

Methodology

Survey participants were selected from a random sample of adults 18 to 64 years old, stratified by health plan. To be eligible for survey participation, members must have been enrolled in the STAR+PLUS program for nine months or longer. Members eligible for both Medicaid and Medicare, and members who participated in the fiscal year 2009 STAR+PLUS survey were excluded.

A target of 1,200 completed telephone surveys was set, representing 300 respondents per managed care organization (MCO). Between June 2010 and November 2010, STAR+PLUS members were surveyed by telephone. Target samples for health plans were met, with the exception of Molina. The response rate for the STAR+PLUS survey was 47 percent and the cooperation rate was 74 percent.

The fiscal year 2010 STAR+PLUS Adult Member Survey included the following questionnaires and items:

- The Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) Health Plan Survey 4.0 (Medicaid module).
- The RAND[®] 36-Item Health Survey, Version 1.0.
- Items developed by ICHP pertaining to member characteristics and their health care experiences, including care coordination.

Descriptive analyses were performed on all survey items, with a focus on the Health and Human Services Commission (HHSC) Performance Indicator Dashboard for fiscal year 2009, and the CAHPS[®] Health Plan Survey ratings and composite measures.

Statistical tests were conducted to determine if there were differences in the results based on health plan membership and member characteristics. Analyses were also done to compare this year's findings with the fiscal year 2009 STAR+PLUS survey. In addition, multivariate analyses were conducted to test the influence of health plan membership on member satisfaction with their health care, and the influence of having a service coordinator on access to specialists and specialized services.

Summary of Findings

<i>Survey Respondent Profile:</i>	
<ul style="list-style-type: none"> 68 percent were female. The average age was 49. 39 percent were Hispanic and 29 percent were Black, non-Hispanic. 42 percent had not completed high school. 93 percent were unemployed. 	<ul style="list-style-type: none"> 83 percent were single, separated, divorced, or widowed. 62 percent rated their health as fair or poor. 51 percent were obese, and 24 percent were overweight. 30 percent were smokers.

Positive Findings

- CAHPS® composites.* Among the four CAHPS® composites, mean scores for *How Well Doctors Communicate*, *Getting Care Quickly*, and *Customer Service* were at or above 75, which indicates that members generally had positive experiences and were satisfied with their health care in these domains.

<u>CAHPS® Composites</u>	<u>Mean (scale 0-100)</u>
<i>How Well Doctors Communicate</i>	87.9
<i>Getting Care Quickly</i>	78.8
<i>Customer Service</i>	74.5
<i>Getting Needed Care</i>	72.3

- Member ratings.* A majority of members provided high ratings of their health care, personal doctor, specialist, and health plan, as indicated by a rating of 9 or 10 on a 10-point scale. The highest ratings were observed for members' personal doctor and specialist, with considerably lower ratings observed for mental health care.

<u>Members Rating of ...</u>	<u>9 or 10</u>	<u>Mean (scale 0 -10)</u>
Personal doctor	70 percent	8.79
Specialist	69 percent	8.67
Health care	51 percent	8.05
Health plan	51 percent	8.02
Mental health care	46 percent	7.55

- *HHSC Performance Dashboard Indicators.* The STAR+PLUS program met the Dashboard standards for five of the seven performance indicators. The majority of members had good access to routine care, urgent care, specialist referral, and special therapies. In addition, a majority of smokers were advised to quit smoking by their provider in the past six months.

	FY 2010 STAR+PLUS	HHSC Performance Dashboard Standard
<i>Good access to urgent care</i>	79%	76%
<i>Good access to specialist referral</i>	71%	62%
<i>Good access to routine care</i>	80%	78%
<i>No delays in health care while waiting for health plan approval</i>	52%	57%
<i>No exam room wait greater than 15 minutes</i>	29%	42%
<i>Good access to special therapies</i>	66%	47%
<i>Good access to Service Coordination</i>	64%	-
<i>Smokers advised to quit smoking on a visit</i>	68%	28%

Note. Good access to Service Coordination does not have a standard.

Improvement Areas

- *Delays in health care.* Forty-eight percent of members experienced delays in getting health care while waiting for health plan approval for care and services.
- *Exam room wait.* The majority of members reported they waited in the exam room for doctor's appointments for longer than 15 minutes (71 percent).
- *Getting Needed Care.* The CAHPS® composite *Getting Needed Care* was slightly below the 75-point threshold, which indicates that some members experienced difficulty in getting appointments with specialists and getting the care, tests, and treatment they needed through their health plan.
- *Getting specialized services.* Approximately 1 in 3 members reported problems getting specialized services, such as special medical equipment, home health care, and special therapy.
- *Care coordination.* Seventy-seven percent of members said they did not have a service coordinator. Among these members, 41 percent said they would like to have a service coordinator help them arrange their doctors' appointments and services.

Recommendations

External Quality Review Organization, ICHP recommends the following strategies to HHSC for improving the delivery and quality of care for adult members in STAR+PLUS.

Domain	EQRO Recommendation	Rationale	HHSC Recommendations
Getting timely care	<p>Assess the reasons why members experienced delays in their health care while waiting for health plan approval.</p> <p>Encourage providers to evaluate their patient flow problems and implement strategies to reduce the office wait times of members.</p>	<p>The STAR+PLUS program overall had low performance on two HHSC performance indicators: (1) <i>Delays in health care while waiting for health plan approval</i>, and (2) <i>Exam room wait times greater than 15 minutes</i>.</p>	<p>The results of the survey indicated that 75% of members reported no or rare wait times over 15 minutes. In addition, 80% of members reported they were usually or always able to make an appointment as soon as they thought it was needed. HHSC will share the results with MCOs and continue to track performance.</p> <p>HHSC will consider adding questions to future STAR+PLUS surveys to determine how long members have to wait for health plan approval, depending upon service type and location.</p>
Getting needed care	<p>Expedite the referral process to improve member access to specialist care and other types of tests and treatment, and ensure members have access to service coordination.</p>	<p>The STAR+PLUS program overall had low performance on <i>Getting Needed Care</i>, which assesses access to specialist care, and care, tests, and treatment from the health plan. Members also had need for improved access to specialized services.</p>	<p>HHSC will consider setting a program goal related to getting needed care to address the members' concerns regarding access to specialized services.</p>
Care coordination	<p>Evaluate the need for service coordination among members, examine the health plan staffing capacity for providing service coordination, and educate members about</p>	<p>A low percentage of members said they had a service coordinator. However, many of these members indicated they would like to have a service coordinator.</p>	<p>For 2011, one of the program goals for STAR+PLUS is "Improve member understanding and utilization of service coordination." Performance improvement projects</p>

	available services.		(PIPs) have been developed by the MCOs to address this goal.
Member obesity	Enhance or implement obesity prevention and weight management programs for members in STAR+PLUS.	STAR+PLUS members had high rates of overweight and obesity, particularly among women and Hispanics.	HHSC will include the Healthcare Effectiveness Data and Information Set (HEDIS [®]) Adult Body Mass Index (BMI) Assessment quality measure in the 5% At-Risk Premium.

Introduction and Purpose

The STAR+PLUS program is a Texas Medicaid Managed Care program for the low-income aged and disabled that combines traditional health care with long-term services and supports, such as personal assistance, meal services, and adult day care services. The STAR+PLUS program operates in 29 counties in the state of Texas and is served by four health plans – Amerigroup Community Care, Evercare of Texas, Molina Texas Community Plus, and Superior HealthPlan Plus. A hallmark feature of the STAR+PLUS program is service coordination, in which health plans provide members with basic case management assistance with health care, long-term services, and community support services.

As part of external quality review activities for the state of Texas, ICHP collects satisfaction data on STAR+PLUS members through an annual telephone survey.

The purpose of the fiscal year 2010 STAR+PLUS Adult Member Survey report is to:

- Describe the demographic characteristics of adults enrolled in STAR+PLUS.
- Document the physical and mental health status and overall functioning of adult members.
- Document members' experiences and general satisfaction with the care they received in STAR+PLUS.
- Evaluate the STAR+PLUS program and health plan performance with regard to:
 - Access and timeliness of care.
 - Preventive care and health promotion.
 - Patient-centered care.
 - Care coordination.
 - Health plan information and customer service.
- Identify disparities in member experiences and satisfaction with care across population groups.
- Compare results to fiscal year 2009 STAR+PLUS survey results.

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

Survey participants were selected from a stratified random sample of adults who were enrolled in STAR+PLUS for nine months or longer between June 2009 and May 2010. Members who had participated in the prior year's survey (fiscal year 2009) were excluded from the sample, as were members who were eligible for both Medicaid and Medicare. These criteria ensured that members would have sufficient experience with the program to respond to the survey questions.

A target sample of 300 completed interviews was set for each of the four MCOs participating in STAR+PLUS during fiscal year 2010, for a total of 1,200 targeted completes. The target sample was met for each MCO except Molina, which was due to a high frequency of ineligible respondents, a high frequency of incorrect phone numbers, and limitations on the size of the eligible population.

Survey Instruments

The fiscal year 2010 STAR+PLUS Adult Member Survey is comprised of:

- The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 4.0 (Medicaid module).¹
- The RAND® 36-Item Health Survey, Version 1.0.²
- Items developed by ICHP pertaining to member characteristics and their health care experiences, including care 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 Member Survey is based on the Medicaid module of the CAHPS® survey that assesses members' health care experiences in the past six months with health care providers, getting routine and urgent care, receiving specialized services and care coordination, and communication with their health plan. The survey includes six questions that function as indicators of health plan performance, as listed on HHSC's Performance Indicator Dashboard for fiscal year 2010. It also 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. CAHPS® composite scores were calculated in the following four domains:

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

Table B1 provides a list of the CAHPS® survey items that comprise each composite. For each composite, a mean score ranging from 0 to 100 was calculated. Higher composite scores suggest more positive health care experiences. A score of 75 or higher generally indicates that member experiences in a health care domain were *usually* or *always* positive.

The RAND® 36-Item Health Survey was created to survey health status in the Medical Outcomes Study. The instrument was designed for use in health policy evaluations and general population surveys. The RAND®-36 assesses eight separate health domains: 1) General health status; 2) Bodily pain; 3) Energy and fatigue; 4) Limitations in physical activities; 5) Limitations in usual role activities because of physical health problems; 6) Limitations in social activities; 7) General mental health; and 8) Limitations in usual role activities because of emotional problems. For each domain, a mean score ranging from 0 to 100 was calculated. Higher mean scores generally indicate better health status and/or functioning.

Survey Data Collection Techniques

The EQRO sent letters written in English and Spanish to caregivers of 7,554 sampled STAR+PLUS members, requesting their participation in the survey. Among addresses in the total sample (8,164), 7.5 percent were not mailed due to bad addresses. Of the advance letters sent, 28 (0.34 percent of sample) were returned undeliverable.

The Survey Research Center (SRC) at the University of Florida conducted the survey using computer-assisted telephone interviewing (CATI) between June 2010 and November 2010. Calls were made from 10 a.m. to 9 p.m. Central Time, seven days a week. SRC utilized the Sawtooth Software System to rotate calls throughout the morning, afternoon, and evening, maximizing the likelihood of reaching members. If a respondent required that the interview be conducted in Spanish, arrangements were made for a Spanish-speaking interviewer to call at a later date and time. Of 1,187 completed interviews, 45 (3.8 percent) were done in Spanish.

Up to 25 attempts were made to reach a member before his or her phone number was removed from the calling circuit. If the member was not reached after that time, the software system selected the next individual on the list. On average, 7.3 calls were made per telephone number in the sample.

Attempts were made to telephone 8,156 adults who were enrolled in STAR+PLUS. Fifty percent of members could not be located. Among those located, 2 percent indicated they were not enrolled in STAR+PLUS and 11 percent refused to participate. The response rate was 47 percent and the cooperation rate was 74 percent.

Data Analysis

Descriptive statistics and formal statistical tests were performed using the statistical software package SPSS 17.0 (Chicago, IL: SPSS, Inc). Frequency tables showing descriptive results for each survey question are provided in a separate Technical Appendix.³ The statistics presented in this report exclude “do not know” and “refused” responses. Percentages shown in figures and tables are rounded to the nearest whole number; therefore, percentages may not add up to 100 percent.

To compare results among demographic sub-groups within the sample, among the four MCOs, and between the 2009 and 2010 STAR+PLUS surveys, the Pearson Chi-square test of independence and analysis of variance (ANOVA) were used.⁴

Researchers also performed two multivariate analyses. One analysis was designed to predict the relative influence of MCO membership on the members' CAHPS® composite scores, controlling for demographic, health status, and health delivery characteristics. The second analysis was designed to predict the influence of care coordination on access to various types of health services (special medical equipment and devices, home health care and assistance, and specialist referral), controlling for demographic, health status, and health delivery characteristics. The detailed methodology and results for these analyses can be found in Appendix C of this report.

Survey Results

This section presents survey findings regarding the characteristics of STAR+PLUS members participating in the survey and their satisfaction with the health care they have received in the past six months. Presented findings include members' self-report of access to and timeliness of receiving care, seeking preventive care, quality of their health care provider(s), use of care coordination, and experiences with their health plan's member services.

Characteristics of Members

Table 1 presents the demographic characteristics of adult members participating in the STAR+PLUS survey.

Women comprised 68 percent of all survey respondents. The average age of members was 49, ranging from 20 to 64 years old.

Hispanics accounted for 39 percent of respondents, followed by Black, non-Hispanics (29 percent), and White, non-Hispanics (26 percent).

The educational attainment of members was relatively low, compared to the Texas population. Forty-two percent had not completed high school, compared to 24 percent in the Texas population (25 years and older).⁵

Table 1. Demographic Characteristics of STAR+PLUS Survey Respondents

Mean age	49.27 (SD = 10.73)
Sex	
Male	32%
Female	68%
Race/ethnicity	
Hispanic	39%
White, non-Hispanic	26%
Black, non-Hispanic	29%
Other race, non-Hispanic	6%
Education	
Less than high school	42%
High school diploma or some college	48%
College degree or higher	10%

Figure 1 provides the marital status of STAR+PLUS survey respondents. The vast majority of members were single, separated, divorced, or widowed (83 percent). Forty-two percent were single, 33 percent

were separated or divorced, and 8 percent were widowed. Only 17 percent were married or had an unmarried partner.

STAR+PLUS members reported that the average number of people living in their household was 2.49 (SD = 1.79). Approximately 1 in 3 members lived alone (34 percent).

Figure 1. The Marital Status of STAR+PLUS Members

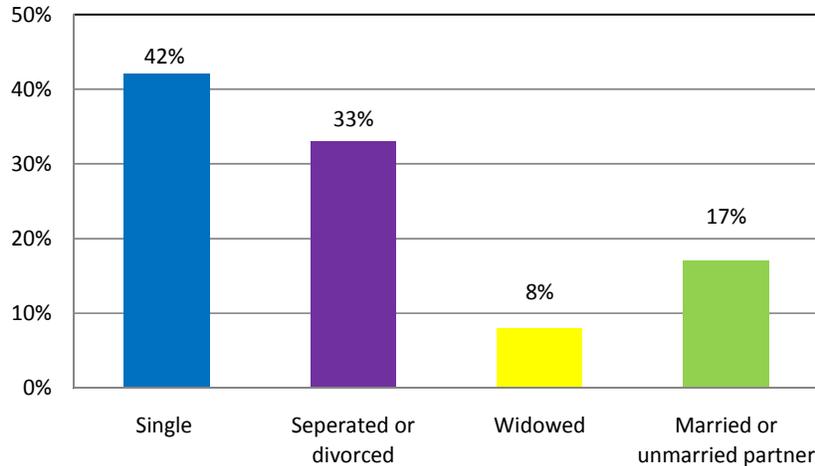


Table 2 provides members' reported employment status and type of housing. The vast majority of members were unemployed in the past six months (93 percent). Among the 7 percent who were employed, the majority worked less than 35 hours (66 percent).

One-quarter of respondents reported they owned their own home (24 percent). Forty-four percent rented housing, 15 percent had public housing provided, and 16 percent reported they had "other" housing arrangements.

Table 2. STAR+PLUS Members' Employment and Housing

Employment status	
Employed full-time or part-time	7%
Unemployed	93%
Housing	
Own home	24%
Rented housing	44%
Public housing	15%
Other	16%

In addition, members reported barriers in access to communication technology. Fifteen percent had their telephone service disconnected in the past 6 months, primarily due to cost (70 percent). Sixty-one percent did not have access to a personal computer at home.

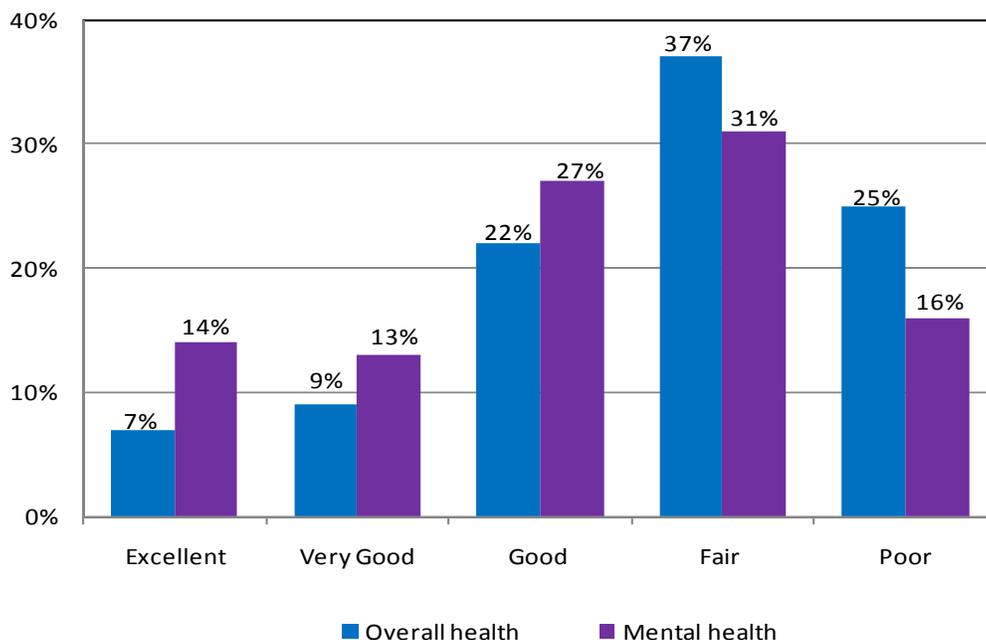
Member Health Status

Members' Ratings of Their Health

Figure 2 presents members' ratings of their overall health and mental health. The majority of respondents rated their overall health as *fair* or *poor* (62 percent). One in five rated their overall health as *good* (22 percent). Only 16 percent rated their overall health as *very good* or *excellent*.

Members' mental health ratings were higher than their overall health ratings. However, a large percentage of members rated their mental health as *fair* or *poor* (46 percent). Twenty-seven percent rated their mental health as *good*, and 27 percent rated their mental health as *very good* or *excellent*.

Figure 2. Members' Ratings of Their Overall Health and Mental Health



Body Mass Index

Figure 3 provides body mass index results for members in the STAR+PLUS survey. Half of STAR+PLUS members were obese (51 percent), and 1 in 4 were overweight (24 percent). Only 19 percent of members were classified as having a healthy weight. Women in STAR+PLUS were significantly more likely than men to be obese.⁶ In addition, Hispanic members were significantly more likely to be obese than members from other racial/ethnic groups.⁷

Figure 3. Body Mass Index Classification for STAR+PLUS Members

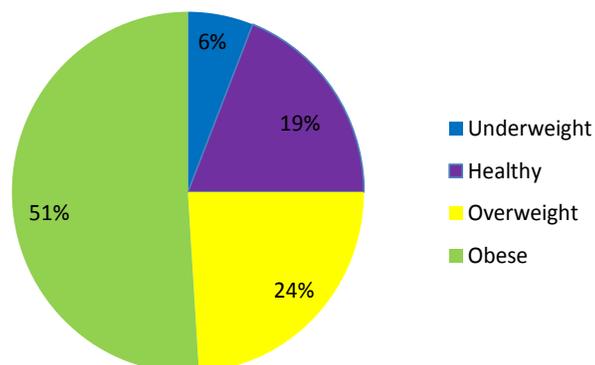


Table 3 provides a comparison of BMI results for adults in the fiscal years 2009 and 2010 STAR+PLUS surveys, and adults in the general population living in Texas (based on U.S. Census data).⁸ BMI results across the STAR+PLUS surveys were similar, with greater than 50 percent of members classified as obese, which is considerably higher than the obesity rate for all Texas adults.

Table 3. Body Mass Index Classification by Survey Population

	FY 2009 STAR+PLUS Survey	FY 2010 STAR+PLUS Survey	Texas Adults (2008)
Underweight (BMI < 18.5)	3%	6%	34%
Normal Weight (BMI 18.5 – 24.9)	20%	19%	
Overweight (BMI 25.0 – 29.9)	25%	24%	37%
Obese (BMI ≥ 30.0)	52%	51%	29%

Note: Underweight and normal weight categories are combined for the general adult population in Texas.

RAND® 36-Item Health Survey

The health status of adults in the STAR+PLUS sample was also assessed using the RAND® 36-Item Health Survey, Version 1.0, which produces scores in eight physical and mental health domains. The RAND®-36 scores range from 0 to 100, with higher scores indicating better health status. **Table 4** provides the RAND® Health Survey results for STAR+PLUS members in fiscal years 2009 and 2010.

The RAND® Health Survey results indicate that the health status of STAR+PLUS members was poor. Members experienced compromised functioning across physical, emotional, and social domains. The lowest scoring domain for STAR+PLUS members was *Role Limitations Due to Physical Health* (mean = 29.4), and the highest scoring domain was *Emotional Well-Being* (mean = 57.3). Although members rated their emotional well-being higher than any other health survey domain, one of the lowest scoring domains was *Role Limitations Due to Emotional Problems* (mean = 38.7).

Table 4. RAND[®]-36 Health Survey Mean Results for STAR+PLUS Members

	FY 2009 STAR+PLUS Survey	FY 2010 STAR+PLUS Survey
General Health	37.4	40.3
Energy/Fatigue	37.0	37.5
Bodily Pain	42.8	41.6
Physical Functioning	40.9	40.4
Role Limitations Due to Physical Health	30.8	29.4
Emotional Well-Being	55.3	57.3
Role Limitations Due to Emotional Problems	39.5	38.7
Social Functioning	48.4	46.3

Analyses of results for the RAND[®] Health Survey across STAR+PLUS survey administrations revealed significant improvement in the domain of General Health for STAR+PLUS members.⁹ Results for other domains have remained relatively consistent, with no clear evidence of improvement in other indicators of health status.

Another 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.

- Seventy-one percent of STAR+PLUS members reported their physical or medical condition seriously interfered with their independence, participation in the community, or quality of life.
- More than half of members reported they needed help with routine needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes because of an impairment or health problem (56 percent).
- Thirty-eight percent of members reported they needed help with their personal care needs, such as eating, dressing, or getting around the house because of an impairment or health problem.

The findings indicate that many members need help and assistance with personal care and daily tasks. As reported earlier, most members do not have a spouse living in the home (83 percent) and 1 in 3 reported living alone, which suggests that many members need outside sources of help and support in order to meet their most basic needs.

Access and Timeliness of Care

This section examines access to and timeliness of care for STAR+PLUS members. Specifically, findings are presented regarding STAR+PLUS members' access to a medical home and timely receipt of non-urgent and urgent care, specialist care, and specialized services.

Access to a Personal Doctor

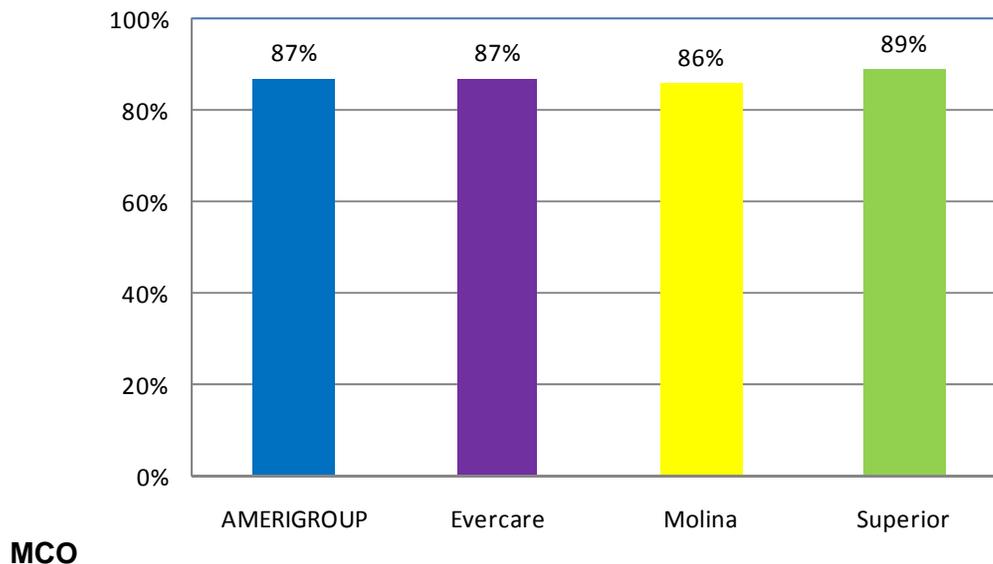
Figure 4 depicts the percentage of STAR+PLUS adult members with a personal doctor by MCO. Eighty-seven percent of adults in STAR+PLUS had a personal doctor. The results for STAR+PLUS MCOs were similar – within three percentage points – for the percentage of adults with a personal doctor.

Forty-six percent said they had the same personal doctor before joining their health plan. The majority of STAR+PLUS members had to change their personal doctor upon joining the health plan (54 percent). Among these members, 68 percent said since joining the health plan it *usually* or *always* was easy to get a personal doctor they were happy with. Almost 1 in 3 reported some degree of difficulty in getting a personal doctor they were happy with since joining the health plan (32 percent).

Twenty-three percent of members reported they had changed their personal doctor in the past six months. However, the majority of members had not experienced recent discontinuity in care, since 70 percent reported they had been going to their personal doctor for two years or longer. Among these members, 41 percent reported they had been going to their personal doctor for more than five years.

Members were asked to rate their personal doctor on a scale ranging from 0 to 10, with 0 indicating the worst doctor and 10 indicating the best doctor. The average rating that STAR+PLUS members gave their personal doctor was 8.79 (SD = 1.93). Seventy percent of members gave their personal doctor a high rating of 9 or 10.

Figure 4. The Percentage of STAR+PLUS Members with a Personal Doctor by



Routine Care

Seventy-seven percent of STAR+PLUS adult members reported making an appointment for routine health care at a doctor's office or clinic in the past six months.

Good access to routine care. Eighty percent of members said that they *usually* or *always* were able to make a routine appointment for health care as soon as they thought they needed. The percentage of STAR+PLUS members with good access to routine care ranged from 75 percent in Amerigroup to 84

percent in Evercare. All MCOs except Amerigroup performed above the Dashboard standard for good access to routine care.

Overall, members reported they had good access to care, tests, treatment, and prescription medicine through their health plan.

- Half of members said they tried to get care, tests, or treatment through their health plan in the past six months (50 percent). Among these members, 71 percent said they *usually* or *always* were able to get the care, tests, or treatment they thought they needed from their health plan. Twenty-nine percent of members said they *never* or only *sometimes* were able to get the care, tests, or treatment they thought they needed from the health plan.
- Prescription medication was commonly used by STAR+PLUS members. Four out of five members said they got a new prescription medicine or prescription refill in the past six months (79 percent). Among these members, the majority said it *usually* or *always* was easy to get their prescription medicine from the health plan (80 percent).

Urgent Care

Almost half of STAR+PLUS members reported they had an illness, injury, or condition that required urgent care in the past six months (49 percent).

Good access to urgent care. Seventy-nine percent of members who needed care right away for an illness, injury, or condition reported they *usually* or *always* were able to get care as soon as they needed. The percentage of STAR+PLUS members with good access to urgent care ranged from 78 percent in Amerigroup to 82 percent in Molina. All MCOs performed above the Dashboard standard for good access to urgent care.

Specialist Care

Forty-seven percent of STAR+PLUS members reported they tried to make an appointment with a specialist in the past six months. Among these members, 72 percent said it *usually* or *always* was easy to get specialist appointments, and 28 percent said it *sometimes* or *never* was easy to get specialist appointments.

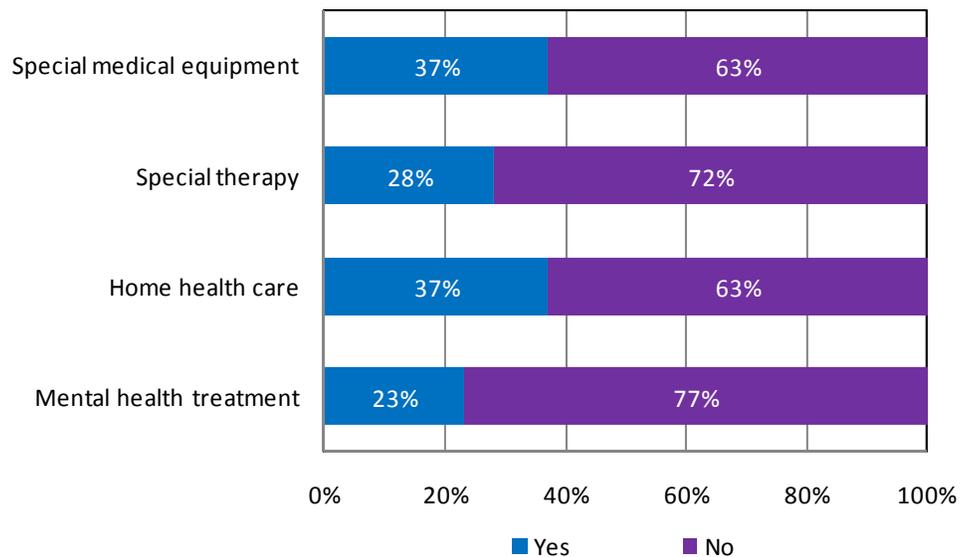
Good access to specialist referral. Members were asked how often it was easy to get a referral to a specialist they needed to see. The percentage of STAR+PLUS members with good access to specialist referrals was 71 percent, ranging from 62 percent in Amerigroup to 78 percent in Superior. All MCOs met or exceeded the Dashboard standard for good access to specialist referral.

Members were asked to rate their specialist on a scale ranging from 0 to 10, with 0 indicating the worst specialist and 10 indicating the best specialist. The average rating that STAR+PLUS members gave their specialist was 8.67 (SD = 2.12). Sixty-nine percent of members gave their specialist a high rating of 9 or 10. Approximately 1 in 3 members reported that the specialist they saw most often was the same doctor as their personal doctor, which may partially account for the similarity in members' ratings of their personal doctor and specialist.

Specialized Services

Figure 5 provides the percentage of STAR+PLUS members that needed specialized services, including special medical equipment, special therapy such as occupational therapy, home health care or assistance, and counseling or treatment for a personal or family problem.

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



The most common specialized services STAR+PLUS members reported needing were special medical equipment and home health care or assistance.

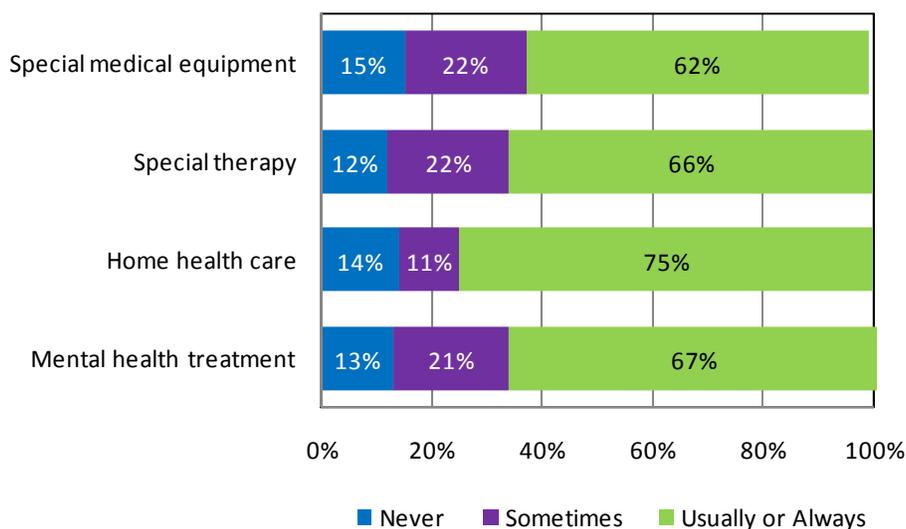
- 37 percent needed special medical equipment.
- 37 percent needed home health care or assistance.
- 28 percent needed special therapy.
- 23 percent needed counseling or treatment for a personal or family problem.

Figure 6 presents the percentage of STAR+PLUS members with good access to specialized services. The majority of members reported good access to specialized services. However, between 12 and 22 percent (depending on the service) reported some degree of difficulty in accessing these services.

- **Good access to special medical equipment.** Sixty-two percent said they *usually* or *always* were able to get the special medical equipment they needed. Thirty-seven percent reported that they *never* or only *sometimes* received special medical equipment when they needed it.
- **Good access to special therapy.** Sixty-six percent said they *usually* or *always* were able to get the special therapy they needed. One in three reported that they *never* or only *sometimes* were able to get special therapy when they needed it (34 percent).
- **Good access to home health care or assistance.** Seventy-five percent said they *usually* or *always* were able to get the home health care or assistance they needed. One in four reported problems accessing home health care services (25 percent).

- **Good access to mental health treatment or counseling.** Among members needing counseling or treatment, 67 percent said they *usually* or *always* were able to get the treatment or counseling they needed through their health plan. One in three members reported problems in getting treatment or counseling through their health plan (34 percent).

Figure 6. The Percentage of STAR+PLUS Members Reporting How Often They Were Able to Get Specialized Services



Members were asked to rate their mental health care on a scale ranging from 0 to 10, with 0 indicating the worst mental health care and 10 indicating the best mental health care. The average rating that STAR+PLUS members gave their mental health care was 7.55 (SD = 2.75), which was the lowest of all member ratings. Less than half of members gave their mental health care a high rating of 9 or 10 (46 percent).

Waiting for Appointments

STAR+PLUS members were asked a series of questions about how soon they were able to get a health care appointment and approval from their health plan for services. In general, STAR+PLUS members did not wait long between making an appointment for routine care and seeing a provider.

Seventy-six percent of members reported they had to wait less than one week between making an appointment for routine care and actually seeing a provider. Among these members, 1 in 4 were able to see their provider on the same day or the next day after making an appointment. Twelve percent reported they had to wait two weeks or longer between making an appointment and seeing a provider.

When asked how often they had to wait for an appointment because the provider worked limited hours or had few available appointments:

- 44 percent of members reported they *never* had to wait for an appointment.
- 31 percent of members reported they *sometimes* had to wait for an appointment.
- 25 percent of members reported they *usually* or *always* had to wait for an appointment.

No delays for health plan approval. Receiving care in a timely manner often depends on approval from the health plan. Fifty-two percent of STAR+PLUS members reported they had no delays in getting health plan approval for care, ranging from 45 percent in Superior to 55 percent in Evercare and Molina. None of the MCOs met the Dashboard standard for members experiencing no delays for health plan approval.

No exam room wait greater than 15 minutes. STAR+PLUS members were also asked how often they were taken into an exam room within 15 minutes of their appointment. This is an important indicator because it is positively associated with patient satisfaction with their health care and personal doctor.¹⁰ Twenty-nine percent of members reported they had no exam room wait at their provider's office that was longer than 15 minutes. Twenty-eight percent of STAR+PLUS members reported they *never* were taken to the exam room within 15 minutes of their doctor's appointment. The percentage of STAR+PLUS members who reported they had no exam room wait greater than 15 minutes ranged from 24 percent in Evercare to 36 percent in Amerigroup. None of the MCOs met the Dashboard standard for this indicator.

Transportation

Twenty-nine percent of members said they called their health plan to get help with transportation in the past six months. Among these members, 3 out of 4 said they *usually* or *always* were able to get help with transportation from their health plan (74 percent). However, 26 percent of members said they *never* or only *sometimes* were able to get help with transportation from their health plan, which suggests that transportation issues could potentially present a barrier to getting care for approximately 1 in 4 STAR+PLUS members.

For those members who indicated they received help with transportation, 4 out of 5 reported that the help with transportation they received from their health plan met their needs (80 percent).

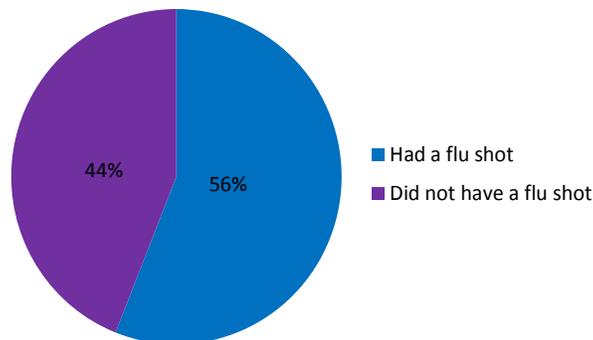
Preventive Care and Health Promotion

This section provides results for STAR+PLUS members' seeking preventive care, getting a flu shot, and smoking cessation.

Most members had a recent medical exam with their personal doctor. Three-quarters indicated they had visited their doctor for a medical check-up in the past year (76 percent). Approximately 15 percent of members reported they did not visit their personal doctor for a timely (within two years), regular check-up.

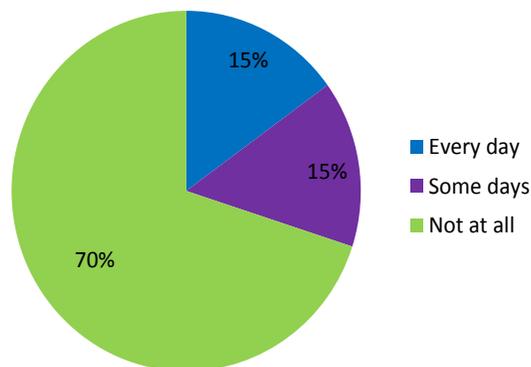
Figure 7 presents the percentage of members who reported receiving a flu shot in the past year. The Centers for Disease Control and Prevention (CDC) recommends that individuals at high risk for influenza, such as those age 50 and older or who have chronic medical problems, should have an annual flu shot to prevent adverse health outcomes.¹¹ Fifty-six percent of members got a flu shot in the past year, and 44 percent of members did not get their flu shot in the past year, thereby increasing their risk of contracting the flu and experiencing other health-related complications.

Figure 7. The Percentage of STAR+PLUS Members that Received a Flu Shot in the Past Year



The Agency for Health Care Policy Research recommends that primary care physicians identify smokers and treat every smoker with a smoking cessation plan, including medication and other strategies for quitting smoking.¹² **Figure 8** provides the percentage of members who smoked cigarettes. Thirty percent reported smoking cigarettes some days or every day.

Figure 8. The Percentage of Smokers in STAR+PLUS



Smokers advised to quit smoking on a visit. Sixty-eight percent of STAR+PLUS members reported they were advised to quit smoking by a doctor on at least one occasion in the past six months, which is considerably greater than the Dashboard standard for the percentage of smokers advised to quit smoking on a visit (28 percent).

Forty-one percent of smokers reported that their doctor recommended or discussed medication to help them quit smoking on at least one occasion in the past six months. In addition, 44 percent of smokers

reported that their doctor recommended or discussed with them, on at least one occasion, methods and strategies other than medication to help them quit smoking.

Patient-Centered Care

This section provides results regarding STAR+PLUS members' experiences with their personal doctor, specifically in seeking help and advice, communicating with their personal doctor, and being involved in treatment decisions.

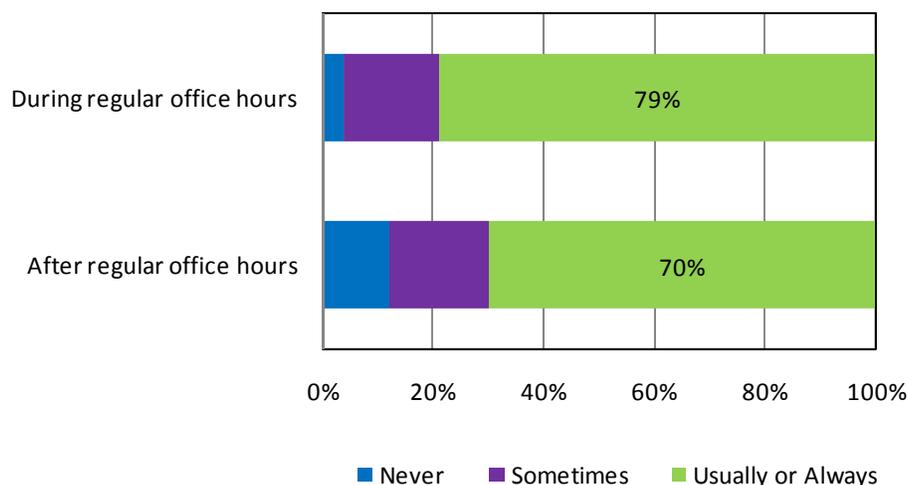
Seeking Help and Advice

Figure 9 presents how often STAR+PLUS members received help or advice when calling their personal doctor's office during and after regular business hours.

Approximately 2 out of 3 members reported they had called their personal doctor's office during regular business hours to get help or advice (64 percent). Most members were satisfied with the outcome of these telephone calls. Seventy-nine percent said they *usually* or *always* were able to get help or advice when needed from their personal doctor's office during regular office hours.

One-quarter of members reported they called their personal doctor's office after regular business hours to get help or advice (24 percent). A majority of members were able to get the help or advice they needed after regular business hours (70 percent). Thirty percent said they *never* or only *sometimes* were able to get help or advice when calling their personal doctor's office after hours, which suggests that some members may need to seek care at an emergency department if their physician is unavailable after hours to take their telephone call.

Figure 9. The Percentage of STAR+PLUS Members Reporting How Often They Received Help or Advice When Calling Their Personal Doctor's Office

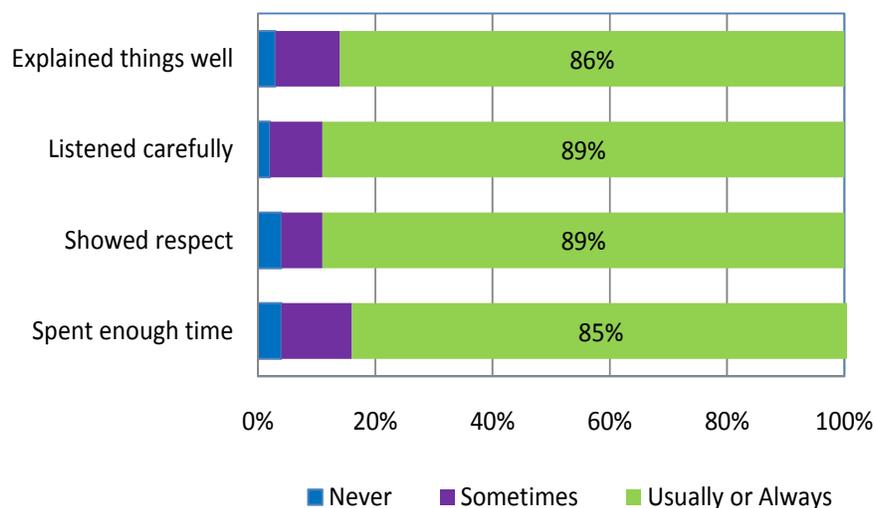


Communication with Personal Doctors

STAR+PLUS members were asked whether they had difficulty communicating with their personal doctor because they spoke different languages. One in five members indicated that they *sometimes*, *usually*, or *always* had a difficult time speaking with or understanding their personal doctor (19 percent). It should be noted that 17 percent of respondents spoke a language other than English at home, most commonly Spanish.

Figure 10 provides the percentage of members reporting how often they had positive communication experiences with their personal doctor.

Figure 10. The Percentage of STAR+PLUS Members Reporting How Often They Had Positive Communication Experiences with Their Personal Doctor



The vast majority of STAR+PLUS survey respondents were satisfied with the quality of communication with their personal doctor.

- 89 percent reported their personal doctor *usually* or *always* listened carefully and showed respect toward them.
- 86 percent reported their personal doctor *usually* or *always* explained things well.
- 85 percent felt their personal doctor *usually* or *always* spent enough time with them.

Shared Decision Making

The collaborative nature of the patient-provider relationship was also assessed. Sixty-three percent of members indicated that decisions about their health care were made in the past six months. Among these members, most were satisfied with their participation in treatment decisions. Eighty-five percent reported they *usually* or *always* were involved as much as they wanted in decisions about their health care.

Members were also asked how often it was easy to get providers to agree with them on the best way to manage their health condition. Seventy-seven percent said it *usually* or *always* was easy to get providers to agree with them. Twenty-three percent of members expressed that they experienced some degree of difficulty in reaching an agreement with providers about managing their health conditions.

Care Coordination

The following section provides a summary of STAR+PLUS members' experiences receiving care coordination and their level of satisfaction with their service coordinator.

General Care Coordination

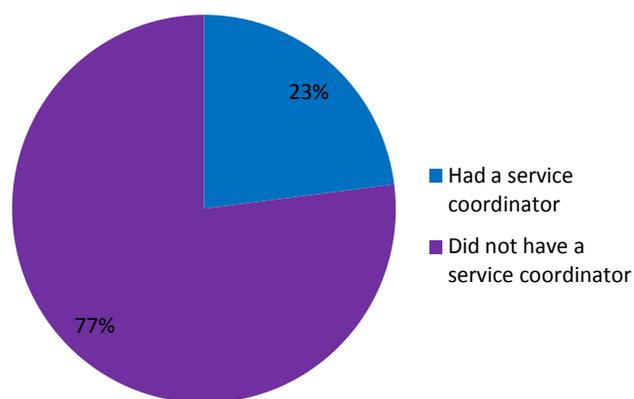
Sixty-one percent of members reported they got care from a doctor or other health provider besides their personal doctor. The majority of members felt their personal doctor *usually* or *always* was informed and up-to-date about the care they received from other doctors or health providers (77 percent). This finding suggests that for most members, their personal doctor served as their medical home and coordinated care across providers. Conversely, 23 percent of members reported their doctor *never* or only *sometimes* was informed and up-to-date about the care they received from other providers.

STAR+PLUS Service Coordinators

Figure 11 provides the percentage of STAR+PLUS survey respondents who reported having a service coordinator. The majority of members reported they did not have a STAR+PLUS service coordinator (77 percent). Twenty-three percent of members reported having a service coordinator from their STAR+PLUS health plan that helped arrange their services, such as doctor visits, transportation, or meals. In addition, 1 in 5 members indicated that someone other than a STAR+PLUS service coordinator helped coordinate their care (20 percent), who in a majority of cases was a family member or friend (55 percent).

Members who reported not having a service coordinator were asked whether they would like someone from their STAR+PLUS health plan to help arrange their services. Forty-one percent said "yes."

Figure 11. The Percentage of STAR+PLUS Members with a Service Coordinator



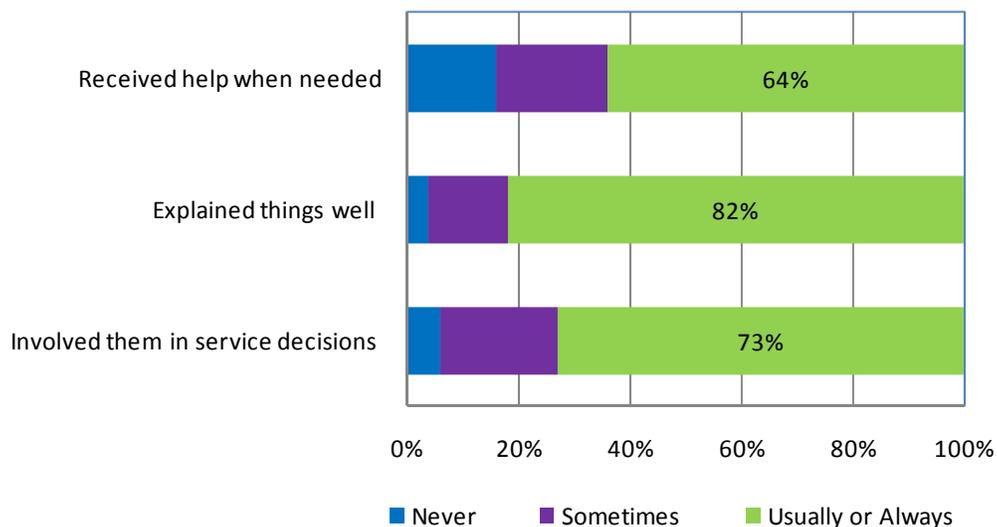
Sixty-three percent of members who had a service coordinator reported being contacted by this individual in the past six months. Half of members said they needed their service coordinator to arrange services for them, such as doctor's visits, transportation, or meals (50 percent).

Figure 12 provides members' satisfaction with their service coordinator in getting the help they needed. Sixty-four percent said they *usually* or *always* received help from their service coordinator as soon they needed. Thirty-six percent said they *never* or only *sometimes* received help from their service coordinator as soon as they needed.

Among respondents who had a STAR+PLUS service coordinator and who received help from the service coordinator in arranging services at least once in the past six months:

- 82 percent said the service coordinator *usually* or *always* explained things in a way they could understand.
- 73 percent said the service coordinator *usually* or *always* involved them in making decisions about their services.
- 90 percent said they were *satisfied* or *very satisfied* with the help they received from their service coordinator.

Figure 12. The Percentage of STAR+PLUS Members Who Were Satisfied with Their Service Coordination



Health Plan Information and Customer Service

This section examines members' experiences with the enrollment process, seeking and obtaining written materials from the health plan, and contacting the health plan's customer service.

Enrollment

Sixty-three percent of STAR+PLUS survey respondents reported they were able to choose their health plan. Thirty-seven percent reported a health plan was selected for them. Sixty two percent of members said they received information about their health plan before joining the health plan. Half of these members said the information they were given about the health plan was correct (51 percent), while 30 percent said the information was mostly correct.

Written Materials

The majority of STAR+PLUS members did not look for information in either written materials or on the Internet about how their plan works (82 percent).

Among members who sought out health plan information, 61 percent said the health plan's written materials or the Internet *usually* or *always* provided them with the information they needed about how their health plan works. Thirty-nine percent said the health plan's written materials or the Internet *never* or only *sometimes* provided them with the information they needed about how their health plan works.

STAR+PLUS members were also asked if they received forms from the health plan to fill out. One in five members reported receiving forms from the health plan (21 percent). Two-thirds of these members indicated the forms *usually* or *always* were easy to fill out (66 percent). However, 1 in 3 members had some degree of difficulty in completing the health plan forms (34 percent).

Customer Service

Twenty-nine percent of respondents tried to get information or help from their health plan's customer service in the past six months. Among these respondents, 64 percent said they *usually* or *always* were able to get the information or help they needed from customer service. Thirty-six percent said they *never* or only *sometimes* were able to get the information or help they needed from their health plan's customer service.

The number of telephone calls members make to get help or information from the health plan is an indicator of customer service quality. To get the information or help they wanted from their health plan's customer service:

- 28 percent of members reported making one telephone call.
- 26 percent of members reported making two telephone calls.
- 37 percent of members reported making three or more telephone calls.
- 9 percent of members reported they were still waiting for help from their health plan's customer service.

Most members felt that their health plan's customer service staff *usually* or *always* treated them with courtesy and respect (83 percent).

Members were asked to rate their health plan on a scale ranging from 0 to 10, with 0 indicating the worst health plan and 10 indicating the best health plan. The average rating that STAR+PLUS members gave their health plan was 8.02 (SD = 2.34). Fifty-one percent of members gave their health plan a high rating of 9 or 10.

Prior-year Comparisons

Results from the fiscal years 2009 and 2010 STAR+PLUS surveys were compared, focusing on the CAHPS® composite measures, member satisfaction ratings, and survey items that are also HHSC Performance indicators. Significant differences between survey years are highlighted in bold in the tables.

Table 5 provides STAR+PLUS survey results for CAHPS® composites in fiscal years 2009 and 2010.

Table 5. CAHPS® Composite Results for the Fiscal Years 2009 and 2010 STAR+PLUS Surveys

CAHPS® Composite Scores	FY 2009 STAR+PLUS	FY 2010 STAR+PLUS
<i>Getting Needed Care</i>	69.6	72.3
<i>Getting Care Quickly</i>	78.0	78.8
<i>Doctor's Communication</i>	85.8	87.9
<i>Customer Service</i>	73.7	74.5

Mean scores on each of the four composites were slightly higher in fiscal year 2010 than in 2009. However, there were no statistically significant differences between the fiscal years 2009 and 2010 STAR+PLUS CAHPS® composite mean scores for *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, or *Health Plan Customer Service*.

Table 6 provides STAR+PLUS member mean ratings of their health care, personal doctor, specialist, behavioral health care, and health plan in fiscal years 2009 and 2010. Statistical comparisons of member ratings in fiscal years 2009 and 2010 indicate that member satisfaction with the care they received in STAR+PLUS has significantly improved since 2009 for all rating items except specialist care. Members in the fiscal years 2010 STAR+PLUS survey rated their health care, personal doctor, behavioral health care, and health plan significantly higher than members in fiscal year 2009.¹³⁻¹⁶

Table 6. STAR+PLUS Member Ratings in Fiscal Years 2009 and 2010

Average rating of ...	FY 2009 STAR+PLUS	FY 2010 STAR+PLUS
Health care	7.35	8.05
Personal doctor	8.29	8.79
Specialist	8.58	8.67
Behavioral health care	6.84	7.55
Health plan	7.31	8.02

Table 7 provides comparisons between the fiscal years 2009 and 2010 STAR+PLUS surveys for the eight HHSC Performance Dashboard indicator survey items. Significant differences between survey years were observed for *Good Access to Specialist Referral* and *No Delay in Health Care While Waiting for Health Plan Approval*.

This year's STAR+PLUS survey respondents were significantly more likely than fiscal year 2009 STAR+PLUS survey respondents to have better access to specialist referral.¹⁷ Seventy-one percent of members in the fiscal year 2010 survey reported they *usually or always* were able to get a referral to a specialist they needed to see, compared to 66 percent of members in fiscal year 2009.

In addition, members in fiscal year 2010 were significantly less likely to experience a delay in receiving health care while waiting for health plan approval.¹⁸ Fifty-two percent of members in fiscal year 2010 reported having no delays in their health care while waiting for health plan approval, compared to 44 percent of members in fiscal year 2009.

Table 7. Fiscal Years 2009 and 2010 STAR+PLUS Results for HHSC Performance Dashboard Indicators

	FY 2009 STAR+PLUS	FY 2010 STAR+PLUS	HHSC Performance Dashboard Standard
<i>Good access to urgent care</i>	80%	79%	76%
<i>Good access to specialist referral</i>	66%	71%	62%
<i>Good access to routine care</i>	78%	80%	78%
<i>No delays in health care while waiting for health plan approval</i>	44%	52%	57%
<i>No exam room wait greater than 15 minutes</i>	30%	29%	42%
<i>Good access to special therapies</i>	66%	66%	47%
<i>Good access to service coordination</i>	64%	64%	-
<i>Smokers advised to quit smoking on a visit</i>	63%	68%	28%

Summary Points and Recommendations

Characteristics of Members

- Two-thirds of STAR+PLUS members participating in the survey were female (68 percent) with an average age of 49. The majority of respondents were either Hispanic (39 percent) or Black, non-Hispanic (29 percent).
- Forty-two percent of members had not completed high school, and the vast majority were unemployed (93 percent).

Member Health Status

- **Physical and mental health ratings.** The majority of respondents rated their overall health as *fair* or *poor* (62 percent). Only 16 percent rated their overall health as *very good* or *excellent*. Member ratings of their mental health were better, with 27 percent rating their mental health as *very good* or *excellent*. However, 46 percent rated their mental health as *fair* or *poor*.
- **Body Mass Index (BMI).** Half of STAR+PLUS members were obese (51 percent), and 1 in 4 were overweight (24 percent). Only 19 percent of members were classified as having a healthy weight.
- **RAND[®]-36 Health Survey results.** Members experienced compromised functioning across physical, emotional, and social domains. The lowest scoring domain for STAR+PLUS members was *Role Limitations Due to Physical Health*. Additional survey items confirmed the functional limitations of this population. For example, 71 percent said their medical condition seriously interfered with their independence, participation in the community, or quality of life.

Access and Timeliness of Care

- **Having a personal doctor.** The vast majority of STAR+PLUS members had a personal doctor (87 percent), and 70 percent of these members had been going to their personal doctor for two years or longer.

After joining their health plan, 54 percent reported they had changed their personal doctor. Twenty-three percent had changed their personal doctor in the past six months. Among members who had changed their personal doctor after joining the health plan, 1 in 3 had difficulty finding a personal doctor they were happy with (32 percent).

Most members were happy with their current personal doctor. Seventy percent of members gave their personal doctor a rating of 9 or 10, on a scale of 0 to 10.

- **Routine care.** Eighty percent of members *usually* or *always* were able to make a routine appointment for health care as soon as they thought they needed. All STAR+PLUS MCOs except Amerigroup performed above the Dashboard standard for good access to routine care.

Seventy-one percent said they *usually* or *always* were able to get the care, tests, or treatment they thought they needed from their health plan.

Four out of five members said they got a new prescription medicine or prescription refill in the past six months (79 percent). Among these members, 80 percent were generally able to get their prescription medicine from the health plan.

- **Urgent care.** Among the 49 percent of members who needed urgent care in the past six months, 79 percent reported they *usually* or *always* were able to get care as soon as they needed. All STAR+PLUS MCOs performed above the Dashboard standard for good access to urgent care
- **Specialist care.** Among members that needed to visit a specialist, 72 percent said they *usually* or *always* were able to make an appointment with a specialist. Twenty-eight percent of members that needed to see a specialist reported difficulty in making an appointment.

Seventy-one percent of members *usually* or *always* were able to get a referral to a specialist they needed to see. All MCOs met or exceeded the Dashboard standard for good access to specialist referral.

Members were generally happy with their specialists. Sixty-nine percent gave their specialist a rating of 9 or 10, on a scale of 0 to 10.

- **Specialized services.** The most common specialized services members needed were special medical equipment and home health care. Thirty-seven percent needed each of these services in the past six months. In addition, 28 percent needed special therapy and 23 percent needed mental health treatment or counseling.

Most members had good access to specialized services (between 62 and 75 percent). However, approximately 1 in 3 members reported having difficulty getting special medical equipment, special therapy, and mental health treatment, and 1 in 4 reported having difficulty getting home health care.

- **Waiting for appointments.** Seventy-six percent of members reported they had to wait less than one week between making an appointment for routine care and actually seeing a provider. More than half said they had to wait for an appointment because the provider worked limited hours or had few available appointments (56 percent).

Fifty-two percent of STAR+PLUS members reported they had no delays in getting health plan approval for care, which is below the HHSC Dashboard standard for this survey item.

Most members waited longer than 15 minutes to be taken to an exam room for a doctor's appointment. Only 28 percent reported they *always* were taken to the exam room within 15 minutes of their appointment. None of the MCOs met the Dashboard standard for this indicator.

- **Transportation assistance.** Twenty-nine percent of respondents called their health plan to get help with transportation in the past six months. Among these members, 74 percent *usually* or *always* were able to get transportation assistance from their health plan. However, 1 in 4 members reported they had difficulty getting transportation assistance from their health plan (26 percent).

Preventive Care

- **Seeking preventive care.** Seventy-six percent of members received preventive care by visiting their doctor for a medical check-up in the past year.
- **Getting a flu shot.** Fifty-six percent of members received a flu shot in the past year.
- **Smoking cessation.** Thirty percent reported smoking cigarettes regularly. Among these members, 68 percent were advised to quit smoking by a doctor at least once in the past six months.

Patient-Centered Care

- **Seeking health and advice.** Two thirds of members called their doctor's office during regular business hours for help or advice (64 percent). Among these members, most were satisfied with the outcome of their phone calls (79 percent). Additionally, 24 percent of members called their doctor's office after hours for help or advice. Seventy percent of members were *usually* or *always* able to get the help or advice they needed.
- **Communication with personal doctor.** One in five members reported they had difficulty speaking with or understanding their personal doctor because they spoke a different language (19 percent).
Greater than 80 percent of members were happy with the quality of communication with their personal doctor, and felt that their doctors listened carefully, showed respect toward them, explained things well, and spent enough time with them.
- **Shared decision-making.** Eighty-five percent of members were involved as much as they wanted in decisions about their health care. Approximately 1 in 4 indicated they experienced some degree of difficulty in reaching an agreement with providers about managing their health conditions (23 percent).

Care Coordination

- **General care coordination.** Among members who received care from providers other than their personal doctor, the majority said their personal doctor was up-to-date and informed about the care they received across providers (77 percent).
- **STAR+PLUS service coordinators.** The majority of STAR+PLUS members indicated they did not have a service coordinator (77 percent). Among these members, 41 percent said they would like to have a service coordinator.
Among members who reported being contacted by their service coordinator in the past six months, 64 percent *usually* or *always* received help from the service coordinator as soon as they needed, and 36 percent *never* or only *sometimes* received help as soon as they needed.
Most members were satisfied with their service coordinator and the way she/he explained things and involved them in making decisions about their services.

Health Plan and Customer Service

- **Enrollment.** Sixty-three percent of members reported they were able to choose their health plan, and 37 percent reported they had a health plan selected for them. Two-thirds of members received information before joining the health plan (62 percent). Most of these members believed the information they received from the health plan was accurate (81 percent).
- **Written materials.** Eighteen percent of members looked for information in written materials or on the Internet about how their health plan works. Among these members, 61 percent indicated that the health plan's written materials or the Internet *usually* or *always* provided them with the information they needed about how their health plan works.
- **Customer service.** Twenty-nine percent of members telephoned their health plan's customer service hotline in the past six months. Sixty-four percent of these members were satisfied with the information

or help they received from their health plan's customer service. However, 37 percent reported making three or more telephone calls to get information or help from their health plan's customer service.

Fifty-one percent gave their health plan a rating of 9 or 10 on a 0- to 10-point scale. Member ratings of their health plan were similar to their ratings of their overall health care, but lower than their ratings of their personal doctor or specialist.

Prior-Year Comparisons

- **CAHPS® Composites.** There were no significant differences between the fiscal years 2009 and 2010 surveys regarding members' experiences and satisfaction with access to care, timeliness of care, doctor's communication, or their health plan's customer service.
- **Member ratings.** Since 2009, members' ratings of the quality of their health care have significantly improved. Specifically, this year's members rated their physical and behavioral health care, personal doctor, and health plan significantly better than members in fiscal year 2009.
- **HHSC Dashboard indicators.** This year's members had significantly better access to specialist referral and significantly fewer delays in their health care while waiting for health plan approval than members in fiscal year 2009.

Recommendations

Many of the EQRO's recommendations in the fiscal year 2009 STAR+PLUS Survey are relevant this year, particularly: (1) Reducing delays in health care for members by expediting the health plan approval process; (2) Decreasing the time members wait to be seen in the provider's office; and (3) Improving the health of the membership through education and health promotion to reduce obesity.

Based on last year's recommendations and the results from the fiscal year 2010 STAR+PLUS Survey, the EQRO recommends the following strategies to Texas HHSC for improving the delivery and quality of care for adult members in the STAR+PLUS program.

Domain	Recommendation	Rationale
Getting timely care	<p>Assess the reasons why members experienced delays in their health care while waiting for health plan approval.</p> <p>Questions should be added to future STAR+PLUS surveys to determine how long members have to wait for health plan approval, depending upon service type and location. It is possible that member perceptions of delayed care are at odds with what is considered an acceptable period of time for health plans to approve care. Thus, survey items could also address member's expectations about receiving care in a timely manner.</p> <p>Encourage providers to evaluate their patient flow problems and implement strategies to reduce the office wait time for members.</p>	<p>Members in STAR+PLUS experienced delays in getting timely health care from their health plan and in getting care at the provider's office. Almost half of members had delays in their health care while waiting for health plan approval (48 percent).</p> <p>In addition, a majority of members reported waiting at their doctor's office longer</p>

	<p>The health plans could provide training and technical assistance to providers in improving patient flow and cycle time.</p> <p>The first step would be for providers to identify bottlenecks in patient flow using the following methods:¹⁹</p> <ul style="list-style-type: none"> • Flow mapping, which involves walking through a patient visit from beginning to end, considering the patient’s perspective. • Cycle time measurement, which involves building upon flow mapping by actually tracking the amount of time associated with each step of the patient’s visit. <p>Once providers identify inefficiencies in their practice, they can implement a number of successful strategies for creating continuous patient flow:²⁰</p> <ul style="list-style-type: none"> • Efficient office design. • Exam room standardization. • Visit planning. • Streamlining check-in and check-out. • Using documentation shortcuts. 	<p>than 15 minutes after their scheduled appointment time before being taken to an exam room.</p> <p>None of the MCOs met the HHSC Dashboard standards for <i>No Delays in Health Care While Waiting for Health Plan Approval or No Exam Room Wait Time Greater than 15 Minutes</i>.</p>
<p>Getting needed care</p>	<p>Expedite the referral process to improve member access to specialist care and other types of care and treatment, and ensure that members have access to service coordination.</p> <p>To reduce delays for members in getting needed care, primary care providers’ offices should implement rapid referral programs such as a referral agreement.²¹ A referral agreement has a number of key elements:²²</p> <ul style="list-style-type: none"> • Developing guidelines between primary care providers and specialists that clarify which conditions each provider type will manage. • Providing primary care providers with an explanation of benefits. • Involving patients in the referral process. • Using an electronic referral system. • Conducting ongoing evaluations of the referral agreement. <p>This referral agreement could also be extended to other entities that provide care, tests, treatment</p>	<p><i>Getting Needed Care</i> was the lowest scoring domain of the four CAHPS® composites (72.5). Twenty-eight percent of respondents had difficulty getting an appointment with a specialist, and 29 percent had difficulty getting the care, tests, or treatment they thought they needed from their health plan.</p> <p>One in three members also reported having difficulty getting specialized services such as special medical equipment and home health care.</p>

	and specialized services to members.	
Care coordination	<p>Evaluate the need for service coordination among members, examine the health plan staffing capacity and resources for providing service coordination, and educate members about available services.</p> <p>1. A health plan should regularly evaluate the service coordination needs of its membership, based on member characteristics such as age and living alone. Evaluation can be done through surveys of members or through claims and encounter data. A service coordinator could then call identified members to explain and offer services.</p> <p>2. To evaluate how health plans enroll their members in service coordination and whether health plans have the resources and staffing levels to adequately provide these services, the EQRO could develop questions to be included in the MCO Administrative Interview, which addresses these issues.</p> <p>3. Since members may not be aware of the availability of service coordination, the health plans should introduce these services to members at the time of enrollment, provide reminders regarding services through member newsletters, and regularly assess their membership to determine who would benefit from these services.</p>	<p>The majority of members reported they did not have a service coordinator (77 percent), which may account for why some members experienced problems getting the care they needed, such as specialist care and specialized services.</p> <p>The results also suggest that members may lack social support, which may heighten their need for service coordination and other social services. Most members felt their health hindered their ability to live independently, forcing them to depend on others for routine and personal care needs. However, 1 in 3 members reported living alone (34 percent), and most members did not have a spouse to provide help or support (83 percent).</p>
Member obesity	<p>Enhance or implement obesity prevention and weight management programs for members in STAR+PLUS.</p> <p>Studies have shown that comprehensive weight management programs that include behavioral, dietary, and exercise components promote weight loss among older adults.²³</p> <p>The EQRO also recommends that HHSC evaluate the health benefits and cost effectiveness of the Molina Weight Watchers Program for STAR+PLUS members to determine if this program should be implemented by other STAR+PLUS health plans as a value-added service.</p>	<p>The majority of members had an unhealthy weight for their height. Fifty-one percent of members were obese, and 1 in 4 were overweight (24 percent).</p>

Endnotes

¹ Consumer Assessment of Healthcare Providers and Systems (CAHPS®). 2008. "CAHPS® Health Plan Survey 4.0, Adult Medicaid Questionnaire." Available at <http://www.cahps.ahrq.gov/cahpskit/>.

² Rand Health. 2008. "Medical Outcomes Study: 36-Item Short Form Survey." Available at http://www.rand.org/health/surveys_tools/mos/mos_core_36item.html.

³ The Institute for Child Health Policy (IHP). 2010. *The Texas Medicaid STAR+PLUS Program Adult Member Survey Report: Technical Appendix*. Gainesville, FL: The Institute for Child Health Policy, University of Florida.

⁴ In statistical significance testing, the "p value" refers to the probability that the differences observed could have occurred by chance alone. For example, if a tested difference is found to have a p value of 0.03 (which is less than 0.05, and therefore statistically significant by the standards of this report), this means that there is only a 3 percent probability that the observed difference could have occurred by chance.

⁵ U.S. Census Bureau. 2010. "State and County Quick Facts." Available at <http://quickfacts.census.gov/qfd/states/48000.html>.

⁶ $X^2 = 22.193$; $p < 0.001$

⁷ $X^2 = 36.060$; $p < 0.001$

⁸ CDC. 2008. *Behavioral Risk Factor Surveillance System Survey Data*. Atlanta, Georgia: U.S. Department of Health and Human Services.

⁹ $F = 5.882$; $p = 0.015$.

¹⁰ Anderson, R.T., F.T. Camacho, and R. Balkrishnan. 2007. "Willing to wait? The influence of patient wait time on satisfaction with primary care." *BMC Health Services Research* 28: 7-31.

¹¹ CDC. 2008. "Key Facts About Seasonal Flu Vaccine." Available at <http://www.cdc.gov/FLU/protect/keyfacts.htm>.

¹² The Smoking Cessation Clinical Practice Panel Staff. 1996. "The Agency for Health Care Policy and Research Smoking Cessation Clinical Practice Guideline." *Journal of the American Medical Association* 275(16):1270–1280.

¹³ Health care: $F = 23.012$; $p < 0.001$

¹⁴ Personal doctor: $F = 16.786$; $p < 0.001$

¹⁵ Behavioral health care: $F = 4.603$; $p = 0.032$

¹⁶ Health plan: $F = 25.598$; $p < 0.001$

¹⁷ $\chi^2 = 3.067$; $p = 0.046$

¹⁸ $\chi^2 = 8.000$; $p < 0.046$

¹⁹ Backer, L. A. 2002. "Strategies for better patient flow and cycle time." *Family Practice Management* 9(6): 45 – 50.

²⁰ Backer, L. A. 2002.

²¹ AHRQ. 2008. "The CAPHS Improvement Guide: Practical Strategies for Improving the Patient Care Experience." Available at <https://www.cahps.ahrq.gov/QIGuide/content/interventions/RapidReferral.aspx>

²² AHRQ. 2008.

²³ McTigue, K.M., R. Hess, and J. Ziouras. 2006. "Obesity in older adults: a systematic review of the evidence for diagnosis and treatment." *Obesity (Silver Spring)* 14 (9): 1485-1497.

²⁴ CAHPS®. 2008.

²⁵ Rand Health. 2008.

²⁶ AHRQ. 2007. "Reporting Measures for the CAHPS® Health Plan Survey 4.0." Available at <http://www.cahps.ahrq.org/cahpskit/>.

²⁷ AHRQ. 2007.

²⁸ Ware, J. J., and C.D. Sherbourne. 1992. "The MOS 36-Item Short-Form Health Survey (SF-36). I. Conceptual Framework and Item Selection." *Medical Care* 30 (6): 473-483.

²⁹ National Center for Health Statistics. 2008. *National Health Interview Survey*. Available at <http://www.cdc.gov/nchs/nhis.htm>.

³⁰ U.S. Census Bureau. 2008. *Current Population Survey*. Available at <http://www.census.gov/cps>.

³¹ Urban Institute. 2008. *National Survey of America's Families*. Available at <http://www.urban.org/center/anf/nsaf.cfm>.

³² ICHP. 2010.

³³ CDC. 2008.

Appendix A. Detailed Survey Methodology

Sample Selection Procedures

Survey participants were selected from a stratified random sample of adults 18 through 64 years of age who were continuously enrolled in STAR+PLUS in Texas for nine months or longer between June 2009 and May 2010. The sample excluded members who were eligible for both Medicaid and Medicare, and members who had participated in the prior year's (fiscal year 2009) survey. These criteria ensured that survey participants had sufficient experience with the program to respond to the survey questions.

A target sample of 300 completed interviews was set for each of the four MCOs participating in STAR+PLUS during fiscal year 2010, for a total of 1,200 targeted completes. 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 comparisons among the four MCO groups.

Table A1 presents each of the four sampling quotas, their eligible populations, the number of members sampled, the targeted number of surveys, and the actual number of surveys completed. The target sample was not met for the Molina quota, due to a high frequency of incorrect phone numbers (42 percent of the Molina sample), a high frequency of ineligible respondents (36 percent of the Molina sample who could be contacted), and limitations on the size of the eligible population. Molina had the smallest eligible population (n = 2,439), all of whom were sampled in an effort to reach the targeted number of completes. The additional completed survey in the Superior quota occurred as a result of the survey fielding methodology, in which telephone interviews may occur with two or more members simultaneously. Overall, 1,187 surveys were completed.

Table A1. STAR+PLUS Member Survey Sampling Strategy

MCO Quota	Eligible Population	Members Sampled	Targeted Completes	Surveys Completed
Amerigroup	6,393	1,765	300	300
Evercare	7,216	1,610	300	300
Molina	2,439	2,439	300	286
Superior	4,876	2,350	300	301
Total	20,924	8,164	1,200	1,187

Using a 95 percent confidence interval, the responses provided in the tables and figures of this report are within 2.8 percentage points of the "true" responses in the adult STAR+PLUS population. At the MCO level, responses are within 5.7 percentage points for Amerigroup and Evercare, 5.8 percentage points for Molina, and 5.6 percentage points for Superior.

Enrollment and claims data were provided to ICHP from a third party administrator for STAR+PLUS in Texas. Researchers used enrollment data to identify members who met the sample selection criteria and to obtain their contact information. Member names, mailing addresses, and telephone contact information for 8,164 eligible STAR+PLUS members were collected and provided to interviewers. For households with multiple eligible adults, one member from the household was randomly chosen as the member to

respond to the survey. Researchers compared respondents and non-respondents on member age, sex, and race/ethnicity to identify any participation biases in the final sample.

Survey Instruments

The fiscal year 2010 STAR+PLUS Member Survey included:

- The CAHPS® Health Plan Survey, version 4.0.²⁴
- The RAND® 36-Item Health Survey, version 1.0.²⁵
- Items developed by ICHP pertaining to member:
 - Demographic, household, and employment characteristics.
 - Experiences with service coordination.
 - Knowledge of and experiences with the Medicaid Buy-In Program.

The CAHPS® Health Plan Survey is a widely used instrument for measuring and reporting consumer experiences and satisfaction with their health plan and providers. The STAR+PLUS Adult Member Survey uses the Medicaid module of the CAHPS® survey and includes both the core questionnaire and supplemental items addressing smoking behavior and cessation, behavioral health care, and the need for personal assistance care. The CAHPS® component of the survey is divided into six sections that assess members' experiences in the past six months with: (1) their health care, (2) their relationship with their personal doctor, (3) participation in STAR+PLUS service coordination, (4) specialist care and specialized services, (5) communication with their health plan, and (6) health and health-related behaviors.

The CAHPS® Health Plan Survey allows for calculation and reporting of health care composites, which are scores that combine results for closely related survey items.²⁶ Composites provide a comprehensive yet concise summary of results for multiple survey questions. Psychometric analyses indicate the composite scores are reliable and valid measures of member experiences.²⁷ For the STAR+PLUS Member Survey, CAHPS® composite scores were calculated in the following four core domains:

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

Researchers scored the composites to produce a mean score ranging from 0 to 100 for each of the four domains, with higher scores indicating greater satisfaction and more positive health care experiences. A score of 75 or higher generally indicates that caregiver experiences in a composite domain were usually or always positive.

The RAND® 36-Item Health Survey was developed to assess health status in the Medical Outcomes Study.²⁸ This instrument was designed for use in health policy evaluations and general population surveys. The RAND®-36 assesses eight separate health domains:

- 1) Limitations in physical activities because of health problems.

- 2) Limitations in social activities because of physical or emotional problems.
- 3) Limitations in usual role activities because of physical health problems.
- 4) Bodily pain.
- 5) General mental health.
- 6) Limitations in usual role activities because of emotional problems.
- 7) Vitality (energy and fatigue).
- 8) General health status.

Using composite scoring methods, ICHP researchers calculated a mean score ranging from 0 to 100 for each of the eight RAND[®]-36 domains. Higher composite scores indicate better health status and/or functioning.

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.²⁹⁻³¹ Questions regarding STAR+PLUS service coordination, the Medicaid Buy-In Program, and housing and employment status are unique to this survey, developed by ICHP in collaboration with Texas HHSC.

Respondents were also asked to report their height and weight. These questions allow calculation of BMI, a common population-level indicator of overweight and obesity.

Survey Data Collection

The EQRO sent letters written in English and Spanish to 7,554 sampled STAR+PLUS members, requesting their participation in the survey. Among addresses in the total sample (8,164), 7.5 percent were not mailed due to bad addresses. Of the advance letters sent, 28 (0.34 percent of sample) were returned undeliverable.

The SRC at the University of Florida conducted the surveys using CATI between June 2010 and November 2010. Calls were made from 10 a.m. to 9 p.m. Central Time, seven days a week. SRC utilized the Sawtooth Software System to rotate calls throughout the morning, afternoon, and evening, maximizing the likelihood of reaching members. If a respondent required that the interview be conducted in Spanish, arrangements were made for a Spanish-speaking interviewer to call at a later date and time. Of 1,187 completed interviews, 45 (3.8 percent) were done in Spanish.

Up to 25 attempts were made to reach a member before his or her phone number was removed from the calling circuit. If the member was not reached after that time, the software system selected the next individual on the list. Incorrect phone numbers were sent to a company that specializes in locating individuals. Any updated information was loaded back into the software system, and attempts were made to reach the member using the updated contact information. No financial incentives were offered to participate in the surveys. On average, 7.3 calls were made per telephone number in the sample.

Attempts were made to telephone 8,156 adults who were enrolled in STAR+PLUS. Fifty percent of members could not be located. Among those located, 2 percent indicated they were not enrolled in STAR+PLUS and 11 percent refused to participate. The response rate was 47 percent and the cooperation rate was 74 percent.

To test for participation bias, the distributions of members' age, sex, and race/ethnicity were collected from the enrollment data and compared between members who responded to the survey and members who refused to participate. These tests found that White, non-Hispanic members were more likely to be located (39 percent) than Hispanic members (30 percent) or Black, non-Hispanic members (31 percent). The tests also found that, among those located, White, non-Hispanic members were less likely to participate in the survey (42 percent) than Hispanic members (49 percent) or Black, non-Hispanic members (50 percent). Women were also more likely to participate than men (50 percent versus 40 percent).

For most survey items, respondents 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 included in the analyses following CAHPS[®] specifications.

Data Analysis

Descriptive statistics and formal statistical tests were performed using the statistical software package SPSS 17.0 (Chicago, IL: SPSS< Inc.). Frequency tables showing descriptive results for each survey question are provided in a separate Technical Appendix.³² The statistics 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 was stratified by MCO, a separate weight was calculated for each MCO, in which frequencies were multiplied by the inverse probability of inclusion in the final sample (the total number of eligible members in the enrollment file divided by the number of members in the final sample). The frequencies and means presented in this report and the accompanying Technical Appendix incorporate survey weights.

Analysis of differences in frequencies used the Pearson Chi-square test of independence, and analysis of differences in means used t-tests and ANOVA. To prevent overestimation of statistical significance resulting from sample size inflation, all tests were performed without weighting. These tests allowed comparison of frequencies and means among the delivery model quotas, and according to the following demographic factors:

- Age.
- Sex.
- Race/Ethnicity.
- Education.
- Employment status.

BMI was calculated by dividing the member's weight in kilograms by their height in meters squared. 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 or greater.

Researchers also performed two multivariate analyses. One analysis was designed to predict the relative influence of MCO membership on the members' CAHPS® composite scores, controlling for demographic, health status, and health delivery characteristics. The second analysis was designed to predict the influence of care coordination on access to various types of health services (special medical equipment and devices, home health care and assistance, and referral to a specialist), controlling for demographic, health status, and health delivery characteristics. The detailed methodology and results for this analysis can be found in Appendix C of this report.

Appendix B: Supplementary Tables

Table B1. Survey Items Comprising the CAHPS® Composites

<p>Getting Needed Care</p> <p>1) How often was it easy for you to get appointments with specialists?</p> <p>2) How often was it easy to get the care, tests, or treatment you thought you needed through your health plan?</p> <p>Getting Care Quickly</p> <p>1) When you needed care right away for an illness, injury, or condition, how often did you get care as soon as you needed?</p> <p>2) Not counting the times you needed care right away, how often did you get an appointment for health care as soon as you thought you needed?</p> <p>How Well Doctors Communicate</p> <p>1) How often did your personal doctor explain things in a way that was easy to understand?</p> <p>2) How often did your personal doctor listen carefully to you?</p> <p>3) How often did your personal doctor show respect for you?</p> <p>4) How often did your personal doctor spend enough time with you?</p> <p>Health Plan Information and Customer Service</p> <p>1) How often did customer service at your health plan give you the information or help you needed?</p> <p>2) How often did customer service staff at your health plan treat you with courtesy and respect?</p>

Table B2. Mean CAHPS® Composite Scores by STAR+PLUS MCO

CAHPS® Composite Scores	AMERI-GROUP	Evercare	Molina	Superior	STAR+PLUS
<i>Getting Needed Care</i>	69.5	73.3	72.6	74.1	72.3
<i>Getting Care Quickly</i>	77.1	80.7	79.6	77.5	78.8
<i>Doctor's Communication</i>	86.5	89.5	87.4	87.4	87.9
<i>Customer Service</i>	75.9	74.7	66.7	76.9	74.5

Appendix C. Multivariate Analysis

Data from the fiscal year 2010 STAR+PLUS Adult Member Survey were used in two multivariate analyses. The first set of analyses assessed the effects of MCO enrollment on the likelihood that a member will have positive experiences and satisfaction with their health care in STAR+PLUS (as measured by the four CAHPS® composite scores), controlling for health status and sociodemographic factors. **Table B2** provides the mean scores for each of the four CAHPS® composites by MCO.

The second set of analyses assessed the effects of having a service coordinator on the likelihood that members will have better access to specialist referral, special medical equipment, and home health care, controlling for sociodemographic factors, health status, and MCO enrollment. The specialized services – special medical equipment and home health care – were chosen for the multivariate analyses because these services were the most commonly used by members.

Methodology

Both multivariate analyses were conducted using unconditional logistic regression, with outcomes dichotomized (coded as 0 or 1) to allow calculation of the likelihood of positive health care experiences. For the first set of analyses, the outcome variable was the odds that the members would *usually* or *always* have positive experiences for each of the four composite measures tested — *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*. A score of 75 points or greater was used to indicate that the member's experience was usually or always positive. For each composite measure, the outcome variable was coded as "1" for members scoring 75 points or greater and "0" for members scoring lower than 75 points.

For the second set of analyses, the outcome variables were the odds that the members would *usually* or *always* be able to get specialist referrals, special medical equipment and home health care. Each outcome variable was coded as "1" for members reporting they *usually* or *always* were able to get the referral or specialized service and "0" for members reporting they *sometimes* or *never* were able to get the referral or specialized service.

The following sociodemographic and health covariates were used in all logistic regression models:

- 1) Member's sex was categorized as male or female, with males as the reference group.
- 2) Member's race/ethnicity was categorized as White, non-Hispanic; Hispanic; Black, non-Hispanic; or Other, non-Hispanic. The reference group was White, non-Hispanic members.
- 3) Member's age was 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 old and older. The reference group was members 18 to 30 years old.
- 4) Member's level of education was categorized into three groups: (1) Less than a high school education, (2) High school graduate, some college, or an Associate's degree; and (3) A Bachelor's degree or higher. The reference group was members with less than a high school education.
- 5) Member's health status was determined by the RAND® 36-Item Health Survey and retained as a scale variable.

Results of ANOVA tests were used to select the MCO reference group for each model. For the first set of analyses, the health plan with the highest score for each composite measure was selected as the reference group. The MCO reference groups were as follows:

- Superior: *Getting Needed Care, Customer Service.*
- Evercare: *Getting Care Quickly, How Well Doctors Communicate.*

Within the first set of analyses, four models were tested and the results of each health plan were compared to the results of the health plan serving as the reference group, after controlling for the covariates listed above.

For the second set of analyses, Superior had the highest percentage of STAR+PLUS members with a service coordinator and was selected as the reference group. Within the second set of analyses, three models were tested and the results of having a service coordinator were compared to the results of not having a service coordinator, which served as the reference group, after controlling for the covariates listed above.

Results are presented in **Table C1** through **Table C7** as odds ratios. In the CAHPS® composite analyses, the odds ratios represent the likelihood of members having positive health care experiences (scoring 75 points or greater) in comparison to members in the reference group. An odds ratio above 1.0 suggests that individuals in a specified category were more likely to have positive health care experiences compared with individuals in the reference group. Conversely, an odds ratio below 1.0 suggests that individuals in a specified category were less likely to have positive health care experiences compared to individuals in the reference group.

The tables also provide 95 percent confidence intervals for the odds ratios, which function as indicators of statistical significance. An odds ratio with a confidence interval that includes 1.0 in its range is not considered statistically significant at $p < 0.05$.

Results

Getting Needed Care (Table C1)

- Members in better health had a greater likelihood of getting needed care.

Getting Care Quickly (Table C2)

- Compared to male members, female members had a 37 percent lower likelihood of getting care quickly.
- Compared to White, non-Hispanic members, a lower likelihood of getting care quickly was observed for Hispanics (29 percent lower) and Other, non-Hispanics (53 percent).

How Well Doctors Communicate (Table C3)

- Black, non-Hispanics had a greater likelihood (66 percent higher) of rating their doctor's communication positively than White non-Hispanics. Conversely, Other, non-Hispanics had a lower likelihood (53 percent lower) of rating their doctor's communication positively than White, non-Hispanics.

Customer Service (Table C4)

- Female members had a lower likelihood (37 percent lower) of having positive experiences with their health plan's customer service than male members.
- Compared to members between 18 and 30 years old, a greater likelihood of having positive experiences with their health plan's customer service was observed for members 31 to 40 years old (2.4 times more likely) and members 61 years of age and older (2.7 times more likely).
- Members in Molina had a lower likelihood (53 percent lower) of having positive experiences with their health plan's customer service than members in Superior.

Getting a Referral to a Specialist (Table C5)

- Compared to members between 18 and 30 years old, a greater likelihood of *usually* or *always* getting a referral to a specialist was observed for members 51 to 60 years old (2.4 times more likely) and members 61 years of age and older (2.0 times more likely).
- Members in Amerigroup had a lower likelihood (55 percent lower) of *usually* or *always* getting a referral to a specialist than members in Superior.

Getting Special Medical Equipment (Table C6)

- Compared to White, non-Hispanic members, a lower likelihood of *usually* or *always* getting special medical equipment was observed for Hispanics (48 percent lower) and Other, non-Hispanics (69 percent).
- Compared to members in Superior, a lower likelihood of *usually* or *always* getting special medical equipment was observed for members in Amerigroup (59 percent lower) and Molina (44 percent lower).

Getting Home Health Care (Table C7)

- There were no significant predictors of getting home health care.

Conclusions

Controlling for sociodemographic characteristics and health status of members, MCO enrollment did not have a significant influence on member experiences in *Getting Needed Care*, *Getting Care Quickly*, or *How Well Doctors Communicate*. However, MCO enrollment did have a significant influence on member experiences with their health plan's customer service. Members in Superior had more positive experiences with their health plan's customer service than members in Molina.

In addition, having a service coordinator did not significantly improve member access to specialist referral, specialist medical equipment, or home health care, after controlling for sociodemographic characteristics, health status, and MCO enrollment. The results did reveal that MCO enrollment had a significant influence on member access to special medical equipment and getting a referral to a specialist. Compared to members in Superior, members in Amerigroup were less likely to get special medical equipment and were less likely to get a referral to a specialist as soon as they needed.

Table C1. Getting Needed Care - Multivariate Analysis

	Getting Needed Care				Odds Ratio	95% Confidence Interval
	0 to 74		75 or Greater			
	N	Percent	N	Percent		
Gender						
Male	41	26%	230	32%	REF	-
Female	119	74%	497	68%	0.780	0.546 - 1.116
Age Category						
18 – 30	19	8%	35	7%	REF	-
31 – 40	31	12%	58	12%	1.189	0.572 - 2.471
41 – 50	69	27%	116	24%	1.123	0.581 - 2.169
51 – 60	96	38%	196	41%	1.437	0.760 - 2.717
61+	39	15%	76	16%	1.239	0.612 - 2.509
Race/Ethnicity						
White, non-Hispanic	68	27%	144	30%	REF	-
Hispanic	96	38%	200	42%	0.976	0.643 - 1.481
Black, non-Hispanic	67	27%	107	23%	0.747	0.482 - 1.157
Other, non-Hispanic	19	8%	25	5%	0.646	0.328 - 1.269
Education Level						
Less than high school	102	41%	186	39%	REF	-
High school or some college	114	45%	231	49%	1.174	0.820 - 1.680
Bachelor's degree or higher	36	14%	58	12%	0.875	0.518 - 1.476
Health Plan						
Superior	61	24%	123	26%	REF	-
Amerigroup	67	26%	115	24%	0.944	0.595 - 1.496
Evercare	62	24%	122	25%	1.021	0.642 - 1.623
Molina	64	25%	121	25%	0.995	0.633 - 1.563
RAND-36 General Health	Mean		Mean		1.011 ^b	1.004 - 1.019
	33.0		37.9			
^a Odds ratio significant at p < 0.10 ^b Odds ratio significant at p < 0.05						

Table C2. Getting Care Quickly - Multivariate Analysis

	Getting Care Quickly				Odds Ratio	95% Confidence Interval
	0 to 74		75 or Greater			
	N	Percent	N	Percent		
Gender						
Male	61	23%	218	31%	REF	-
Female	202	77%	483	69%	0.632 ^b	0.448 - 0.892
Age Category						
18 – 30	21	8%	45	6%	REF	-
31 – 40	35	13%	88	13%	1.304	0.669 - 2.542
41 – 50	66	25%	166	24%	1.141	0.621 - 2.097
51 – 60	96	37%	300	43%	1.508	0.838 - 2.714
61+	45	17%	102	15%	1.212	0.630 - 2.332
Race/Ethnicity						
White, non-Hispanic	53	21%	193	28%	REF	-
Hispanic	112	44%	283	41%	0.710 ^a	0.474 - 1.063
Black, non-Hispanic	70	27%	175	25%	0.709	0.461 - 1.089
Other, non-Hispanic	21	8%	38	6%	0.476 ^b	0.255 - 0.888
Education Level						
Less than high school	114	44%	297	43%	REF	-
High school or some college	115	45%	326	47%	1.035	0.748 - 1.433
Bachelor's degree or higher	29	11%	71	10%	0.888	0.530 - 1.487
Health Plan						
Evercare	69	24.7%	134	28.3%	REF	-
Amerigroup	73	26.2%	107	22.6%	0.791	0.519 - 1.204
Molina	67	24.0%	114	24.1%	0.903	0.588 - 1.388
Superior	70	25.1%	118	24.9%	0.775	0.499 - 1.205
RAND-36 General Health						
	Mean		Mean		0.996	0.989 - 1.003
	38.8		37.1			
^a Odds ratio significant at p < 0.10						
^b Odds ratio significant at p < 0.05						

Table C3. How Well Doctors Communicate - Multivariate Analysis

	How Well Doctors Communicate				Odds Ratio	95% Confidence Interval
	0 to 74		75 or Greater			
	N	Percent	N	Percent		
Gender						
Male	45	30%	219	28%	REF	-
Female	103	70%	557	72%	1.051	0.708 - 1.560
Age Category						
18 – 30	11	7%	45	6%	REF	-
31 – 40	15	10%	103	13%	1.658	0.696 - 3.953
41 – 50	39	26%	187	24%	1.122	0.525 - 2.398
51 – 60	58	39%	316	41%	1.288	0.619 - 2.678
61+	25	17%	125	16%	1.268	0.562 - 2.861
Race/Ethnicity						
White, non-Hispanic	35	24%	195	26%	REF	-
Hispanic	76	52%	308	40%	0.763	0.476 - 1.223
Black, non-Hispanic	24	16%	224	29%	1.663 ^a	0.943 - 2.931
Other, non-Hispanic	12	8%	37	5%	0.525 ^a	0.247 - 1.116
Education Level						
Less than high school	67	46%	326	43%	REF	-
High school or some college	64	44%	360	47%	1.067	0.716 - 1.589
Bachelor's degree or higher	16	11%	81	11%	1.011	0.538 - 1.900
Health Plan						
Evercare	31	21%	198	26%	REF	-
Amerigroup	37	25%	198	26%	0.857	0.503 - 1.460
Molina	33	22%	185	24%	0.933	0.540 - 1.610
Superior	47	32%	195	25%	0.808	0.477 - 1.369
RAND-36 General Health	Mean		Mean		0.998	0.990 - 1.006
	38.9		38.3			
^a Odds ratio significant at p < 0.10						
^b Odds ratio significant at p < 0.05						

Table C4. Customer Service - Multivariate Analysis

	Customer Service				Odds Ratio	95% Confidence Interval
	0 to 74		75 or Greater			
	N	Percent	N	Percent		
Gender						
Male	34	23%	61	31%	REF	-
Female	112	77%	135	69%	0.636 ^a	0.375 - 1.080
Age Category						
18 – 30	17	12%	14	7%	REF	-
31 – 40	16	11%	26	13%	2.355 ^a	0.873 - 6.354
41 – 50	42	29%	51	26%	1.662	0.700 - 3.949
51 – 60	56	38%	75	38%	2.000	0.865 - 4.625
61+	15	10%	30	15%	2.678 ^a	0.993 - 7.219
Race/Ethnicity						
White, non-Hispanic	38	27%	45	23%	REF	-
Hispanic	58	41%	78	40%	1.305	0.692 - 2.461
Black, non-Hispanic	38	27%	61	31%	1.649	0.869 - 3.129
Other, non-Hispanic	9	6%	10	5%	0.930	0.331 - 2.610
Education Level						
Less than high school	51	35%	72	37%	REF	-
High school or some college	79	55%	96	50%	0.947	0.570 - 1.575
Bachelor's degree or higher	15	10%	25	13%	1.421	0.617 - 3.273
Health Plan						
Superior	28	19%	48	25%	REF	-
Amerigroup	29	20%	52	27%	0.996	0.488 - 2.036
Evercare	41	28%	53	27%	0.780	0.396 - 1.535
Molina	48	33%	43	22%	0.471 ^b	0.244 - 0.910
RAND-36 General Health	Mean		Mean		1.007	0.997 - 1.018
	35.5		38.7			

^a Odds ratio significant at $p < 0.10$
^b Odds ratio significant at $p < 0.05$

Table C5. Getting a Referral to a Specialist - Multivariate Analysis

	Referral to a Specialist				Odds Ratio	95% Confidence Interval
	Never/Sometimes		Usually/Always			
	N	Percent	N	Percent		
Gender						
Male	35	23%	111	29%	REF	-
Female	120	77%	279	72%	0.734	0.461 - 1.167
Age Category						
18 – 30	15	10%	24	6%	REF	-
31 – 40	16	10%	43	11%	2.089	0.847 – 5.152
41 – 50	41	27%	94	24%	1.714	0.781 – 3.764
51 – 60	60	39%	170	44%	2.428 ^b	1.134 – 5.199
61+	23	15%	59	15%	2.059 ^a	0.878 – 4.832
Race/Ethnicity						
White, non-Hispanic	44	29%	120	32%	REF	-
Hispanic	56	37%	156	40%	0.811	0.482 - 1.363
Black, non-Hispanic	42	28%	81	21%	0.762	0.444 - 1.308
Other, non-Hispanic	10	7%	27	7%	0.980	0.416 – 2.307
Education Level						
Less than high school	58	37%	153	40%	REF	-
High school or some college	76	49%	181	47%	0.919	0.589 - 1.434
Bachelor's degree or higher	21	14%	53	14%	0.875	0.423 - 1.546
Health Plan						
Superior	31	20%	110	28%	REF	-
Amerigroup	51	33%	82	21%	0.452 ^b	0.253 - 0.808
Evercare	37	24%	101	26%	0.664	0.366 - 1.203
Molina	36	23%	97	25%	0.655	0.364 - 1.179
Care Coordination						
No	115	75%	292	77%	REF	-
Yes	38	25%	89	23%	0.855	0.537 - 1.360
RAND-36 General Health	Mean		Mean		1.005	0.995 - 1.014
	33.0		35.4			
^a Odds ratio significant at p < 0.10						
^b Odds ratio significant at p < 0.05						

Table C6. Getting Special Medical Equipment - Multivariate Analysis

	Special Medical Equipment				Odds Ratio	95% Confidence Interval
	Never/Sometimes		Usually/Always			
	N	Percent	N	Percent		
Gender						
Male	52	33%	72	27%	REF	-
Female	108	68%	195	73%	1.374	0.854 – 2.210
Age Category						
18 – 30	7	4%	6	2%	REF	-
31 – 40	14	9%	22	8%	2.731	0.704 – 10.586
41 – 50	48	30%	62	23%	1.827	0.540 – 6.175
51 – 60	73	46%	135	51%	2.269	0.689 – 7.467
61+	18	11%	42	16%	2.687	0.735 – 9.826
Race/Ethnicity						
White, non-Hispanic	34	22%	74	29%	REF	-
Hispanic	70	45%	105	40%	0.517 ^b	0.288 – 0.927
Black, non-Hispanic	36	23%	68	26%	0.835	0.448 – 1.555
Other, non-Hispanic	17	11%	13	5%	0.307 ^b	0.127 – 0.741
Education Level						
Less than high school	63	40%	118	44%	REF	-
High school or some college	75	48%	112	42%	0.750	0.469 – 1.198
Bachelor's degree or higher	19	12%	36	14%	0.906	0.440 – 1.866
Health Plan						
Superior	39	24%	87	33%	REF	-
Amerigroup	41	26%	46	17%	0.410 ^b	0.214 – 0.783
Evercare	41	26%	74	28%	0.680	0.364 – 1.270
Molina	39	24%	60	23%	0.563 ^a	0.306 – 1.034
Care Coordination						
No	110	71%	184	70%	REF	
Yes	44	29%	79	30%	1.009	0.627 – 1.624
RAND-36 General Health	Mean		Mean		1.003	0.992 - 1.014
	32.1		33.0			
^a Odds ratio significant at p < 0.10						
^b Odds ratio significant at p < 0.05						

Table C7. Getting Home Health Care - Multivariate Analysis

	Home Health Care				Odds Ratio	95% Confidence Interval
	Never/Sometimes		Usually/Always			
	N	Percent	N	Percent		
Gender						
Male	26	25%	57	27%	REF	-
Female	78	75%	154	73%	0.942	0.532 – 1.667
Age Category						
18 – 30	3	3%	7	3%	REF	-
31 – 40	10	10%	22	10%	0.964	0.186 – 4.999
41 – 50	25	24%	61	29%	1.108	0.242 – 5.066
51 – 60	45	43%	90	43%	0.813	0.182 – 3.631
61+	21	20%	31	15%	0.653	0.139 – 3.076
Race/Ethnicity						
White, non-Hispanic	30	29%	52	25%	REF	-
Hispanic	33	32%	85	41%	1.493	0.736 – 3.026
Black, non-Hispanic	31	30%	57	27%	0.989	0.500 – 1.958
Other, non-Hispanic	10	10%	14	7%	0.690	0.259 – 1.839
Education Level						
Less than high school	36	35%	80	38%	REF	-
High school or some college	49	48%	100	47%	0.990	0.560 – 1.749
Bachelor's degree or higher	17	17%	31	15%	1.062	0.477 – 2.367
Health Plan						
Superior	35	34%	64	30%	REF	-
Amerigroup	24	23%	48	23%	1.082	0.552 – 2.118
Evercare	22	21%	52	25%	1.084	0.550 – 2.139
Molina	23	22%	47	22%	1.017	0.484 – 2.137
Care Coordination						
No	72	71%	135	66%	REF	
Yes	30	29%	69	34%	1.356	0.782 – 2.350
RAND-36 General Health	Mean		Mean		1.005	0.993 – 1.018
	32.4		34.7			
^a Odds ratio significant at p < 0.10 ^b Odds ratio significant at p < 0.05						