



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

Texas Medicaid STAR Program Adult Member Survey Report

Contract Year 2012

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**The Institute for Child Health Policy
University of Florida**

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

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Executive Summary

Introduction

This report provides results from the fiscal year 2012 STAR Adult Member Survey for the State of Texas, prepared by the Institute for Child Health Policy (ICHP) at the University of Florida. The STAR program is administered through 14 managed care organizations (MCOs), which provide members with access to a primary care provider, unlimited medically-necessary prescriptions, as well as other additional benefits. As the External Quality Review Organization (EQRO) for Texas Medicaid, ICHP is contracted by the Texas Health and Human Services Commission (HHSC) to evaluate members' experiences and satisfaction with the health care they receive while enrolled in the STAR program.

This report presents results from the fiscal year 2012 STAR Adult Member Survey, specifically regarding:

- Demographic and health characteristics of adults enrolled in STAR
- Members' experiences and satisfaction across four domains of care:
 - Access and timeliness of care
 - Patient-centered medical home
 - Care coordination
 - Health plan information and customer service
- Comparisons with results from fiscal year 2009

Methodology

Survey participants were selected from a stratified random sample of adults 18 to 64 years old who were enrolled in the same STAR MCO in Texas for six months or longer between July 2011 and December 2011. The EQRO set a target sample of 3,500 completed telephone interviews, representing 250 respondents for each of the 14 health plans participating in STAR during calendar year 2011. The response rate was 43 percent and the cooperation rate was 67 percent.

The fiscal year 2012 STAR Adult Survey is comprised of:

- The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 4.0 (Medicaid module).¹
- Items from the CAHPS® Clinician and Group Surveys.²
- Items developed by ICHP pertaining to member demographic and household characteristics.

Summary of Findings

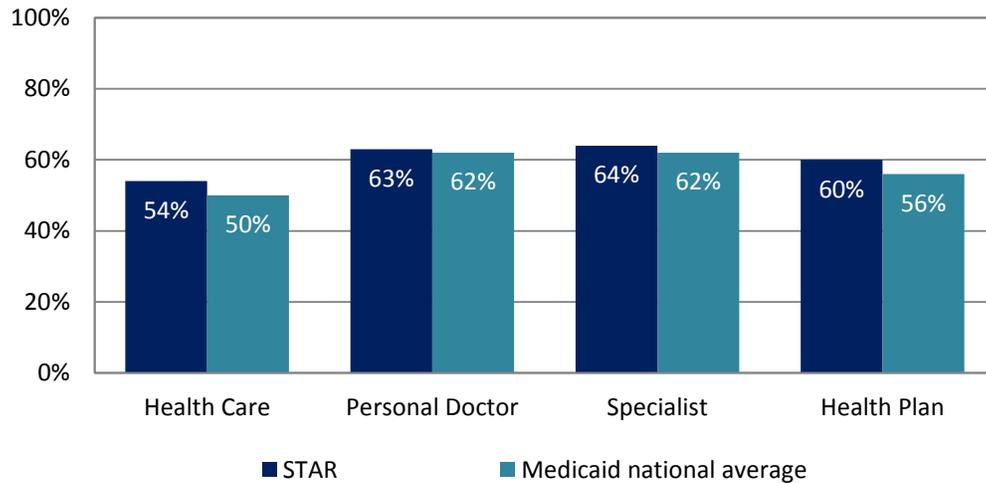
Profile of STAR survey respondents (members):

- The average age of members was 27 years old.
- A vast majority of respondents were female (79 percent).
- Hispanics represented the most common racial/ethnic group (57 percent), followed by Black, non-Hispanic members (20 percent), and White, non-Hispanic members (18 percent). The remaining five percent were of “Other” racial/ethnic groups.
- Most respondents reported that they speak English (96 percent). However, nearly one-third of respondents reported that they spoke mostly Spanish at home (28 percent).
- Approximately three-fourths of respondents had at least a high school diploma or equivalent (71 percent).
- Nearly two out of three respondents reported their relationship status as “single” (64 percent), and more than half of respondents lived in a single-parent household (54 percent).

Positive findings

- *Member Ratings.* Greater than half of survey respondents rated the service of their health care, personal doctor, specialist, and health plan as a 9 or 10 on a 10-point scale. Each rating met or surpassed the Medicaid national average.
- *Good access to special therapies.* Approximately two out of three members who needed special therapies said that it was usually or always easy to get the therapy they needed (62 percent). This rate exceeds the HHSC Dashboard standard of 58 percent.
- *Access to prescription medicines.* Approximately half of members reported that they got new prescription medicines or refilled a medication during the past six months (53 percent). Among these members, 81 percent reported that it was usually or always easy to get the medicine they needed from their health plan.
- *Shared decision-making.* Nearly four out of five members said that they were usually or always involved as much as they wanted in their health care (79 percent) and that they usually or always felt that it was easy to get their doctors to agree on how to manage their health care problems (79 percent).
- *Care coordination.* Nearly two out of three members reported that they had someone helping to coordinate their health care (61 percent). Among these members, a vast majority reported that they were satisfied or very satisfied with the assistance they received (93 percent).

Percent of members rating their health services a “9” or “10”

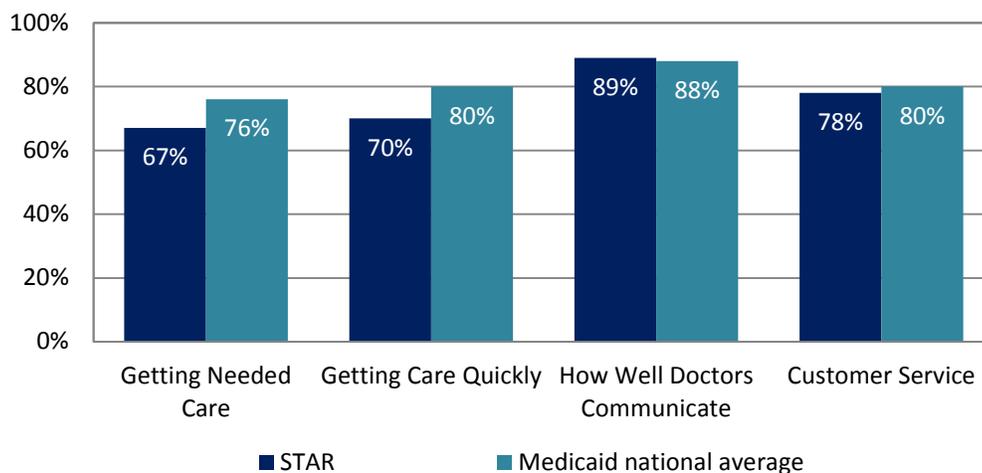


Improvement areas

- *Getting Care Quickly.* Seventy percent of members usually or always had positive experiences with *Getting Care Quickly*, which is lower than the national Medicaid rate of 80 percent for this measure.
- *Good Access to Routine Care.* Approximately two-thirds of members reported that they had good access to routine care (67 percent). This rate is lower than the HHSC Dashboard standard for this indicator (80 percent).
- *Office Wait.* One in five members reported having no wait greater than 15 minutes before being taken to the exam room (21 percent). This rate is considerably lower than the HHSC Dashboard standard of 42 percent.
- *Getting Needed Care.* Sixty-six percent of members usually or always had positive experiences with *Getting Needed Care*. This percentage is considerably lower than the national Medicaid rate of 78 percent.
- *Good Access to Specialist Referral.* Approximately two-thirds of members who needed a referral to a specialist said it was usually or always easy to get a referral (64 percent). This rate is lower than the HHSC Dashboard standard for this indicator (73 percent).
- *Having a personal doctor.* Sixty-eight percent of members reported that they had a personal doctor.
- *Emergency department utilization.* Thirty-eight percent of members visited the emergency department at least once in the past six months. Among these members, 70 percent said they did *not* contact their personal doctor before going to the emergency department. Lack of after-hours access to their personal doctor was one of the most important reasons why they did not contact their personal doctor.

- *Advising Smokers to Quit.* Among members who reported they smoke cigarettes, half said that a doctor or other health provider had advised them to quit smoking in the last six months (51 percent). This rate is considerably lower than the HHSC Dashboard standard for this indicator (70 percent).

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



HHSC Performance Dashboard Indicators	STAR	HHSC Standard
<i>Good access to urgent care</i>	74%	81%
<i>Good access to specialist referral</i>	64%	73%
<i>Good access to routine care</i>	67%	80%
<i>No delays for an approval</i>	50%	57%
<i>No wait to be taken to the exam room greater than 15 minutes</i>	21%	42%
<i>Good access to special therapies</i>	62%	58%
<i>Good access to behavioral health treatment or counseling</i>	48%	54%
<i>Advising smokers to quit</i>	51%	70%

Recommendations

The EQRO recommends the following strategies to Texas HHSC and STAR MCOs for improving the delivery and quality of care for members in the STAR program:

Recommendations	Rationale
Domain: Timeliness of care for adults in STAR	
<ul style="list-style-type: none"> • STAR MCOs should implement or improve upon strategies to ensure their members receive timely care, as well as reduce wait time to be taken to the exam room. STAR network providers should be encouraged to extend appointment opportunities by staggering physician regular work hours,³ or adopting an ‘advanced access’ system⁴. • STAR MCOs should work to reduce delays for approval for treatments and testing by: <ul style="list-style-type: none"> ○ conducting a root cause analysis to identify why delays in health plan approval are occurring, and the most appropriate points for intervention; and ○ ensuring that health plan staff in appropriate roles – such as care coordinators or case managers – systematically work with members, their providers, and the health plan to facilitate approval of needed treatment. 	<p>The percentage of members “usually” or “always” <i>Getting Care Quickly</i> was below the national average (70 percent vs. 81 percent). In addition, members who rated their health as “fair” or “poor” were less likely than healthy members to report getting timely care.</p> <p>No MCO met the HHSC dashboard standard for time to be taken to the exam room. The average percentage of members having <i>No Delays for an Approval</i> was also lower than the HHSC dashboard standard, with only five MCOs meeting the standard.</p> <p>Furthermore, research suggests that timely care can reduce potentially preventable events.^{5,6,7}</p>
Domain: Having a usual source of care for adults in STAR	
<ul style="list-style-type: none"> • STAR MCOs should encourage network providers to adopt standards set by the NCQA for patient-centered medical home (PCMH) recognition.⁸ An enhanced medical home model links each member to a primary care provider who serves as a medical home for the patient, and incentivizes providers to adopt appropriate PCMH standards through increased reimbursement. Research suggests that programs that link members to primary care 	<p>Sixty-eight percent of members in STAR reported that they have a personal doctor. Having a personal doctor is an important component of the patient-centered medical home, which can facilitate partnerships between patients, their physicians, and their families.¹⁰</p>

providers and utilize the PCMH model can improve the quality of health care and reduce costs. ⁹	
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Introduction and Purpose

The STAR program is a Texas Medicaid Managed Care program designed to reduce service fragmentation, increase access to care, reduce costs, and promote more appropriate use of health care services. The STAR program primarily serves non-disabled children, low-income families, and pregnant women.¹¹ Members in this program have access to a primary care provider, unlimited medically-necessary prescriptions, as well as other additional benefits that are determined by individual MCOs on a case-by-case basis.

The Institute for Child Health Policy (ICHP) is contracted by the Texas Health and Human Services Commission (HHSC) to evaluate the health care experiences and satisfaction with services received by adult enrollees in the STAR program.

ICHP uses measures from the Consumer Assessment of Health Providers and Systems (CAHPS[®]) survey, which measures member satisfaction and forms the basis for performance indicators on the HHSC Performance Dashboard. Research has found that member experience and satisfaction are indicators of health care quality and predictors of compliance with treatment, switching providers, and health status^{12,13}. By comparing member survey data with state and national means and standards, this report identifies areas for improvement and makes recommendations for reducing disparities to improve health care.

This report presents results from the fiscal year (FY) 2012 STAR Adult Member Survey, specifically regarding:

- Demographic and health characteristics of adults enrolled in STAR;
- Members' experiences (assessed through CAHPS[®] items and the HHSC Performance Dashboard) across four domains of care:
 - Access and timeliness of care,
 - Patient-centered medical home,
 - Care coordination, and
 - Health plan information

In addition, this report compares CAHPS[®] items and HHSC Performance Dashboard results with those from 2009 to identify trends in health care quality. Findings in this report are examined to provide insight on two overarching goals of the STAR program: reducing potentially preventable events (PPEs) and improving access to care.

Methodology

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

Sample Selection Procedures

The EQRO selected survey participants from a stratified random sample of adults 18 to 64 years old who were enrolled in the same STAR MCO in Texas between July 2011 and December 2011, with no more than one 30-day break in enrollment during this period. A target sample of 3,500 completed telephone interviews was set, representing 250 respondents for each of the 14 health plans participating in STAR during CY 2011.

Survey Instruments

The fiscal year 2012 STAR Adult Member Survey is comprised of:

- The Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) Health Plan Survey 4.0 (Medicaid module).¹⁴
- Items from the CAHPS[®] Clinician and Group Surveys.¹⁵
- Items developed by ICHP pertaining to member demographic and household characteristics.

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

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

Scores for composite measures were calculated using both AHRQ and NCQA specifications. For the CAHPS[®] composites and ratings measures, this report provides national averages from 2012 for comparison, available through the National Committee for Quality Assurance (NCQA) Quality Compass database.¹⁶

Eight survey questions function as indicators of health plan performance for adult STAR members, as listed on the HHSC Performance Indicator Dashboard for calendar year 2012.¹⁷ These include: (1) Good access to urgent care; (2) Good access to specialist referral; (3) Good access to routine care; (4) No delays in health care while waiting for health plan approval; (5) No wait to be taken to the exam room wait greater than 15 minutes; (6) Good access to special therapies; (7) Good access to behavioral health treatment and counseling; and (8) Advising smokers to quit.

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

Data Collection

The EQRO sent letters written in English and Spanish to 19,464 sampled STAR adult members, requesting their participation in the survey. Of the advance letters sent, 55 were returned undeliverable.

The Survey Research Center (SRC) at the University of Florida conducted the survey using computer-assisted telephone interviewing (CATI) between February 2012 and August 2012. The SRC telephoned adult STAR members seven days a week between 10 a.m. and 9 p.m. Central Time. Of 3,029 completed interviews, 123 (4 percent) were conducted in Spanish. On average 11.4 calls per phone number were made in the STAR Adult survey sample.

Thirty-two percent of families could not be located.¹⁸ Among those located, 21 percent indicated that they were not enrolled in STAR and 12 percent refused to participate. The response rate was 43 percent and the cooperation rate was 67 percent.¹⁹

Data Analysis

Descriptive statistics and statistical tests were performed using SPSS 19.0 and focused on the CAHPS[®] composite measures and HHSC Performance Dashboard Indicators. Statistical tests of differences were conducted between members of the STAR program, among members of the 14 MCOs, and among relevant demographic sub-groups of the sample. Multivariate analyses were also conducted to examine the relative influence of several factors on positive experiences on each of the four CAHPS[®] composite domains.

Survey Results

This section presents survey findings for adults in STAR regarding: 1) Demographic characteristics; 2) Health status; 3) Access to and timeliness of care; 4) Patient-centered medical home; 5) Care coordination; and 6) Experiences and satisfaction with STAR health plans.

Demographic Characteristics

The mean age among all survey respondents was 27 years old, and the majority of respondents were female (79 percent). The largest racial/ethnic group represented was Hispanic (57 percent), followed by Black, non-Hispanic members (20 percent) and White, non-Hispanic members (18 percent). Five percent of surveyed members were of "Other" race/ethnicity, which included American Indian/Alaskan Natives and Asian/Pacific Islanders.

A majority of respondents reported that they were born in the United States (88 percent), and nearly one in ten members reported that they were born in a country other than United States (12 percent). Among these members, the average amount of time that they had lived in the United States was 19 years.

Nearly all survey respondents reported that they spoke English (96 percent). However, many respondents revealed that they spoke mostly Spanish at home (28 percent), and another third reported that they spoke both English and Spanish at home (37 percent).

Regarding educational background, 29 percent of respondents had not attained a high school diploma, while nearly half had a high school diploma or equivalent (45 percent). Twenty seven percent of the respondents had some college or a college degree.

When asked about their relationship status, about two-thirds of respondents reported they were single (64 percent). Married individuals represented 17 percent of the sample, and divorced individuals represented six percent of the sample.

In addition, greater than half of respondents lived in a single-parent household (54 percent), and one third reported they lived in a two-parent household (35 percent).

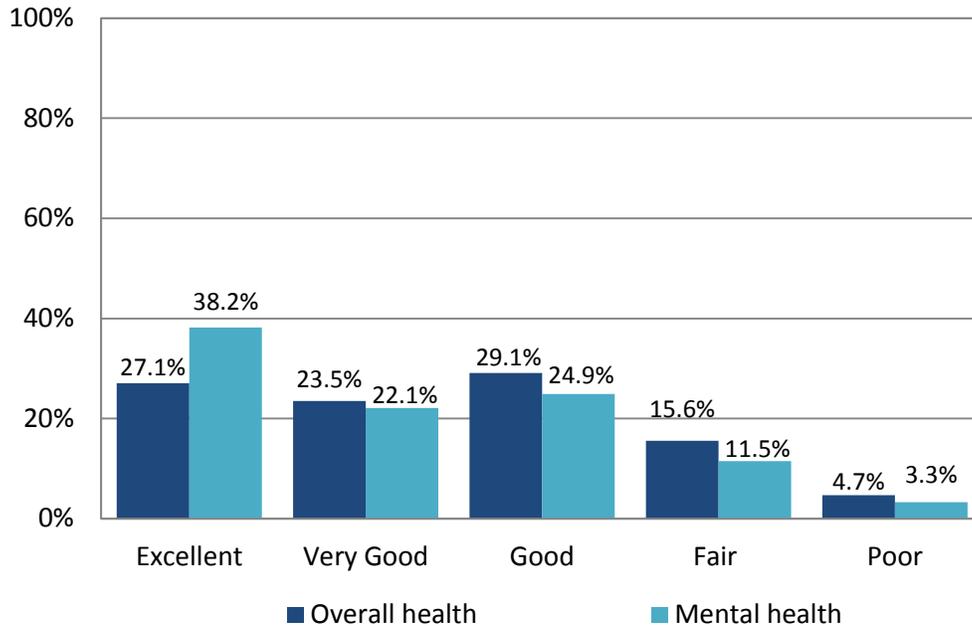
Health Status

STAR members' self-reported health status was generally good for both overall health and mental health (**Figure 1**).

- Over half of respondents rated their health as excellent or very good (51 percent), whereas one out of five respondents rated their overall health as fair or poor (20 percent).
- Members' rated their mental health slightly higher, with nearly two-thirds of respondents rating their mental health as excellent or very good (60 percent), and 15 percent of respondents rating their mental health as fair or poor.

	STAR Members
Mean Age (years)	27.1 (SD = 10.7)
Sex	
Female	79%
Male	21%
Race/Ethnicity	
Hispanic	57%
Black, Non-Hispanic	20%
White, Non-Hispanic	18%
Other	5%
Country of Nativity	
United States	88%
Mexico	7%
Other	5%

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



Body Mass Index

Figure 2 provides the Body Mass Index (BMI) classification for respondents. Based on their weight and height data, over a third of members were classified as obese (36 percent), and an additional 25 percent were classified as overweight. The obesity rate among STAR members was equal to that of the national population (36 percent), and higher than the Texas population (29 percent), as reported by the Centers for Disease Control and Prevention in 2012.²⁰

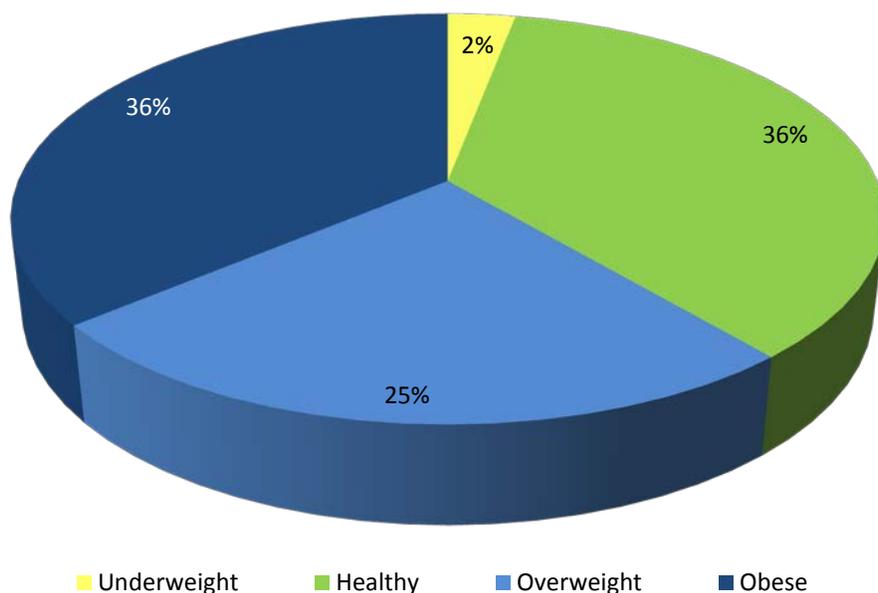
- Female members had a significantly higher rate of obesity than male members (40 percent vs. 26 percent),²² whereas the CDC found no significant gender difference for obesity in the U.S. adult population overall.
- Obesity rates were significantly higher among Hispanic members (39 percent) and Black, non-Hispanic members (39 percent) than among White, non-Hispanic members (33 percent).²³ The racial-ethnic difference in STAR was similar to that observed for the U.S. adult population, except for Black, non-Hispanic respondents, whose obesity rate was 11 percent lower than their national counterparts.

Obesity Prevalence in the U.S. by Sex, Race/Ethnicity, and Age^a	
	% obese in population
Men	36%
Women	36%
Hispanic	39%
Non-Hispanic Black	50%
Non-Hispanic White	34%

^a Based on the National Health Examination and Nutrition Survey, 2009-2010²¹

- The obesity rate among members age 21 and over was more than twice that among members age 18-20 (48 percent vs. 22 percent, respectively).
- Obesity rates also varied considerably by MCO and service area (SA), as shown on **Table B1** in Appendix B, ranging from 28 percent in Texas Children’s-Harris to 49 percent in Aetna-Bexar. Eight plan codes had obesity rates above the national (adult) average. Variation in obesity rates was also observed among health plans within certain SAs – in particular, Bexar and Harris:
 - In Bexar SA, obesity rates ranged from 38 percent in Community First to 49 percent in Aetna.
 - In Harris SA, obesity rates ranged from 28 percent in Texas Children’s to 45 percent in Molina.

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



Activities of Daily Living

Activities of daily living are a good indicator of a person’s health status. Functional limitations with routine and personal care, for instance, could reveal disability and dependence on others.

Activities of daily living were generally very good. Specifically,

- Fewer than one in six respondents reported having a physical or medical condition that seriously interferes with their independence, participation in the community, or quality of life (14 percent).

- About one in ten respondents reported they needed help with their routine needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes (10 percent).
- About one in twenty respondents reported they needed help with their personal care needs, such as eating, dressing, or getting around the house (6 percent).

These findings indicate that only a small minority of STAR members are in need of assistance with personal care and daily tasks.

Access to and Timeliness of Care

This section provides members' reports of access to and timeliness of health services delivered through their STAR MCOs and providers, including (1) urgent and routine care; (2) specialist care; (3) specialized services; and (4) prescription medicines.

Urgent and Routine Care

Survey responses indicated that urgent and routine care are important in the lives of STAR members. Nearly a third of respondents said they had an illness, injury, or condition for which they needed urgent medical care in the past six months (31 percent). In addition, three out of five respondents said they made appointments for their health care at a doctor's office or clinic in the past six months (59 percent), indicating a need for routine care.

Getting Care Quickly is an average of two CAHPS® survey questions that assess how often members are able to get routine and urgent care. Overall, 70 percent of members "usually" or "always" had positive experiences with *Getting Care Quickly*. This is below the 80 percent reported for this composite measure in Medicaid plans nationally.

Getting Care Quickly was also calculated on a 3-point scale following NCQA specifications. The mean score for this CAHPS® composite was 2.16 out of 3.00. Differences between MCO groups on this composite were not statistically or meaningfully significant (**Table B2** in Appendix B).

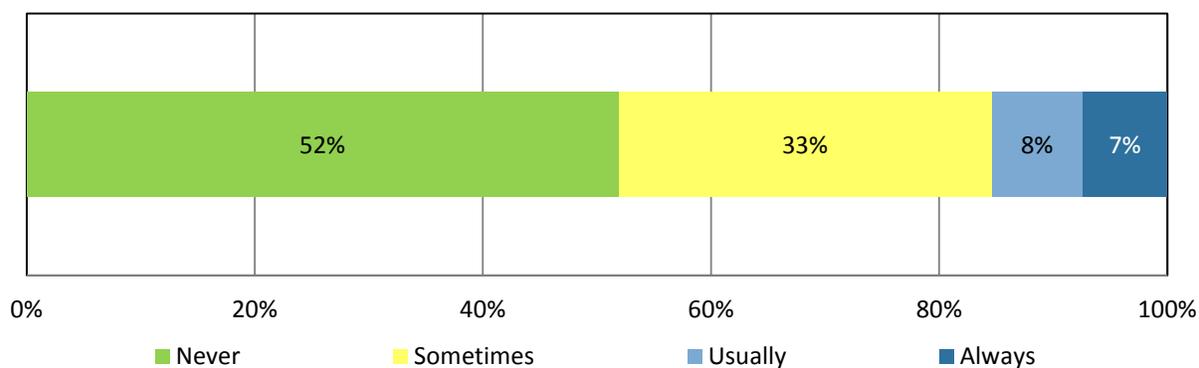
The two survey items that make up the *Getting Care Quickly* composite are also HHSC Performance Dashboard Indicators (**Table B3** in Appendix B):

- *Good Access to Urgent Care*. Seventy-four percent of members who needed care right away for an illness, injury, or condition reported they usually or always received care as soon as needed. This percentage is below the HHSC Dashboard standard of 81 percent. Two of the 14 MCOs performed at or above the Dashboard standard for good access to urgent care.
- *Good Access to Routine Care*. Sixty-seven percent of members reported that they usually or always were able to make a routine appointment as soon as they thought they needed. This percentage is lower than the HHSC Dashboard standard of 80 percent. None of the 14 MCOs met the Dashboard standard for good access to routine care.

An additional item assessed how many days members usually had to wait between making an appointment for routine care and actually seeing a health provider. Nearly two-thirds of members said they were able to get an appointment within three days (63 percent), whereas about one in five members said they had to wait longer than one week (18 percent).

Some members reported that they experienced limited access to care due to provider hours and availability (see **Figure 3**). When asked how often they had to wait for an appointment because their provider worked limited hours or had few appointment slots available, half of all members said they never had to wait for an appointment (52 percent), a third said they sometimes had to wait for an appointment (33 percent), and 15 percent said they usually or always had to wait.

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



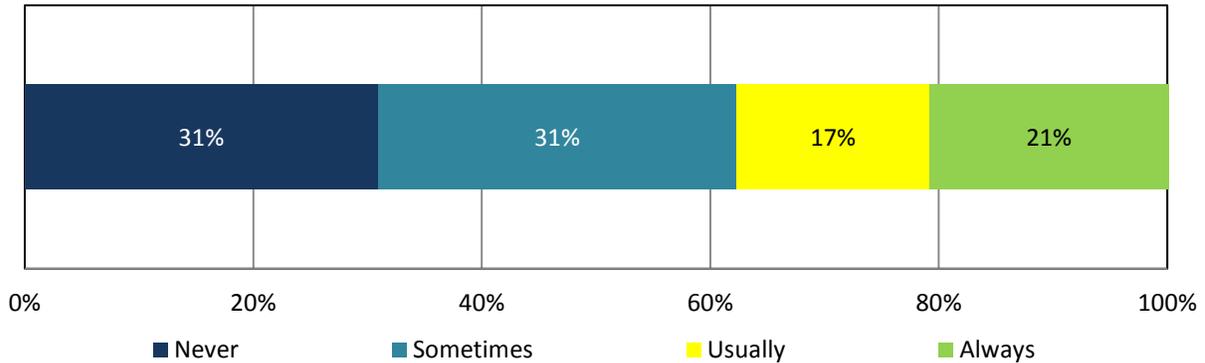
Another item asked members about their experiences seeking after-hours care. About one in ten members said they needed to visit a doctor’s office or clinic for after-hours care (9 percent). Among these members, nearly half said it was usually or always easy to get after-hours care (47 percent), and 53 percent said it was sometimes or never easy to get after-hours care.

Next, members were asked how often they were seen within 15 minutes of their appointment time in the past six months (**Figure 4**). Over a third of members reported that they usually or always were seen within 15 minutes of their appointment time (38 percent), whereas about a third reported that they sometimes were seen within 15 minutes (31 percent) and another third said that they were never seen within 15 minutes of their appointment time (31 percent).

This question is an HHSC Dashboard Indicator for the STAR program (as shown on **Table B3** in **Appendix B**):

- *No Wait to be Taken to the Exam Room Greater than 15 Minutes.* Overall, 21 percent of members reported having no wait greater than 15 minutes before being taken to the exam room, which is considerably lower than the HHSC Dashboard standard of 42 percent. None of the MCO groups met the HHSC Dashboard standard for this measure.

Figure 4. How Often Members Were Taken to the Exam Room Within 15 Minutes



Finally, regarding urgent care that involved the emergency room:

- A third of members contacted their personal doctor before going to the emergency room (30 percent).
- A third of members went to the emergency room for care because they could not get an appointment at their doctor's office or clinic (32 percent). This finding may be related to difficulties reaching personal doctors' offices after hours, as discussed in the "Having a Personal Doctor" section below.
- When asked to rate their emergency room care in the past six months on a scale of 0 to 10, 41 percent of members gave a rating of 9 or 10. An additional third of members gave their emergency room care a rating of 7 or 8 (33 percent).

Specialist Care

One out of four members reported that they tried to make an appointment to see a specialist in the last six months (24 percent). Among these members, two-thirds indicated that it was usually or always easy to get a specialist appointment (66 percent).

Having good access to specialist referrals is also an HHSC Performance Dashboard Indicator:

- *Good Access to Specialist Referrals.* Two out of three members reported it was usually or always easy to get a referral to a specialist they needed to see (64 percent). This percentage is lower than the HHSC Dashboard standard for this indicator (73 percent). Two of the 14 MCO groups met the Dashboard standard for this survey item.

Members were also asked to rate their specialist on a scale of 0 to 10. Sixty-four percent of members gave a rating of 9 or 10. This is comparable to the 62 percent of the national Medicaid population who gave their specialist a rating of 9 or 10. The mean specialist rating was 8.5 (SD = 2.2).

Getting Needed Care is an average of two CAHPS® survey items that assess: (1) How often it was easy for members to get appointments with specialists, and (2) How often it was easy for members to get the care, tests and treatment they needed through their health plan. Sixty-six percent of members “usually” or “always” had positive experiences with *Getting Needed Care*, which is lower than the 76 percent in the national Medicaid population.

Getting Needed Care was also calculated on a 3-point scale following NCQA specifications. The mean score for this CAHPS® composite was 2.13 out of 3.00. Differences between MCO groups on this composite were not significant (**Table B2** in Appendix B).

Specialized Services

The STAR survey assessed the need for and access to a number of specialized services, including special medical equipment, special therapies, home health care, and mental health treatment. A majority of members did not need specialized services.

- Approximately one in 10 members needed mental health treatment (11 percent).
- Seven percent of members needed special medical equipment.
- Six percent of members needed special therapies.
- Four percent of members needed home health care or assistance.

These members were asked how often it was easy to get the specialized services they needed (**Figure 5**). The percentage of members who were “usually” or “always” able to have good access to specialized services was highest for special medical equipment (65 percent), followed by special therapies (62 percent). The percentage of members who said it was “never” easy to get specialized services was greatest for those needing home health care (34 percent), although this percentage is based on a relatively small number of cases (n = 107).²⁴

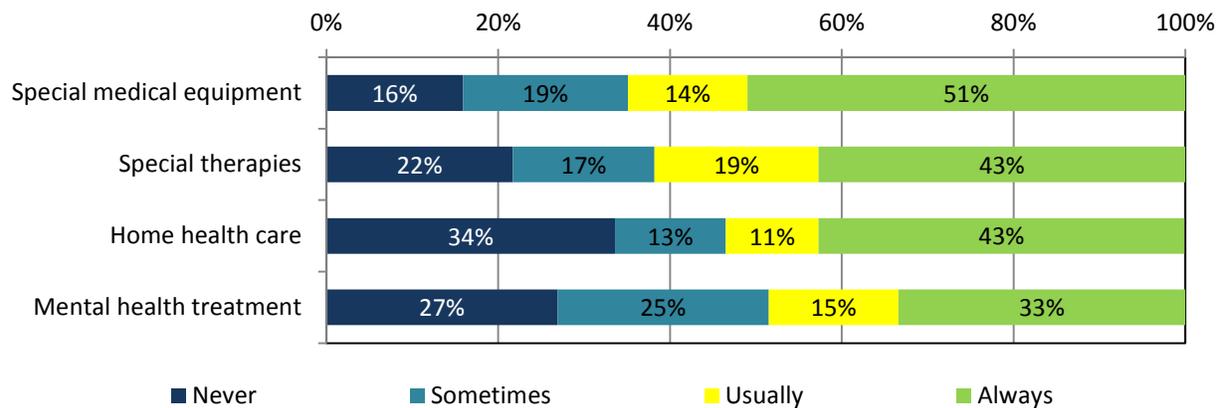
Having good access to behavioral health treatment or counseling is an HHSC Performance Dashboard Indicator for STAR:

- *Good Access to Behavioral Health Treatment or Counseling*. Forty-eight percent of STAR members needing behavioral health treatment or counseling said it was usually or always easy to get this counseling. The percentage is lower than the HHSC Dashboard standard of 54 percent for this indicator. However, only two MCOs had sufficient denominators to report results for this indicator at the MCO level (see **Table B3** in Appendix B).

Having good access to special therapies is an HHSC Performance Dashboard Indicator for STAR:

- *Good Access to Special Therapies*. Sixty-two percent of STAR members needing special therapies said it was usually or always easy to get this therapy. This percentage exceeds the HHSC Dashboard standard of 58 percent for this indicator. However, none of the 14 MCOs had a sufficient denominator to report results for this indicator at the MCO level.

Figure 5. STAR Member Responses for How Easy It Was to Get Specialized Services



Prescription Medicines

Fifty-three percent of STAR members said they got new prescription medicines or refilled a medication during the past six months. Among these members, 81 percent said it was “usually” or “always” easy to get prescription medicine from their health plan.

Members’ Overall Satisfaction with Their Health Care

Members were asked to rate their health care overall in the past six months. On a scale of 0 to 10, 54 percent of members gave a rating of 9 or 10. This is slightly higher than that of the national Medicaid population (50 percent). STAR members gave a mean rating of 8.4 (SD = 1.9) for all of the health care they received.

Patient-Centered Medical Home

This section examines STAR member experiences receiving care from a patient-centered medical home model. In a joint statement released in 2007, the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Physicians, and the American Osteopathic Association identified seven principles of the medical home model.²⁵

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

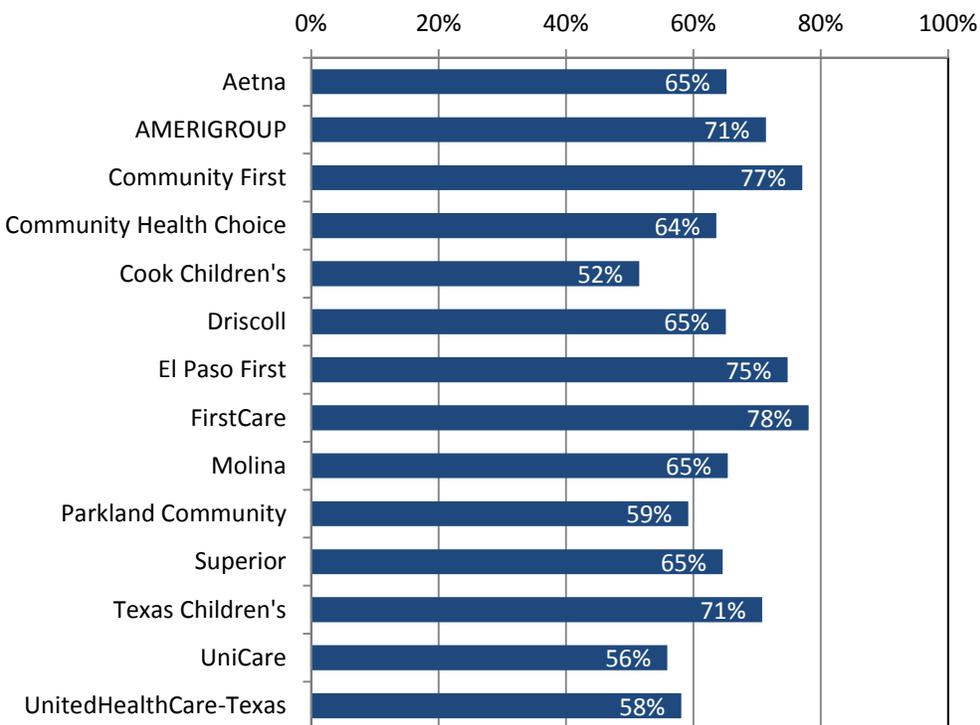
This survey addressed several components of the medical home model, including personal physician, whole person orientation, coordinated care, and enhanced access. Specifically, members reported on whether they had a personal doctor, had access to advice and care during and after regular business hours, and received high-quality, patient-centered, and compassionate care from their personal doctor and office staff.

Having a Personal Doctor

Overall, two-thirds of STAR members reported having a personal doctor (68 percent), of which a large majority specified a general—rather than specialist—personal doctor (87 percent). **Figure 6** presents the percentage of STAR members who had a personal doctor in each MCO group.²⁶ Differences among the MCO groups were statistically significant, with the percentage of members with a personal doctor ranging from 52 percent in Cook Children’s to 78 percent in FirstCare.²⁷

Regarding continuity of care, about half of members who had a personal doctor had been going to their personal doctor for two or more years (51 percent), suggesting that some members experience a continuous, long-term relationship with a usual source of care.

Figure 6. The Percentage of STAR Members with a Personal Doctor by MCO



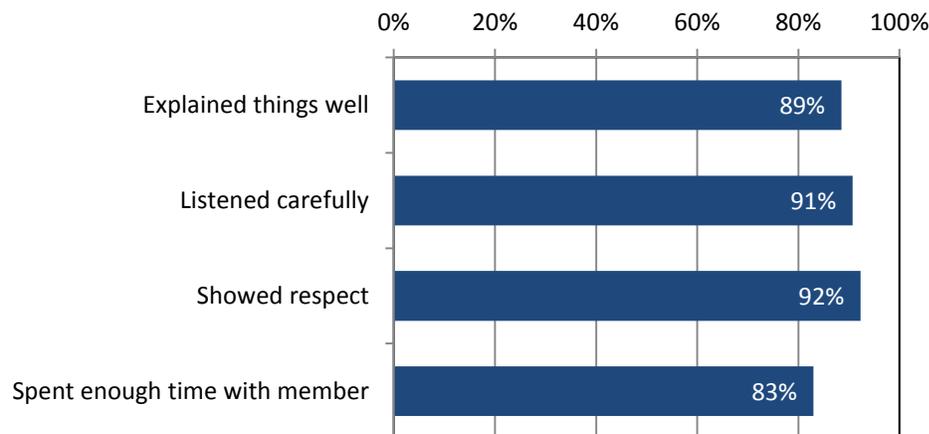
STAR members who reported having a personal doctor reported their solicitation of help by phone both during and after hours, and whether or not they received the help they needed:

- During regular office hours: Half of members said they phoned their personal doctor's office to get help or advice (49 percent). Most of these members said they usually or always got the help or advice they needed (80 percent).
- After regular office hours: Nearly one in five said they phoned their personal doctor's office to get help or advice (19 percent) after regular office hours. Two-thirds of these members said they usually or always got the help or advice they needed (66 percent).

Satisfaction with Doctors' Communication

How Well Doctors Communicate is an average of four CAHPS® survey questions that assess how often a member's personal doctor explains things well, listens carefully, shows respect, and spends enough time with the member. **Figure 7** presents the percentage of members who reported they usually or always had positive communication experiences with their personal doctor for each of the survey questions comprising the *How Well Doctors Communicate* composite.

Figure 7. How Well Doctors Communicate – The Percentage of Members Who Reported Their Personal Doctor Usually or Always...



The majority of members were highly satisfied with the quality of communication they had with their personal doctor. Combining responses to all four questions in the *How Well Doctors Communicate* composite, 89 percent of STAR members usually or always had positive experiences with their doctor's communication. This percentage is similar to the 88 percent reported for Medicaid members nationally.

How Well Doctors Communicate was also calculated on a 3-point scale following NCQA specifications. The mean score for this CAHPS® composite was 2.68 out of 3.00. Differences among the MCO groups on this composite were not statistically significant (**Table B2** in **Appendix B**).

Preventive Care and Health Promotion

STAR members were asked several questions that assessed preventive care and health promotion. Research suggests that routine checkups are an important component of preventive care²⁸. When asked how long it had been since they last visited a doctor for a routine checkup, the majority of members reported having had a routine checkup within the past year (71 percent). Four percent of members said their last routine checkup was five or more years ago, and five percent reported never having had a routine checkup.

Regarding health promotion, one way that doctors can promote health is by advising smokers to quit. One-fifth of the survey sample said they smoked cigarettes or used tobacco (20 percent), with a significant difference observed by race/ethnicity. Specifically, 38 percent of White, non-Hispanic members, 21 percent of Black, non-Hispanic members, and 14 percent of Hispanic members said that they smoked cigarettes or used tobacco.²⁹

The percentage of members who were advised to quit smoking by a doctor or other health provider at least once during the past six months is an HHSC Performance Dashboard Indicator for STAR.

- *Advising Smokers to Quit.* Just over half of STAR members who smoked reported they had been advised to quit smoking by a doctor or other health provider at least once during the past six months (51 percent). This percentage is lower than the HHSC Dashboard standard of 70 percent for this indicator. None of the 14 MCO groups met the Dashboard standard for this survey item. There was a significant difference observed by race/ethnicity for advising smokers to quit.³⁰ Specifically, 60 percent of White, non-Hispanic members, 49 percent of Black, non-Hispanic members, and 44 percent of Hispanic members were advised to quit smoking. Female members were more likely than male members to have been advised to quit smoking (54 percent vs. 40 percent).³¹

In addition, smokers in the STAR survey sample were asked on how many visits their doctor recommended specific strategies to quit smoking. Twenty-four percent of these members said their doctor recommended or discussed medication to assist them in quitting on at least one visit, whereas nearly a third of members said their doctor recommended or discussed methods and strategies other than medication to assist them in quitting on at least one visit (29 percent).

Shared Decision-Making

An important aspect of patient-centered care is shared decision-making, especially as this practice becomes normative.³² About a third of STAR members said that decisions were made about their health care in the last six months (36 percent). Among these members, 79 percent said they usually or always were involved as much as they wanted in decisions about their health care, and 79 percent said it usually or always was easy to get their doctors to agree with them on the best way to manage their health problems. These numbers suggest high patient involvement in health decision-making.

In addition, 39 percent of STAR members said they received care from a doctor or other health provider besides their personal doctor. Among these members, 61 percent said their personal doctor usually or always seemed informed and up-to-date about the care they received from these other providers.

Members' Satisfaction with Their Personal Doctor

Members were also asked to rate their personal doctor on a scale of 0 to 10. Nearly two-thirds of members gave a rating of 9 or 10 (63 percent). This is comparable to the 62 percent of the national Medicaid population who gave their personal doctor a rating of 9 or 10. The mean personal doctor rating in STAR was high at 8.58 (SD = 1.95).

Care Coordination

Survey respondents were also asked a series of questions regarding any help they received to coordinate their health care. Sixty-one percent of members reported that someone assisted them with coordinating services in the last six months.

Among members who reported having such care coordination, over half said that someone from their doctor's office or clinic coordinated their care (56 percent), and 93 percent of members said they were satisfied or very satisfied with the help they received.

Health Plan

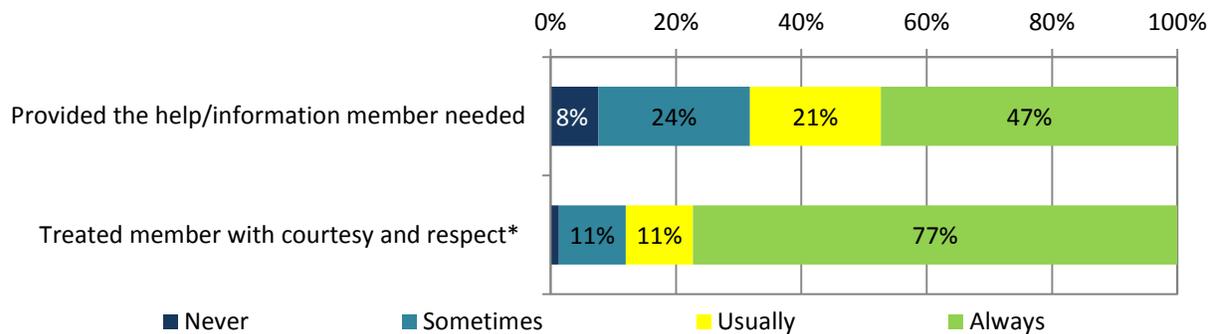
The survey also assessed members' experiences and satisfaction with other aspects of their health plan, including health plan information and customer service; approval for care, tests, or treatment; and transportation services.

Health Plan Information and Customer Service

Regarding attaining information about their health plan, approximately one in five members said they looked for information about how their health plan works in written materials or on the Internet (21 percent). Among these members, 65 percent said they usually or always got the information they needed.

Another question revealed that one in four members tried to get help or information from their health plan's customer service in the past six months (26 percent). **Figure 8** shows member satisfaction with two aspects of STAR health plan customer service: (1) how often customer service gave members the help or information they needed; and (2) how often customer service treated members with courtesy and respect. Sixty-eight percent of members said they always got the help or information they needed from customer service. Members were highly satisfied with their customer service experience—88 percent reported that customer service “usually” or “always” treated them with courtesy and respect.

Figure 8. Percentage of STAR Members Who Said Their Health Plan’s Customer Service...



*Note: For this item, “Never” is 1%.

These two customer service items comprise the CAHPS® composite *Health Plan Information and Customer Service*. Seventy-eight percent of STAR members “usually” or “always” had positive experiences with *Health Plan Information and Customer Service*, which is just below the 80 percent reported for Medicaid plans nationally.

Health Plan Information and Customer Service was also calculated on a 3-point scale following NCQA specifications. The mean score for this CAHPS® composite was 2.40 out of 3.00. Differences among the MCO groups on this composite were not significant (**Table B2 in Appendix B**).

Last, more than one third of STAR members reported that their health plan gave them forms to fill out (36 percent). Seventy-six percent of members said that the forms from their health plan were “usually” or “always” easy to fill out.

Health Plan Approval

Approximately one third of survey respondents said they tried to get care, tests, or treatment through their STAR health plan in the past six months (30 percent). Two-thirds of these members said it was usually or always easy to get the care, tests, or treatment they needed (68 percent).

The percentage of members who had no delays for health plan approval is an HHSC Performance Dashboard Indicator for STAR:

- *No Delays for an Approval*: Half of STAR members reported having no delays in their health care while waiting for approval from their health plan (50 percent). This percentage does not meet the HHSC Dashboard standard of 57 percent for this indicator. Five of the 14 MCO groups met the Dashboard standard for this survey item.

Transportation

Eleven percent of members reported phoning their STAR health plan for assistance with transportation. Two-thirds of this minority said they usually or always received the transportation services they needed from their health plan (65 percent). Seventy-nine percent of this minority indicated that their needs were usually or always met by the health plan.

Members' Satisfaction with Their STAR Health Plan

Members were also asked to rate their health plan on a scale of 0 to 10; 60 percent of members gave a rating of 9 or 10. This percentage exceeds the 56 percent of the national Medicaid population who gave their health plan a rating of 9 or 10. The mean health plan rating in STAR was 8.6 (SD = 1.9).

Prior-year Comparisons

Table 1 shows the percentage of members who reported that they have a personal doctor in fiscal year 2009 and 2012. Since 2009, a significantly greater percentage of members report having a personal doctor.

Table 1. Having a Personal Doctor in 2009 and 2012

2009	2012	Chi-square	p-value
63.5%	66.2%	5.408	0.020

Table 2 shows scaled results for the four CAHPS® Composite measures for STAR in fiscal year 2009 and 2012, using modified NCQA specifications.³³ Since 2009, performance improved significantly for *How Well Doctors Communicate* and declined significantly for *Getting Needed Care*.

Table 2. CAHPS® Composite Measures in 2009 and 2012

	2009 mean	2012 mean	t-test	p-value
Getting Needed Care	2.227	2.134	2.92	0.004
Getting Care Quickly	2.193	2.166	1.06	0.290
How Well Doctors Communicate	2.652	2.687	1.95	0.052
Customer Service	2.388	2.427	1.25	0.213

Table 3 shows results for six HHSC Performance Dashboard Indicators for STAR in fiscal year 2009 and fiscal year 2012. The HHSC Performance Indicator *No Delays for an Approval* was not included in this comparison, as the fiscal year 2009 survey utilized a different indicator than that

of the fiscal year 2012 survey. The HHSC Performance Indicator *Good Access to Behavioral Health Treatment or Counseling* was added to the HHSC Performance Dashboard in fiscal year 2012, and results for this indicator are therefore not available for fiscal year 2009. As a result, no direct comparisons can be made between the two years for either of these Dashboard indicators. The only significant difference between the survey years for the Dashboard Indicators was for *Good Access to Urgent Care*. Since 2009, members were significantly less likely to report that they usually or always had good access to urgent care.

It is important to note that results for HHSC Performance Dashboard Indicators presented here were calculated using unweighted data in order to permit statistical comparisons. The results shown in Table 3 for 2012 are therefore slightly different than those presented in the body of this report (which were calculated using weighted data).

Table 3. HHSC Performance Dashboard Indicators in 2009 and 2012

	2009	2012	Chi-square	p-value
Good access to urgent care	78.2%	73.9%	5.211	0.022
Good access to specialist referral	64.2%	64.7%	0.031	0.859
Good access to routine care	68.1%	68.3%	0.017	0.898
No wait to be taken to the exam room > 15 minutes	19.6%	21.0%	1.326	0.249
Good access to special therapies	58.6%	60.7%	0.180	0.671
Advising smokers to quit	47.5%	50.6%	1.304	0.253

Summary Points and Recommendations

This report provides results from the fiscal year 2012 STAR Adult Member Survey regarding: (1) demographic characteristics of STAR members, including race/ethnicity, educational background, and relationship status of members; (2) the health status of STAR members, including overall and mental health, body mass index, and activities of daily living; (3) member experiences and satisfaction with the access and timeliness of their routine, urgent, and specialized care; and member need for and access to specialized services and prescription medicines; (4) elements of and experiences with the patient-centered medical home, including presence of a personal doctor, satisfaction with doctor’s communication, providers’ engagement in preventive care, shared decision-making; and access to care coordination; and (5) member experiences and satisfaction with their health plan, including health plan information, customer service, and transportation.

Demographic characteristics

- **Member demographics.** The mean age of respondents was 27 years old, and the majority of respondents were female (79 percent). Hispanics represented the largest racial/ethnic

group (57 percent). A vast majority of respondents spoke English (96 percent); however, one-third of respondents reported that they spoke mostly Spanish at home (28 percent). Regarding educational status, approximately three-quarters of members had at least a high school diploma or equivalent (71 percent).

- **Relationship and household status.** A majority of members reported their relationship status as “single” (64 percent) and greater than half of respondents lived in a single-parent household (54 percent).

Health Status

- **Overall health and mental health.** Greater than half of the respondents reported their overall health as “excellent” or “very good” (51 percent). Nearly two-thirds of respondents classified their mental health as “excellent” or “very good” (60 percent).
- **Body Mass Index.** Nearly two-thirds of respondents were classified as overweight (25 percent) or obese (36 percent). The prevalence of obesity in the STAR program is equal to the national obesity rate of 36 percent; however, the obesity rate among eight health plans was above the national (adult) average. Women and Hispanics had a significantly higher rate of obesity compared to their counterparts (40 percent and 39 percent, respectively). In addition, members aged 21 to 64 years old had a significantly higher rate of obesity (48 percent) than members aged 18 to 20 years old (22 percent).
- **Activities of Daily Living.** Fewer than one in five respondents reported having a physical or mental condition that seriously interfered with their independence, participation in the community, or quality of life (14 percent).

Access to and Timeliness of Care

- **Getting Care Quickly.** Seventy percent of members “usually” or “always” had positive experiences with *Getting Care Quickly*, which is considerably lower than the national Medicaid rate for this measure (80 percent).
- **Good Access to Urgent Care.** Nearly three quarters of members reported that they usually or always received care as soon as they needed (74 percent). This percentage is lower than the HHSC Dashboard standard of 81 percent.
- **Good Access to Routine Care.** Sixty-seven percent of members were usually or always able to make a routine appointment as soon as they thought they needed, which is lower than the HHSC Dashboard standard of 80 percent.
- **Appointment availability and provider hours.** Approximately two-thirds of respondents were able to get an appointment within three days (63 percent), and nearly one-fifth of respondents said that they had to wait longer than three days to make an appointment (18 percent). Half of respondents said that they never had to wait for an appointment due to limited provider hours (52 percent), and one in six respondents said that they usually or always had to wait (15 percent).

- **Office wait.** Nearly one in five members reported having no wait greater than 15 minutes before being taken to the exam room (21 percent), which is much lower than the HHSC Dashboard standard of 42 percent.
- **Access to specialist care.** Nearly one quarter of members reported that they tried to make an appointment to see a specialist in the last six months (24 percent). Of those who reported that they tried to make an appointment, two-thirds reported that it was usually or always easy to get a specialist appointment (66 percent).
- **Good access to specialist referral.** Two out of three members reported that it was usually or always easy to get a referral to a specialist (64 percent), which is lower than the Dashboard standard of 73 percent.
- **Getting needed care.** Sixty-six percent of members usually or always had positive experiences with *Getting Needed Care*, which is lower than the rate for the national Medicaid population (76 percent).
- **Access to specialized services.** Nearly one in ten members needed access to mental health treatment (11 percent), while a smaller percentage of members needed access to special medical equipment (7 percent), special therapies (6 percent), and home health care or assistance (4 percent).
- **Good access to special therapies.** Approximately two-thirds of members who needed special therapies said that it was usually or always easy to get the therapy (62 percent). This is greater than the HHSC Dashboard standard of 58 percent for this indicator.
- **Access to prescription medicines.** Greater than half of respondents said that they got new prescription medicines or refilled a medication during the past six months (53 percent). Among these respondents, 84 percent said that it was usually or always easy to get the prescription medicine from their health plan.
- **Members' overall satisfaction with their health care.** When asked to give a rating of their health plan on a scale from 0-10, more than half of respondents gave a rating of 9 or 10 (54 percent), which is higher than the percentage for the national Medicaid population, which is 50 percent. Respondents rated their health plan with a mean score of 8.4.

Patient-centered medical home

- **Having a personal doctor.** Sixty-eight percent of members reported having a personal doctor. Approximately half of members who had a personal doctor reported that they had been seeing their doctor for two or more years (51 percent), indicating the presence of continuity of care.
- **Seeking help and advice.** Nearly half of members reported that they phoned their doctor's office for help or advice (49 percent). Among these members, 80 percent reported that they usually or always got the help or advice they needed. Nearly one in five members reported that they phoned their doctor's office after regular office hours for help or advice (19

percent). Among these members, sixty-six percent reported that they usually or always got the help or advice they needed.

- **Satisfaction with doctors' communication.** Eighty-nine percent of members reported that they were usually or always satisfied with *How Well Doctors Communicate*, which is equal to the national Medicaid average of 88 percent.
- **Preventive care and health promotion.** A majority of the participants reported having a routine check-up in the last year (71 percent), with five percent of the members indicating they had not had a routine check-up in over five years. Twenty percent of members reported smoking cigarettes, and 51 percent of these members reported that a doctor advised them to quit within the last six months. This percentage is considerably lower than the HHSC Dashboard standard of 70 percent.
- **Shared decision-making.** Most members said they usually or always were involved as much as they wanted in decisions about their health care (79 percent), and that it was usually or always easy to get their doctors to agree on how to manage their health care problems (79 percent). Of members who said they had received care from a doctor other than their personal doctor, 61 percent said their personal doctor seemed up-to-date on that care.
- **Members' rating of their personal doctor.** Members rated their personal doctor on a scale from 0 to 10, with an average rating of 8.6. Sixty-three percent of the members gave a rating of 9 or 10, which is comparable to national Medicaid average of 62 percent.

Care coordination

- **Care coordination.** Two-thirds of members reported getting assistance with coordinating health care services (61 percent). Among these members, the overwhelming majority reported that they were satisfied or very satisfied with the help they received (93 percent).

Health plan

- **Health plan information and customer service.** Three-quarters of members usually or always had positive experiences on the CAHPS® composite *Health Plan Information and Customer Service* (78 percent), which is below the national average of 80 percent. Members reported generally positive experiences with customer service; 88 percent reported being treated with respect, and two-thirds reported “usually” or “always” getting the information they needed when they called (68 percent).
- **Health plan approval.** Fifty percent of members reported having no delays in health care while waiting for health plan approval, which is below the HHSC Dashboard standard of 57 percent. Five of the MCOs met the Dashboard standard for this indicator. Two-thirds of members reported it was “usually” or “always” easy to get the tests or treatment they needed (68 percent).

- **Transportation.** One in ten members requested transportation assistance (11 percent); of these members, two out of three said they usually or always received the transportation services they needed from their health plan (65 percent).
- **Members' rating of their health plan.** Members rated their STAR health plan on a scale from 0 to 10, with an average rating of 8.6. Sixty percent of the members gave a rating of 9 or 10, which exceeds the national Medicaid average of 56 percent.

Recommendations

The EQRO recommends the following strategies to Texas HHSC and STAR MCOs for improving the delivery and quality of care for members in the STAR program:

Domain	Recommendations	Rationale
Timeliness of care for adults in STAR	<ul style="list-style-type: none"> • STAR MCOs should implement or improve upon strategies to ensure their members receive timely care, as well as reduce wait time to be taken to the exam room. STAR network providers should be encouraged to extend appointment opportunities by staggering physician regular work hours,³⁴ or adopting an 'advanced access' system³⁵. • STAR MCOs should work to reduce delays for health care approval for treatments and testing by: <ul style="list-style-type: none"> ○ conducting a root cause analysis to identify why delays in health plan approval are occurring, and the most appropriate points for intervention; and ○ ensuring that health plan staff in appropriate roles – such as care coordinators or case managers – systematically work with members, their providers, and the health plan to facilitate approval of needed treatment. 	<p>The percentage of members “usually” or “always” <i>Getting Care Quickly</i> was below the national average (70 percent vs. 81 percent). In addition, members who rated their health as “fair” or “poor” were less likely than healthy members to report positive experiences getting timely care.</p> <p>No MCO met the HHSC dashboard standard for time to be taken to the exam room. The average percentage of members having <i>No Delays for an Approval</i> was also lower than the HHSC dashboard standard, with only 5 MCOs meeting the standard.</p> <p>Furthermore, research suggests that timely care can reduce potentially preventable events.^{36,37,38}</p>

<p>Having a usual source of care for adults in STAR</p>	<ul style="list-style-type: none"> STAR MCOs should encourage network providers to adopt standards set by the NCQA for patient-centered medical home (PCMH) recognition.³⁹ An enhanced medical home model links each member to a primary care provider who serves as a medical home for the patient, and incentivizes providers to adopt appropriate PCMH standards through increased reimbursement. Research suggests that programs that link members to primary care providers and utilize the PCMH model can improve the quality of health care and reduce costs.⁴⁰ 	<p>Sixty-eight percent of members in STAR reported that they have a personal doctor. Having a personal doctor is an important component of the patient-centered medical home, which can facilitate partnerships between patients, their physicians, and their families.⁴¹</p>
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The EQRO also recommends that HHSC and STAR MCOs monitor the following areas, based on findings of low member satisfaction in domains that do not directly address the overarching goals. Continued issues with quality of care in these domains may warrant additional studies and their eventual inclusion in MCO performance improvement projects.

- Communication with doctors for members in “fair” or “poor” health.* Members who reported their health as “fair” or “poor” were less likely than were members in “good,” “very good,” or “excellent” health to have positive experiences with *How Well Doctors Communicate* (64 percent vs. 76 percent)⁴². Although having positive experiences with doctors’ communication is important for all members, those who are already in poor health have a particularly high need for quality communication with their doctor.
- Smoking cessation advice.* None of the 14 MCOs met the HHSC dashboard indicator for physicians advising smoking members to quit on at least one visit. On average just over half (51 percent) of smoking members were advised to quit, which is considerably lower than the Dashboard standard of 70 percent. Given the downstream effects of smoking on health care needs,⁴³ smoking cessation advisement is an area worth increasing and monitoring. Furthermore, advisement of smoking cessation was uneven among members: specifically, women were more likely than men to be advised to quit smoking (54 percent vs. 40 percent) even though men were slightly more likely to smoke.

Appendix A. Detailed Methodology

Sample Selection Procedures

Survey participants were selected from a stratified random sample of adults 18 to 64 years old who were enrolled in the same STAR MCO in Texas between July 2011 and December 2011. Following CAHPS[®] specifications, members having no more than one 30-day break in enrollment during this period were included in the sample. These criteria ensured that members would have sufficient experience with the program to respond to the survey questions. Members who had participated in the prior year's survey (fiscal year 2009) were excluded from the sample. The sample was stratified to include representation from the 14 health plans participating in STAR during CY 2011.

The target sample was 3,500 completed telephone interviews, representing 250 respondents per health plan. This sample size was selected to: (1) provide a reasonable confidence interval for the survey responses; and (2) ensure there was a sufficient sample size to allow for comparisons among health plans. **Table A1** presents the stratification strategy by health plan, showing both the number of targeted interviews (N = 3,500) and the number of completed interviews (N = 3,029).

Table A1. STAR Adult Survey Sampling Strategy

Health Plan	Targeted Interviews	Completed Interviews
Aetna	250	248
AMERIGROUP	250	221
Community First	250	221
Community Health Choice (CHC)	250	238
Cook Children's	250	245
Driscoll	250	239
El Paso First	250	250
FirstCare	250	234
Molina	250	108
Parkland Community	250	231
Superior	250	250

Texas Children's	250	234
UniCare	250	138
UnitedHealthcare-Texas	250	172

The final number of completed surveys was less than 250 for all health plans except El Paso First and Superior, which was largely due to small sampling frames. In particular, the numbers of eligible members in Molina (N = 705), UniCare (N = 968), and UnitedHealthcare-Texas (N = 1,242) were not sufficient to achieve the targets within these health plans.

Using a 95 percent confidence interval, the responses provided in the tables and figures are within ± 1.8 percentage points of the "true" responses in the STAR adult member population. At the MCO level, the margin of error ranged from ± 5.9 percentage points in Cook Children's Health Care System to ± 8.7 percentage points in Molina Healthcare. Higher margins of error were observed in MCOs with lower completion rates, which occurred due to small sampling frames for these MCOs, as described above.

Enrollment data were used to identify the members who met the sample selection criteria and to obtain their contact information. Member names, mailing addresses, and telephone contact information for 19,464 eligible STAR members were collected and provided to interviewers. For households with multiple adults enrolled in STAR, one member from the household was randomly chosen to be included in the sample.

Survey instruments

The fiscal year 2012 STAR Adult Survey is comprised of:

- The Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) Health Plan Survey 4.0 (Medicaid module).⁴⁴
- Items from the CAHPS[®] Clinician and Group Surveys.⁴⁵
- Items developed by ICHP pertaining to member demographic and household characteristics.

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

The CAHPS® Health Plan Survey allows for the calculation and reporting of health care composites, which are measures that combine results for closely related survey items. Composites provide a comprehensive yet concise summary of results for multiple survey questions. For adults, CAHPS® composite scores are calculated in the following four domains: (1) *Getting Needed Care*; (2) *Getting Care Quickly*; (3) *How Well Doctors Communicate*; and (4) *Health Plan Information and Customer Service*. Scores for the core composite measures were calculated using both AHRQ and NCQA specifications. Specifications by AHRQ produce scores that represent the percentage of members who had positive experiences in the given domain. These percentage-based scores can be compared with Medicaid national data available through the NCQA Quality Compass database.⁴⁶ Composite scores were calculated following AHRQ specifications for all four domains.

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

In addition, supplemental items from the CAHPS® Clinician and Groups Surveys were included in the STAR Adult Survey. The selected items assess members' experiences with receiving information about care, and appointments and self-management support in the context of the patient-centered medical home. It should be noted that these items were modified to fit the format and six-month time frame of the CAHPS® Health Plan Survey 4.0.

Eight survey questions function as indicators of health plan performance for adult STAR members, as listed on HHSC's Performance Indicator Dashboard for CY 2012.⁴⁷ These include: (1) Good access to urgent care; (2) Good access to specialist referral; (3) Good access to routine care; (4) No delays in health care while waiting for health plan approval; (5) No wait to be taken to the exam room greater than 15 minutes; (6) Good access to special therapies; (7) Good access to behavioral health treatment or counseling; and (8) Advising smokers to quit.

The survey also includes questions regarding the demographic and household characteristics of adult STAR 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.^{48,49,50}

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

Survey data collection

The EQRO sent letters written in English and Spanish to 19,464 sampled STAR adult members, requesting their participation in the survey. Of the advance letters sent, 55 were returned undeliverable.

The Survey Research Center (SRC) at the University of Florida conducted the survey using computer-assisted telephone interviewing (CATI) between February 2012 and August 2012. The SRC telephoned adult STAR members seven days a week between 10 a.m. and 9 p.m. Central Time. The Sawtooth Software System was used to rotate calls in the morning, afternoon, and evening to maximize the likelihood of reaching potential survey respondents. If a respondent was unable to complete the interview in English, SRC rescheduled the interview at a later date and time with a Spanish-speaking interviewer. Of 3,029 completed interviews, 123 (4 percent) were conducted in Spanish. On average 11.4 calls per phone number were made in the STAR Adult survey sample.

Up to 30 attempts were made to reach a member, and if the member was not reached after that time, the software selected the next individual on the list. No financial incentives were offered to participate in the surveys. Thirty-two percent of families could not be located.⁵¹ Among those located, 21 percent indicated that they were not enrolled in STAR and 12 percent refused to participate. The response rate was 43 percent and the cooperation rate was 67 percent.⁵²

To test for participation bias, the distributions of members' age, sex, and race/ethnicity were collected from the enrollment data and compared between members who responded to the survey and members who did not participate. Among members who could be contacted by SRC, the participation rate was higher among Hispanic members (47 percent) than among White, non-Hispanic or Black, non-Hispanic members (37 percent and 39 percent, respectively).⁵³ Results for program-level frequencies and means were weighted to account for participation bias by race/ethnicity, as shown on **Table A2**, below.

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

Data analysis

Descriptive statistics and statistical tests were performed using SPSS 19.0 (Chicago, IL: SPSS, Inc.). Frequency tables showing descriptive results for each survey question are provided in a separate Technical Appendix. The statistics presented in this report exclude "do not know" and "refused" responses. Percentages shown in 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 member population, results were weighted to the full set of eligible beneficiaries in the enrollment dataset. Because sampling for STAR 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 sample (the total number of eligible MCO members in the dataset divided by the number of MCO members with completed surveys). The MCO weighting factor was then multiplied by a second weighting factor to account for differences in participation rates by member race/ethnicity. **Table A2** provides the weights for each of the 14 health plans and four racial/ethnic groups in the survey. Unless otherwise specified, the frequencies and means presented in this report and the technical appendix that accompanies this report incorporate survey weights.

Table A2. Survey Weighting Strategy

Health plan	Eligible members (N)	Completed surveys (n)	Weight
Aetna	4,071	248	16.42
AMERIGROUP	18,433	221	83.41
Community First	4,766	221	21.57
Community Health Choice	6,919	238	29.07
Cook Children's	2,367	245	9.66
Driscoll	2,628	239	11.00
El Paso First	4,560	250	18.24
FirstCare	2,346	234	10.03
Molina	705	108	6.53
Parkland Community	6,134	231	26.55
Superior	18,587	250	74.35
Texas Children's	6,312	234	26.97
UniCare	968	138	7.01
UnitedHealthcare-Texas	1,242	172	7.22
Race/ethnicity	Eligible members (%)	Completed surveys (%)	Weight
White, non-Hispanic	22.3%	20.6%	1.08
Black, non-Hispanic	22.2%	19.9%	1.12
Hispanic	52.1%	56.2%	0.93
Other, non-Hispanic	3.4%	3.3%	1.03

Analysis of differences in frequencies used the Pearson Chi-square test of independence, and analysis of differences in means used t-tests and analysis of variance (ANOVA). To prevent overestimation of statistical significance resulting from sample size inflation, all tests were performed without weighting. These tests allowed comparison of frequencies and means between 2009 and 2012 results, among the 14 MCO groups, and among different demographic sub-groups within the sample. Differences were considered to be statistically significant at $p < 0.05$. When significant omnibus tests revealed between-groups differences by health plan or demographic sub-groups that had more than two groups (e.g. race/ethnicity), post-hoc least significant differences (LSD) pairwise comparisons were conducted to determine which groups differed. For demographic sub-groups that had only two groups (e.g. gender), independent sample t-tests were performed. Cohen's d was then used to assess the effect size (i.e. magnitude) of each observed significant mean difference. Effect sizes larger than 0.30 are discussed in the narrative, and a complete list of significant post-hoc analyses appears in **Table B4**.

Body mass index (BMI) was calculated by dividing the member's weight in kilograms by their height in meters squared. BMI could be calculated for 2,894 members in the sample (96 percent) for whom height and weight data were complete. Height data were missing for 56 members (2 percent), and weight data were missing for 90 members (3 percent). Survey respondents were classified into one of four clinically relevant BMI categories, which are recognized by the Centers for Disease Control and Prevention.⁵⁴

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

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

Lastly, the EQRO conducted a multivariate analysis to examine the relative influence of health plan membership on positive experiences with each of the four CAHPS® composite domains, controlling for member demographics and health status. The detailed methodology and results for this analysis can be found in **Appendix C** of this report.

Appendix B. Supplementary Tables and Figures

Table B1. Obesity Rates by MCO and Service Area

Health Plan/Service Area	Obesity rate (% of members in survey sample) ^a
Aetna-Bexar	49.2%
Aetna-Tarrant	42.3%
Amerigroup-Dallas	29.1%
Amerigroup-Harris	31.4%
Amerigroup-Nueces	LD ^b
Amerigroup-Tarrant	31.9%
Amerigroup-Travis	LD ^b
Community First-Bexar	38.0%
Community Health Choice-Harris	39.0%
Cook Children's-Tarrant	32.2%
Driscoll-Nueces	34.5%
El Paso First-El Paso	36.5%
FirstCare-Lubbock	48.4%
Molina-Harris	45.3%
Parkland Community-Dallas	35.5%
Superior-Bexar	42.6%

Superior-El Paso	34.2%
Superior-Lubbock	LD ^b
Superior-Nueces	LD ^b
Superior-Travis	36.2%
Texas Children's-Harris	27.6%
UniCare-Dallas	33.1%
UnitedHealthcare-Texas-Harris	36.4%
X ² test for significant differences	46.844 (p = 0.002)

^a Obesity is defined as BMI 30 or greater.

^b Rates are not shown for plan codes with fewer than 30 members in the denominator.

Table B2. CAHPS[®] Health Plan Survey Core Composite Scores by STAR MCO

Health Plan	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Aetna	1.95	2.15	2.67	2.31
Amerigroup	2.09	2.07	2.71	2.37
Community First	2.28	2.15	2.72	2.31
Community Health Choice	2.22	2.23	2.68	2.55
Cook Children's	2.14	2.07	2.66	2.41
Driscoll	2.14	2.10	2.75	2.49
El Paso First	2.17	2.18	2.71	2.56
FirstCare	2.28	2.26	2.72	2.31
Molina	1.86	2.16	2.56	2.59
Parkland Community	1.95	2.12	2.68	2.43
Superior	2.15	2.20	2.64	2.35
Texas Children's	2.13	2.18	2.68	2.54

UniCare	2.25	2.18	2.69	2.50
UnitedHealthcare-Texas	2.13	2.27	2.64	2.39
F significance ^b	N.S.	N.S.	N.S.	N.S.

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

^b Analyses performed on unweighted data.

Table B3. HHSC Performance Indicator Results by STAR MCO

MCO	1	2	3	4	5	6	7	8	# ≥ Std.
Aetna	62%	57%	68%	47%	16%	LD	33%	46%	0
Amerigroup	70%	58%	60%	56%	19%	LD	LD	46%	0
Community First	79%	73%	70%	47%	19%	LD	LD	43%	1
Community Health Choice	84%	73%	73%	58%	23%	LD	LD	53%	3
Cook Children's	77%	69%	60%	53%	20%	LD	LD	52%	0
Driscoll	69%	62%	65%	52%	22%	LD	LD	44%	0
El Paso First	75%	72%	69%	58%	21%	LD	LD	53%	1
FirstCare	77%	65%	74%	47%	18%	LD	LD	64%	0
Molina	73%	LD	72%	61%	25%	LD	LD	LD	1
Parkland Community	73%	48%	63%	53%	18%	LD	LD	52%	0
Superior	75%	67%	68%	40%	20%	LD	57%	56%	1
Texas Children's	81%	64%	67%	57%	29%	LD	LD	51%	2

UniCare	65%	LD	73%	72%	26%	LD	LD	LD	1
UnitedHealthcare-Texas	75%	67%	79%	49%	22%	LD	LD	42%	0
HHSC Standard	81%	73%	80%	57%	42%	58%	54%	70%	-
# MCOs \geq Standard	2	2	0	5	0	NA	NA	0	-
X ² significance ^b	N.S.	N.S.	= 0.07	N.S.	N.S.	N.S.	N.S.	N.S.	-

^a Percentage of members who...

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

^b Analyses performed on unweighted data.

Table B4. Post Hoc Analysis Results for CAHPS[®] Health Plan Core Composite Scores by Race/Ethnicity, Education, Member Sex, Age, and Health Status

	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Race/Ethnicity				
Hispanic	2.15	2.11 ^b	2.69 ^{a,b}	2.48
White, NH	2.13	2.25 ^a	2.64 ^a	2.37
Black, NH	2.10	2.28 ^a	2.75 ^b	2.38
F significance *	N.S.	< 0.001**	= 0.036***	N.S.
Education				
Less than high school degree	2.08 ^a	2.08 ^a	2.68	2.46
High school degree or GED	2.10 ^a	2.16 ^a	2.69	2.44

Some college or college degree	2.24 ^b	2.27 ^b	2.70	2.39
F significance *	= 0.026****	= 0.001*****	N.S.	N.S.
Member Sex				
Male	2.14	2.03	2.67	2.34
Female	2.13	2.19	2.69	2.44
T-test significance *	N.S.	= 0.003	N.S.	N.S.
Cohen's d	-	0.18	-	-
Age				
Under age 21	2.13	2.01	2.67	2.45
Age 21 and older	2.14	2.25	2.69	2.42
T-test significance ^a	N.S.	< 0.001	N.S.	N.S.
Cohen's d	-	0.29	-	-
Health Status				
Healthy	2.19	2.16	2.73	2.46
Unhealthy	2.02	2.19	2.58	2.35
T-test significance ^a	= 0.002	N.S.	< 0.001	= 0.05
Cohen's d	0.20	-	0.26	0.15

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

** Hispanic vs. White, $p = 0.004$, $d = 0.17$; Hispanic vs. Black, $p = 0.001$, $d = 0.20$

*** White vs. Black, $p = 0.01$, $d = 0.21$

**** Less than high school degree vs. Some college or college degree, $p = .017$, $d = 0.18$; High school degree or GED vs. Some college or college degree, $p = 0.022$, $d = 0.16$

***** Less than high school degree vs. Some college or college degree, $p < 0.001$, $d = 0.22$; High school degree or GED vs. Some college or college degree, $p = 0.014$, $d = 0.13$

Appendix C. Multivariate Analysis – Influence of Health Plan Membership on Satisfaction with Care

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

The multivariate analysis tested the likelihood that a member would have positive experiences in each of the four CAHPS® composite domains, based on the member's racial/ethnic group, biological sex, age, health status, and health plan membership.

Methodology

The multivariate analysis was conducted using unconditional logistic regression, with the outcomes dichotomized – coded as 1 for members who had positive health care experiences, and 0 for members who did not have positive health care experiences. A separate model was tested for each of the four CAHPS® composite domains: (1) *Getting Needed Care*; (2) *Getting Care Quickly*; (3) *How Well Doctors Communicate*; and (4) *Health Plan Information and Customer Service*. Based on analysis of the quartiles of distribution of scores in these four domains (which range from 1 to 3 following NCQA specifications), a score of 3 was chosen as an appropriate cutoff point for defining “positive” health care experiences.

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

- 1) *Race/ethnicity*. Members were categorized as White, non-Hispanic; Hispanic; or Black, non-Hispanic. The reference group was White, non-Hispanic members. Due to the small number of survey respondents classified as “other” race/ethnicity, these members were excluded from the models.
- 2) *Biological sex*. Members were categorized as male or female, with males as the reference group.
- 3) *Age*. Based on the distribution of age in the survey sample, members were grouped into two age categories – under 21 years old, and 21 years of age or older. Members under 21 years old were the reference group.
- 4) *Health status*. The health status of members was categorized using the CAHPS® item on self-reported physical health status. Members who stated their health was “good”, “very good”, or “excellent” were included in the “healthy” category, and members who stated their health was “fair” or “poor” were included in the “unhealthy” category.

Within each model, the health plan with the highest mean CAHPS[®] score was selected as the reference group against which the other health plans were compared (as shown in **Table B2** in **Appendix B**).

- Community First had the highest mean score for *Getting Needed Care* (mean = 2.28).
- UnitedHealthcare-Texas had the highest mean score for *Getting Care Quickly* (mean = 2.27).
- Driscoll Health Plan had the highest mean score for *How Well Doctors Communicate* (mean = 2.75).
- Molina Healthcare had the highest mean score for *Health Plan Information and Customer Service* (mean = 2.59).

Results

Results of the multivariate analysis are presented in **Tables C1** through **C4** as odds ratios. The odds ratios represent the likelihood of a member having positive experiences in the CAHPS[®] domain, compared to members in the reference group. For any particular test variable or covariate, an odds ratio above 1.0 suggests that members in the specified category were more likely to have had positive experiences than members in the reference group. Conversely, an odds ratio below 1.0 suggests that members in the specified category were less likely to have positive experiences than members in the reference group.

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

In general, few of the factors included in the models significantly predicted the likelihood of a member having positive health care experiences – suggesting that the variability in CAHPS[®] scores is more likely explained by other factors that were not tested. Specific findings for each of the four models are described below:

- *Getting Needed Care*. Biological sex was the only significant factor in the model, with female members being 47 percent more likely than male members to have had positive experiences with getting the care they needed.
- *Getting Care Quickly*. Compared to members under 21 years old, members 21 years of age or older were 63 percent more likely to have had positive experiences with timeliness of care. Compared to healthy members, members who rated their health status as “fair” or “poor” were 22 percent less likely to have had positive experiences with timeliness of care.
- *How Well Doctors Communicate*. Compared to members under 21 years old, members 21 years of age or older were 78 percent more likely to have had positive experiences communicating with their doctors. Compared to healthy members, members who rated their

health status as “fair” or “poor” were 51 percent less likely to have had positive experiences communicating with their doctors.

- *Health Plan Information and Customer Service.* None of the factors in the model predicted the likelihood of having positive experiences with getting information or customer service from the health plan.

Although there was variation in the percentage of members who had positive health care experiences by health plan, after controlling for demographic and health status factors, health plan membership did not significantly predict positive health care experiences for any of the four CAHPS® domains.

The findings of this analysis suggest that: (1) female members are more likely than male members to report getting the care they need; (2) older members are more likely than younger members to report getting timely care and having positive experiences communicating with their doctors; and (3) members with low self-reported health status are less likely than healthier members to report getting timely care and having positive doctors’ communication. The associations between health status and the *Getting Care Quickly* and *How Well Doctors Communicate* domains are of particular relevance to quality improvement in the STAR program, and suggest the need for additional studies to replicate these findings and determine their root causes.

Table C1. Getting Needed Care – Multivariate Analysis

Factor	% With Positive Experiences	Odds Ratio	95% CI
Race/Ethnicity			
White, non-Hispanic	39%	REF	-
Hispanic	43%	1.14	(0.82 – 1.57)
Black, non-Hispanic	43%	1.19	(0.81 - 1.75)
Member Sex			
Male	43%	REF	-
Female	42%	1.01	(0.71 - 1.44)
Member Age			
Under 21 years old	42%	REF	-
21 years old and over	42%	1.16	(0.85 - 1.59)
Health Status			
Healthy	45%	REF	-
Unhealthy	35%	0.62	(0.47 – 0.82)
MCO			
Aetna	35%	0.76	(0.41 – 1.39)
Amerigroup	40%	0.90	(0.47 – 1.73)
Community First	46%	REF	-
Community Health Choice	45%	0.95	(0.51 – 1.77)
Cook Children's	38%	0.69	(0.36 – 1.32)
Driscoll	44%	1.05	(0.56 – 1.95)
El Paso First	44%	0.98	(0.55 – 1.75)
FirstCare	53%	1.55	(0.86 – 2.79)
Molina	30%	0.48	(0.21 – 1.08)
Parkland Community	32%	0.56	(0.29 – 1.10)
Superior	43%	0.97	(0.54 – 1.74)
Texas Children's	42%	0.95	(0.50 – 1.79)

UniCare	50%	1.11	(0.54 – 2.29)
UnitedHealthcare-Texas	41%	0.78	(0.40 – 1.52)

Table C2. Getting Care Quickly – Multivariate Analysis

Factor	% With Positive Experiences	Odds Ratio	95% CI
Race/Ethnicity			
White, non-Hispanic	47%	REF	-
Hispanic	40%	0.81	(0.63 - 1.03)
Black, non-Hispanic	50%	1.14	(0.85 - 1.53)
Member Sex			
Male	37%	REF	-
Female	44%	1.05	(0.79 - 1.40)
Member Age			
Under 21 years old	35%	REF	-
21 years old and over	46%	1.63	(1.30 – 2.05)
Health Status			
Healthy	43%	REF	-
Unhealthy	41%	0.78	(0.63 – 0.98)
MCO			
Aetna	43%	0.84	(0.50 – 1.41)
Amerigroup	41%	0.93	(0.54 – 1.60)
Community First	39%	0.83	(0.49 – 1.43)
Community Health Choice	42%	0.78	(0.46 – 1.34)
Cook Children's	40%	0.87	(0.50 – 1.49)
Driscoll	40%	0.84	(0.50 – 1.44)
El Paso First	42%	0.93	(0.54 – 1.59)
FirstCare	46%	0.95	(0.57 – 1.59)
Molina	43%	0.78	(0.41 – 1.48)
Parkland Community	44%	0.99	(0.57 – 1.72)
Superior	46%	1.01	(0.60 – 1.70)
Texas Children's	43%	0.95	(0.55 – 1.63)
UniCare	41%	0.72	(0.39 – 1.32)
UnitedHealthcare-Texas	48%	REF	-

Table C3. How Well Doctors Communicate – Multivariate Analysis

Factor	% With Positive Experiences	Odds Ratio	95% CI
Race/Ethnicity			
White, non-Hispanic	73%	REF	-
Hispanic	71%	0.93	(0.66 – 1.31)
Black, non-Hispanic	78%	1.27	(0.82 – 1.96)
Member Sex			
Male	70%	REF	-
Female	73%	1.04	(0.72 - 1.48)
Member Age			
Under 21 years old	69%	REF	-
21 years old and over	74%	1.78	(1.30 – 2.45)
Health Status			
Healthy	76%	REF	-
Unhealthy	64%	0.49	(0.36 – 0.66)
MCO			
Aetna	69%	0.65	(0.34 – 1.23)
Amerigroup	74%	1.04	(0.52 - 2.08)
Community First	74%	0.99	(0.52 – 1.89)
Community Health Choice	78%	1.03	(0.52 – 2.07)
Cook Children's	74%	0.99	(0.47 – 2.07)
Driscoll	74%	REF	-
El Paso First	75%	1.09	(0.59 – 2.02)
FirstCare	76%	1.10	(0.59 - 2.05)
Molina	65%	0.53	(0.24 – 1.18)
Parkland Community	66%	0.75	(0.39 – 1.46)
Superior	65%	0.64	(0.34 – 1.19)
Texas Children's	73%	0.93	(0.49 – 1.77)
UniCare	75%	0.79	(0.35 – 1.79)
UnitedHealthcare-Texas	74%	1.11	(0.49 – 2.49)

Table C4. Health Plan Information and Customer Service – Multivariate Analysis

Factor	% With Positive Experiences	Odds Ratio	95% CI
Race/Ethnicity			
White, non-Hispanic	44%	REF	-
Hispanic	51%	1.31	(0.89 – 1.93)
Black, non-Hispanic	45%	1.00	(0.63 – 1.58)
Member Sex			
Male	41%	REF	-
Female	49%	1.43	(0.88 – 2.32)
Member Age			
Under 21 years old	48%	REF	-
21 years old and over	48%	1.04	(0.73 - 1.49)
Health Status			
Healthy	49%	REF	-
Unhealthy	45%	0.89	(0.64 - 1.23)
MCO			
Aetna	42%	0.53	(0.22 – 1.26)
Amerigroup	38%	0.40	(0.16 – 1.03)
Community First	42%	0.49	(0.19 – 1.25)
Community Health Choice	55%	0.94	(0.37 – 2.35)
Cook Children's	51%	0.73	(0.29 – 1.84)
Driscoll	56%	0.82	(0.33 – 2.02)
El Paso First	56%	0.95	(0.38 – 2.36)
FirstCare	42%	0.48	(0.20 – 1.19)
Molina	58%	REF	-
Parkland Community	47%	0.60	(0.23 – 1.58)
Superior	40%	0.44	(0.18 – 1.09)
Texas Children's	55%	0.73	(0.28 – 1.88)
UniCare	57%	0.88	(0.34 – 2.24)
UnitedHealthcare-Texas	40%	0.49	(0.19 – 1.24)

Appendix D. Open-Ended Analysis: Emergency Department Utilization

Thirty-eight percent of STAR adult members reported they visited the ED to get care for themselves in the past six months. Thirty percent of members who visited the ED reported they contacted their personal doctor before going to the ED. These members were asked “*What did your doctor tell you to do when you contacted him or her?*” **Table D1** provides member responses to this question grouped into nine categories. The frequencies in Table D1 show the distribution of open-ended responses among members who tried to contact their personal doctor before going to the ED.

Sixty-six percent of members reported when they phoned their doctor they were told to go to the ER. Most of these members did not provide further explanation as to why their doctor had advised them to go to the ER. When members provided a rationale for their doctor’s advice, the most common reasons were to go to the ER because:

- The member was having pregnancy complications or was in labor (n = 17);
- It was after hours and the doctor’s office was closed (n = 13); and
- The doctor had no appointments available (n = 7).

These findings suggest that some members may not know whether or when their personal doctors are available after hours, highlighting the relevance of member education and awareness of provider availability for understanding potentially avoidable ED visits. However, it is important to note that the survey did not include questions that directly assess member education about provider availability.

A small percentage of members reported that their doctor advised them go to the ED if they did not feel better in a little while (4 percent) or gave them the option of going to the ED or making an appointment with the doctor (4 percent).

In some cases, members were advised to see a physician or be evaluated in an outpatient setting. Four percent of members said their doctor told them to make an appointment with them, and three percent said their doctor told them to go to a clinic and/or get a check-up. In two percent of cases, members said their doctor recommended treatment for the illness or medical condition such as prescribing a medication or directing the patient in self-care.

For some members, lack of timely access to their doctor resulted in an ED visit. Six percent of members said that when they phoned their personal doctor, they were either unable to speak to their doctor or were unable to make an appointment as soon as they wanted:

“Sometimes this is a problem. You can't get to the doctor, you just get a voice mail that says if this is an emergency dial 911. Sometimes that's a pain in the butt. I'll dial 2 or 3 times a day, the whole day, and then the next morning I'll get up and go to the emergency room...”

Table D1. Members' Reported Communication with Doctor Before Going to the ER

Categories of responses	n	%
Doctor said go to the ED	150	65.8%
Member was unable to reach his/her doctor or make an appointment	13	5.7%
Doctor said go to ED if member was not feeling better in a while	8	3.5%
Doctor said either go to ED or make an appointment to see him or her	8	3.5%
Doctor said make an appointment with him/her	8	3.5%
Doctor said go to a clinic and/or get a check-up	7	3.1%
Doctor recommended treatment (e.g., self-care, medication)	6	2.6%
Don't know	5	2.2%
Miscellaneous	23	10.1%
Total	228	-

Seventy percent of members reported they did not contact their doctor before going to the ED. These members were asked during the survey “*What was the reason you did not contact your personal doctor?*” **Table D2** provides the reasons members gave for not calling their personal doctor before going to the ED.

Table D2. The Reasons Members Gave For Not Contacting Their Personal Doctor Before Going to the ED

Categories of responses	n	%
After hours (e.g., evening or weekend) and the office was closed	150	28.5%
It was an emergency	112	21.3%
Did not have a personal doctor	93	17.7%
Doctor was not available	34	6.5%
Does not know or does not remember	24	4.6%
Did not think about it or think it was necessary or important	32	6.1%
Could not contact doctor	13	2.5%
Did not think they had insurance at the time	7	3.3%
Just went straight to ER	6	1.1%

Convenience (e.g., close to home, quicker)	5	0.9%
Did not like personal doctor	4	0.8%
Miscellaneous	46	8.7%
Total	526	-

The three most common reasons members cited for not calling their personal doctor were:

- It was after hours (29 percent);
- It was an emergency (21 percent); and
- Did not have a personal doctor (18 percent).

Twenty-nine percent of members said they did not call their personal doctor before going to the ER because it was “after hours” late in the evening, on a weekend, or a holiday:

“At the time, they was closed and I just went because it was on a Saturday.”

“There weren’t available after hours, it was late at night and they don’t return the call until the morning or late afternoon.”

Twenty-one percent of members reported not contacting their personal doctor because it was an emergency. Members reported various types of emergencies such as:

- Having pregnancy complications and/or being in labor;
- Having an injury - hurting one’s back or breaking an ankle;
- Being in a car accident;
- Being in pain;
- Having a chronic condition that led to an emergency (i.e., asthma, kidney disease); and
- Having other urgent medical needs.

Eighteen percent of members reported not having a personal doctor to call in an emergency:

“Because I don’t have one, and I need one, I’m looking for one, and every time I call one they tell me they won’t see me. I just want to know why every doctor they give me won’t see me.”

“I hadn’t seen my doctor in ages. He’s just on my card. I didn’t even get to be able to see him. I get to see students.”

“I’m not sure if he’s my doctor anymore. I was on Medicaid and I turned 19, and they were supposed to take me off of it.”

The findings indicate that approximately one in five members does not have a usual source of care, and may have no other choice but to go to the ED when they have an illness or injury.

Endnotes

¹ CAHPS® (Consumer Assessment of Healthcare Providers and Systems). 2011a. "CAHPS Health Plan Survey 4.0, Adult Medicaid Questionnaire."

² CAHPS® 2011b. "CAHPS Clinician and Group Surveys". Available at: https://cahps.ahrq.gov/clinician_group/.

³ Satiani, M.D., D Kiser, T Mason. 2012. "Turnaround time and timeliness of physician interpretation in the vascular laboratory." *Vascular and Endovascular Surgery*, 46, 167-171.

⁴ Murray, M., D.M. Berwick 2003. "Advanced access: Reducing Waiting and Delays in Primary Care." *JAMA*. 289, 1035-1040.

⁵ Institute of Medicine. 2001. *Crossing the Quality Chasm*. National Academy Press, Washington, DC.

⁶ ADA (American Diabetes Association). 2005. "Standards of medical care in diabetes." *Diabetes Care*. 2005;28(1):S4–S36.

⁷ Pizer, S.D., J.C. Prentice. 2011. "What are the consequences of waiting for health care in the veteran population?" *Journal of General Internal Medicine*, 26(Suppl 2), 676–82.

⁸ NCQA (National Committee for Quality Assurance). 2012. "Patient-Centered Medical Home." Available at: <http://www.ncqa.org/tabid/631/default.aspx>.

⁹ The Henry J. Kaiser Family. 2009. *Community Care of North Carolina: Putting Health Reform Ideas into Practice in Medicaid*. Available at: <http://www.kff.org/medicaid/upload/7899.pdf>.

¹⁰ NCQA. 2012.

¹¹ HHSC (Texas Health and Human Services Commission). 2011. *Texas Medicaid in Perspective, Eighth Edition*. "Chapter 6: Medicaid Managed Care." Available at <http://www.hhsc.state.tx.us/Medicaid/reports/PB8/PinkBookTOC.html>.

¹² Wickizer, T.M., G. Franklin, D. Fulton-Kehoe, J.A. Turner, R. Mootz, and T. Smith-Weller. 2004. "Patient Satisfaction, Treatment Experience, and Disability Outcomes in a Population-Based Cohort of Injured Workers in Washington State: Implications for Quality Improvement." *Health Services Research* 40(2): 551-576.

¹³ Pascoe, G.C. 1983. "Patient Satisfaction in Primary Health Care: A Literature Review and Analysis." *Evaluation and Program Planning* 6: 185-210.

¹⁴ CAHPS® 2011a.

¹⁵ CAHPS® 2011b.

¹⁶ NCQA. 2012. *Quality Compass*. Available at: <http://www.ncqa.org/tabid/177/Default.aspx>.

¹⁷ HHSC. 2012. CY 2011 HHSC MCO Quality Performance Indicators. Available at: http://www.hhsc.state.tx.us/medicaid/umcm/Chp10/10_1_7.pdf.

¹⁸ The location rate represents the number of members who were confirmed for the listed phone number divided by all members in the sample.

¹⁹ The response rate represents the number of completed and partial interviews divided by the number of eligible members in the sample (those who were confirmed for the listed phone number and met program eligibility criteria). The cooperation rate represents the number of completed and partial interviews divided by the number of eligible members who were contacted. Source: American Association of Public Opinion Research. *Standard Definitions*. Available at: http://www.aapor.org/Standard_Definitions2.htm.

²⁰ CDC (Centers for Disease Control and Prevention). 2012. Obesity and Overweight for Professionals: Data and Statistics: Adult Obesity. Available at: <http://www.cdc.gov/obesity/data/adult.html>.

²¹ Flegal, K.M., M.D. Carroll, B.K. Kit, C.L. Ogden. 2012. "Prevalence of obesity and trends in the distribution of body mass index among US adults, 1999-2010." *JAMA* 307(5): 491-497.

²² Chi-square = 38.728, $p < 0.001$.

²³ Chi-square = 6.457, $p = 0.04$.

²⁴ It should be noted that the number of members who said they needed home health care was 107. When interpreting results for access to home health care, readers should take into account the relatively low denominator for this measure. However, this denominator meets NCQA criteria for CAHPS[®] measure reporting (minimum of 100 cases).

²⁵ ACP (American College of Physicians). 2007. *Joint Principles of the Patient-Centered Medical Home*. Available at: http://www.acponline.org/running_practice/pcmh/demonstrations/jointprinc_05_17.pdf.

²⁶ To permit statistical comparisons among the MCO groups, percentages in this figure are not weighted.

²⁷ Chi-square = 80.506, $p < 0.001$.

²⁸ Ettner, S.L. 1996. "The timing of preventive services for women and children: The effect of having a usual source of care." *American Journal of Public Health*, 86, 1748-1754.

²⁹ White, non-Hispanic vs. Hispanic: Chi-square = 211.216, $p < 0.001$.

³⁰ Chi-square = 12.118, $p < 0.01$.

³¹ White, non-Hispanic vs. Black, non-Hispanic: Chi-square = 7.372, $p < 0.01$.

³² Godolphin, W. 2009. "Shared decision-making." *Healthcare Quarterly*, 12, 186-190.

³³ The method of calculation follows NCQA specifications, with the exception that a separate score is calculated for each member and then averaged. As a result, individual item responses are weighted according to their frequency. This method of scoring permits statistical comparisons.

³⁴ Satiani, M.D., et al. 2012.

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- ³⁵ Murray, M., D.M. Berwick 2003.
- ³⁶ Institute of Medicine. 2001.
- ³⁷ ADA. 2005.
- ³⁸ Pizer, S.D., J.C. Prentice. 2011.
- ³⁹ NCQA. 2012.
- ⁴⁰ The Henry J. Kaiser Family. 2009.
- ⁴¹ NCQA. 2012.
- ⁴² Chi square = 15.639, $p < .001$.
- ⁴³ Aday, L.A. 2001. *At risk in America: The health and health care needs of vulnerable populations in the United States*. Jossey-Bass, San Francisco.
- ⁴⁴ CAHPS® 2011a.
- ⁴⁵ CAHPS® 2011b.
- ⁴⁶ NCQA. 2012.
- ⁴⁷ HHSC. 2012.
- ⁴⁸ National Center for Health Statistics. 2008. *National Health Interview Survey*. Available at: <http://www.cdc.gov/nchs/nhis.htm>.
- ⁴⁹ U.S. Census Bureau. 2008. *Current Population Survey*. Available at: <http://www.census.gov/cps>.
- ⁵⁰ Urban Institute. 2008. *National Survey of America's Families*. Available at: <http://www.urban.org/center/anf/nsaf.cfm>.
- ⁵¹ The location rate represents the number of members who were confirmed for the listed phone number divided by all members in the sample.
- ⁵² The response rate represents the number of completed and partial interviews divided by the number of eligible members in the sample (those who were confirmed for the listed phone number and met program eligibility criteria). The cooperation rate represents the number of completed and partial interviews divided by the number of eligible members who were contacted. Source: American Association of Public Opinion Research. *Standard Definitions*. Available at: http://www.aapor.org/Standard_Definitions2.htm.
- ⁵³ Chi-square = 65.311, $p < 0.001$.
- ⁵⁴ CDC, 2012.