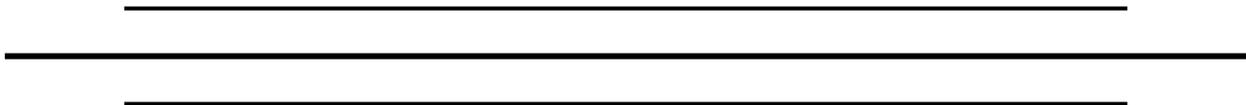




Institute for Child Health Policy at the University of Florida  
Texas External Quality Review Organization

# **Texas STAR+PLUS Established Enrollee Survey Report**

**Fiscal Year 2008**



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

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# Executive Summary

The 2008 Texas STAR+PLUS Established Enrollee Survey Report provides results from the 2008 Texas STAR+PLUS Established Enrollee Survey. The purpose of this survey is to provide a demographic and health profile of STAR+PLUS members, to assess healthy behaviors and health promotion activities, and to assess enrollees' experiences and satisfaction with getting urgent, routine, and specialty care and care coordination services

A random sample of 1,200 STAR+PLUS enrollees in Texas was targeted to participate in this survey. There are four health plans that participate in the STAR+PLUS program in Texas: AMERIGROUP, Evercare, Molina Healthcare, and Superior HealthPlan. A target sample of 300 completed surveys was collected for 3 of the 4 health plans. Due to sample limitations, only 272 surveys were completed for the fourth health plan. The total number of completed surveys for all 4 health plans was 1,172. The surveys were conducted between May and August 2008.

The report includes findings from several different quality "domains," or subject areas. Overall, STAR+PLUS enrollees had a strong satisfaction rate with care coordination and experienced good access to urgent care and routine care. Specifically, the STAR+PLUS program performed better than or comparable to the Texas Health and Human Services Commission (HHSC) Performance Indicator Dashboard standards in the following areas:

- Access to urgent care (73 percent vs. 76 percent).
- Access to specialist referrals (63 percent vs. 62 percent).
- Access to specialized therapies (45 percent vs. 47 percent).
- Smoking cessation advice (63 percent vs. 28 percent).

While comparatively high performance was achieved for many measures, there were several areas where improvement could be made, such as: low health status scores, high overweight and obesity rates, and low satisfaction rates with personal doctors since joining the program. Specifically, reported performance for some measures was less than desired when compared to national benchmarks set by the National Committee for Quality Assurance or the HHSC Performance Indicator Dashboard standards.

## Performance Below National Benchmarks

- Enrollee Satisfaction (CAHPS Composite Scores) for:
  - Getting Needed Care (64.4 vs. 74.2).
  - Getting Care Quickly (72.4 vs. 78.7).
  - Doctor's Communication (84.6 vs. 86.3).

## Performance Below HHSC Performance Indicator Dashboard Standards

- Frequency of delays while waiting for health plan approval (33 percent vs. 57 percent).
- Frequency of entering the exam room within 15 minutes of appointment (27 percent vs. 42 percent).

To address areas needing improvement noted above, HHSC has taken the following actions:

## Internal Improvements

- Initiated a review of HHSC Performance Indicator Dashboard standards for managed care organizations (MCOs) to determine if the standards reflect current national quality assurance guidelines and are appropriate to the population served in STAR+PLUS.
- Established analytical reviews, including trending of performance over time.

- Established a process to share results of analytical reviews with MCOs and document actions taken to improve deficient performance.
- Initiated quarterly performance management meetings between the Institute for Child Health Policy (IHP) (HHSC's external quality review organization [EQRO]) and HHSC staff who oversees MCO contracts, to improve HHSC staff understanding and expertise.

#### External Performance Gap Improvements

HHSC, with IHP's assistance, is implementing a plan to investigate program, MCO, individual beneficiary, and community factors that may be contributing to low performance in the following areas:

- Health status scores.
- High overweight and obesity rates.
- Low satisfaction rates with personal doctors since joining the program..
- Frequency of delays while waiting for health plan approval.
- Frequency of entering the exam room within 15 minutes of appointment.
- Getting needed care.
- Getting care quickly.
- Doctor's communication.

This plan includes:

- A review of continuity of care improvement programs to improve care for disabled and chronically ill patients.
- A review of education and promotion programs to reduce overweight and obesity in an older population with high rates of disability.
- An investigation of ways HHSC can improve the level of resources for assisting new enrollees in finding personal doctors who are appropriate for their health care needs and their cultural or personal needs or concerns.
- An investigation of potential reasons for long waiting periods, including understaffing; large patient load; insufficient space; and poor communication among office staff and between office staff and members.

This plan focuses on the following population groups:

- Enrollees with impairments or chronic health problems.
- Enrollees with high overweight and obesity rates.
- New enrollees without a personal doctor.

In summary, the report highlights many areas of excellent or satisfactory performance. However, it also points to areas where performance needs to improve. For these areas, HHSC is establishing a plan to investigate the reasons for less than satisfactory performance and to work with the MCOs to address those factors that will foster better performance in the future.

# Introduction and Purpose

The University of Florida's Institute for Child Health Policy (ICHP) is the Texas External Quality Review Organization (EQRO) contractor for Medicaid and the Children's Health Insurance Program on behalf of the Texas Health and Human Services Commission (HHSC). As part of its external evaluation activities, ICHP conducts annual telephone surveys with members of the STAR+PLUS Program. This program, funded at federal and state levels, provides healthcare coverage to adults ages 18 and older who meet Medicaid income eligibility requirements and who have chronic and complex conditions requiring comprehensive care, long-term services, and support.<sup>1</sup>

This report presents results from the 2008 STAR+PLUS Enrollee Survey. Specifically, this report provides readers with information regarding:

- the sociodemographic characteristics of enrollees;
- the health status of enrollees;
- the enrollees' experiences with healthy behaviors and health promotion activities;
- documentation of a personal doctor;
- the enrollees' experiences with getting needed and specialist care;
- the enrollees' experiences with getting specialized services;
- the enrollees' experiences with care coordination; and
- the enrollees' satisfaction with their health care.

In 2008 there were four health plans that participated in the STAR+PLUS Program in Texas: AMERIGROUP, Evercare, Superior, and Molina. Results presented in this report are not stratified by health plan. However, the Technical Appendix that accompanies this report provides results for each item in the survey by health plan.<sup>2</sup>

A stratified random sample of adults enrolled in the STAR+PLUS Program in Texas was selected to participate in this survey, using the following criteria:

- 1) the adult must have been enrolled in the STAR+PLUS Program in Texas for at least nine consecutive months;
- 2) the adult must be over the age of 18; and,
- 3) the adult must be eligible for Medicaid, but cannot be eligible for both Medicaid and Medicare.

## Purpose

This report provides results from the 2008 STAR+PLUS Established Enrollee Survey for the State of Texas, prepared by the Institute for Child Health Policy (ICHP) at the University of Florida. The purpose of this survey is to provide a demographic and health profile of STAR+PLUS members, to assess healthy behaviors and health promotion activities, to document enrollees' experiences with getting needed and specialty care, to understand enrollees' experiences with their care coordinators, and to assess enrollees' satisfaction with several components of their healthcare.

## Methods

A random sample of 1,200 STAR+PLUS enrollees in Texas was targeted to participate in this survey. There are four health plans that participate in the STAR+PLUS Program in Texas. A target sample of 300 completed surveys was collected for three of the four health plans. Due to sample limitations, only 272 surveys were completed for the fourth health plan. The total number of completed surveys for all four health plans was 1,172. The surveys were conducted between May and August 2008.

The survey questionnaire was comprised of the following sections:

- 1) the Consumer Assessment Healthcare Providers and Systems (CAHPS<sup>®</sup>) Health Plan Survey 4.0 (Medicaid module);
- 2) the RAND<sup>®</sup> 36-Item Health Survey, version 1.0;
- 3) questions related to care coordination; and,
- 4) sociodemographic and household characteristics.

Data were analyzed using SPSS 15.0 software. Descriptive analyses were conducted on all survey questions. Multivariate analyses were conducted to test the influence of several individual factors on satisfaction.

## Summary of Findings

- Forty-three percent of STAR+PLUS enrollees were Hispanic, 28% Black, non-Hispanic, 23% White, non-Hispanic, and six percent were of other, non-Hispanic ethnicity. Fifty-two percent had less than a high school education, 69 percent were female, and 83 percent primarily spoke English. Although the STAR+PLUS enrollees had lower health status scores than the U.S. general population, 64 percent did not smoke and 39 percent reported engaging in a health promotion activity by getting a flu shot. Rates of overweight and obesity among STAR+PLUS enrollees were high, with 76 percent of respondents either overweight or obese.
- The majority of STAR+PLUS enrollees reported they had a personal doctor (85 percent). Among these enrollees, 60 percent reported that they phoned their personal doctor during office hours for help in the last six months, and 56 percent of those who called always got the help they needed. Twenty-one percent reported that they phoned their personal doctor for help after business hours, and 55 percent of those who called always got the help they needed. Among enrollees who did not have the same personal doctor before they joined the program, 44 percent said it was always easy to find a personal doctor they were happy with.
- About three-quarters (73 percent) of STAR+PLUS enrollees were usually or always able to get urgent care as soon as they needed. Seventy-one percent were usually or always able to get appointments for routine care as soon as they thought they needed. Fifty-four percent of STAR+PLUS enrollees reported that they were able to make an appointment for routine care with their provider in less than 3 days. One-quarter (27 percent) of respondents reported always being taken to the exam room within 15 minutes of their appointment.
- Slightly less than half of the STAR+PLUS enrollees (44 percent) reported needing an appointment with a specialist, and 63 percent of those who needed a specialist care appointment found it was usually or always easy to get a referral.
- About one-quarter of STAR+PLUS enrollees needed specialized services, such as special medical equipment (34 percent), special therapies (22 percent), or home health care (27 percent) within the six months prior to the survey. Almost 80 percent of STAR+PLUS enrollees needed a new prescription or a prescription refill in the six months prior to the survey.
- Twenty-four percent of STAR+PLUS enrollees reported they had a care coordinator, among whom about 88 percent said they were “satisfied” or “very satisfied” with their care coordinator. Overall, member experiences with care coordination were positive, with 53 percent of respondents indicating they always received care coordination as soon as they thought it was needed, 73 percent reporting that their care coordinator always explained things in a way they could understand, and 52 percent stating that their care coordinator always involved them in decision-making. However, one-fifth (19 percent) of enrollees with care coordinators reported never being involved in decision-making.
- Descriptive results of CAHPS composite scores revealed that STAR+PLUS enrollees were most satisfied with their *Doctor's Communication* and least satisfied with *Getting Needed Care*. Results from the multivariate analyses revealed that after controlling for several individual factors, there were no significant differences across health plans regarding *Doctor's Communication*. However, there

were significant differences with two of the health plans related to *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*.

## EQRO Recommendations

Texas HHSC may wish to consider the following strategies when developing future policy regarding STAR+PLUS enrollees:

- Health plans should be encouraged to ensure care coordination programs are meeting the needs of their members.
  - More than three-quarters of STAR+PLUS enrollees are limited in various activities of daily life due to a physical or medical condition, yet only one-quarter reported having a care coordinator. Among respondents who did not have a care coordinator, nearly half indicated wanting someone from their health plan to help arrange services for them.
  - Assessment or monitoring of care coordination programs should address coverage rates among qualified health plan members, the timeliness of care, and standards for inclusion of the member in decision-making.
- The timely and appropriate delivery of specialized services, such as special medical equipment, special therapies, or home health care, should be assessed in future studies.
  - About one-fifth to one-quarter of STAR+PLUS enrollees needing specialized services said that it was not easy to get specialized services through their health plan. Additional research may show the extent to which these problems are related to getting referrals or prescriptions, health plan approval, transportation, and/or cost.
  - Ensuring that care coordination programs are thoroughly connected with providers of medical equipment, special therapies, and home health care may have a positive impact on delivery of specialized services.
- Resources should be developed to help health plan members find a personal doctor who is appropriate, both for their health care needs and their cultural or personal needs and concerns.
  - Nearly one-fifth of respondents said it was not easy to get a personal doctor they were happy with.
- Develop strategies toward reducing the time members wait for health plan approval and to be taken to the exam room.
  - Health plans should assess potential reasons for long waiting periods, including understaffing, large patient load, insufficient space, and poor communication among office staff and between office staff and members.
  - Encourage health plans and providers to reduce appointment scheduling complexity, following steps outlined by the Institute for Healthcare Improvement: <http://www.ihl.org>.
- Develop or improve upon education and promotion programs to reduce overweight and obesity. Obesity programs should be comprehensive and include nutrition education, exercise programs, and weight management strategies. Overweight and obesity among health plan members should also be monitored by primary care providers, possibly as part of a disease management program.
- Discuss findings with the health plans and possible strategies to address areas for improvement, particularly where health plans have CAHPS<sup>®</sup> scores that are significantly lower than anticipated based on the comparison health plan.

# Methodology

## **Sample Selection Procedures**

A target sample of 300 completed telephone surveys for each of the four participating STAR+PLUS health plans in Texas was set, for a total of 1,200 targeted completes. This sample size was selected to provide a reasonable confidence interval for the survey responses, based on selected survey items with uniformly distributed responses. The target number of 300 surveys was met for three of the four health plans. The fourth health plan, Molina, had a smaller number of enrollees who met the sample inclusion criteria. Despite several strategies used to maximize the number of completed surveys for Molina enrollees, such as increasing the number of attempted calls and identifying alternative telephone numbers for those which were no longer in service, the final number of completed enrollee surveys for Molina was 272. Overall, 1,172 surveys were completed.

Stratified sampling weights were developed to account for the probability of inclusion into the survey sample by health plan. For example, 16,449 AMERIGROUP enrollees met the sample inclusion criteria. Of those, 300 randomly selected respondents participated in the survey. Therefore, each response from an AMERIGROUP enrollee was weighted by 54.83 (16,449/300). All results presented in this report and the technical appendix that accompanies this report incorporate survey weights.

Enrollment data were provided to ICHP from a third party administrator for the STAR+PLUS Program in Texas. These data were used to identify the enrollees who met the sample selection criteria and to obtain their contact information. Member names, mailing addresses, and telephone contact information for 8,167 randomly selected, eligible enrollees were collected.

## **Measures**

The STAR+PLUS enrollee survey is comprised of the following sections:

- 1) Consumer Assessment of Healthcare Providers and Systems (CAHPS<sup>®</sup>) Health Plan Survey, version 4.0;<sup>3</sup>
- 2) RAND<sup>®</sup> 36-Item Health Survey, version 1.0;<sup>4</sup>
- 3) questions regarding care coordination services; and,
- 4) sociodemographic characteristics of the respondent.

For all items, respondents were given the option to indicate if they did not know the answer. They also were given the choice to refuse to answer any particular item. The percentage of respondents indicating they did not know an answer or refused to answer was very small for most individual items (four percent or less). If a respondent refused to answer an individual item or items but completed the interview, their responses were used in the analyses. If the respondent broke off an interview before all questions had been asked, his or her responses were not used.

Some survey items had an option for an open-ended response in addition to close-ended choices. If the respondent provided an open-ended response that fit one of the existing categories, the interviewer reminded the respondent of the response categories, and if the respondent agreed with the category, he or she coded the response into a pre-existing category. After all interviews were complete, a researcher reviewed all open-ended responses. If possible, these were re-coded into pre-existing categories, or when there were a sufficient number of consistent responses to do so, new categories were created.

## **Survey Data Collection Techniques**

Advance letters written in both English and Spanish were sent to the STAR+PLUS members sampled, explaining the purpose of the study and requesting their participation. The Bureau of Economic and Business Research (BEBR) at the University of Florida conducted the telephone surveys using computer-assisted telephone interviewing (CATI). Calls were made from 10 A.M. to 9 P.M. Central Time, seven days a week. BEBR utilized the Sawtooth Software System to rotate calls throughout the morning, afternoon, and evening, maximizing the likelihood of reaching the families. If a respondent required that the interview be conducted in

Spanish, arrangements were made for a Spanish-speaking interviewer to call at a later date and time. Four percent of the completed survey interviews were conducted in Spanish.

## ***Data Analysis***

Descriptive statistics and statistical tests used in this report were performed using SPSS 15.0 (Chicago, IL: SPSS, Inc.). Frequency tables showing descriptive results for each survey question are provided in a separate Technical Appendix.<sup>5</sup> The statistics presented in this report exclude “do not know” and “refused” responses.

A more detailed description of the sampling methods, survey instruments, data collection, and data analysis can be found in Appendix A of this report.

Multivariate analyses were performed to determine the effect of several sociodemographic and health characteristics on satisfaction and to compare satisfaction scores across health plans. Details of these analyses are provided in Appendix B.

# SFY 2008 Survey Results

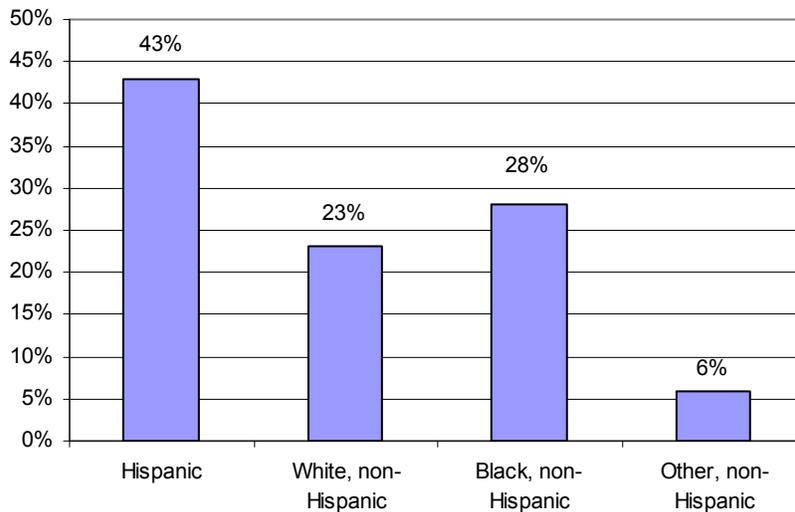
This section details survey findings regarding STAR+PLUS enrollee sociodemographics, health status, healthy behaviors and health promotion activities, presence of a personal doctor, experiences with getting needed and specialty services, experiences with getting specialized services, perception of care coordination services, and enrollees' satisfaction with their health care.

## Demographic Information

Research has shown disparities exist among racial and ethnic groups in regard to health status, health outcomes, and access to health care.<sup>6</sup> Due to the rich diversity evident in the Texas population and the importance of ensuring accessible health care for low-income individuals, assessing demographic characteristics of the enrollees in the STAR+PLUS Program is crucial.

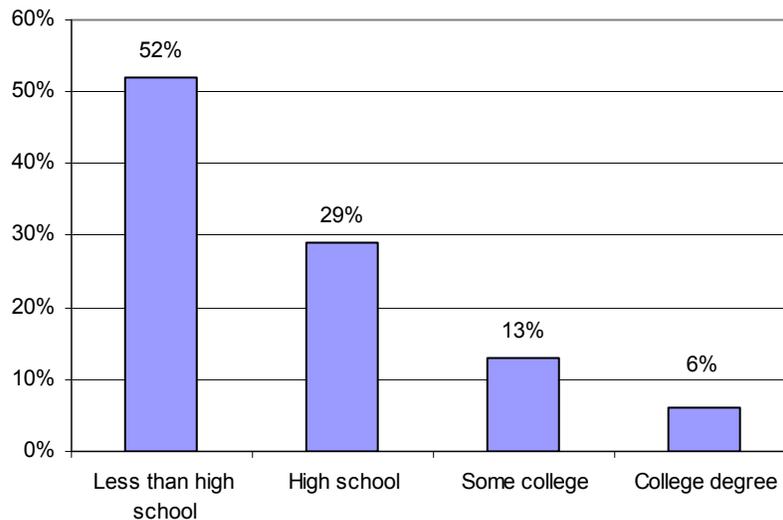
The average age of STAR+PLUS Program enrollees was 49 years, with a range from 18 to 86 years of age. A greater percentage of women (69 percent) than men (31 percent) responded to the survey.

**Figure 1. Respondent race/ethnicity**



**Figure 1** shows the racial/ethnic breakdown of enrollees in the 2008 STAR+PLUS enrollee survey. Hispanic enrollees represented 43 percent of the sample, while 23 percent were White, non-Hispanic, and 28 percent were Black, non-Hispanic.

**Figure 2. Respondent education**



**Figure 2** shows the educational level of the 2008 survey respondents. The majority of respondents (52 percent) reported they had less than a high school education. Twenty-nine percent of respondents reported having a GED or high school diploma, and very few enrollees had any college education.

The primary language spoken by survey respondents was English (83 percent), followed by Spanish (15 percent), and other languages (2 percent).

### ***Enrollees' Health Status***

Survey respondents were asked a series of questions about their health status. Rating health status is important for two major reasons. First, this information forms a baseline from which to track changes in health status over time. Second, such information can assist in program planning and financing. Assessing the percentage of enrollees who are in poor health or who have chronic conditions is important to ensure adequate provider access, appropriate range of services, and financing for health services.

The health status of STAR+PLUS enrollees was assessed using the RAND® 36-Item Health Survey, Version 1.0 (SF-36).<sup>7</sup> Overall, the SF-36 scores for the STAR+PLUS enrollees were lower than national norms for all eight physical and mental health domains (**Table 1**). The smallest difference in scores between STAR+PLUS enrollees and the U.S. population norms was on the emotional well-being domain (20 points). The largest difference was in the domain of role limitations due to physical health (47 points).

**Table 1. RAND®-36 Health Survey Mean Results: STAR+PLUS Enrollees Compared to U.S. Norms<sup>8</sup>**

	<b>U.S. Norms (1)</b>	<b>STAR+PLUS Scores (2)</b>	<b>Difference (1) – (2)</b>
<b>Role Limitations Due to Physical Health</b>	81.0	34.0	47.0
<b>Physical Functioning</b>	84.2	40.0	44.2
<b>Social Functioning</b>	83.3	43.5	39.8
<b>Role Limitations Due to Emotional Problems</b>	81.3	42.2	39.1
<b>General Health</b>	72.0	37.6	34.4
<b>Pain</b>	75.2	43.1	32.1
<b>Energy/Fatigue</b>	60.9	37.9	23.0
<b>Emotional Well-Being</b>	74.7	54.7	20.0

Health status was also measured by asking survey respondents a series of questions about their ability to perform activities of daily living. Assessing the percentage who need help performing activities of daily living because of an impairment or health problem provides insight into the unique needs of the STAR+PLUS enrollees.

The majority (71 percent) of STAR+PLUS enrollees reported needing the help of other persons with their personal care needs, such as eating, dressing, or getting around the house. About one-half (51 percent) reported needing help with routine needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes. Eighty-five percent of STAR+PLUS enrollees reported having a physical or medical condition that seriously interferes with their ability to work, attend school, or manage day-to-day activities.

The differences in these scores reflect the fact that the adult population of the STAR+PLUS Program is unique compared to society as a whole. Lower health status scores are expected for STAR+PLUS enrollees because this program serves disabled and chronically ill Medicaid members. Poverty and lack of insurance coverage and access to health services prior to enrollment in Medicaid may also contribute to the significantly higher rates of poor physical and mental health compared to the U.S. general population. Enrollees with poor health status present unique challenges to the health care delivery system because their needs for health care services, including specialty services, are higher than the needs of those who are healthy. One of the ways the STAR+PLUS Program addresses these challenges is by providing a continuum of care for disabled and chronically ill Medicaid patients through integration of acute and long term care services in a managed care environment.

Overweight and obesity have been associated with increased rates of disease and mortality. According to the National Institutes of Health, there is strong evidence that weight loss among overweight and obese individuals reduces risk factors for diabetes and cardiovascular disease.<sup>9</sup> Overweight and obesity are assessed using the body mass index (BMI), which is calculated by dividing a person’s weight (in kilograms) by their height (in meters squared).

**Table 2. BMI Classification of STAR+PLUS Enrollees**

	<b>STAR+PLUS Enrollees</b>	<b>Texas Adults (2007)<sup>10</sup></b>
Mean BMI (Standard Deviation)	32.7 (10.3)	--
Obese (BMI ≥ 30.0)	54%	29%
Overweight (BMI 25.0 – 29.9)	23%	37%
Normal Weight (BMI 18.5 – 24.9)	21%	34%
Underweight (BMI < 18.5)	2%	

**Table 2** shows BMI results for the STAR+PLUS survey respondents. The mean BMI was 33, which is considered obese according to the Centers for Disease Control and Prevention (CDC).<sup>11</sup> Seventy-seven percent of survey respondents were either overweight or obese, suggesting a high level of overweight- and obesity-related disease burden is likely present in the STAR+PLUS population. Two percent of STAR+PLUS survey respondents were underweight. While a large disparity in obesity is noted between STAR+PLUS enrollees and adults in the Texas population, higher prevalence of obesity is expected among STAR+PLUS enrollees, who represent a low-income, disabled population.

***Healthy Behaviors and Health Promotion Activities***

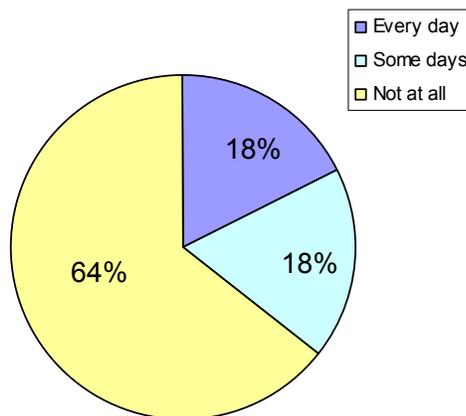
A number of health behaviors and promotion practices can reduce illness and health care costs. Such practices include flu shots, smoking cessation, and maintaining a healthy weight. The CDC recommends that individuals at high risk for influenza, such as those ages 50 and older, residents of long-term care facilities, and people who have chronic medical problems, should receive an annual flu shot to prevent adverse health outcomes such as hospitalization or death.<sup>12</sup> The Agency for Health Care Policy and Research recommends

that primary care physicians identify smokers, treat every smoker with a cessation or motivational intervention, offer nicotine replacement except in special circumstances, and schedule follow-up contacts after cessation.<sup>13</sup>

This section of the report shows the survey responses to questions about receiving a flu shot and smoking cessation.

About two in five respondents (39 percent) reported receiving a flu shot during the 2007 flu season. Among respondents aged 50 years and older, less than half (46 percent) reported receiving a flu shot during the 2007 flu season.

**Figure 3. "Do you now smoke every day, some days, or not at all?"**



**Figure 3** shows the current smoking status of STAR+PLUS enrollees. The majority of survey respondents (64 percent) said they were not current smokers, while 36 percent reported they smoked some days or every day. Those who indicated being smokers at the time of interview were also asked how frequently their doctors or other health providers advised them to quit smoking, recommended or discussed medication to quit smoking, or recommended or discussed other methods or strategies to quit smoking (**Table 3**).

**Table 3. Smoking Cessation Advice/Assistance by Doctors or Health Providers**

	None	One to 4 visits	5 or more visits	I had no visits
<b>In the last 6 months, on how many visits...</b>				
<b>...were you advised to quit smoking by a doctor or other health provider in your plan?</b>	25%	40%	23%	12%
<b>...was medication recommended or discussed to assist you with quitting smoking?</b>	60%	26%	7%	7%
<b>...did your doctor recommend or discuss methods and strategies (other than medication) to assist you with quitting smoking?</b>	63%	22%	8%	7%

Among enrollees who were smokers at the time of the interview, 63 percent were advised to quit smoking during at least one office visit in the last six months (**Table 3**). Thirty-three percent of smokers indicated that their doctor recommended medication to assist with quitting smoking during at least one office visit.

Examples of medications include nicotine gum, patches, nasal spray, inhalers, and prescription medications. Thirty percent of smokers indicated that their doctor recommended methods or strategies other than medication to assist with quitting smoking during at least one office visit.

Results for the questions on **Table 3** were also calculated excluding those who had no visits in the last six months – allowing evaluation of smoking cessation advice and assistance for only those smokers who visited their doctors or health providers on at least one occasion. Among those smokers who had at least one visit with their doctors or health providers in the last six months:

- Seventy-one percent were advised to quit smoking during at least one office visit;
- Thirty-six percent were recommended medication to assist with quitting smoking; and
- Thirty-three percent were recommended other strategies to assist with quitting smoking.

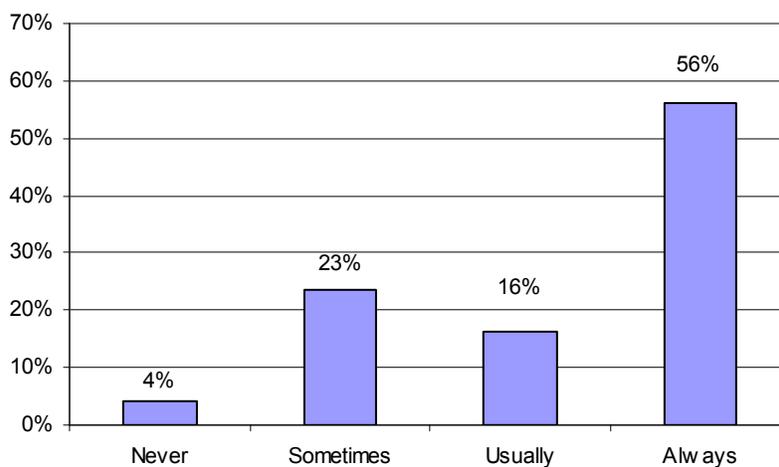
The 2007 HHSC Performance Indicator Dashboard has set “advising smokers to quit” at a 28 percent standard for the STAR+PLUS Program.<sup>14</sup> The findings from this survey – whether calculated among all smokers or among only smokers who visited their doctors in the last six months – substantially exceed the HHSC standard.

### **Personal Doctor**

Having a particular person or place to go to for sick and preventive care contributes to improved health outcomes.<sup>15,16</sup> Health care consumers perceive primary care as an integral aspect of the health care system and appreciate the role of primary care providers in coordinating quality care.<sup>17</sup> In addition to coordination of care, continuity with the same health care provider is highly valued by patients and improves preventive care utilization and prompt detection and treatment of health care problems.<sup>18</sup> This section reports on responses to questions from the CAHPS<sup>®</sup> Health Plan Survey about the presence of a personal doctor as a usual source of care.

Overall, 85 percent of STAR+PLUS respondents said they had a personal doctor. Among those respondents with personal doctors, 60 percent indicated they had phoned their personal doctor’s office during regular office hours in the last six months to get help or advice.

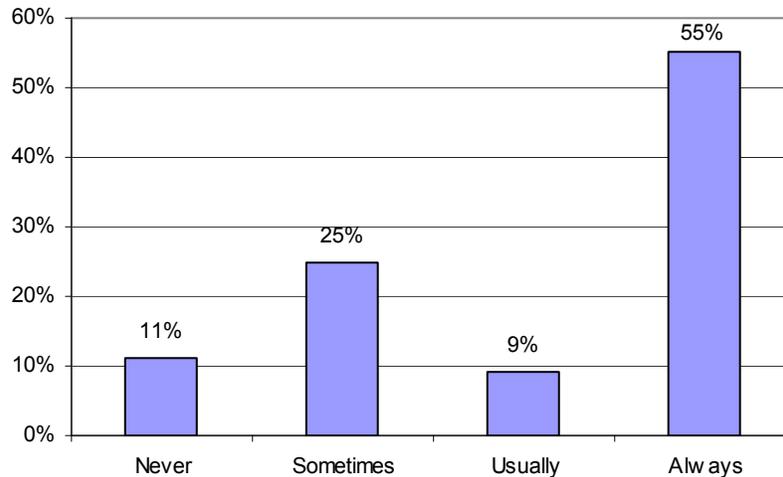
**Figure 4. "In the last 6 months, when you phoned your personal doctor's office during regular hours, how often did you get the help or advice you wanted?"**



Among those respondents who phoned their personal doctor’s office during regular hours, 56 percent indicated they always got the help or advice they wanted from their personal doctor’s office (**Figure 4**).

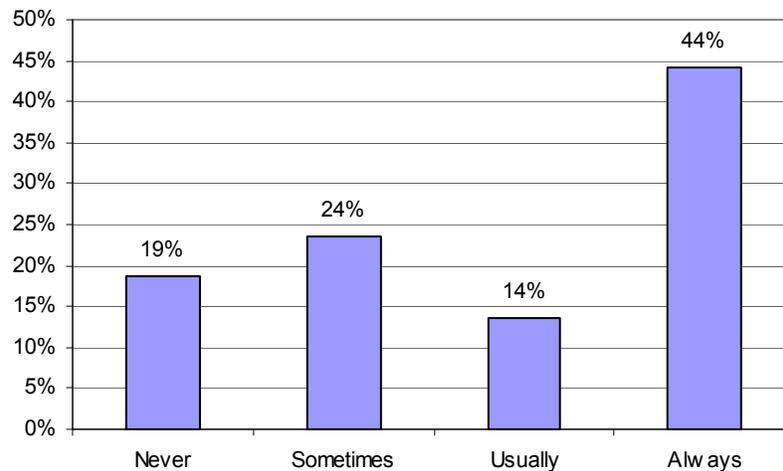
Twenty-one percent of respondents with personal doctors indicated they had phoned their personal doctor's office after regular office hours in the last six months to get help or advice.

**Figure 5. “In the last 6 months, when you phoned after regular office hours, how often did you get the help or advice you wanted?”**



For those who needed help after office hours, 55 percent reported that they always received the help they wanted while 11 percent reported they never received the help they wanted (**Figure 5**).

**Figure 6. “Since you joined your health plan, how often was it easy to get a personal doctor you are happy with?”**

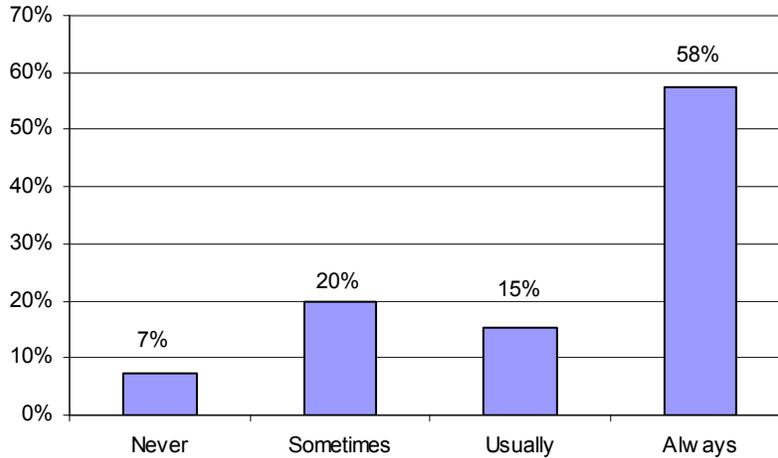


Fifty-six percent of STAR+PLUS enrollees with personal doctors indicated they did not have the same personal doctor before they joined the program. As indicated in **Figure 6**, less than half (44 percent) said it was always easy to get a personal doctor they were happy with. However, 19 percent indicated that it was never easy to get a personal doctor they were happy with. This suggests that up to one-fifth of STAR+PLUS enrollees have low satisfaction with their personal doctors since joining the program and may consequently experience low utilization, quality, and/or continuity of care.

## Getting Needed and Specialist Care

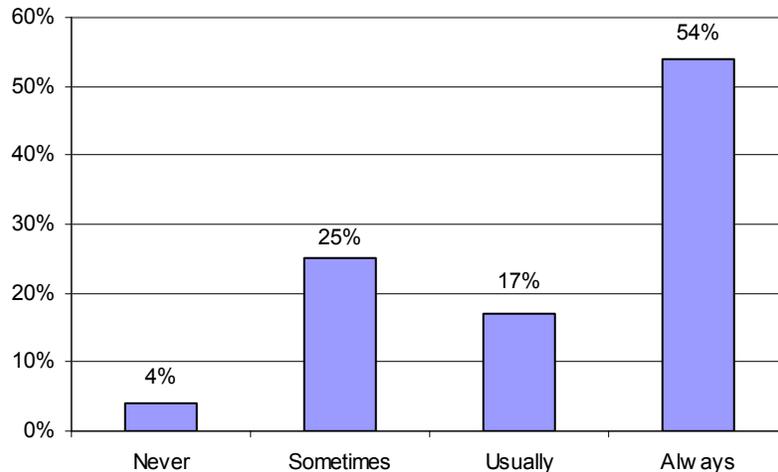
The implementation of managed care, particularly for those with special healthcare needs, sometimes raises questions about potential barriers to healthcare services.<sup>19</sup> The impact of managed care is of particular concern for individuals with complex physical or emotional disorders who may require many specialty services. Relatively healthy individuals may also require specialty services for acute conditions at various times. The ability to access needed and specialty care may affect health outcomes and is important to monitor.

**Figure 7. “In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?”**



The majority of STAR+PLUS enrollees report that they were always or usually able to get urgent care as soon as they thought it was needed (73 percent) (**Figure 7**). This is comparable to the HHSC Performance Dashboard Indicator standard for good access to urgent care in the STAR+PLUS population (76 percent).<sup>20</sup>

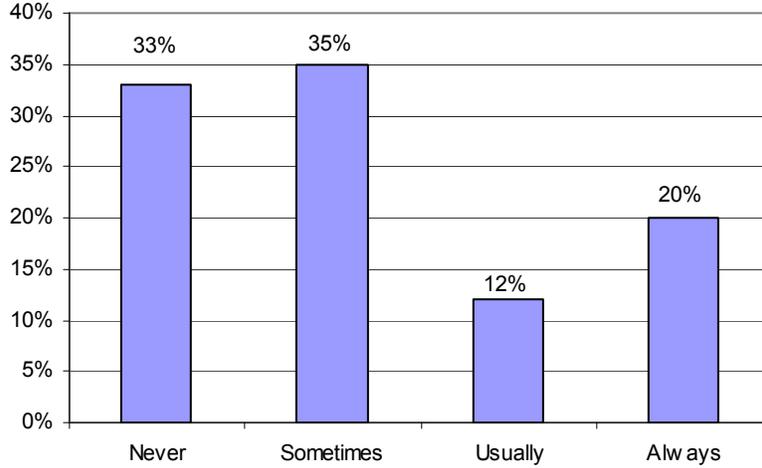
**Figure 8. “In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for your health care as soon as you thought you needed?”**



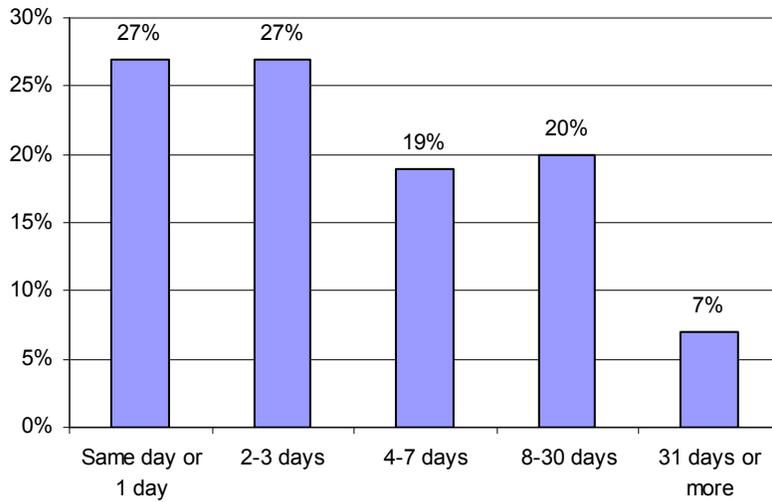
The majority of STAR+PLUS enrollees reported that they were always or usually able to get appointments for routine care as soon as they thought it was needed (71 percent) (**Figure 8**). This is slightly lower than the

HHSC Performance Dashboard Indicator standard for good access to routine care in the STAR+PLUS population (78 percent).<sup>21</sup>

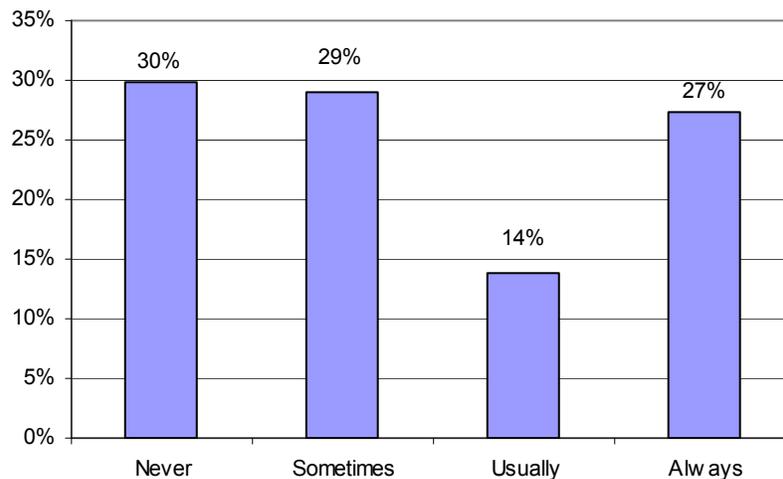
**Figure 9. “In the last 6 months, how often did you have delays in your health care while you waited for approval from your health plan?”**



**Figure 10. “In the last 6 months, not counting the times you needed care right away, how many days did you usually have to wait between making an appointment and actually seeing a provider?”**



**Figure 11. “In the last 6 months, how often were you taken to the exam room within 15 minutes of your appointment?”**

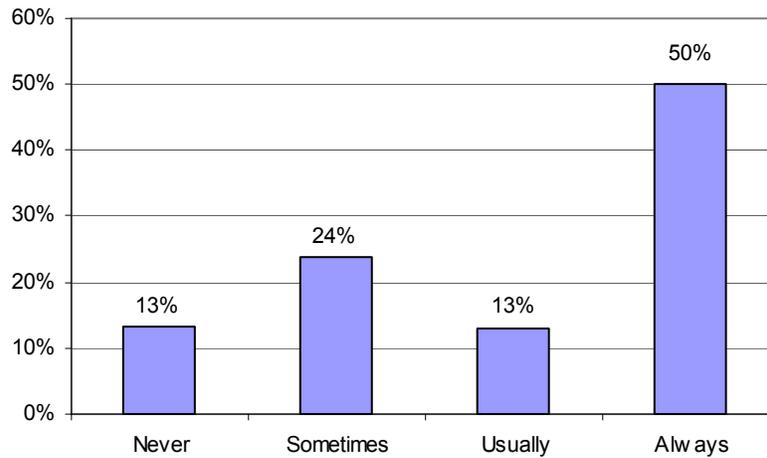


**Figures 9, 10, and 11** present results for three different aspects of waiting for care: (1) waiting for health plan approval to receive health care (**Figure 9**); (2) waiting for a scheduled appointment time (**Figure 10**); and (3) waiting to be taken to the exam room on the day of the appointment (**Figure 11**).

- One-third of respondents (33 percent) never had delays in their health care while they waited for approval from their health plan. This is considerably lower than the HHSC Performance Indicator Dashboard standard for no approval delays in the STAR+PLUS population (57 percent).<sup>21</sup>
- The majority of respondents (54 percent) were able to see a provider within three days of making their appointment. Seven percent reported that they had to wait 31 days or more to see a provider after making an appointment.
- Twenty-seven percent of respondents reported they were always taken to the exam room within 15 minutes of their appointment. This is considerably lower than the HHSC Performance Indicator Dashboard standard for no exam room wait greater than 15 minutes in the STAR+PLUS population (42 percent).<sup>22</sup> This finding suggests a need for participating health plans to address long waiting periods in the clinical setting.

Forty-four percent of respondents reported trying to make an appointment to see a specialist in the six months prior to the survey.

**Figure 12. “In the last 6 months, how often was it easy to get a referral to a specialist that you needed to see?”**

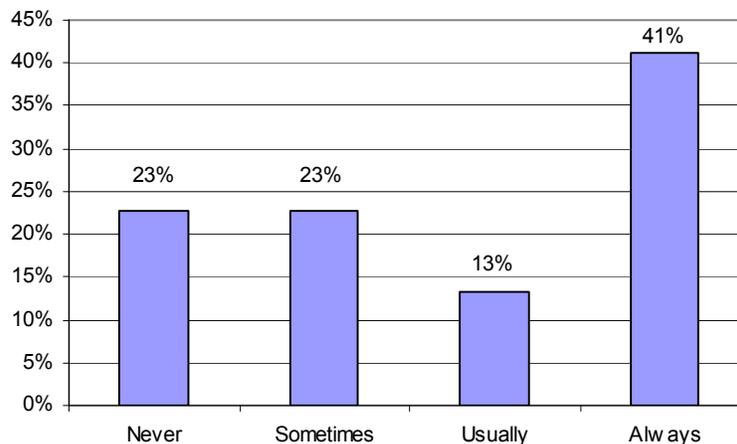


Of the respondents who needed to see a specialist in the last six months, about two-thirds (63 percent) reported that obtaining a referral from their health plan for a specialist was usually or always easy (**Figure 12**). This figure matches the HHSC Performance Dashboard Indicator standard for good access to specialist referrals in the STAR+PLUS population (62 percent).<sup>23</sup> Sixty-five percent of enrollees reported that the specialist they saw most often was the same as their personal doctor.

### ***Getting Specialized Services***

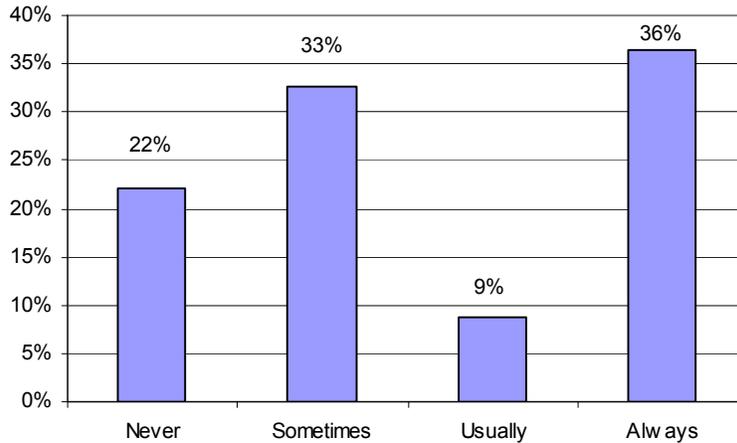
Managed care plans use a range of strategies to coordinate health care and control costs, such as requirements for prior approval for specific types of care, disease management programs, and pharmacy formularies. While these strategies ensure efficiency, they should be monitored to ensure they do not impede access to care for disabled or chronically ill individuals. This section of the survey asked respondents about their access to, and need for, specialized services, such as tests, equipment, therapies, home health care, or prescription medication. It should be noted that not all STAR+PLUS enrollees need these services, yet it is important to provide information about the experiences of those enrollees who do to identify areas for improvement.

**Figure 13. “In the last 6 months, how often was it easy to get the medical equipment you needed through your health plan?”**



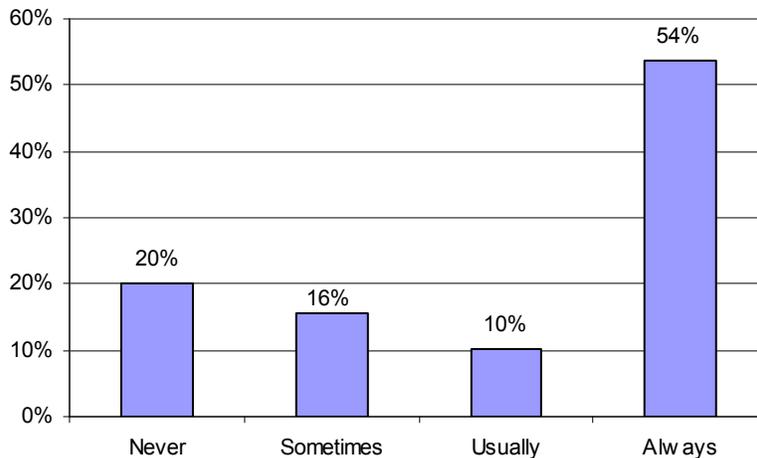
Thirty-four percent of respondents indicated they had a health problem for which they needed special medical equipment, such as a cane, wheelchair, or oxygen equipment. Among these respondents, 41 percent indicated that it was always easy to get the medical equipment they needed, while 23 percent indicated that it was never easy (Figure 13).

**Figure 14. “In the last 6 months, how often was it easy to get the special therapy you needed through your health plan?”**



Twenty-two percent of respondents indicated they had a health problem for which they needed special therapy, such as physical, occupational, or speech therapy. Among those who needed special therapies, 45 percent indicated that obtaining these therapies was always or usually easy (Figure 14). This is comparable to the HHSC Performance Indicator Dashboard standard for good access to special therapies in the STAR+PLUS population (47 percent).<sup>24</sup>

**Figure 15. “In the last 6 months, how often was it easy to get the home health care you needed through your health plan?”**



Twenty-seven percent of respondents indicated needing home health care or assistance in the six months prior to the survey. Among those who needed these services, 54 percent of respondents said obtaining home health care was always easy (Figure 15).

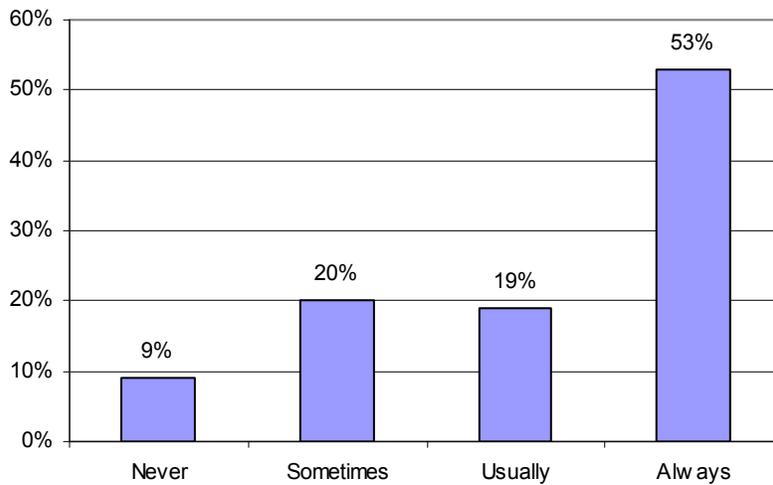
Seventy-nine percent of STAR+PLUS respondents indicated that in the last six months they got new prescription medication or refilled a prescription.

### Care Coordination

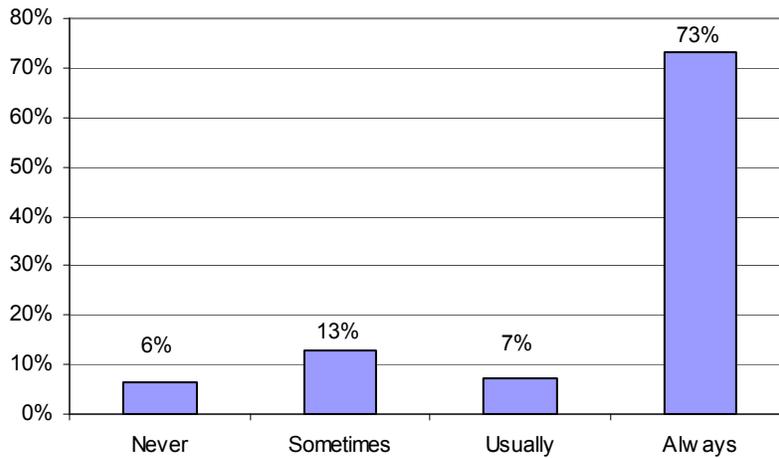
In the STAR+PLUS Program, all enrollees who receive long-term care services receive care coordination services from their health plan. Long-term care services may include daily activities and health services, personal attendant services, and short-term (up to 120 days) nursing facility care. Additional services provided to clients are adaptive aids, adult foster home services, assisted living, emergency response services, medical supplies, minor home modifications, nursing services, respite care, and therapies (occupational, physical, and speech-language). Enrollees who require long-term care services must request care coordination services.<sup>25</sup> These services include development of an individual plan of care with the client, family members, and provider, and authorization of long-term care services for the client.

Twenty-four percent of respondents indicated having a care coordinator from their STAR+PLUS health plan who helps arrange services such as doctor visits, transportation, or meals. Among those enrollees with a care coordinator, 58 percent indicated their care coordinator had contacted them in the six months prior to the survey. Among those STAR+PLUS enrollees who did not have a care coordinator (76 percent of the sample), 49 percent indicated they would like someone from their STAR+PLUS health plan to help arrange services for them.

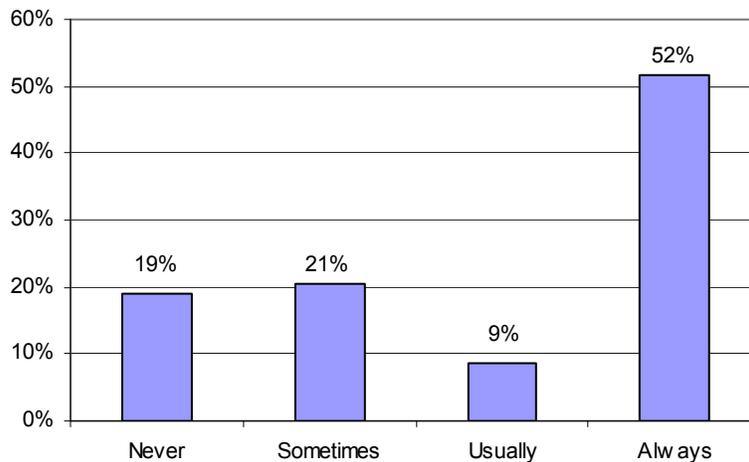
**Figure 16. “In the last 6 months, when you needed a care coordinator from your STAR+PLUS health plan to help you, how often did you get care coordination help as soon as you thought you needed?”**



**Figure 17. “In the last 6 months, how often did the care coordinator at your STAR+PLUS health plan explain things in a way you could understand?”**

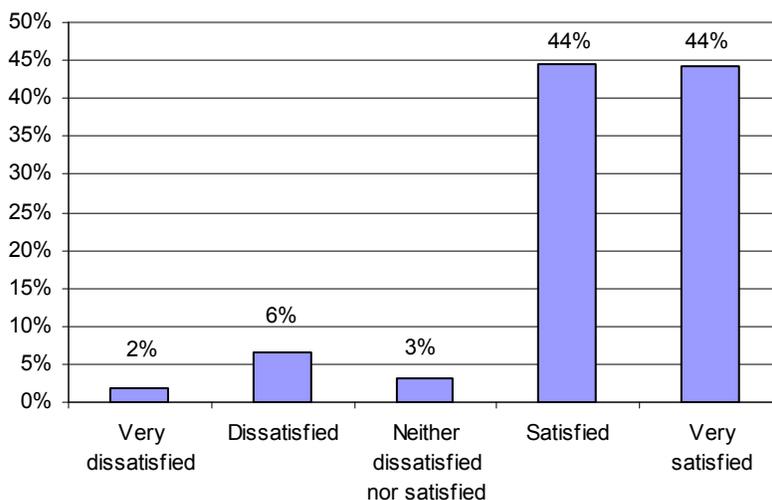


**Figure 18. “In the last 6 months, how often did the care coordinator at your STAR+PLUS health plan involve you in making decisions about your services?”**



**Figures 16, 17, and 18** provide information on the frequency of care coordination services, communication with the care coordinator, and member’s involvement in decision-making with the care coordinator. Overall, 53 percent of respondents indicated they always received coordination help from their health plan as soon as they thought they needed it. The majority of respondents (73 percent) indicated the care coordinator always explained things in a way they could understand. About one-half of respondents (52 percent) felt the care coordinator always involved them in making decisions about their services. However, approximately one-fifth (19 percent) reported that their care coordinators never involved them in making decisions about the services they received.

**Figure 19. “In the last 6 months, how satisfied were you with the help you received from the care coordinator at your STAR+PLUS health plan?”**



Respondents were also asked how satisfied they were with the help they received from the care coordinator at their health plan (**Figure 19**). Eighty-eight percent were satisfied or very satisfied with the help they received. Very few respondents reported being dissatisfied with the help they received from their care coordinator.

### **Satisfaction with Health Care – Descriptive Results**

As detailed in Appendix A, individual item responses from the CAHPS® survey can be combined into composite scores. **Table 4** lists the mean composite scores for the following four domains:

- 1) *Getting Needed Care*,
- 2) *Getting Care Quickly*,
- 3) *Doctor’s Communication*, and
- 4) *Health Plan Customer Service*.

Each of the domains had a possible score ranging from 0 to 100, with higher scores indicating greater satisfaction. A score of 75 points or higher is considered an indication of positive healthcare experiences.

The overall scores for STAR+PLUS Program enrollees were lower than the Medicaid national means for three of the four domains.<sup>26</sup> The Medicaid national mean scores are the scores from Medicaid managed care plans that choose to report their CAHPS® Health Plan Survey results to the National Committee for Quality Assurance (NCQA).<sup>27</sup> The last reporting period publicly available for national comparison is calendar year 2006. National means for the *Customer Service* composite were not available for that year. STAR+PLUS composite scores were nearly equal to the national average for the *Doctor’s Communication* composite measure. STAR+PLUS composite scores were about six points lower than the national mean for *Getting Care Quickly* and 10 points lower than the national mean for *Getting Needed Care*.

**Table 4. Mean CAHPS® Health Plan Survey Composite Scores: Enrollee Satisfaction with Their Health Care - Descriptive Results**

CAHPS® Composite Scores	Getting Needed Care	Getting Care Quickly	Doctor’s Communication	Customer Service
<b>2006 National Medicaid CAHPS® Health Plan Survey Mean</b>	74.2	78.7	86.3	N/A
<b>STAR+PLUS Mean</b>	64.4	72.4	84.6	67.7

## Satisfaction with Health Care – Multivariate Results

Multivariate logistic regression analyses were performed to predict the effects of several individual factors on the CAHPS® composite scores. Because logistic regression requires a binary outcome, the outcome variable was the odds the enrollee would “usually” or “always” have positive experiences for each cluster. A score of 75 points or higher was used to indicate the experience was “usually” or “always” positive. The following variables were used in the logistic regression models to predict the probability of scoring higher than 75 on the composites:

- (1) Health status,
- (2) Race/ethnicity,
- (3) Educational status,
- (4) Age category,
- (5) Gender, and
- (6) Health plan.

The health plan with the highest score for each CAHPS® Health Plan Survey cluster was selected as the reference group. The purpose of the reference group is to provide a point of comparison. Therefore, the results of the other STAR+PLUS health plans are compared to the results of referent health plan after controlling for the predictor variables listed above.

**Table 5** contains a summary of the logistic regression or odds ratio results for each CAHPS® Health Plan Survey composites. After controlling for the predictor variables listed above, the scores for the CAHPS® composites were not significantly different across the STAR+PLUS health plans for *Doctor’s Communication*. There were significant differences in scores across health plans for the *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service* composite scores. A complete presentation and discussion of logistic regression results showing the odds ratios and confidence intervals for all of the predictor variables is contained in Appendix B.

**Table 5. CAHPS® Health Plan Survey Composite Scores: Differences Among STAR+PLUS Health Plans in Satisfaction Scores - Logistic Regression Results**

Health Plan	Getting Needed Care	Getting Care Quickly	Doctor’s Communication	Customer Service
AMERIGROUP	NS	NS	Ref	NS
Evercare	NS	-0.42	NS	-0.69
Molina	-0.71	NS	NS	NS
Superior	Ref	Ref	NS	Ref

Note: “Ref” = reference health plan with the highest mean composite score; “NS” = not significant; “-“= score significantly lower than reference.

## Summary and Recommendations

The present report highlights results from the fiscal year 2008 STAR+PLUS Enrollee Survey that reveal: (1) demographic characteristics of the STAR+PLUS enrollee population; (2) health status of the STAR+PLUS enrollee population; (3) healthy behaviors and health promotion activities; (4) personal doctors; (5) getting needed and specialist care; (6) getting specialized services; (7) care coordination; and (8) enrollees’ satisfaction with various aspects of their healthcare.

## **Summary Point #1 – Enrollee Demographics**

- Forty-three percent of established STAR+PLUS enrollees were Hispanic, 23 percent were White, non-Hispanic, 28 percent were Black, non-Hispanic, and six percent were Other, non-Hispanic ethnicity.
- The majority of enrollees had achieved less than a high school education (52 percent), while 29 percent had received high school diplomas, and 19 percent had either some college or college degrees.

## **Summary Point #2 – Health Status**

- Health status scores, as measured by the RAND<sup>®</sup> 36-Item Health Survey, were lower among STAR+PLUS enrollees than within the U.S. population. STAR+PLUS enrollees scored lowest with respect to role limitations due to physical health (34.0), general health (37.6), and energy/fatigue (37.9). STAR+PLUS enrollees scored highest with respect to emotional well-being (54.7), although this figure remained considerably lower than that reported for the U.S. population (74.7).
- The majority of STAR+PLUS enrollees reported having limitations in performing activities of daily living. Seventy-one percent required the help of others with their personal care needs. Fifty-one percent required help with routine needs. Eighty-five percent reported having a physical or medical condition that seriously interferes with their ability to work, attend school, or manage day-to-day activities.
- Rates of overweight and obesity were high among STAR+PLUS enrollees, with 76 percent of respondents being either overweight or obese. This finding suggests that a high level of obesity-related disease burden may be present in the STAR+PLUS population.

## **Summary Point #3 – Healthy Behaviors / Health Promotion Activities**

- Thirty-nine percent of respondents reported receiving a flu shot during the 2007 flu season. Among enrollees age 50 years or older, less than half (46 percent) received a flu shot. This figure is lower than that recommended by the CDC, recognizing that persons aged 50 years or older are at higher risk of serious complications due to influenza.
- The majority of survey respondents (64 percent) said they were not current smokers, while 36 percent smoked some days or every day. Among enrollees who were smokers at the time of interview, 63 percent were advised to quit smoking, 33 percent were recommended medication to assist with quitting smoking, and 30 percent were recommended other methods or strategies to assist with quitting smoking during at least one office visit with their doctors or health providers in the last six months.

## **Summary Point #4 – Personal Doctors**

- Overall, 85 percent of STAR+PLUS enrollees reporting having a personal doctor.
- Among those with personal doctors:
  - 60 percent had phoned their personal doctor's office during regular office hours to get help or advice in the last six months. Among those who phoned during regular office hours, 56 percent indicated they always got the help or advice they wanted.
  - 21 percent had phoned their personal doctor's office after regular office hours to get help or advice in the last six months. Among those who phoned after regular office hours, 55 percent indicated they always got the help or advice they wanted. Eleven percent reported they never received the help or advice they wanted.

- 56 percent did not have the same personal doctor before they joined their current health plan. Among these respondents, 44 percent said it was always easy to get a personal doctor they were happy with. Nearly one-fifth of respondents said it was never easy to get a personal doctor they were happy with, representing a large proportion of the STAR+PLUS population who may experience low utilization, quality, and/or continuity of care.

### **Summary Point #5 – Getting Needed and Specialist Care**

- The majority of STAR+PLUS enrollees experienced good access to urgent care (73 percent) and to routine care (71 percent). Access to routine care was slightly lower than the HHSC Performance Indicator Dashboard standard (78 percent).
- Members' experiences with waiting to receive care were largely positive, although HHSC Performance Indicator Dashboard standards were not met regarding delays for health plan approval and time waiting to be taken to an exam room.
  - One third of respondents (33 percent) never had delays in their health care while they waited for approval from their health plan. This is considerably lower than the 57 percent standard set by HHSC. Another 35 % of respondents reported they sometimes had delays in their health care while they waited for approval from their health plan.
  - The majority of respondents (54 percent) were able to see a provider for routine care within three days of making their appointment. Appointment waiting periods greater than one month were reported among only seven percent of the sample.
  - Twenty-seven percent of respondents reported always being taken to the exam room within 15 minutes of their appointment. This is considerably lower than the 42 percent standard set by HHSC.
- Forty-four percent of respondents reported trying to make an appointment to see a specialist in the six months prior to the survey. Among these respondents, 63 percent said that obtaining a referral from their health plan to see a specialist was usually or always easy. Sixty-five percent of enrollees reported that the specialist they saw most often was the same as their personal doctor.

### **Summary Point #6 – Getting Specialized Services**

- Thirty-four percent of STAR+PLUS enrollees had a health problem for which they need special medical equipment. Among these respondents, 54 percent said it was always or usually easy to get the medical equipment they needed, while 23 percent said it was never easy.
- Twenty-two percent of enrollees had a health problem for which they needed special therapy, such as physical, occupational, or speech therapy. Among these respondents, 46 percent said that obtaining these therapies was always or usually easy, while 22 percent said that it was never easy.
- Twenty-seven percent of enrollees indicated needing home health care or assistance in the six months prior to the survey. Among these respondents, 64 percent said that obtaining home health care was always or usually easy, while 20 percent said that it was never easy.
- Seventy-nine percent of enrollees received new prescription medication or refilled a prescription in the six months prior to the survey.

### **Summary Point #7 – Care Coordination**

- Twenty-four percent of respondents indicated having a care coordinator from their STAR+PLUS health plan. Among those enrollees with a care coordinator, 58 percent reported that their care coordinator had contacted them in the six months prior to the survey.

- Overall, 53 percent of these respondents always received coordination help from their health plan as soon as they thought they needed it. The majority (73 percent) said their care coordinator always explained things in a way they could understand. Over one-half of respondents (52 percent) felt that the care coordinator always involved them in making decisions about their services. However, approximately one-fifth (19 percent) reported that their care coordinators never involved them in decision-making.
- Among STAR+PLUS enrollees with a care coordinator, 88 percent indicated they were satisfied or very satisfied with the help they received.
- Seventy-six percent of respondents did not have a care coordinator. Among these respondents, nearly half (49 percent) said they would like someone from their STAR+PLUS health plan to help arrange services for them.

### **Summary Point #8 – Enrollee Satisfaction**

- Overall, CAHPS® Health Plan Survey composite scores for *Getting Needed Care*, *Getting Care Quickly*, *Doctor's Communication*, and *Health Plan Customer Service* were lower among STAR+PLUS enrollees than Medicaid national means.
  - Among STAR+PLUS enrollees, the highest composite score was observed for *Doctor's Communication* (84.6). Each of the remaining three scores fell below the 75-point threshold considered to represent positive healthcare experiences – *Getting Needed Care* (64.4), *Getting Care Quickly* (72.4), and *Customer Service* (67.7).
- In multivariate analyses, which controlled for enrollees' health status, race/ethnicity, educational status, age, and gender, scores were not significantly different across health plans for *Doctor's Communication*. For the remaining three composite measures, Superior was the highest-scoring health plan. In comparison with Superior, scores for *Getting Needed Care* were significantly lower among members of Molina, and scores for *Getting Care Quickly* and *Customer Service* were significantly lower among members of Evercare.

### **Recommendations**

Texas HHSC may wish to consider the following strategies when developing future policy regarding STAR+PLUS enrollees:

- Health plans should be encouraged to ensure care coordination programs are meeting the needs of their members.
  - More than three-quarters of STAR+PLUS enrollees report limitations in various activities of daily life due to a physical or medical condition, yet only one-quarter have a care coordinator. Among respondents who did not have a care coordinator, nearly half indicated wanting someone from their health plan to help arrange services for them.
  - Assessment or monitoring of care coordination programs should address coverage rates among qualified health plan members, the timeliness of care, and standards for inclusion of the member in decision-making.
- The timely and appropriate delivery of specialized services, such as special medical equipment, special therapies, or home health care, should be assessed in future studies.
  - About one-fifth to one-quarter of STAR+PLUS enrollees needing specialized services said that it was not easy to get specialized services through their health plan. Additional research may show the extent to which these problems are related to getting referrals or prescriptions, health plan approval, transportation, and/or cost.

- Ensuring that care coordination programs are thoroughly connected with providers of medical equipment, special therapies, and home health care may have a positive impact on delivery of specialized services.
- Resources should be developed to help health plan members find a personal doctor who is appropriate, both for their health care needs and their cultural or personal needs and concerns.
  - Nearly one-fifth of respondents said it was never easy to get a personal doctor they were happy with, representing a large proportion of the STAR+PLUS population who may experience low utilization, quality, and/or continuity of care.
- Develop strategies toward reducing the time members wait for health plan approval and to be taken to the exam room.
  - Health plans should assess potential reasons for long waiting periods, including understaffing, large patient load, insufficient space, and poor communication among office staff and between office staff and members.
  - Encourage health plans and providers to reduce appointment scheduling complexity, following steps outlined by the Institute for Healthcare Improvement: <http://www.ihl.org>.<sup>28</sup>
- Develop or improve upon education and promotion programs to reduce overweight and obesity. Obesity programs should be comprehensive and include nutrition education, exercise programs, and weight management strategies. Overweight and obesity among health plan members should also be monitored by primary care providers, possibly as part of a disease management program.
- Discuss findings with the health plans and possible strategies to address areas for improvement, particularly where health plans have CAHPS<sup>®</sup> scores that are significantly lower than anticipated based on the comparison health plan.

## Appendix A. Detailed Survey Methodology

This report presents results from the 2008 STAR+PLUS enrollee survey. This survey is intended to provide a demographic and health profile of STAR+PLUS members, assess healthy behaviors and health promotion activities, document the enrollees' experiences with getting needed and specialty care, understand enrollees' experiences with their care coordinator, and assess enrollee satisfaction with several components of their health care. There are four health plans that participate in the STAR+PLUS Program in Texas:

AMERIGROUP, Evercare, Superior, and Molina. This report provides readers with information regarding:

- the sociodemographic characteristics of enrollees;
- the health status of enrollees;
- the enrollees' experiences with healthy behaviors and health promotion activities;
- documentation of a personal doctor;
- the enrollees' experiences with getting needed and specialist care;
- the enrollees' experiences with getting specialized services;
- the enrollees' experiences with care coordination; and,
- the enrollees' satisfaction with their health care.

### Sample selection

A stratified random sample of adults enrolled in the STAR+PLUS Program in Texas was selected to participate in this survey using the following criteria:

- 1) the adult must have been enrolled in the STAR+PLUS Program in Texas for at least nine months;
- 2) the adult must be over the age of 18; and,
- 3) the adult must not be dually eligible for both Medicaid and Medicare, and must only be eligible for Medicaid.

Target samples of 300 completed telephone surveys with STAR+PLUS enrollees who are enrolled in one of the four health plans was set for a total of 1,200 completed surveys. This sample size was selected to provide a reasonable confidence interval for the survey responses, based on selected survey items with uniformly distributed responses. Using a 95 percent confidence interval, the responses provided in the tables and figures are within  $\pm 4$  percentage points of the "true" responses for the STAR+PLUS enrollee health plans.

It should be noted that Molina, one of the participating health plans, was a new health plan in fiscal year 2008. As a result, enrollment in the Molina health plan was not as high as enrollment in the established health plans, and the available sample was limited. Several strategies were used to maximize the number of completed surveys with the Molina enrollees, such as increasing the number of attempts and calling back those who completed partial surveys. However, only 272 Molina enrollees completed the survey. The targeted number of surveys was met for Superior, AMERIGROUP, and Evercare, resulting in a total of 1,172 completed surveys.

Enrollment data were provided to the Institute for Child Health Policy (IHP) from a third party administrator for the STAR+PLUS Program in Texas. These data were used to identify the enrollees who met the sample selection criteria and to obtain their contact information. Member names, mailing addresses, and telephone contact information for 8,167 randomly selected, eligible enrollees were collected.

### Survey instruments

The 2008 STAR+PLUS enrollee survey was comprised of the following sections:

- 1) Consumer Assessment of Healthcare Providers and Systems (CAHPS<sup>®</sup>) Health Plan Survey, version 4.0;<sup>29</sup>
- 2) RAND<sup>®</sup> 36-Item Health Survey, version 1.0;<sup>30</sup>
- 3) questions regarding care coordination services; and,
- 4) sociodemographic and household characteristics.

The CAHPS<sup>®</sup> Health Plan Survey 4.0 was used to assess enrollees' satisfaction with several components of their health care.<sup>31</sup> Specifically, the Medicaid module with supplemental questions addressing behavioral health care, need for personal assistance care, smoking behaviors, and smoking cessation was used. The CAHPS<sup>®</sup> Health Plan Survey contains composites, which are scores that combine results for closely related survey items to provide comprehensive yet concise results.<sup>32</sup> Psychometric analyses indicate the composite scores are a reliable and valid measure of member experiences.<sup>33,34</sup> CAHPS<sup>®</sup> Health Plan Survey composite scores address the following domains: (1) *Getting Needed Care*, (2) *Getting Care Quickly*, (3) *Doctor's Communication*, and (4) *Health Plan Customer Service*. Using the composite scoring method, a mean score ranging from 0 to 100 was calculated for each of the four domains with higher scores indicating greater satisfaction.

The RAND<sup>®</sup> 36-Item Health Survey (SF-36) was created to survey health status in the Medical Outcomes Study.<sup>35</sup> The SF-36 was designed for use in health policy evaluations and general population surveys. The SF-36 assesses eight separate health domains: (1) limitations in physical activities because of health problems; (2) limitations in social activities because of physical or emotional problems; (3) limitations in usual role activities because of physical health problems; (4) bodily pain; (5) general mental health; (6) limitations in usual role activities because of emotional problems; (7) vitality (energy and fatigue); and (8) general health perceptions. The survey was designed for administration in person or by telephone by a trained interviewer. Using composite scoring methods, a mean score ranging from 0 to 100 was calculated for each of the eight areas, with higher scores indicating greater health status.

Questions about the enrollees' experiences with care coordination were developed by ICHP and focus on availability of, need for, and satisfaction with care coordination.

Demographic and household questions were also developed by ICHP and have been used in more than 25,000 surveys with Medicaid and CHIP enrollees in Texas and in 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.<sup>36,37,38</sup>

For all items, respondents were given the option to indicate if they did not know the answer. They were also given the choice to refuse to answer any particular item. The percentage of respondents indicating they did not know an answer or refused to answer was very small for most individual items (four percent or less). If a respondent refused to answer an individual item or items but completed the interview, their responses were used in the analyses. If the respondent broke off an interview before all questions had been asked, his or her responses were not used.

Some survey items had an option for an open-ended response in addition to close-ended choices. If the respondent provided an open-ended response that fit one of the existing categories, the interviewer reminded the respondent of the response categories, and if the respondent agreed with a category, he or she coded the response into the pre-existing category. After all interviews were complete, a researcher reviewed all open-ended responses. If possible, these were re-coded into pre-existing categories or, when there were a sufficient number of consistent responses to do so, new categories were created.

### Survey methods

The surveys were conducted by phone from May through August 2008.

Advance letters written in both English and Spanish were sent to the STAR+PLUS members sampled, explaining the purpose of the study and requesting their participation. The Bureau of Economic and Business Research (BEBR) at the University of Florida conducted the telephone surveys using computer-assisted telephone interviewing (CATI). Calls were made from 10 A.M. to 9 P.M. Central Time, seven days a week. BEBR utilized the Sawtooth Software System to rotate calls throughout the morning, afternoon, and evening, maximizing the likelihood of reaching the families. If a respondent required that the interview be conducted in Spanish, arrangements were made for a Spanish-speaking interviewer to call at a later date and time. Of the 1,172 completed survey interviews, four percent were conducted in Spanish.

As many as 30 attempts were made to reach each randomly selected STAR+PLUS enrollee in the sample. If the enrollee was not reached after that time, the software system selected the next individual on the list. Incorrect phone numbers were sent to a company that specializes in locating individuals. Any updated information was loaded back into the software system, and attempts were made to reach the family using the updated contact information. No financial incentives were offered to participate in the surveys. On average, nine calls were made per telephone number in the sample.

Attempts were made to contact 7,687 adults who were enrolled in the STAR+PLUS Program in Texas and who met the inclusion criteria. Forty-two percent of families could not be located. Among those located, 18 percent of respondents were not eligible to complete the survey, one percent reported that they were not enrolled in STAR+PLUS, and six percent refused to participate. The response rate was 54 percent and the cooperation rate was 74 percent. There were 1,172 completed surveys.

On average, the telephone survey took 34 minutes to complete.

### Data analysis

Descriptive statistics and formal statistical tests used in this report were performed using SPSS 15.0 (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.

To facilitate inferences from the survey results to the entire STAR+PLUS enrollee population, all responses were weighted to the full set of eligible beneficiaries in the HHSC Enrollment Broker dataset. Stratified sampling weights were developed to account for the probability of inclusion into the survey sample by health plan. For example, 16,449 AMERIGROUP enrollees met the sample inclusion criteria. Of those 16,449 enrollees, 300 randomly selected respondents participated in the survey. Therefore, each respondent in the sample represented approximately 55 (16,449/300) individuals in the population of eligible AMERIGROUP beneficiaries. This weighting is reflected in the frequencies presented in all the tables and figures in this report and the technical appendix.

Multivariate analyses were performed to investigate the effects of several sociodemographic characteristics, health status, and health plan enrollment on each of the satisfaction composite scores. Details on these analyses are provided in Appendix B.

## Appendix B. Multivariate Analysis

### Effects of sociodemographic, health status, and health plan enrollment on enrollee satisfaction -- Multivariate results

To estimate the effects of individuals' sociodemographic, health status, and health plan enrollment on enrollee satisfaction with several components of their health care, multivariate analyses were conducted using logistic regression.

The outcome variables for these analyses, which the individual factors were modeled to predict, were based on the following four CAHPS® composite scores: *Getting Needed Care*, *Getting Care Quickly*, *Doctor's Communication*, and *Health Plan Customer Service*. Because logistic regression requires a binary outcome variable, and the composite scores range from 0 to 100, scores of 75 or higher were assigned a value of one, and scores lower than 75 received a zero value. The multivariate analyses were designed to determine the extent to which a particular individual factor predicted a satisfaction composite score greater than or equal to 75.

To control for variation across individuals, six factors were included as independent variables in the multivariate analyses:

1. Respondent RAND® general health status,
2. Respondent gender,
3. Respondent age category,
4. Respondent race/ethnicity,
5. Respondent education level, and
6. Respondent health plan.

Effects of all six individual factors on each of the four satisfaction composites are presented in **Table B1**. The "parameter estimates" represent the increase or decrease in the likelihood of scoring 75 or more on the satisfaction composite for those respondents with a particular individual factor, as compared with the reference group. For example, in the model for *Getting Needed Care*, the parameter estimate for Molina was .706, meaning that Molina enrollees were .706 times more likely to have a score of 75 or higher on the composite for *Getting Needed Care*, as compared with enrollees from Superior (the referent group).

**Table B1. Multivariate results – predicting respondent rating of program by program experience**

	Dependent Variable			
	Getting Needed Care	Getting Care Quickly	Doctor Communication	Health Plan Customer Service
	Parameter Estimate	Parameter Estimate	Parameter Estimate	Parameter Estimate
<b>RAND® General Health Score</b>	.004	-.006	.002	.003
<b>Gender</b>				
Male	Referent	Referent	Referent	Referent
Female	-.176	-.041	.015	-.439
<b>Age Category</b>				
18-30	Referent	Referent	Referent	Referent
31-40	-.308	.021	.276	.781
41-50	-.095	.241	.541	.694
51-60	-.027	.355	.468	.662
61+	.727	.569	<b>1.151</b>	<b>1.417</b>
<b>Race/Ethnicity</b>				
Hispanic	<b>.553</b>	.031	.350	.236
Black, non-Hispanic	.096	.338	.108	.593
Other, non-Hispanic	-.039	.235	.034	-.401
White, non-Hispanic	Referent	Referent	Referent	Referent
<b>Education Level</b>				
Less than high school education	Referent	Referent	Referent	Referent
High school graduate	-.186	-.154	.583	.058
Some college	-.171	-.441	<b>.292</b>	-.154
College graduate	-.588	-.300	.319	<b>-.972</b>
<b>Health Plan</b>				
AMERIGROUP	-.290	-.325	Referent	-.454
Evercare	-.325	<b>-.417</b>	-.019	<b>-.691</b>
Molina	<b>-.706</b>	-.280	-.276	-.557
Superior	Referent	Referent	.165	Referent

Parameter estimates are considered statistically significant if their p values are less than or equal to 0.05. Statistically significant parameter estimates are bolded in **Table B1**. Based on the results of the multivariate analyses, the significant and relevant factors of satisfaction for the four composites were:

Composite

Getting Needed Care  
 Getting Care Quickly  
 Doctor Communication  
 Health Plan Customer Service

Factors

Hispanic ethnicity, Molina enrollment  
 Evercare enrollment  
 Age 61 and older, Some College  
 Age 61 and older, College Graduate, Evercare enrollment

In summary, results from the multivariate analyses suggest that there are few differences in satisfaction composite scores, even after controlling for individual factors and health plan enrollment. The differences that do exist suggest that enrollees age 61 and older and those with some college or a college degree are more satisfied, and that Evercare and Molina enrollees might be slightly less satisfied.

## Endnotes

<sup>1</sup> HHSC (Texas Health and Human Services Commission). 2007. *Texas Medicaid in Perspective, Sixth Edition*. "Chapter 6: Medicaid Managed Care." Available at <http://www.hhsc.state.tx.us/Medicaid/reports/PB6/PinkBookTOC.html>.

<sup>2</sup> ICHP (The Institute for Child Health Policy). 2008. *Texas STAR+PLUS Enrollee Report: Technical Appendix*. Gainesville, FL: The Institute for Child Health Policy, University of Florida.

<sup>3</sup> Consumer Assessment of Healthcare Providers and Systems (CAHPS®). 2008. "CAHPS® Health Plan Survey 4.0, Adult Medicaid Questionnaire." Available at [https://www.cahps.ahrq.gov/cahpskit/files/1152a\\_engadultmed\\_40.pdf](https://www.cahps.ahrq.gov/cahpskit/files/1152a_engadultmed_40.pdf).

<sup>4</sup> Ware, J. E., M. Kosinski and B. Gandek. 2005. *SF-36 Health Survey: Manual and Interpretation*. Lincoln, RI.

<sup>5</sup> ICHP. 2008. *Texas STAR+PLUS Enrollee Report: Technical Appendix*.

<sup>6</sup> U. S. Department of Health and Human Services. 2002. *Protecting the Health of Minority Communities*. United States Department of Health and Human Services. Washington, DC.

<sup>7</sup> Ware, J. E., M. Kosinski and B. Gandek. 2005.

<sup>8</sup> Please note that the 'U.S. National Norms' column in this table reports results on SF-36 scores as presented in Ware, J. E., M Kosinski and B. Gandek. 2005. *SF-36 Health Survey: Manual and Interpretation*. Lincoln, RI. Ware et al. report on mean scores and standard deviations but not on standard errors. As a result, we are unable to report on the standard errors in the 'U.S. National Norms' column, but have kept the information on standard deviations for informational purposes

<sup>9</sup> National Institutes of Health. 1998. *Clinical Guidelines on the Identification, Evaluation and Treatment of Overweight and Obesity in Adults*. NIH Publication No. 98-4083. Available at [http://www.nhlbi.nih.gov/guidelines/obesity/ob\\_gdlns.pdf](http://www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.pdf).

<sup>10</sup> CDC (Centers for Disease Control and Prevention). 2006. *Behavioral Risk Factor Surveillance System Survey Data*. Atlanta, Georgia: U.S. Department of Health and Human Services.

<sup>11</sup> CDC. 2008. "Defining Overweight and Obesity." Available at <http://www.cdc.gov/nccdphp/dnpa/obesity/defining.htm>.

<sup>12</sup> CDC. 2008. "Key Facts About Seasonal Flu Vaccine." Available at <http://www.cdc.gov/FLU/protect/keyfacts.htm>.

<sup>13</sup> The Smoking Cessation Clinical Practice Panel Staff. 1996. "The Agency for Health Care Policy and Research Smoking Cessation Clinical Practice Guideline." *Journal of the American Medical Association* 275 (16):1270–1280.

<sup>14</sup> HHSC. 2007. "Chapter 10.1.1: Performance Indicator Dashboard, Version 1.2." *Uniform Managed Care Manual*. Available at <http://www.hhsc.state.tx.us/Medicaid/UMCM/>.

<sup>15</sup> Safran, D.G., D. A. Taira, W. H. Rogers, M. Kosinski, J. E. Ware, and A. R. Tarlov. 1998. "Linking Primary Care Performance to Outcomes of Care." *Journal of Family Practice* 47 (3): 213-220.

<sup>16</sup> Donaldson, M.S., K. D. Yordy, K. N. Lohr, and N. A. Vanselow, (eds.) 1996. *Primary Care: America's Health in a New Era*. Washington DC: National Academy Press.

<sup>17</sup> Grumbach, K., J. V. Selby, C. Damberg, A. B. Bindman, C. Quesenberry, A. Truman, and C. Uratsu. 1999. "Resolving the Gate-Keeper Conundrum: What Patients Value in Primary Care and Referrals to Specialists." *Journal of the American Medical Association* 282 (3): 261-266.

<sup>18</sup> Mainous, A.G., R. Baker, M. M. Love, D. P. Gray, and J. M. Gill. 2001. "Continuity of Care and Trust in One's Physician: Evidence from Primary Care in the United States and the United Kingdom." *Family Medicine* 33 (1): 22-27.

<sup>19</sup> Szilagyi, P.G. 1998. "Managed Care for Children: Effect on Access to Care and Utilization of Health Services." *The Future of Children* 8 (2): 39-59.

<sup>20</sup> HHSC. 2007. "Chapter 10.1.1: Performance Indicator Dashboard, Version 1.2." *Uniform Managed Care Manual*.

<sup>21</sup> Ibid.

<sup>22</sup> Ibid.

<sup>23</sup> Ibid.

<sup>24</sup> Ibid.

<sup>25</sup> HHSC. 2007. "STAR+PLUS '101'". Available at [http://www.hhsc.state.tx.us/starplus/star\\_plus\\_101/Starplus101.htm](http://www.hhsc.state.tx.us/starplus/star_plus_101/Starplus101.htm).

<sup>26</sup> It should be noted that Medicaid national means for these domains rely on an earlier version of the CAHPS<sup>®</sup> Health Plan Survey. As described earlier, this report uses information from the newest version of CAHPS<sup>®</sup>, i.e., CAHPS<sup>®</sup> Health Plan Survey 4.0. As such, part of the differences in the Medicaid national means and STAR+PLUS Program means may be due to the differences in survey items used in scoring these domains.

<sup>27</sup> NCQA (National Committee for Quality Assurance). 2007. *The State of Health Care Quality*. Washington, D.C. Available at [http://www.ncqa.org/Portals/0/Publications/Resource%20Library/SOHC/SOHC\\_07.pdf](http://www.ncqa.org/Portals/0/Publications/Resource%20Library/SOHC/SOHC_07.pdf).

<sup>28</sup> Institute for Healthcare Improvement. 2008. "Reduce Scheduling Complexity." Available at <http://www.ihl.org/IHI/Topics/OfficePractices/Access/Changes/ReduceSchedulingComplexity.htm>

<sup>29</sup> Consumer Assessment of Healthcare Providers and Systems (CAHPS<sup>®</sup>). 2008.

<sup>30</sup> Ware, J. E., M. Kosinski and B. Gandek. 2005.

<sup>31</sup> NCQA. 2002. *HEDIS<sup>®</sup> 2003: Specifications for Survey Measures*. Washington, D.C.

<sup>32</sup> AHRQ (U.S. Agency for Healthcare Research and Quality). 2006. *Reporting Measures for the CAHPS<sup>®</sup> Health Plan Survey 4.0, CAHPS Survey and Reporting Kit*.

<sup>33</sup> McGee, J., D. E. Kanouse, S. Sofaer, J. L. Hargraves, E. Hoy, and S. Kleimann. 1999. "Making Survey Results Easy to Report to Consumers: How Reporting Needs Guided Survey Design in CAHPS<sup>®</sup>. Consumer Assessment of Health Plans Study." *Medical Care* 37 (3 suppl.): MS32-MS40.

<sup>34</sup> Hargraves, J.L., R. D. Hays, and P. D. Cleary. 2003. "Psychometric Properties of the Consumer Assessment of Health Plans Study (CAHPS<sup>®</sup>) 2.0 Adult Core Survey." *Health Services Research* 38 (6 Pt 1): 1509-1528.

<sup>35</sup> Ware, J. J., and C.D. Sherbourne. 1992. "The MOS 36-Item Short-Form Health Survey (SF-36). I. Conceptual Framework and Item Selection." *Medical Care* 30 (6): 473-483.

<sup>36</sup> National Center for Health Statistics. 2008. *National Health Interview Survey*. Available at <http://www.cdc.gov/nchs/nhis.htm>.

<sup>37</sup> U.S. Census Bureau. 2008. *Current Population Survey*. Available at <http://www.census.gov/cps>.

<sup>38</sup> Urban Institute. 2008. *National Survey of America's Families*. Available at <http://www.urban.org/center/anf/nsaf.cfm>.