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

Texas STAR+PLUS Enrollee Survey Report

Fiscal Year 2009

Institute for Child Health Policy
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Executive Summary

he 2009 Texas STAR+PLUS Enrollee Survey Report provides results from the 2009 STAR+PLUS 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 document 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 each of the four health plans, with one additional survey completed for Superior HealthPlan. The total number of completed surveys for all four health plans was 1,201. Data were analyzed using SPSS 17.0 software and descriptive analyses were conducted on all survey questions.

The report includes findings from several different quality "domains", or subject areas. Overall, STAR+PLUS program enrollees reported positive results in the areas of having a personal doctor, continuity of care, access to medication, and care coordination. Specifically, the STAR+PLUS program reported considerable improvement from 2008 to 2009 in several key indicators:

- Flu shots received (39 percent improved to 49 percent).
- Access to urgent care (73 percent improved to 80 percent).
- Access to routine care (71 percent improved to 78 percent).
- Frequency of delays while waiting for health plan approval (33 percent improved to 44 percent).
- Access to special medical equipment (55 percent improved to 65 percent).
- Access to special therapies (45 percent improved to 66 percent).
- Enrollee Satisfaction (CAHPS Composite Scores) for:
  - Getting Needed Care (64.4 improved to 69.6).
  - Getting Care Quickly (72.5 improved to 78).
  - Customer Service (68.8 improved to 73.7).

It is also noteworthy that the STAR+PLUS program performed better than the national average in the following areas:

- Personal doctor visits of five or more (35 percent vs. 17 percent).
- Specialist visits (two to four) in the past six months (53 percent vs. 39 percent).
- Specialist visits (five or more) in the past six months (7 percent vs. 3 percent).

While comparatively high performance or noticeable improvement 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 difficulty finding personal doctors after joining a health plan. Specifically, reported performance for some measures is less than desired when compared to national benchmarks set by the National Committee for Quality Assurance (NCQA) or Texas Health and Human Services Commission (HHSC) Performance Indicator Dashboard standards:

<u>Performance Below National Benchmarks</u>

- Health status scores of "poor" (30 percent vs. 10 percent).
- Health status scores of "excellent" (14 percent vs. 34 percent).

- Enrollee Satisfaction (CAHPS Composite Scores) for:
  - Getting Needed Care (69.6 vs. 75.2).
  - Customer Service (73.7 vs. 79.1).

Performance Below HHSC Standards (Performance Indicator Dashboard)

- 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 (30 percent vs. 42 percent).

To address areas of less than desired performance noted above, HHSC has taken the following actions related to improving these rates:

Internal Improvements

- Initiated a review of performance indicator targets for managed care organization (MCO) performance measures to determine if the targets 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 with the External Quality Review Organization (EQRO) and HHSC staff that oversee contracts with MCOs to improve staff understanding and expertise.

External Performance Gap Improvements

- HHSC assisted by ICHP (the External Quality Review Organization) 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.
  - Difficulty finding personal doctors.
  - Frequency of delays while waiting for health plan approval.
  - Frequency of entering the exam room within 15 minutes of appointment.
  - Getting Needed Care.
  - Customer Service.

This plan is being put in place to identify areas of under-addressed needs in the following ways:

- A review of continuity of care improvement programs to provide care for disabled and chronically ill patients that will document integration efforts for acute and long term care services in a managed care environment.
- A review of education and promotion programs to reduce overweight and obesity in an older population with high rates of disability.

- Investigate 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.
- Investigate 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.

Population groups for the focus for this investigation include:

- 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 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, integrates acute care and long-term services and supports for SSI and SSI-related Medicaid members who have chronic and complex conditions.[1]

Disabled and chronically ill Medicaid members represent a vulnerable and fast-growing population with unique health services needs. Research has identified a number of challenges for ensuring good access and quality of health care for this population, including long travel time to appointments, long wait times in providers' offices, and communication difficulties with providers.[2] To address these and other challenges, the STAR+PLUS program includes a service coordination program for members with complex medical conditions. These members are assigned a service coordinator who develops an individual plan of care with the enrollee, family members and providers, and who can authorize services. The emphasis of STAR+PLUS care coordination is on providing home and community-based services to avoid the need for institutionalization. Care coordination stands out as a priority component of the STAR+PLUS program for external quality assessment.

This report presents results from the 2009 STAR+PLUS Enrollee Survey. Specifically, this report provides information regarding enrollees':

- sociodemographic characteristics and health status;
- healthy behavior practices and health promotion activities; and
- utilization, experiences and satisfaction with:
    - personal doctors
    - getting urgent, routine, and specialist care
    - getting specialized and other services, and
    - care coordination.

In SFY 2009 four health plans participated in the STAR+PLUS program in Texas: AMERIGROUP, Evercare, Superior, and Molina. While most results presented in the report are aggregated across all four health plans, the Technical Appendix that accompanies the report provides results for each item in the survey by health plan.[3]

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 member must have been enrolled in the STAR+PLUS program in Texas for at least nine consecutive months between September 2007 and August 2008.
2) the member must have been over the age of 18 during the eligibility period;
3) the member must have been eligible for Medicaid, but not for both Medicaid and Medicare; and
4) the member must not have participated in the prior year's (SFY 2008) STAR+PLUS Survey.

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 each of the four health plans, with one additional survey completed for the Superior health plan. The additional completed survey occurred as a result of the survey fielding methodology, in which telephone interviews may occur with two or more members simultaneously. Overall, 1,201 surveys were completed.

Stratified sampling weights were developed to account for the probability of inclusion into the survey sample by health plan. For example, 14,091 AMERIGROUP enrollees met the sample inclusion criteria. Of those, 300 randomly selected respondents participated in the survey. Therefore, each AMERIGROUP enrollee response was weighted by 46.97 (14,091/300). All frequencies and means 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 8,500 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®) Health Plan Survey, version 4.0; [4]
2) RAND® 36-Item Health Survey, version 1.0;[5]
3) questions related to care coordination services;
4) sociodemographic characteristics of the respondent; and,
5) questions related to members' housing and employment status.

The CAHPS® Health Plan Survey for adult Medicaid members assesses experiences and satisfaction with health care received during the preceding six months. Responses to the STAR+PLUS Enrollee Survey (which began in December 2008) therefore cover health care received by enrollees from June 2008 to April 2009, when survey efforts were completed. Comparative results from the national Medicaid population are available for selected CAHPS® questions through the CAHPS® Benchmarking Database, and when relevant, are presented alongside STAR+PLUS enrollee responses in the results below.[6] Because of the unique demographic and health profile of the STAR+PLUS population, comparisons with the Medicaid national rates should be interpreted with caution.

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 ranged up to 13 percent, while the percentage of respondents who refused to answer a question ranged up to five percent. Overall, the percentage of "do not know" and "refused" responses was very small for most individual items (two 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 new categories were created when there were sufficient consistent responses to do so.

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 Survey Research Center (SRC) 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. SRC 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. Six 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 17.0 (Chicago, IL: SPSS, Inc.). Frequency tables showing descriptive results for each survey question are provided in a separate Technical Appendix.[7] The statistics presented in this report exclude "do not know" and "refused" responses.

All percentages and means presented in this report were weighted according to the probability of inclusion by health plan (as detailed in Sample Selection Procedures, above). Statistical tests of differences between relevant subgroups and between SFY 2008 and SFY 2009 survey data employed the Pearson chi-square test (for differences in proportions) and t-tests and one-way analysis of variance (ANOVA) (for differences in means). Differences were considered statistically significant when p was less than or equal to 0.05. The p-value refers to the probability that observed differences could have occurred by chance alone. Therefore, the lower the p-value of a statistical test, the greater the likelihood that an external factor (whether program-related, demographic, or other) may explain the observed difference. To prevent overestimation of statistical significance resulting from sample size inflation, all tests were performed without weighting. The statistics and p-values for differences that were both statistically and practically significant are presented as endnotes.

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.

Fiscal Year 2009 Survey Results

This section provides survey findings regarding STAR+PLUS enrollee demographics, housing and employment situation, health status, healthy behaviors and health promotion activities, presence of a personal doctor and enrollee experiences with their personal doctors, experiences and satisfaction with getting urgent, routine, and specialist care, experiences receiving specialized and services, experiences and satisfaction with care coordination services, and enrollees' satisfaction with their health care as measured by CAHPS composite scores.

Statistical tests of differences in proportions and means among relevant sub-groups of the STAR+PLUS sample (e.g., by gender, race/ethnicity, or health status) and between SFY 2008 and SFY 2009 responses were performed for most survey items. Only those differences that were both statistically and practically significant are presented below.

Demographic Information

The average age of STAR+PLUS enrollees was 50 years, with a range from 18 to 90 years of age. A greater percentage of women (69 percent) than men (31 percent) responded to the survey.

Research has found disparities among racial and ethnic groups in regard to health status, health outcomes, and access to health care.[8] These disparities are especially relevant for those with chronic conditions or disabilities, whose severity of limitations to activities of daily living have been found to vary by linguistic and ethnic group.[9,10] Understanding the racial/ethnic composition of the STAR+PLUS population is therefore essential for identifying strategies to minimize disparities in health care access and health outcomes.

Figure 1 shows the racial/ethnic breakdown of enrollees in the 2009 STAR+PLUS enrollee survey. Hispanic enrollees represented 41 percent of the sample, while 25 percent were White, non-Hispanic, and 28 percent were Black, non-Hispanic. The Other, non-Hispanic category included Asian or Pacific Islander, American Indian or Alaska Native, and other unspecified races/ethnicities, representing six percent of the sample.

Figure 1. Respondent race/ethnicity

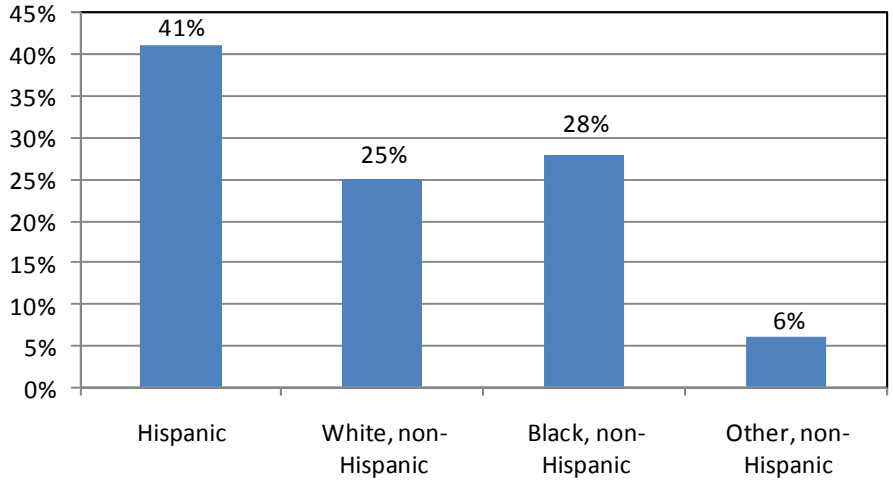
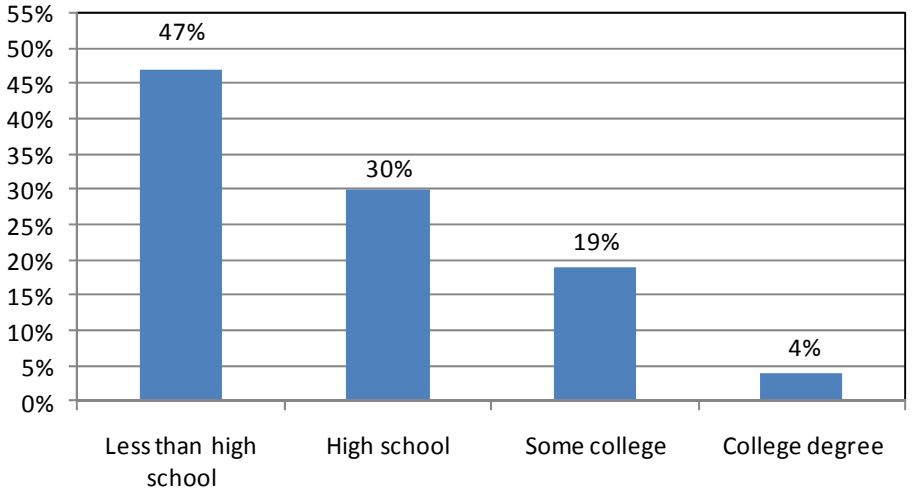


Figure 2 shows the educational level of the 2009 survey respondents. Forty-seven percent of respondents reported they had less than a high school education. Thirty percent of respondents reported having a GED or high school diploma. Nineteen percent had completed some college or received their Associate's degree, while four percent had a Bachelor's degree or higher; in total, 23 percent of the respondents had at least some college education. Overall, SFY 2009 survey respondents were more educated than those who responded to the SFY 2008 survey, where 53 percent had less than a high school education and 19 percent had at least some college education.[11]

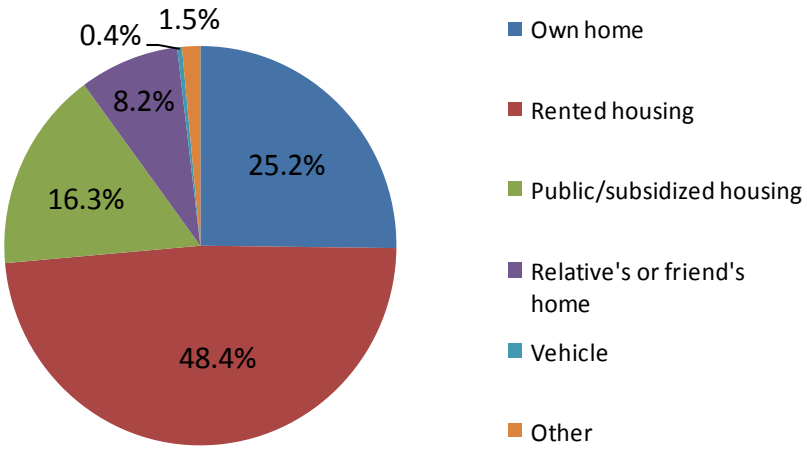
Figure 2. Respondent education



The primary language spoken by survey respondents was English (82 percent), followed by Spanish (16 percent), and other languages (2 percent).

Approximately half of survey respondents (N = 603) answered a series of questions dealing with housing and employment. **Figure 3** shows the primary type of housing or residence STAR+PLUS enrollees lived in during the six months prior to the survey. Nearly half of those who responded to housing and employment questions (48 percent) lived in rented housing, while one-quarter lived in their own home. Sixteen percent lived in public or subsidized housing.

Figure 3. Respondent's primary type of housing [a]



[a] Frequencies differ from those in the technical appendix after adjusting for open-ended responses

Ninety-three percent of those who responded to housing and employment questions said they did not work in the six months prior to the survey. Among those who did work, nearly three-quarters (73 percent) had been employed part-time (less than 35 hours per week).

All respondents who answered the housing and employment questions were asked about their opinions regarding work, measuring their level of agreement to six statements about working (**Table C1** in **Appendix C**). Seventy percent of these enrollees strongly agreed with the statement: "Working helps me pay for things my family and I need." Sixty-nine percent of enrollees strongly agreed with the statement: "Working is a way for me to stay independent". However, only 20 percent strongly agreed with the statement: "I see myself working in the next year." Having enough money to meet basic needs and having a sense of independence are both important components for positive quality of life. While the majority of STAR+PLUS enrollees indicated that working could help them achieve or maintain these components, only one in five believed they would be employed in the next year.

Both age and health status are associated with enrollees' expectations of future employment. Among respondents 18 to 30 years old, 42 percent strongly agreed with the statement, "I see myself working in the next year", compared with only 14 percent of respondents 61 years or older.[12] Among respondents who rated their overall health as "excellent", 60 percent strongly agreed, compared with only 13 percent who rated their overall health as "poor".[13]

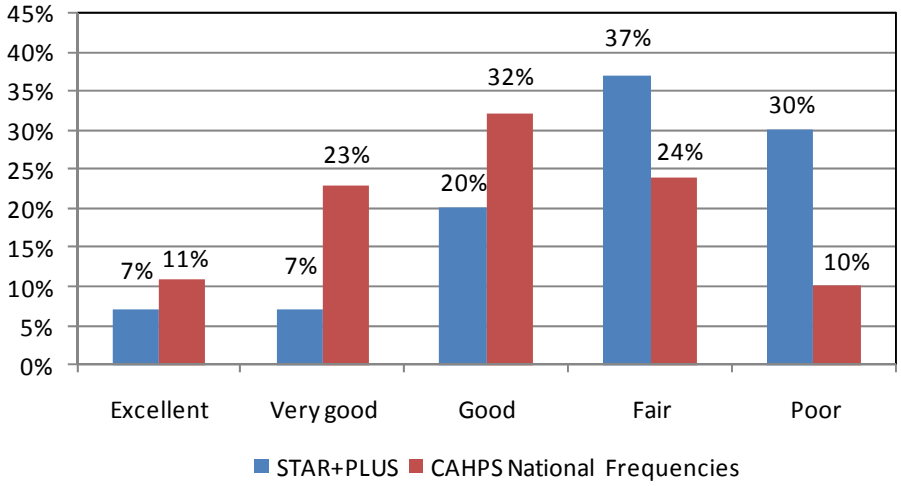
STAR+PLUS enrollees who did not work in the six months prior to the survey were also asked about reasons they were unable to work, measuring their level of agreement to ten statements about being unemployed (**Table C2** in **Appendix C**). The most frequently cited reasons for being unable to work included: (1) deterioration of health resulting from work (69 percent somewhat or strongly agreed); (2) work being too stressful (48 percent somewhat or strongly agreed); (3) being unable to find a job that met the enrollee's needs (40 percent somewhat or strongly agreed); and (4) being unable to find a job that provided needed special accommodations (40 percent somewhat or strongly agreed).

Enrollees' Health Status

Survey respondents were asked a series of questions about their health status, ranging from general health to specific domains such as mental health and role and activity limitations due to physical or emotional problems. Rating health status is important for two major reasons. First, this information forms a baseline 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.

Overall, respondent self-rated health status was low. Nearly one-third of survey respondents (30 percent) rated their overall health as "poor", which compares with only 10 percent of Medicaid members nationally. (**Figure 4**). Fourteen percent of survey respondents rated their overall health as "excellent" or "very good", compared with 34 percent of Medicaid members nationally.

Figure 4. Self-reported overall health: STAR+PLUS and Medicaid national rates [14]



The health status of STAR+PLUS enrollees was also assessed using the RAND® 36-Item Health Survey, Version 1.0, which produces scores in eight physical and mental health domains.[15] The RAND®-36 scores range from 0 to 100, with higher scores indicating better health status. Overall, scores for the STAR+PLUS enrollees were low, with means below 50.00 for all domains except Emotional Well-Being (**Table 1**). The lowest-scoring domain was Role Limitations Due to Physical Health (30.83), which was significantly lower than the score for this domain among SFY 2008 survey respondents (34.01).[16]

Table 1. RAND®-36 Health Survey Mean Results among STAR+PLUS Enrollees

	STAR+PLUS Means
Physical Functioning	40.86
Role Limitations Due to Physical Health	30.83
Role Limitations Due to Emotional Problems	39.53
Energy/Fatigue	36.95
Emotional Well-Being	55.27
Social Functioning	48.39
Bodily Pain	42.79
General Health	37.39

Another component of health status involves a person's ability to perform specific activities of daily living, in which low rates function as measures of disability and dependence on others. Two-thirds (67 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 (52 percent) reported needing help with routine needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes. Eighty-seven percent of STAR+PLUS enrollees said they had a physical or medical condition that seriously interfered with their ability to work, attend school, or manage day-to-day activities.

Low 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 poor physical and mental health in this 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

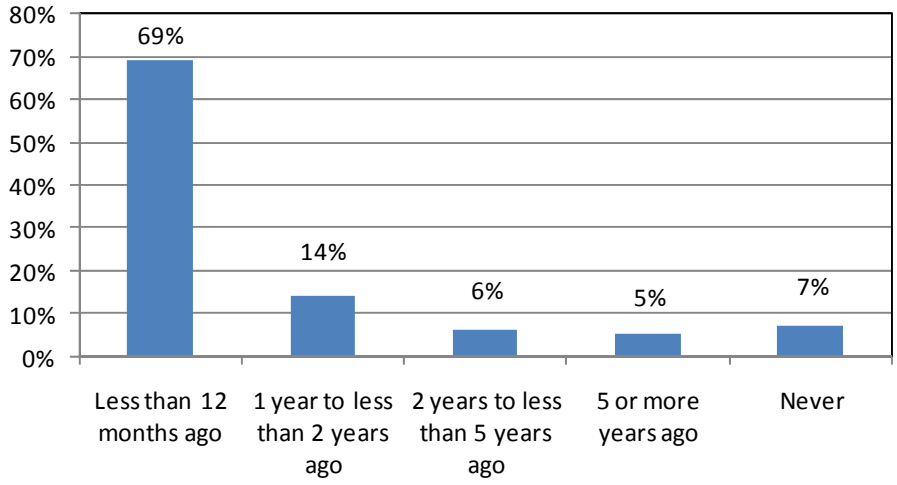
of care for disabled and chronically ill Medicaid patients through integration of acute and long term care services in a managed care environment.

Healthy Behaviors and Health Promotion Activities

A number of health behaviors and promotion practices can reduce illness and health care costs. Such practices include seeing a healthcare provider for routine checkups, maintaining a healthy weight, receiving flu shots, and smoking cessation.

Rates of visiting a doctor for a routine checkup were high among STAR+PLUS enrollees (**Figure 5**). More than two-thirds of survey respondents (69 percent) had visited a doctor for a routine checkup in the 12 months prior to the survey. While only seven percent of respondents reported never having a routine checkup, in a managed care setting this rate should be minimized through program and health plan efforts to improve member outreach and health literacy.

Figure 5. Last time having a routine check-up with a doctor



Overweight and obesity have been associated with increased rates of disease and mortality. According to the National Institutes of Health, overweight and obese individuals are at increased risk for hypertension, diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea and respiratory problems, and some types of cancer.[17] 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 shows BMI results for the STAR+PLUS survey respondents. The mean BMI was 32, which is considered obese according to the Centers for Disease Control and Prevention (CDC).[18] Seventy-seven percent of survey respondents were either overweight or obese, suggesting a high likelihood of overweight- and obesity-related disease burden in the STAR+PLUS population. Three percent of STAR+PLUS survey respondents were underweight. While a large disparity in obesity is noted between STAR+PLUS enrollees and all adults in the Texas population, higher prevalence of obesity is expected among STAR+PLUS enrollees, who represent a low-income, disabled population.

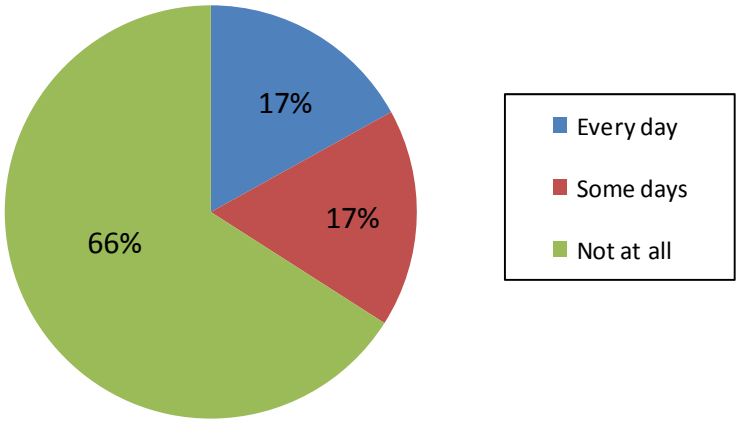
Table 2. BMI classification of STAR+PLUS enrollees

	STAR+PLUS Enrollees	Texas Adults (2008) [19]
Mean BMI (Standard Deviation)	32.1 (9.8)	--
Obese (BMI ≥ 30.0)	52%	29%
Overweight (BMI 25.0 – 29.9)	25%	37%
Normal Weight (BMI 18.5 – 24.9)	20%	34%
Underweight (BMI < 18.5)	3%	

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.[20] Nearly half of survey respondents (49 percent) reported receiving a flu shot during the 2008 flu season. This was significantly greater than the 39 percent of SFY 2008 survey respondents who received a flu shot during the 2007 flu season.[21]

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 therapy except in special circumstances, and schedule follow-up contacts after cessation.[22] **Figure 6** shows the current smoking status of STAR+PLUS enrollees. Two-thirds of survey respondents said they were not current smokers, while 34 percent reported they smoked some days or every day.

Figure 6. STAR+PLUS enrollee smoking status



Those who indicated being smokers at the time of the survey 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).** Among these enrollees, 63 percent were advised to quit smoking during at least one office visit in the last six months, which is considerably greater than the HHSC Performance Indicator Dashboard standard of 28 percent for SFY 2008.[23] However, the percentage of smokers who had one or more office visits but were not advised to quit smoking (34 percent) was significantly higher than in SFY 2008 (25 percent).[24] This difference does not necessarily mean there was a reduction in efforts by providers to recommend cessation. In SFY 2008, the percentage of smokers who had no visits in the last six months was 12 percent, compared with four percent in the present report. It is likely that most of the providers of enrollees who had no visits in SFY 2008 represented those who would not advise smoking cessation in SFY 2009, resulting in the decrease.

Table 3. Smoking cessation advice/assistance by doctors or health providers

	None	One to 4 visits	5 or more visits	I had no visits
In the last 6 months, on how many visits…				
…were you advised to quit smoking by a doctor or other health provider in your plan?	34%	39%	24%	4%
…was medication recommended or discussed to assist you with quitting smoking?	63%	27%	7%	4%
…did your doctor recommend or discuss methods and strategies (other than medication) to assist you with quitting smoking?	63%	24%	10%	4%

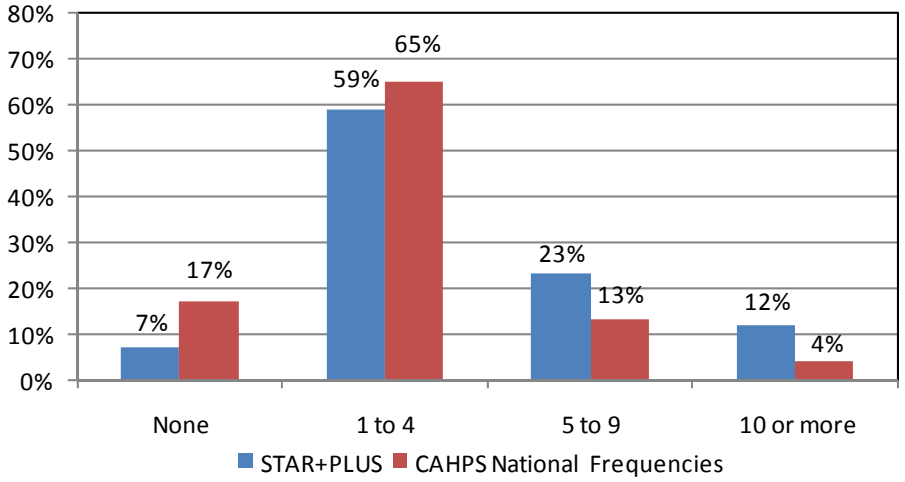
Personal Doctor

Having a particular person or place to go to for sick and preventive care contributes to improved health outcomes.[25,26] 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.[27] Continuity with the same health care provider is also highly valued by patients and improves utilization of preventive care, leading to prompt detection and treatment of health problems.[28] This section reports on responses to questions from the CAHPS® Health Plan Survey about the presence of a personal doctor as a usual source of care and enrollees' experiences with their personal doctors.

Overall, 87 percent of STAR+PLUS respondents said they had a personal doctor. The majority of those with personal doctors (64 percent) received care from their personal doctors for two years or longer, with over two-thirds (36 percent) receiving care for five years or longer. Continuity of care among STAR+PLUS enrollees is good, which is reflected in high overall ratings of personal doctors by their patients. On a scale of 0 to 10, survey respondents on average rated their personal doctors 8.51.

Figure 7 shows utilization of personal doctors by STAR+PLUS enrollees and among Medicaid members nationally. STAR+PLUS enrollees visited their personal doctors considerably more often than Medicaid members in health plans reporting to the CAHPS national database in 2008, with 35 percent reporting five or more visits compared with 17 percent nationally. This is an expected difference given the special health care needs of the STAR+PLUS population, and one that should be interpreted as a positive for health care quality.

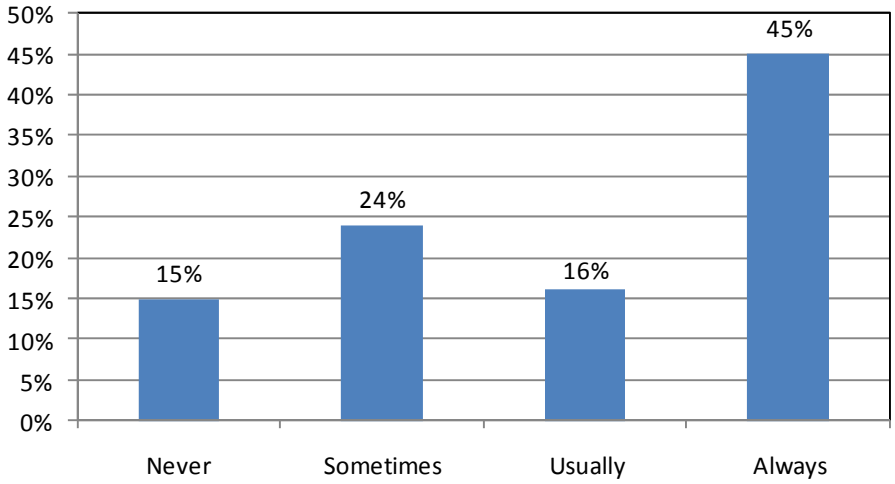
Figure 7. Personal doctor visits in last 6 months: STAR+PLUS and Medicaid national rates [29]



Among those respondents with personal doctors, 63 percent said they had phoned their personal doctor's office during regular office hours in the last six months to get help or advice. The majority of those who called (73 percent) said they usually or always got the help or advice they needed. About one-quarter (23 percent) of respondents with personal doctors phoned their personal doctor's office after regular office hours. Likewise, the majority of these respondents (70 percent) said they usually or always got the help or advice they needed. This suggests that telephone consultation responsiveness is positive among primary care physicians who treat STAR+PLUS enrollees, regardless of when enrollees call. For those enrollees who did report difficulty getting help or advice when calling after hours, **Table C3** in **Appendix C** lists the different reasons cited. The most frequently cited reason was that the enrollee left a message but no one from their doctor's office returned their call (47 percent).

Fifty-six percent of STAR+PLUS enrollees with personal doctors indicated they did not have the same personal doctor before they joined their health plan, suggesting either that their original personal doctor was not in their health plan's network or that they did not have a personal doctor prior to joining. As shown in **Figure 8**, less than half of these respondents (45 percent) said it was always easy to get a personal doctor they were happy with. However, 15 percent indicated that it was never easy to get a personal doctor they were happy with. Among the half of STAR+PLUS enrollees who had to choose a personal doctor after joining their health plan, a substantial proportion have had some difficulty finding the right doctor.

Figure 8. "How often was it easy to get a personal doctor you are happy with?"



Communication between personal doctors and their patients, especially in clinical encounters, is an important component of health care quality and satisfaction. Studies have also confirmed that effective communication by providers is associated with positive health outcomes – particularly when communication is patient-centered, respectful, and characterized by shared decision-making and cultural competency.[30]

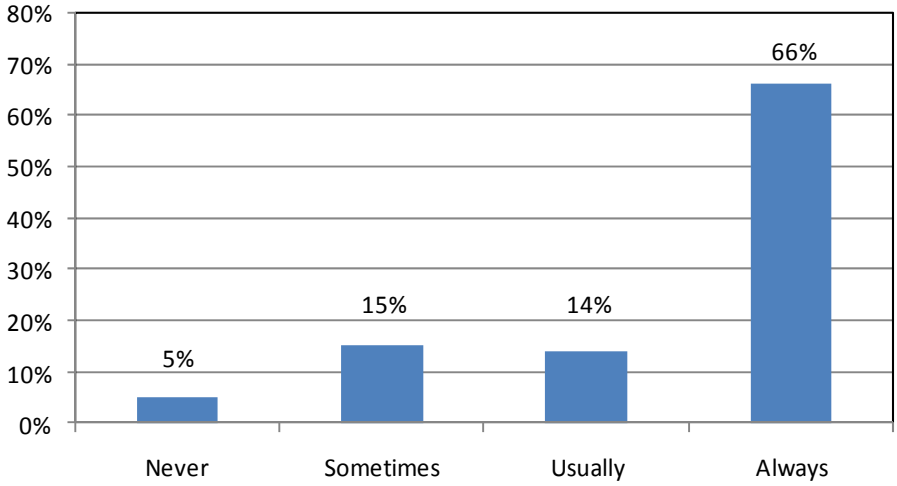
Overall, STAR+PLUS enrollees reported positive experiences with their personal doctors' communication. Eighty-six percent of those with personal doctors said their personal doctor usually or always explained things in a way that was easy to understand. The same percentage (86 percent) said their personal doctor usually or always listened carefully to them. Eighty-eight percent said their personal doctor usually or always showed respect for what they had to say. These results were not substantially different from those reported by Medicaid programs nationally to the CAHPS® Benchmarking Database.[31] The quality of doctor-patient communication is also assessed as a CAHPS® composite measure – *Doctors' Communication* – detailed below.

Getting Urgent, Routine, and Specialist Care

The implementation of managed care sometimes raises questions about potential barriers to healthcare services.[32] The impact of managed care is of particular concern for individuals with complex physical or emotional problems who may require the care of specialist physicians. The ability to access urgent, routine, and specialist care affects both health outcomes and health services satisfaction and is important to monitor.

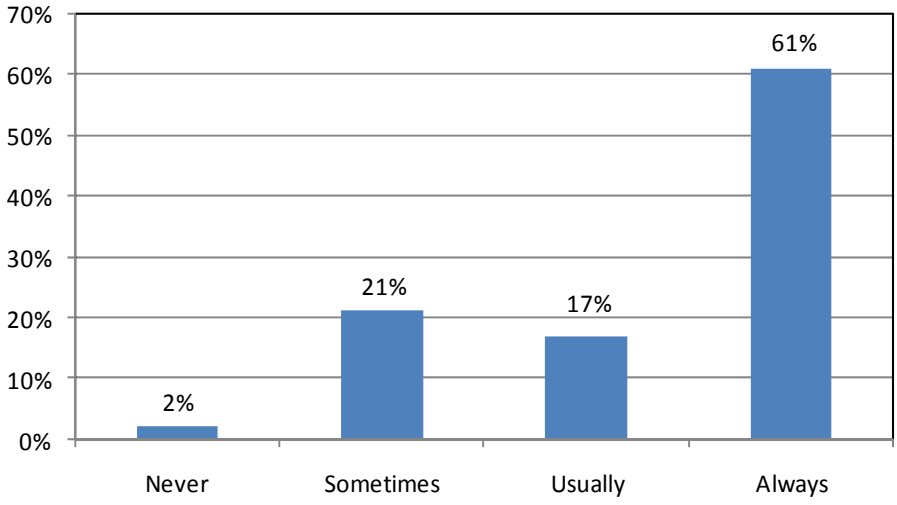
The majority of STAR+PLUS enrollees reported that they were usually or always able to get urgent care as soon as they thought it was needed (80 percent) (**Figure 9**). This represents a significant improvement since the SFY 2008 survey, in which 73 percent of respondents reported usually or always being able to get urgent care.[33] It also exceeds the HHSC Performance Dashboard Indicator standard of 76 percent for good access to urgent care in the STAR+PLUS population.[34]

Figure 9. Frequency of getting urgent care as soon as needed



The majority of STAR+PLUS enrollees also reported that they were usually or always able to get appointments for routine care as soon as they thought it was needed (78 percent) (**Figure 10**). This represents a significant improvement since the SFY 2008 survey, in which 71 percent of respondents reported usually or always being able to get appointments.[35] It is also comparable to the HHSC Performance Dashboard Indicator standard of 78 percent for good access to routine care in the STAR+PLUS population.[36]

Figure 10. Frequency of getting non-urgent appointment as soon as needed

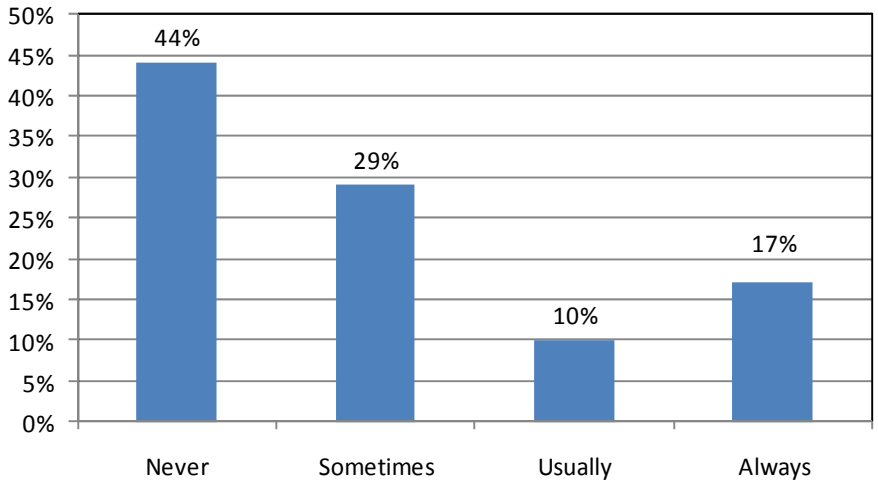


Overall, STAR+PLUS enrollees experienced few delays in getting needed health care. **Figures 11, 12,** and **13** present results for three different aspects of waiting for care: (1) waiting for health plan approval to receive health care (**Figure 11**); (2) waiting for a scheduled appointment time (**Figure 12**); and (3) waiting to be taken to the exam room on the day of the appointment (**Figure 13**).

Forty-four percent of respondents said they never had delays in their health care while they waited for approval from their health plan (**Figure 11**). This is a significant improvement since the SFY 2008 survey, in which only 33 percent of respondents said they never had approval-related delays.[37] However, this

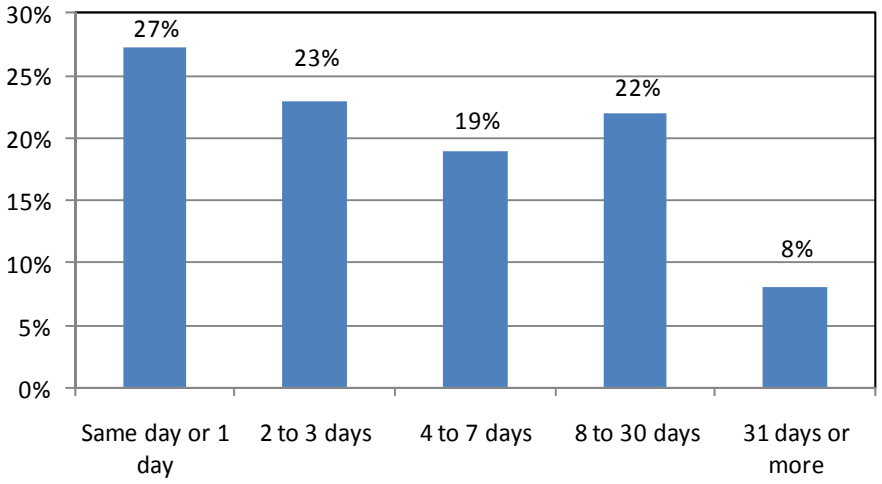
percentage remains lower than the HHSC Performance Indicator Dashboard standard of 57 percent for no approval delays in the STAR+PLUS population.[38]

Figure 11. Frequency of having health care delays while waiting for health plan approval



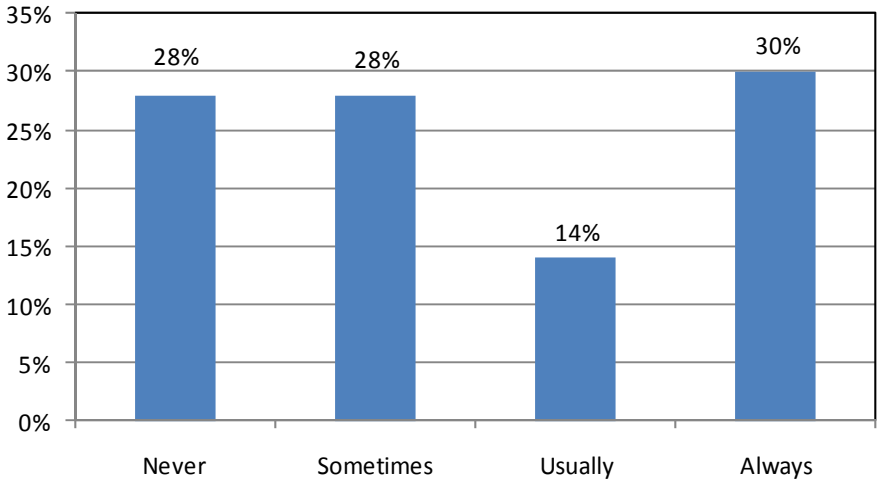
Half of the survey respondents (50 percent) were able to see a provider within three days of making their appointment, and 69 percent were able to see a provider within one week (**Figure 12**). Eight percent reported that they had to wait 31 days or more.

Figure 12. Number of days between making an appointment and seeing a provider



Thirty percent of respondents reported they were always taken to the exam room within 15 minutes of their appointment (**Figure 13**). This is lower than the HHSC Performance Indicator Dashboard standard of 42 percent for no exam room wait greater than 15 minutes in the STAR+PLUS population.[39] More than a quarter of respondents (28 percent) said they were never taken to the exam room within 15 minutes. This finding suggests a need for participating health plans to address long waiting periods in the clinical setting.

Figure 13. Frequency of being taken to the exam room within 15 minutes of appointment



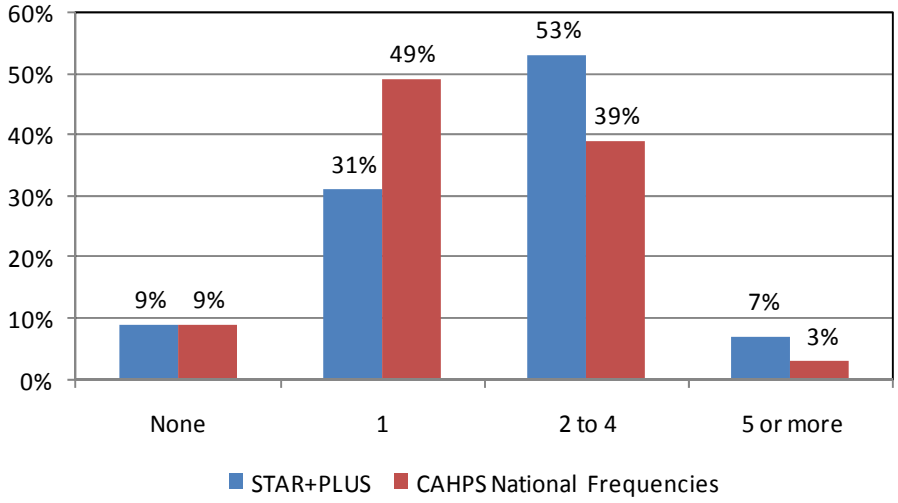
Need for and utilization of specialist physicians was high among STAR+PLUS enrollees, which is an expected finding given the special health care needs of the population. Forty-five percent of respondents reported trying to make an appointment to see a specialist in the six months prior to the survey. Among these respondents, 66 percent said it was usually or always easy to get a referral to see a specialist. This percentage exceeds the HHSC Performance Dashboard Indicator standard of 62 percent for good access to specialist referrals in the STAR+PLUS population.[40]

Sixty-eight percent of survey respondents who tried to make an appointment with a specialist said it was usually or always easy to get appointments with specialists. For those who cited difficulty getting specialist appointments, **Table C4** in **Appendix C** lists the different reasons given. The most frequently cited difficulty was that the specialist the enrollee wanted did not belong to their health plan or network (48 percent), followed by preferred specialists being too far away (38 percent).

Figure 14 shows differences in specialist utilization between STAR+PLUS enrollees and Medicaid enrollees nationally, measured by the number of specialists seen in the last six months. While an equal percentage (nine percent) of STAR+PLUS and national Medicaid enrollees did not see a specialist, the percentage of STAR+PLUS enrollees seeing two to four specialists (53 percent) and those seeing five or more specialists (7 percent) was considerably greater than among national Medicaid enrollees (39 percent and 3 percent, respectively).

Sixty-seven percent of enrollees reported that the specialist they saw most often was the same as their personal doctor.

Figure 14. Number of specialists seen in past 6 months: STAR+PLUS and Medicaid national rates [41]

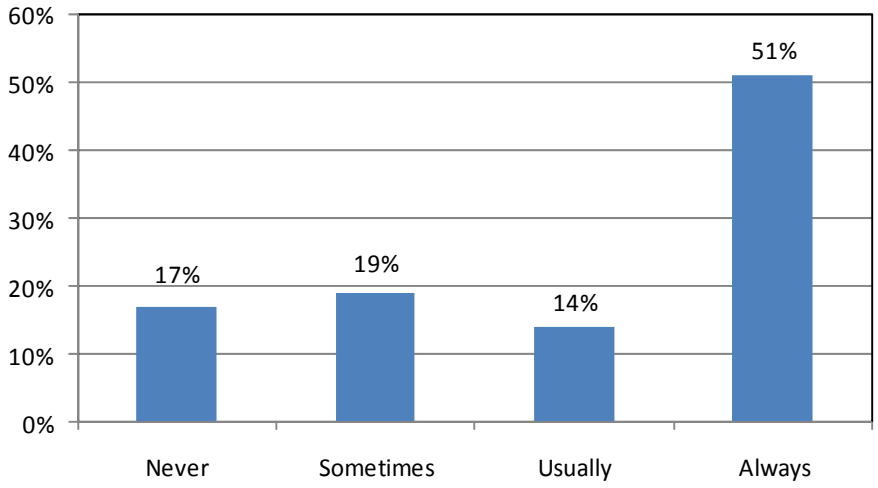


Getting Specialized Services

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 need for, and access to, specialized services, such as equipment, therapies, home health care, mental health care, or prescription medication.

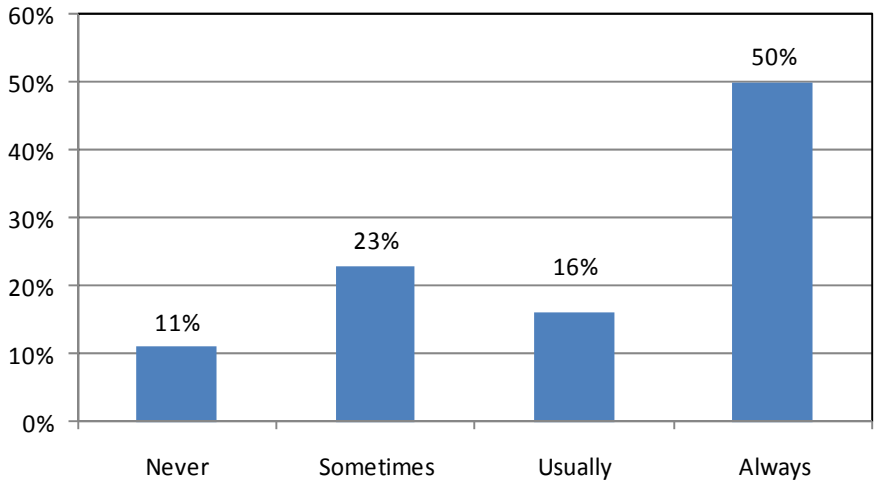
Thirty-six percent of respondents indicated they had a health problem for which they needed special medical equipment, such as a cane, wheelchair, or oxygen equipment. Among these respondents, 65 percent said it was usually or always easy to get the medical equipment they needed, while 17 percent said that it was never easy (**Figure 15**). Access to special medical equipment has improved since the SFY 2008 survey, in which 55 percent of respondents said medical equipment was usually or always easy to obtain and 23 percent of respondents said it was never easy to obtain.[42]

Figure 15. "How often was it easy to get medical equipment through your health plan?"



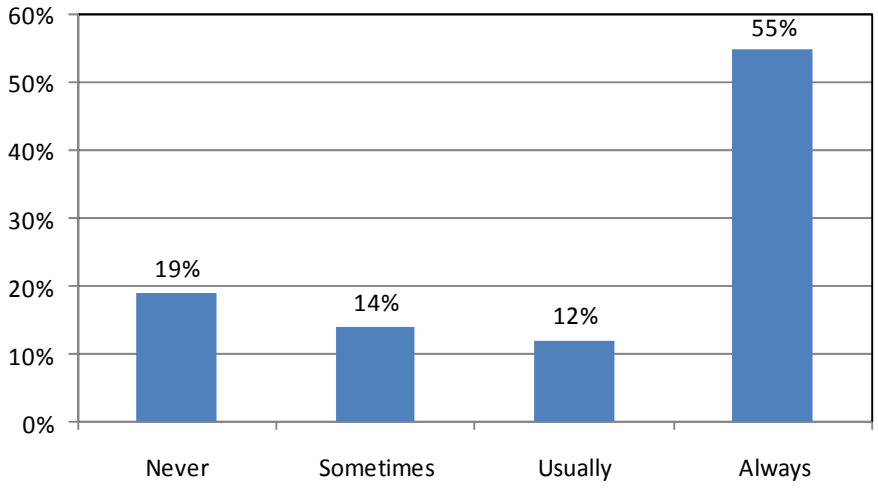
Twenty-two percent of respondents indicated they had a health problem for which they needed special therapy, such as physical, occupational, or speech therapy. Among those who needed special therapies, 66 percent said that obtaining these therapies was usually or always easy (**Figure 16**). Access to special therapies has significantly improved since the SFY 2008 survey, in which 45 percent of respondents said special therapy was usually or always easy to get.[43] This year's findings also substantially exceed the HHSC Performance Indicator Dashboard standard of 47 percent for good access to special therapies in the STAR+PLUS population.[44]

Figure 16. "How often was it easy to get special therapies through your health plan?"



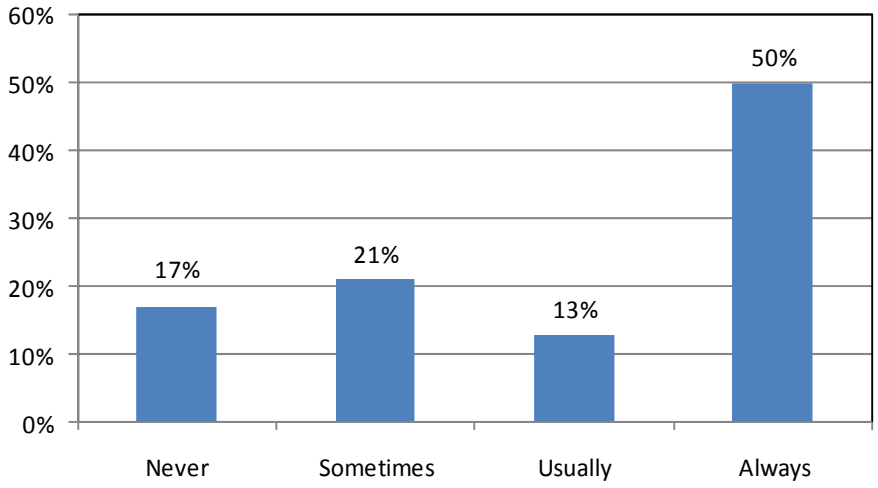
Twenty-nine percent of respondents indicated needing home health care or assistance in the six months prior to the survey. Among those who needed these services, 67 percent of respondents said obtaining home health care was usually or always easy, while 19 percent said it was never easy (**Figure 17**).

Figure 17. "How often was it easy to get home health care/assistance through your health plan?"



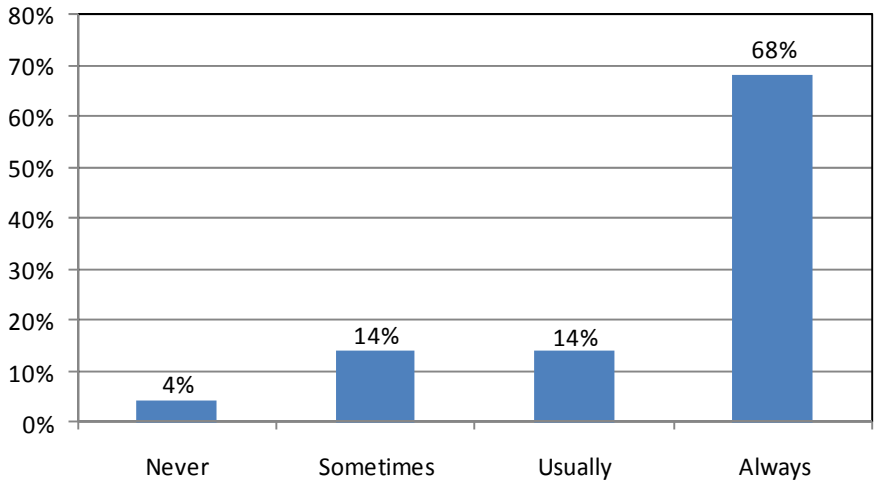
Overall, STAR+PLUS enrollees had low self-ratings of their mental or emotional health, with 32 percent rating their mental or emotional health as “fair” and 17 percent rating it as “poor.” One-quarter (24 percent) of survey respondents indicated needing treatment or counseling for a personal or family problem. Among these respondents, 63 percent said treatment or counseling was usually or always easy to get, while 17 percent said it was never easy to get (**Figure 18**). On a scale of 0 to 10, these respondents rated the treatment or counseling they received during the last six months a mean of 7.74.

Figure 18. "How often was it easy to get treatment or counseling through your health plan?"



Eighty-one percent of STAR+PLUS enrollees indicated they had obtained new prescription medicines or refilled a prescription in the six months prior to the survey. Among these respondents, 82 percent said it was usually or always easy to get the prescription medicine they needed through their health plan (**Figure 19**).

Figure 19. "How often was it easy to get prescription medicine through your health plan?"



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.[45] 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.

Care coordination is a priority component of external quality review for the STAR+PLUS program. As such, the EQRO analyzed the survey results by sub-groups of the STAR+PLUS enrollee population (race/ethnicity, health status, and education). Significant differences in responses among these sub-groups are shown below, which may potentially lead to a better understanding of the quality of care coordination and highlight areas for improvement.

Twenty-three 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. Significant differences in having a care coordinator were observed by health status, with 39 percent of those rating their overall health as "excellent" having a care coordinator, compared with 25 percent of those rating their overall health as "poor".[46] This suggests that care coordination may not be reaching those in most need as effectively as those in good health. Alternately, it could suggest that the presence of care coordination itself results in improvements in enrollee's self-rated health status.

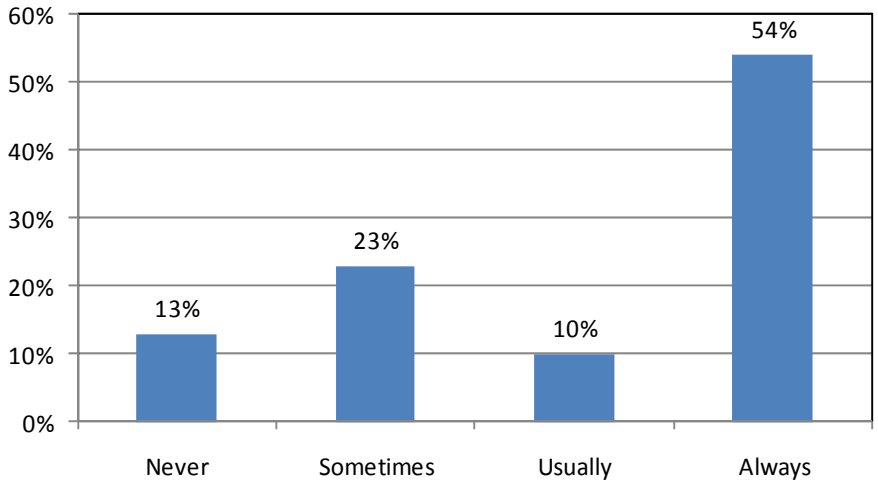
Among those enrollees who reported they did not have a care coordinator, 17 percent said they received care coordination from someone else. These respondents were asked who, other than a STAR+PLUS health plan care coordinator, helped to coordinate their health care (**Table C5** in **Appendix C**). Family members or friends were the most frequently cited (59 percent), followed by the enrollee's primary care doctor (14 percent). A significantly greater percentage of respondents with a Bachelor's degree or higher (43 percent) compared to those with some college education (14 percent), high school education (15 percent), or less than high school education (16 percent) said they had someone else help arrange their services.[47]

Forty-four percent of enrollees who did not have a care coordinator said they would like someone from their STAR+PLUS health plan to help arrange their services. A significantly lower percentage of White, non-

Hispanic enrollees (37 percent) compared to Hispanic enrollees (47 percent), Black, non-Hispanic enrollees (47 percent), or Other, non-Hispanic enrollees (46 percent) said they would like someone from their health plan to help arrange their services.[48] Results also differed significantly by respondent self-reported health status, with 42 percent of those rating their overall health as "excellent" saying they would like care coordination, compared with 54 percent of those rating their overall health as "poor." [49]

Among those enrollees with a care coordinator, 56 percent indicated their care coordinator had contacted them in the six months prior to the survey, and 49 percent said they needed a care coordinator in the last six months to help them arrange services. Need for care coordination services differed significantly by respondent race/ethnicity, with the highest need among Other, non-Hispanic enrollees (89 percent), followed by Hispanic enrollees (58 percent), Black, non-Hispanic enrollees (38 percent), and White, non-Hispanic enrollees (35 percent).[50] Among those who reported needing the help of their care coordinator, 64 percent stated they usually or always got care coordination help as soon as they thought they needed (**Figure 20**).

Figure 20. "How often did you get care coordination help as soon as you thought you needed?"



As with other aspects of health care, doctor-patient communication and shared decision-making are important components of quality and satisfaction with care coordination. Among STAR+PLUS enrollees who received help from their care coordinators, 69 percent said their care coordinator usually or always explained things in a way they could understand (**Figure 21**) and 60 percent said their care coordinator usually or always involved them in making decisions about their services (**Figure 22**).

Figure 21. "How often did the care coordinator explain things in a way you could understand?"

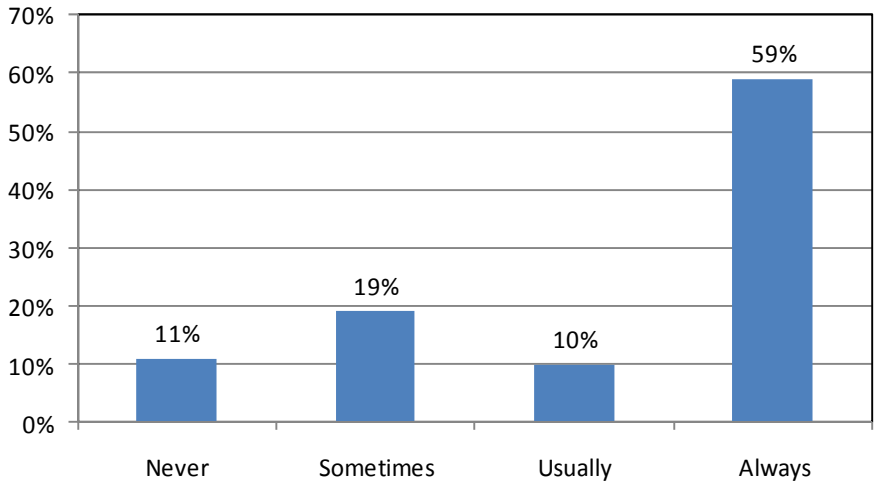
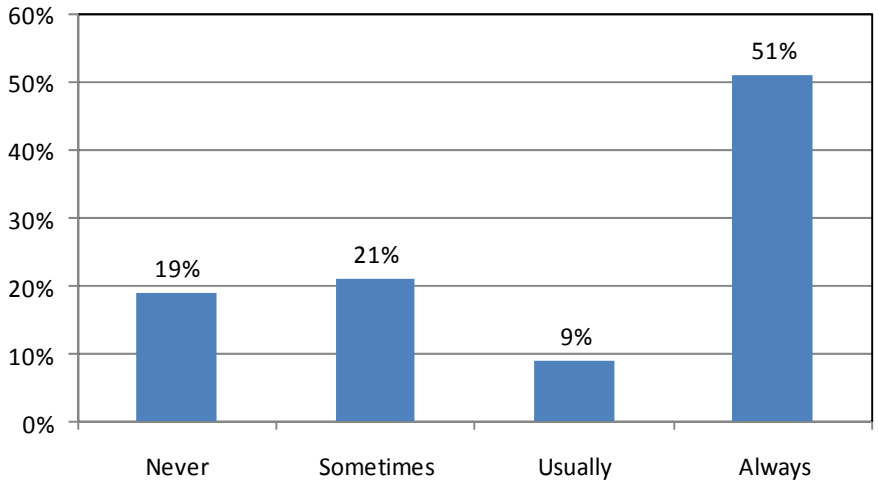
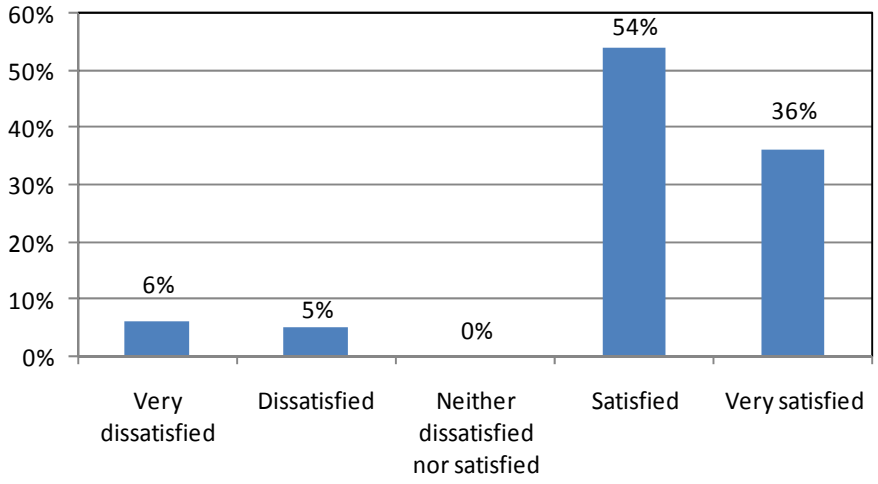


Figure 22. "How often did the care coordinator involve you in making decisions about your services?"



Respondents were also asked how satisfied they were with the help they received from the care coordinator at their health plan (**Figure 23**). Ninety 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.

Figure 23. Satisfaction with care coordination



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:

- Getting Needed Care,
- Getting Care Quickly,
- Doctor's Communication, and
- 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 enrollees were lower than the Medicaid national means for each of the four domains. 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).[51] The last reporting period publicly available for national comparison is calendar year 2007. STAR+PLUS composite scores were comparable to the national average for the *Getting Care Quickly* and *Doctor's Communication* composite measures. *Getting Needed Care* and *Customer Service* fell below the 75-point threshold for positive healthcare experiences – each being approximately five points lower among STAR+PLUS enrollees than the national mean.

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
2007 National Medicaid CAHPS® Health Plan Survey Mean	75.2	80.2	86.7	79.1
STAR+PLUS Mean	69.6	78.0	85.8	73.7

Significant increases in three of the four CAHPS® composite scores were observed between SFY 2008 and SFY 2009. These increases, which suggest an improvement in health care delivery and quality since the prior fiscal year, occurred in the following domains:

- *Getting Needed Care:* 64.4 in SFY 2008 improved to 69.6 in SFY 2009.[52]

- *Getting Care Quickly:* 72.5 in SFY 2008 improved to 78.0 in SFY 2009.[53]
- *Customer Service:* 68.8 in SFY 2008 improved to 73.7 in SFY 2009.[54]

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:

- Health status,
- Race/ethnicity,
- Educational status,
- Age category,
- Gender, and
- 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. For all four composite measures, the Superior health plan had the highest scores and functioned as the reference group.

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 in any domain except *Getting Care Quickly*. For *Getting Care Quickly*, composite scores among members of AMERIGROUP and Molina were significantly lower than those among members of Superior. 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	
	Mean	MVR	Mean	MVR	Mean	MVR	Mean	MVR
AMERIGROUP	66.3	NS	76.7	-	85.6	NS	73.0	NS
Evercare	69.9	NS	76.4	NS	84.4	NS	72.5	NS
Molina	68.9	NS	75.7	-	86.5	NS	67.8	NS
Superior	73.1	Ref	81.8	Ref	87.3	Ref	77.7	Ref

Note: "MVR" = multivariate result; "Ref" = reference health plan with the highest mean composite score; "NS" = not significant; "-"= score significantly lower than reference.

Summary and Recommendations

This 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

urgent, routine, and specialist care; (6) getting specialized services; (7) care coordination; and (8) enrollees' satisfaction with various aspects of their healthcare as measured by CAHPS® composite measures.

Summary Point #1 – Enrollee Demographics

- Forty-one percent of STAR+PLUS enrollees were Hispanic, 25 percent were White, non-Hispanic, 28 percent were Black, non-Hispanic, and six percent were of Other, non-Hispanic ethnicity.
- Nearly half (47 percent) of enrollees had not completed a high school education, while 30 percent had received a GED or high school diploma, and 23 percent had either some college or college degrees. Overall, SFY 2009 survey respondents were more educated than those who responded to the SFY 2008 survey.
- Among the approximately half of survey respondents who answered questions on housing and employment, nearly half (48 percent) lived in rented housing and one-quarter lived in their own home. Ninety-three percent said they did not work in the six months prior to the survey. The most frequently cited reasons for being unable to work included: (1) deterioration of health resulting from work; (2) work being too stressful; (3) being unable to find a job that met the enrollee's needs; and (4) being unable to find a job that provided needed special accommodations.

Summary Point #2 – Health Status

- Overall, STAR+PLUS enrollees' health status was poor, with one-third rating their health as "poor" compared with 10 percent of Medicaid enrollees nationally. RAND-36® scores were also low, with means below 50 points for all domains except Emotional Well-Being (55.27 points). The lowest-scoring domain was Role Limitations Due to Physical Health (30.83 points).
- The majority of STAR+PLUS enrollees reported having limitations in performing activities of daily living, suggesting high rates of disability and dependence on others in this population. Greater than two-thirds of respondents (67 percent) reported needing the help of other persons with their personal care needs, such as eating, dressing, or getting around the house. About one-half (52 percent) reported they needed help with routine needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes.

Summary Point #3 – Healthy Behaviors and Health Promotion Activities

- More than two-thirds of survey respondents (69 percent) reported they had visited a doctor for a routine checkup in the 12 months prior to the survey, while only seven percent reported never having a routine checkup. However, in managed care settings the percentage of members who report never having a routine checkup should be minimized through improvements in member outreach and health literacy.
- Rates of overweight and obesity were high among STAR+PLUS enrollees, with 77 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.
- Nearly half of survey respondents (49 percent) reported receiving a flu shot during the 2008 flu season, which was significantly greater than the 39 percent of SFY 2008 survey respondents who received a flu shot during the 2007 flu season.
- Two-thirds of respondents (66 percent) said they were not current smokers, while 34 percent said they smoked some days or every day. Among enrollees who reported they were smokers at the time of the survey, 63 percent were advised to quit smoking by their healthcare providers, 34 percent were recommended medication to assist with quitting smoking, and 34 percent were recommended other 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, 87 percent of STAR+PLUS enrollees reported they had a personal doctor. Continuity of care among STAR+PLUS enrollees was good, with greater than two-thirds (64 percent) receiving care from their personal doctors for two years or longer. STAR+PLUS enrollees visited their personal doctors considerably more often than Medicaid members nationally.
- Among those with personal doctors:
    - 63 percent said they 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, 73 percent said they usually or always got the help or advice they needed.
    - 23 percent said they 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, 70 percent said they usually or always got the help or advice they needed.
    - 56 percent reported they did not have the same personal doctor before they joined their current health plan. Among these respondents, less than half (45 percent) said it was always easy to get a personal doctor they were happy with, while 15 percent said it was never easy. A substantial proportion of STAR+PLUS enrollees have therefore had some difficulty finding the right doctor.

Summary Point #5 – Getting Urgent, Routine, and Specialist Care

- The majority of STAR+PLUS enrollees reported they experienced good access to urgent care (80 percent) and to routine care (78 percent). Both findings were significantly greater than respective results reported in the SFY 2008 survey and met or exceeded HHSC Performance Indicator Dashboard standards for the STAR+PLUS population.
- Member's reported experiences with waiting to receive care were largely positive, although HHSC Performance Indicator Dashboard standards were not met regarding delays for health plan approval or time waiting to be taken to an exam room.
    - Forty-four percent of respondents said they never had delays in their health care while they waited for health plan approval. While this was a significant improvement since the SFY 2008 survey (33 percent), it is still lower than the 57 percent standard set by HHSC.
    - Half of respondents reported they were able to see a provider within three days of making their appointment. Only eight percent of the sample reported appointment waiting periods of greater than one month.
    - Thirty percent of respondents reported they were always taken to the exam room within 15 minutes of their appointment. This is lower than the 42 percent standard set by HHSC.
- Nearly half (45 percent) of survey respondents reported having tried to make an appointment to see a specialist in the last six months. Among these respondents, two-thirds (66 percent) said it was usually or always easy to get a referral to see a specialist, exceeding the HHSC Performance Indicator Dashboard standard of 62 percent for this measure. Utilization of specialists among STAR+PLUS enrollees was considerably greater than among national Medicaid enrollees. Sixty-seven percent of enrollees said the specialist they saw most often was the same as their personal doctor.

Summary Point #6 – Getting Specialized Services

- Thirty-six percent of respondents reported they had a health problem for which they needed special medical equipment. Among these respondents, 65 percent said it was usually or always easy to get medical equipment. Good access to special medical equipment improved significantly since the SFY 2008 survey (55 percent).
- Twenty-two percent of respondents reported they had a health problem for which they needed special therapy. Among these respondents, 66 percent said it was usually or always easy to get special therapy. Good access to special therapy improved significantly since the SFY 2008 survey (45 percent), and substantially exceeded the HHSC Performance Indicator Dashboard standard of 47 percent for this measure.
- Twenty-nine percent of respondents reported they needed home health care or assistance. Among these respondents, two-thirds (67 percent) said it was usually or always easy to get home health care or assistance.
- Twenty-four percent of respondents reported they needed treatment or counseling for a personal or family problem. Among these respondents, 63 percent said it was usually or always easy to get treatment or counseling.
- Eighty-one percent of respondents reported they had obtained new prescription medicines or refilled a prescription in the six months prior to the survey. Among these respondents, 82 percent said it was usually or always easy to get the prescription medicine they needed through their health plan.

Summary Point #7 – Care Coordination

- Twenty-three percent of respondents said they had a care coordinator from their STAR+PLUS health plan. Those who rated their health as "excellent" were more likely to have a care coordinator than those who rated their health as "poor" (39 percent vs. 25 percent).
- Among those enrollees who reported they did not have a care coordinator, 44 percent said they would like someone from their STAR+PLUS health plan to help arrange their services. White, non-Hispanic enrollees were less likely to say they wanted a care coordinator (37 percent) than Hispanic enrollees (47 percent), Black, non-Hispanic enrollees (47 percent), or Other, non-Hispanic enrollees (46 percent). Those who rated their health as "excellent" were less likely to want a care coordinator than those who rated their health as "poor" (42 percent vs. 54 percent).
- Among enrollees who said they had a care coordinator, 56 percent said their care coordinator had contacted them in the six months prior to the survey, and 49 percent said they needed a care coordinator in the last six months to help arrange services. Need for care coordination differed by race/ethnicity, ranging from 89 percent among Other, non-Hispanic enrollees, to 58 percent among Hispanic enrollees, 38 percent among Black, non-Hispanic enrollees, and 35 percent among White, non-Hispanic enrollees.
- Among those who reported needing the help of their care coordinator, 64 percent stated they usually or always got care coordination help as soon as they needed.
- Ninety percent of enrollees who said they had a care coordinator 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.

Summary Point #8 – Enrollee Satisfaction (CAHPS® composite scores)

- 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* (85.8), followed by *Getting Care Quickly* (78.0). The remaining two scores fell below the 75-point threshold considered to represent positive healthcare experiences -- *Getting Needed Care* (69.6) and *Customer Service* (73.7).
- Composite scores in three domains – *Getting Needed Care, Getting Care Quickly,* and *Customer Service* – had significant improvement since the SFY 2008 survey.

- In multivariate analyses, which controlled for enrollee's health status, race/ethnicity, educational status, age, and gender, scores were not significantly different across STAR+PLUS health plans in any domain except *Getting Care Quickly*. For *Getting Care Quickly*, scores were significantly lower in AMERIGROUP and Molina than in Superior, which had the highest mean composite scores for all four domains. The score for Evercare was not significantly different from the score for Superior on this measure.

Recommendations

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

- Focused studies of quality of life, employment and mental health among STAR+PLUS enrollees may lead to strategies for tailoring health services to better fit the needs of this population.
  - STAR+PLUS enrollees have low health status scores, high rates of disability and dependence on others, and high rates of unemployment (largely because of health problems). These factors suggest that the STAR+PLUS population experiences low quality of life – a commonly used measure of well-being that could be included more comprehensively in future EQRO surveys.
  - The employment questions in the present survey (added in SFY 2009) point to a number of potential relationships between STAR+PLUS enrollees' employment and health status. Of particular interest to the state of Texas is the behavioral and mental health among Medicaid members. More detailed, focused analyses of the SFY 2009 survey data may be conducted to explore associations among enrollees' employment status, their attitudes about employment, and measures of mental and behavioral health, among other factors.
- Ensure that health plans have education and promotion programs to reduce overweight and obesity in an older population with high rates of disability. Studies have shown that intensive counseling strategies incorporating behavioral, dietary, and exercise components promote sustained weight loss among older adults.[55] However, obesity treatment in this population should include strategies to prevent loss of bone density.
- Fifty-seven percent of STAR+PLUS enrollees reported having some difficulty finding the right personal doctor after joining their health plan. Health plans should develop or improve upon resources to assist new enrollees in finding personal doctors who are appropriate for their health care needs and their cultural or personal needs and concerns.
- While enrollee reported experiences with most components of getting urgent and routine care have improved since the prior fiscal year and meet or exceed HHSC Performance Indicator Dashboard standards, enrollees are still experiencing delays in receiving care while waiting for health plan approval or waiting to be taken to the exam room.
  - Health plans should assess potential reasons for long waiting periods, including under-staffing, large patient load, insufficient space, and poor communication among office staff and between office staff and members.
- While enrollees who rated their overall health as "poor" were more likely than healthy enrollees to *want* care coordination services, they were less likely than healthy enrollees to *have* care coordination services. Studies should be conducted to determine whether associations between

health status and care coordination result from disparities in access or, conversely, from improvements in self-rated health status that result from care coordination.

Appendix A. Detailed Survey Methodology

This report presents results from the 2009 STAR+PLUS enrollee survey. This survey is intended to provide a demographic and health profile of STAR+PLUS members, to document healthy behaviors and health promotion activities, and to assess enrollees' experiences and satisfaction with getting urgent, routine, and specialty care and care coordination. There are four health plans that participate in the STAR+PLUS program in Texas: AMERIGROUP, Evercare, Superior, and Molina. This report provides information regarding enrollees':

- sociodemographic characteristics and health status;
- healthy behavior practices and health promotion activities; and
- utilization, experiences and satisfaction with:
    - personal doctors
    - getting urgent, routine, and specialist care
    - getting specialized and other services, and
    - care coordination.

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 member must have been enrolled in the STAR+PLUS program in Texas for at least nine consecutive months between September 2007 and August 2008;
2) the member must have been over the age of 18 at the time of during the eligibility period;
3) the member must have been eligible for Medicaid, but not for both Medicaid and Medicare; and
4) the member must not have participated in the prior year's (SFY 2008) STAR+PLUS Survey.

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. Using a 95 percent confidence interval, the responses provided in the tables and figures are within ± 4 percentage points of the "true" responses for the STAR+PLUS enrollee health plans.

The target number of 300 surveys was met for each of the four health plans, with one additional survey completed for the Superior health plan. The additional completed survey occurred as a result of the survey fielding methodology, in which telephone interviews may occur with two or more members simultaneously. Overall, 1,201 surveys were completed.

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 8,500 randomly selected, eligible enrollees were collected.

Survey instruments

The SFY 2009 STAR+PLUS Enrollee Survey is comprised of the following sections:

1) Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey, version 4.0;[56]
2) RAND® 36-Item Health Survey, version 1.0;[57]
3) questions related to care coordination services;
4) sociodemographic characteristics of the respondent; and
5) questions related to members' housing and employment status.

The CAHPS® Health Plan Survey 4.0 was used to assess enrollees' satisfaction with several components of their health care.[58] 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® Health Plan Survey contains composites, which are scores that combine results for closely related survey items to provide comprehensive yet concise results.[59] Psychometric analyses indicate the composite scores are a reliable and valid measure of member experiences.[60,61] CAHPS® 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 CAHPS® Health Plan Survey for adult Medicaid members assesses experiences and satisfaction with health care received during the preceding six months. Responses to the STAR+PLUS Enrollee Survey (which began in December 2008) therefore cover health care received by enrollees from June 2008 to April 2009, when survey efforts were completed. Comparative results from the national Medicaid population are available for selected CAHPS® questions through the CAHPS® Benchmarking Database, and when relevant, are presented alongside STAR+PLUS enrollee responses in the results.[62] The CAHPS® 4.0 survey results for the Medicaid sector are obtained from data submitted directly to the CAHPS® Database by state Medicaid agencies and individual health plans. For the present report, 2008 results were used for comparison, which includes data submitted by 17 states. Because of the unique demographic and health profile of the STAR+PLUS population, comparisons with the Medicaid national rates should be interpreted with caution.

The RAND® 36-Item Health Survey was created to survey health status in the Medical Outcomes Study.[63] This instrument was designed for use in health policy evaluations and general population surveys. The RAND®-36 assesses eight separate health domains: (1) limitations in physical activities because of health problems; (2) limitations in social activities because of physical or emotional problems; (3) limitations in usual role activities because of physical health problems; (4) bodily pain; (5) general mental health; (6) limitations in usual role activities because of emotional problems; (7) vitality (energy and fatigue); 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 better 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.[64,65,66]

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 ranged up to 13 percent, while the percentage of respondents who refused to answer a question ranged up to five percent. Overall, the percentage of "do not know" and "refused" responses was very small for most individual items (two 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 new categories were created when there were sufficient consistent responses to do so.

Survey methods

The surveys were conducted by phone from December 2008 through April 2009.

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 Survey Research Center (SRC) 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. SRC 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 1,201 completed survey interviews, six percent were conducted in Spanish.

As many as 25 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, seven calls were made per telephone number in the sample.

Attempts were made to contact 8,047 adults who were enrolled in the STAR+PLUS program in Texas and who met the inclusion criteria. Fifty-two percent of enrollees could not be located. Among those located, 36 percent of respondents were not eligible to complete the survey, two percent reported that they were not enrolled in STAR+PLUS, and nine percent refused to participate. The response rate was 53 percent and the cooperation rate was 78 percent.[67] There were 1,201 completed surveys.

Data analysis

Descriptive statistics and statistical tests used in this report were performed using SPSS 17.0 (Chicago, IL: SPSS, Inc.). Frequency tables showing descriptive results for each survey question are provided in a separate Technical Appendix.[68] 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, 14,091 AMERIGROUP enrollees met the sample inclusion criteria. Of those, 300 randomly selected respondents participated in the survey. Therefore, each AMERIGROUP enrollee response was weighted by 46.97 (14,091/300). All frequencies and means presented in this report and the technical appendix that accompanies this report incorporate survey weights.

Statistical tests of differences between relevant subgroups and between SFY 2008 and SFY 2009 survey data employed the Pearson chi-square test (for differences in proportions) and t-tests and one-way analysis of variance (ANOVA) (for differences in means). Differences were considered statistically significant when p was less than or equal to 0.05. The p-value refers to the probability that observed differences could have occurred by chance alone. Therefore, the lower the p-value of a statistical test, the greater the likelihood that an external factor (whether program-related, demographic, or other) may explain the observed difference. To prevent overestimation of statistical significance resulting from sample size inflation, all statistical tests were performed without weighting. The statistics and p-values for differences that were both statistically and practically significant are presented as endnotes.

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 sociodemographics, health status, and health plan enrollment on enrollee satisfaction – Multivariate results

To estimate the effects of enrollees' sociodemographic characteristics, health status, and health plan enrollment on 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 *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 were assigned a value of zero. These analyses were designed to determine the extent to which a particular individual factor predicted a 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®-36 general health status,
2. Respondent gender,
3. Respondent age category,
4. Respondent race/ethnicity,
5. Respondent education level, and
6. Respondent health plan.

Respondent health status was treated as a continuous variable, while the remaining five independent variables were categorical – separated into categories, with one "reference group" against which the other categories were compared. For gender, the reference group was male. For age category, the reference group was 18 to 30 years old. For race/ethnicity, the reference group was White, non-Hispanic. For education level, the reference group was less than high school education. For health plan, the health plan with the highest weighted mean for each of the four composites was selected as the reference group. In the SFY 2009 survey, Superior had the highest weighted mean for all four composites, and therefore functioned as the health plan reference group for each of the four multivariate models.

Effects of all six individual factors on each of the four satisfaction composites are presented in the following tables: *Getting Needed Care* (**Table B1**), *Getting Care Quickly* (**Table B2**), *Doctor's Communication* (**Table B3**), and *Customer Service* (**Table B4**). Results are presented as "odds ratios," representing the likelihood of an enrollee in the specified category having positive experiences (scoring 75 points or greater) in comparison to enrollees in the reference category. An odds ratio below 1.00 suggests that enrollees in the specified category are less likely to have positive experiences in the given domain compared with the reference group. An odds ratio above 1.00 suggests that enrollees in the specified category are more likely to have positive experiences in the given domain compared with 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 within its range is not considered statistically significant at $p < 0.05$. In multivariate models, odds ratios that were significant at $p < 0.10$ were also highlighted.

Overall, multivariate results show few associations between respondent sociodemographics, health status, or health plan and satisfaction with health care.

- For *Getting Needed Care* (**Table B1**), satisfaction tended to increase with respondent age, although this trend was not statistically significant. No other associations were observed.
- For *Getting Care Quickly* (**Table B2**), respondents in AMERIGROUP were nearly 40 percent less likely (1.00 – 0.602) than those in Superior to have positive experiences. Some associations were marginally significant ($p < 0.10$), including: (1) a 28 percent decreased likelihood of positive

experiences among respondents with high school education than those with less than high school education, and; (2) a 32 percent decreased likelihood of positive experiences among respondents in Molina than those in Superior.

- For *Doctor's Communication* (**Table B3**), respondents with some college education were twice as likely to have positive experiences as those with less than high school education.
- For *Customer Service* (**Table B4**), only marginally significant ($p < 0.10$) associations were observed. These included: (1) an increased likelihood of positive experiences by 2.7 times among respondents age 61 or older, compared with those 18 to 30 years old; and (2) an increased likelihood of positive experiences by 1.8 times among Hispanic respondents, compared with White, non-Hispanic respondents.

In summary, results from the multivariate analyses suggest that there are few differences in health care satisfaction as measured by composite scores, even after controlling for individual factors and health plan enrollment.

Table B1. *Getting Needed Care* - Multivariate Analysis

	Getting Needed Care				Odds ratio	95% Confidence interval
	0 to 74		75 or greater			
	N	Percent	N	Percent		
Gender						
Male	84	30.1%	142	30.0%	REF	-
Female	195	69.9%	331	70.0%	0.999	0.711 - 1.404
Age Category						
18 – 30	15	5.4%	24	5.1%	REF	-
31 – 40	35	12.6%	44	9.4%	0.750	0.337 - 1.667
41 – 50	73	26.4%	112	23.9%	1.048	0.500 - 2.197
51 – 60	120	43.3%	211	45.1%	1.133	0.556 - 2.309
61+	34	12.3%	77	16.5%	1.428	0.646 - 3.157
Race/ethnicity						
White, non-Hispanic	80	29.9%	134	29.1%	REF	-
Hispanic	102	38.1%	193	41.9%	1.118	0.743 - 1.682
Black, non-Hispanic	66	24.6%	110	23.9%	1.001	0.647 - 1.547
Other, non-Hispanic	20	7.5%	24	5.2%	0.695	0.351 - 1.373
Education Level						
Less than high school	120	44.1%	203	43.8%	REF	-
High school	77	28.3%	127	27.4%	1.079	0.733 - 1.588
Some college	57	21.0%	113	24.4%	1.415	0.913 - 2.194
Bachelor's degree or higher	18	6.6%	21	4.5%	0.801	0.392 - 1.636
Health Plan						
Superior	69	24.7%	134	28.3%	REF	-
AMERIGROUP	73	26.2%	107	22.6%	0.817	0.516 - 1.294
Evercare	67	24.0%	114	24.1%	0.963	0.608 - 1.525
Molina	70	25.1%	118	24.9%	0.898	0.577 - 1.397
RAND-36 General Health	**Mean**		**Mean**		1.000	0.993 - 1.007
	34.16		34.35			

[a] Odds ratio significant at $p < 0.10$

[b] Odds ratio significant at $p < 0.05$

Table B2. *Getting Care Quickly* - Multivariate Analysis

	Getting Care Quickly				Odds ratio	95% Confidence interval
	0 to 74		75 or greater			
	N	Percent	N	Percent		
Gender						
Male	89	32.6%	200	28.6%	REF	-
Female	184	67.4%	499	71.4%	1.226	0.890 - 1.689
Age Category						
18 – 30	20	7.4%	31	4.5%	REF	-
31 – 40	33	12.2%	86	12.4%	1.440	0.702 - 2.954
41 – 50	67	24.7%	159	22.9%	1.245	0.638 - 2.432
51 – 60	106	39.1%	304	43.8%	1.432	0.754 - 2.720
61+	45	16.6%	114	16.4%	1.301	0.645 - 2.624
Race/ethnicity						
White, non-Hispanic	70	26.8%	182	26.8%	REF	-
Hispanic	105	40.2%	283	41.7%	0.869	0.585 - 1.291
Black, non-Hispanic	67	25.7%	175	25.8%	0.923	0.610 - 1.399
Other, non-Hispanic	19	7.3%	39	5.7%	0.745	0.392 - 1.416
Education Level						
Less than high school	101	38.4%	326	47.6%	REF	-
High school	88	33.5%	194	28.3%	0.717 [a]	0.499 - 1.031
Some college	60	22.8%	139	20.3%	0.768	0.506 - 1.166
Bachelor's degree or higher	14	5.3%	26	3.8%	0.622	0.300 - 1.290
Health Plan						
Superior	55	20.1%	196	28.0%	REF	-
AMERIGROUP	75	27.5%	159	22.7%	0.602 [b]	0.385 - 0.941
Evercare	71	26.0%	173	24.7%	0.710	0.454 - 1.111
Molina	72	26.4%	171	24.5%	0.684 [a]	0.443 - 1.055
RAND-36 General Health	**Mean**		**Mean**		0.995	0.988 - 1.001
	37.39		34.35			

[a] Odds ratio significant at $p < 0.10$

[b] Odds ratio significant at $p < 0.05$

Table B3. *Doctor's Communication* - Multivariate Analysis

	Doctor's Communication				Odds ratio	95% Confidence interval
	0 to 74		75 or greater			
	N	Percent	N	Percent		
Gender						
Male	41	25.6%	230	31.6%	REF	-
Female	119	74.4%	497	68.4%	0.771	0.513 - 1.160
Age Category						
18 – 30	5	3.1%	35	4.9%	REF	-
31 – 40	18	11.3%	88	12.3%	0.906	0.304 - 2.704
41 – 50	44	27.7%	168	23.4%	0.745	0.268 - 2.077
51 – 60	64	40.3%	304	42.4%	0.891	0.326 - 2.431
61+	28	17.6%	122	17.0%	0.804	0.281 - 2.303
Race/ethnicity						
White, non-Hispanic	43	28.1%	187	26.3%	REF	-
Hispanic	65	42.5%	298	41.9%	1.200	0.748 - 1.926
Black, non-Hispanic	38	24.8%	192	27.0%	1.334	0.805 - 2.212
Other, non-Hispanic	7	4.6%	34	4.8%	0.951	0.384 - 2.356
Education Level						
Less than high school	78	50.3%	318	44.4%	REF	-
High school	47	30.3%	208	29.1%	1.145	0.747 - 1.756
Some college	24	15.5%	160	22.3%	2.057 [b]	1.173 - 3.607
Bachelor's degree or higher	6	3.9%	30	4.2%	1.196	0.462 - 3.098
Health Plan						
Superior	39	24.4%	200	27.5%	REF	-
AMERIGROUP	39	24.4%	177	24.3%	0.788	0.460 - 1.350
Evercare	44	27.5%	171	23.5%	0.725	0.425 - 1.237
Molina	38	23.8%	179	24.6%	0.835	0.496 - 1.407
RAND-36 General Health	**Mean**		**Mean**		1.007	0.998 - 1.015
	32.63		36.24			

[a] Odds ratio significant at $p < 0.10$

[b] Odds ratio significant at $p < 0.05$

Table B4. *Customer Service* - Multivariate Analysis

	Customer Service				Odds ratio	95% Confidence interval
	0 to 74		75 or greater			
	N	Percent	N	Percent		
Gender						
Male	39	28.1%	59	30.3%	REF	-
Female	100	71.9%	136	69.7%	0.883	0.525 - 1.484
Age Category						
18 – 30	11	8.0%	11	5.6%	REF	-
31 – 40	21	15.3%	21	10.8%	1.103	0.374 - 3.253
41 – 50	32	23.4%	47	24.1%	1.860	0.669 - 5.174
51 – 60	61	44.5%	89	45.6%	1.774	0.665 - 4.731
61+	12	8.8%	27	13.8%	2.731 [a]	0.861 - 8.661
Race/ethnicity						
White, non-Hispanic	50	37.3%	53	27.9%	REF	-
Hispanic	43	32.1%	85	44.7%	1.777 [a]	0.975 - 3.239
Black, non-Hispanic	29	21.6%	42	22.1%	1.504	0.782 - 2.890
Other, non-Hispanic	12	9.0%	10	5.3%	0.780	0.293 - 2.075
Education Level						
Less than high school	51	37.2%	83	43.2%	REF	-
High school	48	35.0%	52	27.1%	0.821	0.460 - 1.467
Some college	27	19.7%	45	23.4%	1.363	0.686 - 2.706
Bachelor's degree or higher	11	8.0%	12	6.3%	1.005	0.381 - 2.649
Health Plan						
Superior	29	20.9%	50	25.6%	REF	-
AMERIGROUP	32	23.0%	49	25.1%	0.887	0.431 - 1.827
Evercare	38	27.3%	51	26.2%	0.760	0.380 - 1.520
Molina	40	28.8%	45	23.1%	0.627	0.316 - 1.244
RAND-36 General Health	**Mean**		**Mean**		1.008	0.997 - 1.019
	32.07		36.01			

[a] Odds ratio significant at $p < 0.10$

[b] Odds ratio significant at $p < 0.05$

Appendix C. Supplementary Tables

Table C1. Respondent agreement to statements about working (weighted)

	Strongly disagree		Somewhat disagree		Somewhat agree		Strongly agree	
	N	%	N	%	N	%	N	%
"Working makes me feel good about myself." (N = 18,200)	1,800	9.9%	1,532	8.4%	3,973	21.8%	10,895	59.9%
"Working helps me pay for things my family and I need." (N = 18,107)	1,730	9.6%	607	3.4%	3,093	17.1%	12,676	70.0%
"I feel that working contributes to my ability to achieve important goals in my life." (N = 18,069)	2,104	11.6%	1,152	6.4%	3,222	17.8%	11,591	64.1%
"Working provides me the financial resources to do the things I like to do." (N = 18,392)	2,592	14.1%	848	4.6%	2,752	15.0%	12,200	66.3%
"Working is a way for me to stay independent." (N = 18,443)	2,477	13.4%	608	3.3%	2,555	13.9%	12,803	69.4%
"I see myself working in the next year." (N = 18,395)	10,545	57.3%	1,884	10.2%	2,218	12.1%	3,748	20.4%

Table C2. Reasons respondent has been unable to work (weighted)

	Strongly disagree		Somewhat disagree		Somewhat agree		Strongly agree	
	N	%	N	%	N	%	N	%
"I am concerned about losing Medicaid benefits." (N = 18,746)	11,054	59.0%	2,592	13.8%	1,648	8.8%	3,453	18.4%
"I am concerned about losing Social Security, SSI, or SSDI." (N = 18,598)	10,731	57.7%	2,273	12.2%	1,389	7.5%	4,204	22.6%
"I am concerned about losing other benefits like food, rent, or utility assistance." (N = 18,787)	12,369	65.8%	2,162	11.5%	1,137	6.1%	3,119	16.6%
"I need education or training." (N = 18,679)	10,868	58.2%	2,006	10.7%	1,202	6.4%	4,603	24.6%
"I lack transportation." (N = 18,882)	11,109	58.8%	1,751	9.3%	1,576	8.3%	4,446	23.5%
"I lack child care." (N = 18,782)	14,942	79.6%	1,562	8.3%	564	3.0%	1,714	9.1%
"My health often gets worse when I work." (N = 19,025)	4,433	23.3%	1,507	7.9%	1,447	7.6%	11,639	61.2%
"I cannot find a job that meets my needs." (N = 18,371)	9,179	50.0%	1,801	9.8%	1,443	7.9%	5,948	32.4%
"Work is too stressful." (N = 18,749)	7,929	42.3%	1,892	10.1%	2,442	13.0%	6,486	34.6%
"I might not be able to get the special accommodations I need to work." (N = 18,786)	9,385	50.0%	1,952	10.4%	1,675	8.9%	5,775	30.7%

Table C3. Reasons it was difficult to get help when phoning after hours (weighted)

	Weighted	
	N	% [a]
Member left a message, but no one returned the call	1,421	46.6%
Another doctor was covering for member's personal doctor	958	31.4%
Member could not leave a message at the number called	738	24.2%
Member did not know what number to call	663	21.7%
Some other reason: [b]	1,109	36.4%
The doctor was not otherwise available	207	6.8%
An appointment was required to get help	143	4.7%
Staff was not available to take call due to office closure	116	3.8%
Member was referred to the emergency room	111	3.6%
Communication problems with answering service or staff	100	3.3%
Staff was not informed about member's case	47	1.5%
Staff was disrespectful	9	0.3%

[a] Percentages calculated out of respondents who reported difficulty getting help or advice, excluding "don't know" and "refused" responses (Weighted N = 3,050). Totals will exceed 100 percent because some respondents indicated more than one reason.

[b] Includes responses in seven open-ended categories as well as unspecified reasons.

Table C4. Reasons it was difficult to get a specialist appointment (weighted)

	Weighted	
	N	% [a]
The requested specialist did not belong to health plan/network	3,811	47.6%
Specialists member had to choose from were too far away	3,006	37.6%
Member could not get appointment at a convenient time	2,597	32.5%
Member's health plan approval/authorization was delayed	2,253	28.2%
Member was not sure where to find a list of specialists in network	2,251	28.1%
There were not enough specialists to choose from	2,141	26.8%
Member's doctor did not think they needed to see a specialist	1,187	14.8%
Some other reason: [b]	1,780	22.3%
Problems with referral (delays, miscommunication, etc.)	395	4.9%
Lack of transportation	293	3.7%
Specialist would not take member as a patient (high caseload, etc.)	271	3.4%
Member did not receive a response from specialist's office	121	1.5%
Specialist was too busy or unavailable	94	1.2%
Providers or staff were disrespectful	73	0.9%
Do not know	296	3.4%
Refused to answer	316	3.7%

[a] Percentages calculated out of respondents who reported difficulty getting a specialist appointment, excluding "don't know" and "refused" responses (Weighted N = 7,999). Totals will exceed 100 percent because some respondents indicated more than one reason.

[b] Includes responses in six open-ended categories as well as unspecified reasons.

Table C5. Person other than a care coordinator who helps coordinate care (weighted)

	Weighted	
	N	% [a]
Family member or friend	3,012	59.3%
Primary care doctor	720	14.2%
Nurse/other health professional in doctor's office	280	5.5%
Home health nurse	273	5.4%
Insurance representative or office staff	199	3.9%
Other home health provider (not a nurse)	194	3.8%
Social worker or caseworker	141	2.8%
Member him/herself	83	1.6%
Mental health provider	44	0.9%
Some other person	133	2.6%

[a] Percentages calculated out of respondents who reported having someone other than a care coordinator who helps them coordinate their care, excluding "don't know" and "refused" responses (Weighted N = 5,077).

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[12] $X^2 = 69.890$, $p < 0.001$

[13] $X^2 = 59.007$, $p < 0.001$

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[35] $X^2 = 10.416$, $p = 0.015$

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[37] $X^2 = 16.798$, $p = 0.001$

[38] HHSC. 2007. "Chapter 10.1.1: Performance Indicator Dashboard, Version 1.3." *Uniform Managed Care Manual.*

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[43] $X^2 = 21.580$, $p < 0.001$

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[47] $X^2 = 14.991$, $p = 0.002$

[48] $X^2 = 8.115$, $p = 0.044$

[49] $X^2 = 15.366$, $p = 0.004$

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[53] $t = 3.475$, $p = 0.001$

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