Medicaid Managed Care Waiver Study: An Independent Assessment of Access, Quality, and Cost-Effectiveness of the STAR+PLUS Program

Prepared for

The Texas Department of Human Services

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1 Executive Summary

This independent assessment of the STAR+PLUS waiver program was prepared by the Public Policy Research Institute (PPRI) at Texas A&M University for the Texas Department of Human Services (TDHS). The federal Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration, requires an independent assessment of access, quality, and cost effectiveness of all 1915(b) waivers. The original waiver for the STAR+PLUS Program was approved in January 1998. This assessment is for the second STAR+PLUS waiver period, September 1999 through August 2002.

Access to Care. It appears that STAR+PLUS is generally ensuring member access to care. STAR+PLUS HMOs performed very well during compliance monitoring for access standards. Member satisfaction with access to services and to care coordination is generally high. In this context, higher-than-baseline emergency room utilization does not appear to be a cause for alarm, although it may be a good area for additional study. Reductions in inpatient discharges and ALOS may be due to better access to primary care, the availability of care coordination, and better management of patient conditions. Due to conflicting indicators, STAR+PLUS may want to explore whether and to what extent language barriers may exist. The program may also want to undertake improvement efforts around member education.

Quality of Care. It appears that STAR+PLUS is generally ensuring an adequate level of quality in the services provided to its members but a number of steps can be taken to raise the level of quality. Member satisfaction is generally high and providers are generally satisfied with clinical aspects of Medicaid managed care. While these indicators suggest some areas for improvement they do not appear to be critical. To ensure continued participation of sufficient providers the program needs additional focus on provider satisfaction with administrative processes. In addition, focused study results highlight areas for improvement specific to care for depression and diabetes. Member complaints also do not appear to be an area of significant concern, however, program administrators should continue to standardize the complaint process and closely monitor complaint as they provide a sentinel effect in quickly identifying access and quality problems within the STAR+PLUS program.

Cost Effectiveness. According to the data provided to PPRI by TDHS, the implementation of the STAR+PLUS program in Harris County indicated savings of approximately $123 million to the state during the waiver period. The cost effectiveness evaluation was calculated within the STAR+PLUS service area for the two years in which the area operated under the waiver (Waiver Year (WY) 1: Feb, 2000 – Jan, 2001 and; Waiver Year 2: Feb, 2001 – Jan, 2002). The STAR+PLUS program saved the state approximately $66 million in WY 1 and $56 million in WY 2. The estimated results are

savings for the state that produced nearly a 17 percent reduction in state expenditures had the waiver not been in effect in Harris County.

2 Overview of the STAR+PLUS Program

2.1 Program Background

The STAR+PLUS program is part of a larger effort in Texas to contain Medicaid costs. The state began pilot testing managed care as a delivery system for the TANF and TANF-related Medicaid population in 1993. In 1997, anticipating a considerable budget shortfall, Texas began a conversion of these populations into managed care that included all metropolitan areas of the state, as well as a small number of individuals on Supplemental Security Income who are allowed to participate voluntarily, by 2000. Today, nearly 40 percent of the state's Medicaid population (about 756,000 individuals) is enrolled in managed care.[1]

Starting in April 1998, the state began requiring SSI and SSI-related recipients in Harris County to enroll in managed care to receive their Medicaid services. This project, called STAR+PLUS, is designed to integrate delivery of acute and long-term care services through a managed care system. Today, approximately 57,000 aged and disabled Medicaid recipients in Harris County are enrolled in STAR+PLUS.

2.2 Health Plans and Services

During the first waiver period, three health maintenance organizations (HMOs) participated in STAR+PLUS. Currently, there are two: Amerigroup and HMO Blue.

The STAR+PLUS HMOs provide members who are not eligible for Medicare (called Medicaid-only members) with all Medicaid primary, acute, and long-term care services through one service delivery system. This includes ensuring each Medicaid-only enrollee has a primary care doctor. Other acute care services the HMOs provide to Medicaid-only members include specialists, home health, medical equipment, lab, x-ray, and hospital services. Dually eligible enrollees – those who are also on Medicare - continue to receive acute care services from the Medicare provider of their choice, and receive only Medicaid long-term care services from their STAR+PLUS HMO. STAR+PLUS long-term care services include personal care services and adult day health services, as well as the state's 1915(c) Community Based Alternatives waiver.

Prescription drugs remain outside the managed care system but an enhanced benefit is available to managed care participants. STAR+PLUS participants who are not on Medicare receive as many medically necessary prescriptions each month as they need, rather than being limited to three as they are under Texas' traditional Medicaid program. STAR+PLUS also offers unlimited medically necessary prescriptions to dual eligibles

[1] Texas Health and Human Services Commission – Quarterly Forecasting Report.

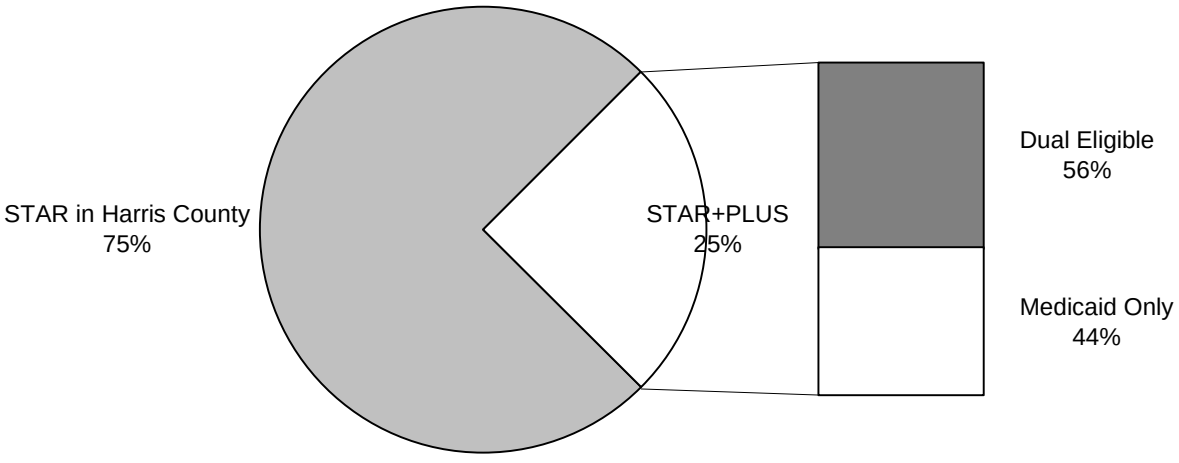
who participate in a Medicare managed care product operated by their STAR+PLUS health plan's company. However, there are currently no such Medicare products available.

Care coordination is the cornerstone of the STAR+PLUS program. Enrollees receiving long-term care services, as well as any enrollees who request it, receive care coordination services. Care coordination is provided by an HMO employee who is responsible for coordinating all the enrollee's services, developing an individual plan of care with the enrollee, family members, and providers, and authorizing long-term care services.

2.3 Average Enrollment

The STAR+PLUS program operates in Harris County with the STAR program. The STAR program primarily serves the TANF and TANF-related populations and the bulk of Medicaid recipients participating in Medicaid managed care in Harris County are enrolled in the STAR program. Although a smaller number of Medicaid recipients are served by the STAR+PLUS program (25 percent), this group of Medicaid recipients (the blind, disabled and aged) consume about 60 percent of the state's Medicaid expenditures each year.[2] Of the 57,000 Medicaid recipients participating the STAR+PLUS program in Harris County, 56 percent are dual eligible and 44 percent receive Medicaid benefits only.

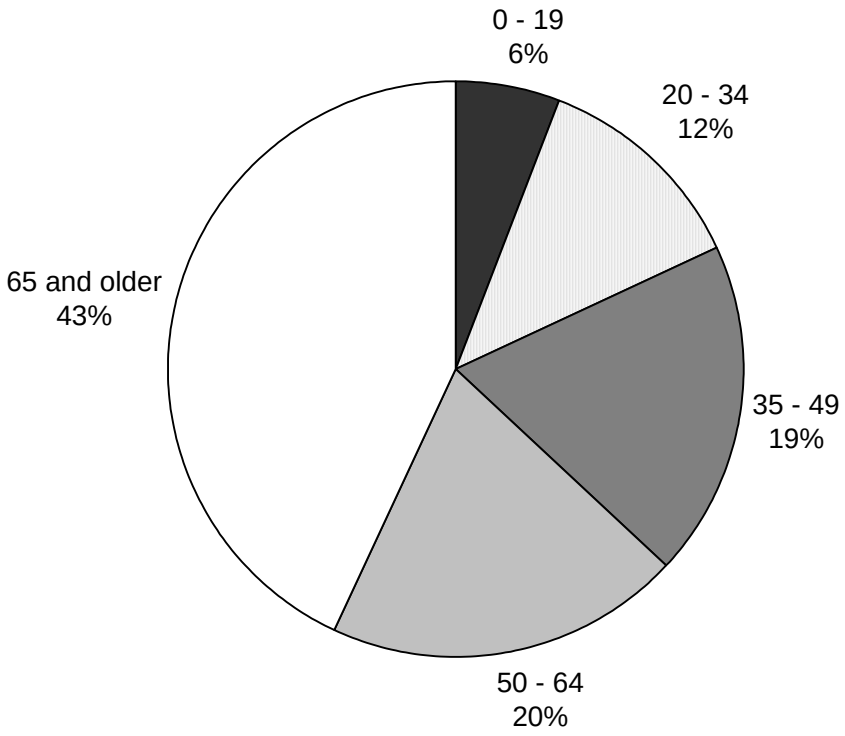
Figure 2.1: Medicaid Managed Care Population in Harris County



[2] Texas Medicaid in Perspective.

Not only is the STAR+PLUS program much smaller than the STAR program, but the demographics are also quite different. The majority of STAR program participants are children. In 2002, nearly 80 percent of the STAR population was under the age of 20.[3] STAR+PLUS primarily serves adults and in 2002 94 percent of the STAR+PLUS population was over the age of 20. In fact, most of the STAR+PLUS members are seniors, with 43 percent age 65 and over.

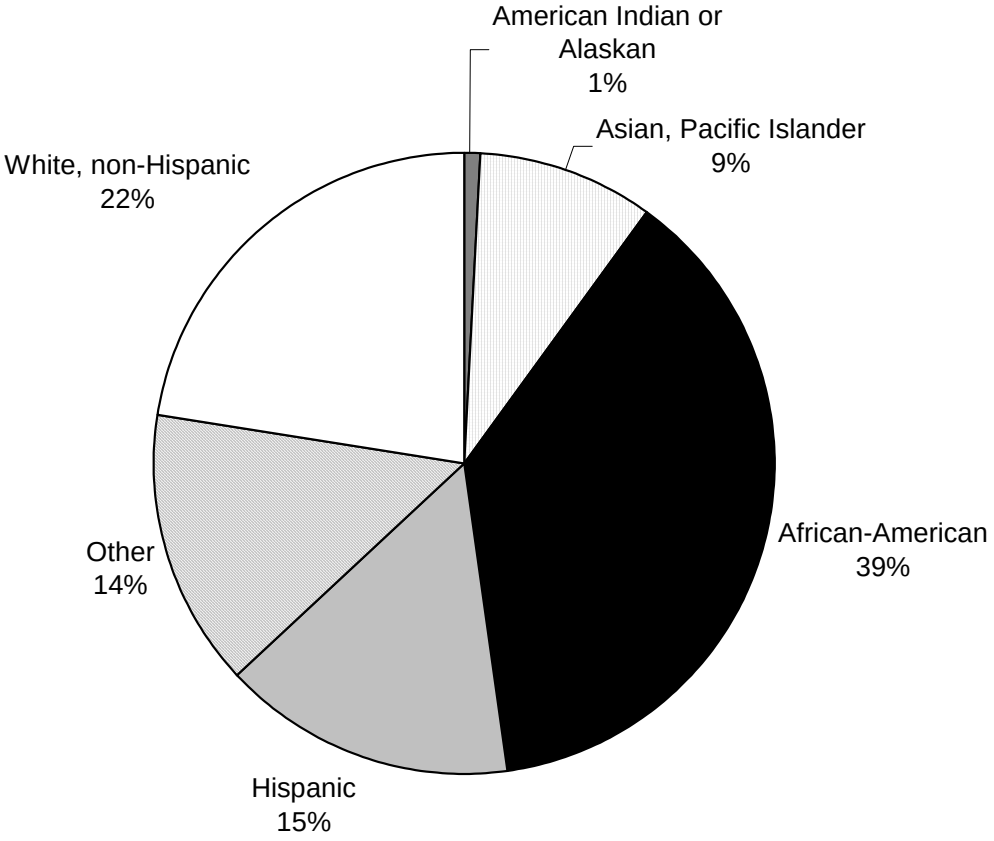
Figure 2.2: STAR+PLUS Members by Age: State Fiscal Year 2002



[3] Texas Medicaid in Perspective 4th edition

The ethnic makeup of the STAR+PLUS program is also quite different from the STAR population. The majority of participants in the STAR program are Hispanic, comprising 50 percent of the STAR population. In the STAR+PLUS program, Hispanics make up only 15 percent of the population. African-Americans are the single largest ethnic group in the STAR+PLUS program, comprising nearly 40 percent of the population, followed by Whites who make up 22 percent of the population.

Figure 2.3: STAR+PLUS Members by Ethnicity: State Fiscal Year 2002



3 Overview of Study Methodology

This assessment examines access, quality and cost effectiveness of the STAR+PLUS program during its second waiver period (September 1999 through August 2002). PPRI began the assessment in March 2002 and completed it in June 2002. PPRI and the Texas Department of Human Services selected the following indicators for each area of study based on appropriateness and data availability:

Access to Care

- TDHS contract requirements for access
- Member satisfaction survey results relating to access
- Member satisfaction survey and interview results related to access to care coordination
- Member satisfaction survey results related to behavioral health services
- Provider satisfaction survey results relating to access
- Utilization measures for inpatient hospital discharges, emergency room visits and average inpatient hospital lengths of stay

Quality of Care

- Member complaints
- Overall member satisfaction survey results
- Member satisfaction with care coordination survey and interview results
- Provider satisfaction survey results
- Focused study results

Cost Effectiveness

- Costs incurred under the STAR+PLUS program during the second waiver period
- Projected costs for the same period had the waiver not been in effect.

More detailed information on methodology is included in the following sections on access, quality and cost effectiveness.

4 Access

4.1 Summary

Measuring Access. Assessing STAR+PLUS member access to care is a challenge, given that reliable baselines were not established under the traditional Medicaid program and that no national managed care baselines specific to the aged and disabled population are available.

Access Standards. The access standards contained in the TDHS contract with STAR+PLUS HMOs are consistent with QARI standards. Results of monitoring by the state's External Quality Review Organization (EQRO) indicate that participating HMOs are meeting requirements related to 24-hour/7 day a week member access to the HMO, information needed to access services, and Spanish interpreters.

Overall Member Satisfaction. Responses to the Consumer Assessment of Health Plans Survey (CAHPS) survey indicate that STAR+PLUS members are generally satisfied with their access to health care under the program. However, analysis of the responses and comparison with national benchmarks suggest some opportunity to improve satisfaction with access. These should be construed not as areas in which the program is failing to ensure access to care but rather as opportunities to increase an already high overall level of member satisfaction.

Member Satisfaction with Access to Care Coordination. Responses to a special survey and interviews indicate that members are generally satisfied with their access to care coordination services and to long-term care services. While the overall picture of access to care coordination is positive, responses suggest that additional member education regarding procedures for accessing care coordinators when the person responsible for coordinating care changes and when members change HMOs could be useful.

Provider Satisfaction. A 2001 survey of providers who participate in STAR and STAR+PLUS found that physicians do not believe Medicaid managed care increases access. Survey respondents believe that members lack an understanding of managed care, and that this, combined with other barriers, may prevent members from benefiting as fully as possible from these programs. Because provider satisfaction with access under STAR+PLUS was measured along with satisfaction of STAR providers, program-specific conclusions are difficult to draw. However, results do highlight possible areas for further inquiry.

Utilization. STAR+PLUS has generally lowered the rate of inpatient hospital discharges compared to the rate for this population in the year preceding the program's

implementation. Average length of stay dropped consistently over the waiver period, and was lower under STAR+PLUS during this period than under the traditional program in 1998. Emergency room utilization has been higher during the second STAR+PLUS waiver period than it was in the year prior to program implementation, although utilization declined toward the end of the waiver period. It is difficult to make conclusive statements regarding utilization without patient-level information, especially in light of the disabling and chronic nature of the health conditions common to the STAR+PLUS population. However, PPRI believes the level of ER utilization is an area for additional study.

4.2 Background and Methodology

Studies vary in their findings about the effects of Medicaid managed care on access. Overall, little conclusive evidence exists that indicates managed care either increases or decreases the number of physician visits, the use of preventive health services, or inpatient hospital care.[4] In addition, because traditional Medicaid in Texas lacked the requirements for monitoring access that exist in Medicaid managed care, reliable baselines that could be used to measure changes in access due to implementation of managed care were not established. Furthermore, for those with disabilities and chronic conditions, such as STAR+PLUS enrollees, Medicaid managed care is largely untested and standard access benchmarks for this population do not exist.

To assess STAR+PLUS enrollees' access to care, PPRI:

- Examined the access standards in the TDHS contract with participating HMOs to determine their comparability to national access standards
- Reviewed results of access "spot checks" conducted by the state's EQRO
- Analyzed member responses to CAHPS satisfaction survey questions regarding access and compared these responses to national benchmarks
- Reviewed access-related results of a survey and interviews that measured member satisfaction with care coordination
- Reviewed access-related results of a survey that measured provider satisfaction with Medicaid managed care.

PPRI also examined utilization of:

- Inpatient hospital discharges per 1,000 member months (excluding mental health and chemical dependency)
- Average inpatient hospital length of stay (ALOS) in days

[4] Kaiser Commission on the Future of Medicaid, Medicaid Enrollment and Spending Growth. The Kaiser Family Foundation. November 1996

- Emergency room (ER) encounters per 1,000 member months.

PPRI calculated these measures using data reported by the HMOs from September 1999 through August 2001, and formulas specified by TDHS for the STAR+PLUS HMO Utilization Management Report (Physical Health)[5]. Traditional Medicaid program data from 1998 (pre-STAR+PLUS) for SSI and Medical Assistance Only (MAO) recipients in Harris County was used to establish baselines for determining whether managed care implementation has changed utilization for the selected measures. PPRI calculated the overall rate for each measure for the 1998 traditional program data, and compared it to the rate for each quarter for the managed care data.

4.3 Results

4.3.1 Access Standards

The TDHS contract with STAR+PLUS HMOs specifies required minimum standards for service availability and accessibility. The contract requires the HMOs to include these standards in their contracts with network providers. Standard HMO contracts with providers must be approved by TDHS, which verifies that the provider contracts contain the specified access requirements.

These requirements include PCP and specialist network capacity; primary care providers (PCPs) to enrollee ratios; 24 hour/7 day PCP accessibility; and ceilings for travel distances and times to access PCPs and specialists. The HMOs must arrange for medically necessary physical and behavioral health care within the following guidelines with respect to PCPs:

- Urgent care: Within 24 hours of request
- Routine care: Within 2 weeks of request
- Physical / Wellness exams (adults): Within 8-10 weeks of request
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT - now known in Texas as Texas Health Steps) check-ups: Within 90 days of new enrollment.

The HMOs must also ensure that referrals to specialists meet the following timeframes:

- Urgent care: Within 24 hours of request
- Routine care: Within 2 weeks of request
- Prenatal care: Within 2 weeks of request.

[5] *Utilization Management Report: Physical Health – State Fiscal Year, 1998.* 12/30/97.

In addition, HMOs must have standards and methods to monitor in-office, telephone call and appointment wait times.

PPRI's review of the STAR+PLUS contract provisions found that these provisions are consistent with national standards, such as the Quality Assurance Reform Initiative (QARI). QARI is a federally-developed set of standards, modeled on the principles used by the National Committee for Quality Assurance (NCQA), a nationally recognized managed care accreditation organization. QARI standards were developed to monitor and improve the quality of Medicaid managed care services. These standards include guidelines for internal quality assurance programs, performance monitoring, focused studies of clinical care, and state and independent oversight.[6]

4.3.1.1 THQA Spot Checks

Between December 2000 and February 2001, THQA conducted a telephone review, called a spot check, of STAR+PLUS HMO compliance with contractual requirements for access to behavioral health care, HMO customer service and language interpreters. Each STAR+PLUS HMO contracts with a specialized managed care organization, called a Behavioral Health Organization (BHO), to provide the behavioral health benefits required in the TDHS contract. The goal of the spot check was to identify areas for improvement within the HMOs and BHOs relating to:

- Access to the HMOs and BHOs;
- Information (customer service) provided by the HMOs and BHOs; and
- The ability of the HMOs and BHOs to communicate with STAR+PLUS members in both English and Spanish.

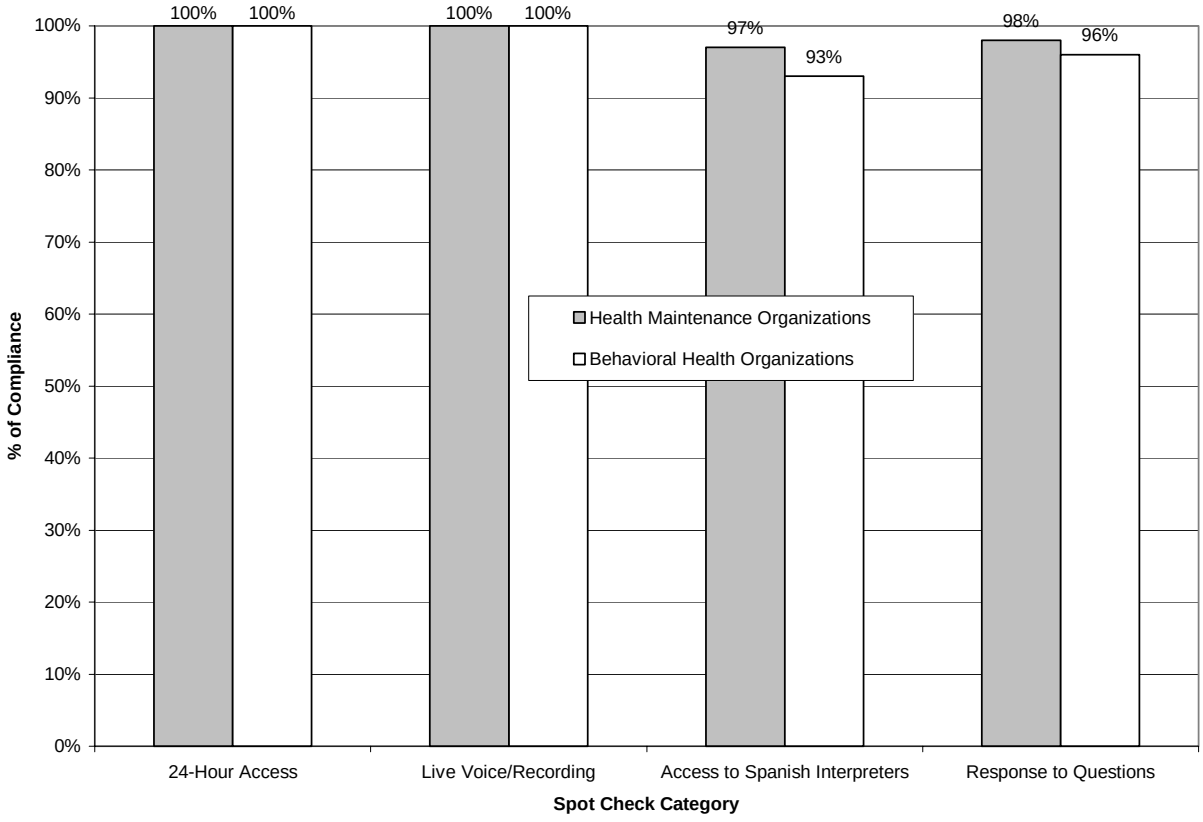
THQA developed nine scenarios to assess each HMO and BHO. The elements used to evaluate the HMOs and BHOs included:

- Maintenance of a toll-free member helpline, available 24 hours a day, that ensures access to a live voice rather than a recording
- Availability of Spanish interpreter services
- Receipt of instructions about how to obtain assistance in accessing services
- Appropriate telephone wait time
- Verification of eligibility for services

[6] Arnold, E (1997). Medicaid Managed Care and High Quality: Can We Have Both? Journal of the American Medical Association, 279 (19), 1617-1621.

All HMOs and BHOs demonstrated 100 percent compliance with maintenance of 24-hour helpline accessibility and with ensuring member ability to reach a live voice rather than a recording. Access to Spanish interpreters was also very good, with an overall HMO compliance rating of 97 percent and a BHO rating of 93 percent. Both HMOs and BHOs received a 96 percent compliance rating for response to questions, such as instructions on how to access services.

Figure 4.1: STAR+PLUS Spot Check Results of Member Access



4.3.2 Overall Member Satisfaction with Access

STAR+PLUS member satisfaction is measured annually using the Consumer Assessment of Health Plans Survey (CAHPS) instrument. Detailed information on the CAHPS survey and PPRI's methodology in analyzing CAHPS results are included in the following chapter. This section reports results of two CAHPS "composites", which combine results of multiple questions into a single measure: Getting needed care and getting care quickly.

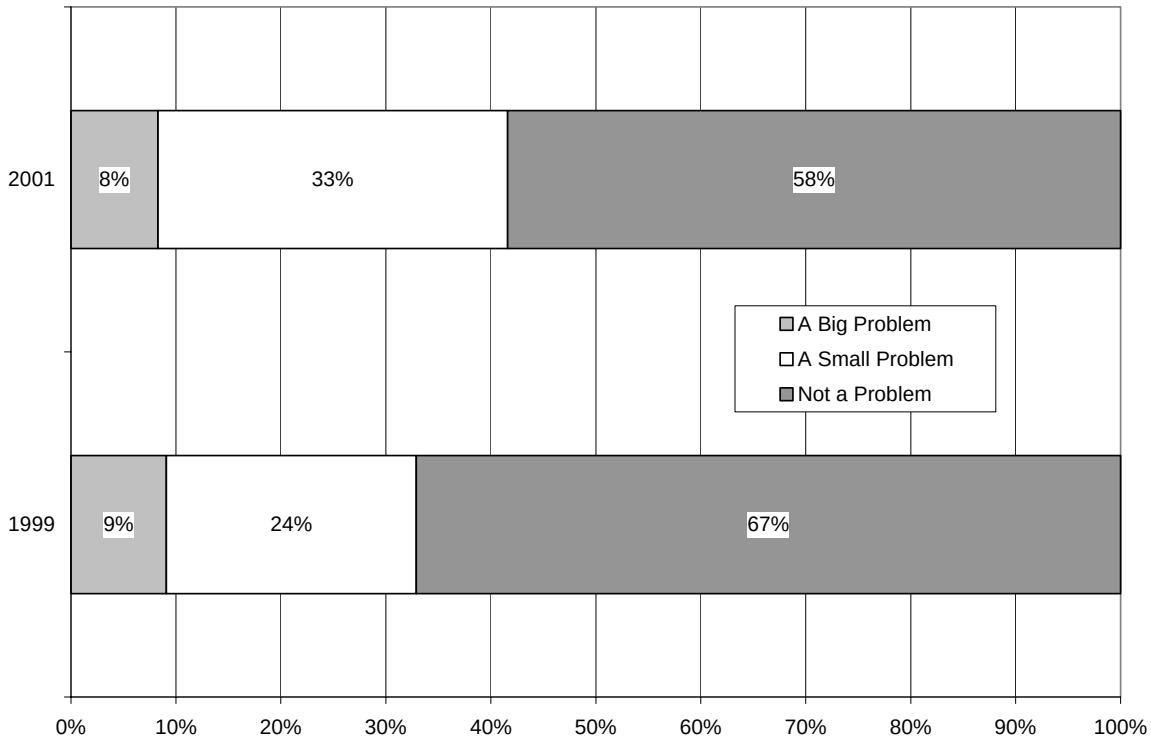
4.3.2.1 Getting Needed Care

This composite aggregates results of four questions:

- How much of a problem was it to find a personal doctor or nurse you are happy with?
- How much of a problem was it to get a referral to a specialist that you needed to see?
- How much of a problem was it to get the care you or your doctor believed was necessary?
- How much of a problem were delays in health care while you waited for approval from your health plan?

The majority of STAR+PLUS respondents in both years reported that getting needed care is not a problem. However, they reported more difficulty getting care in 2001 than in 1999, a statistically significant difference ($p<0.000$). The percentage indicating that getting needed care is not a problem dropped from 67 percent to about 58 percent, while the percentage indicating that it is a small problem rose from almost 24 percent to just over 33 percent. The percentage reporting that getting needed care is a "big problem" stayed about the same.

Figure 4.2: Getting Needed Care



Difference between 1999 and 2001 is statistically significant at 0.000 level.

In contrast to the change seen in STAR+PLUS, the percentages of both Medicaid and commercial respondents reporting that getting needed care is not a problem did not change much from 1999 to 2001. In 1999, STAR+PLUS had a similar but slightly lower percentage of respondents reporting no problem getting needed care than Medicaid had, and a lower percentage than commercial managed care had. In 2001, the STAR+PLUS had a lower percentage reporting no problem than either of the national groups had.

4.3.2.2 Getting Care Quickly

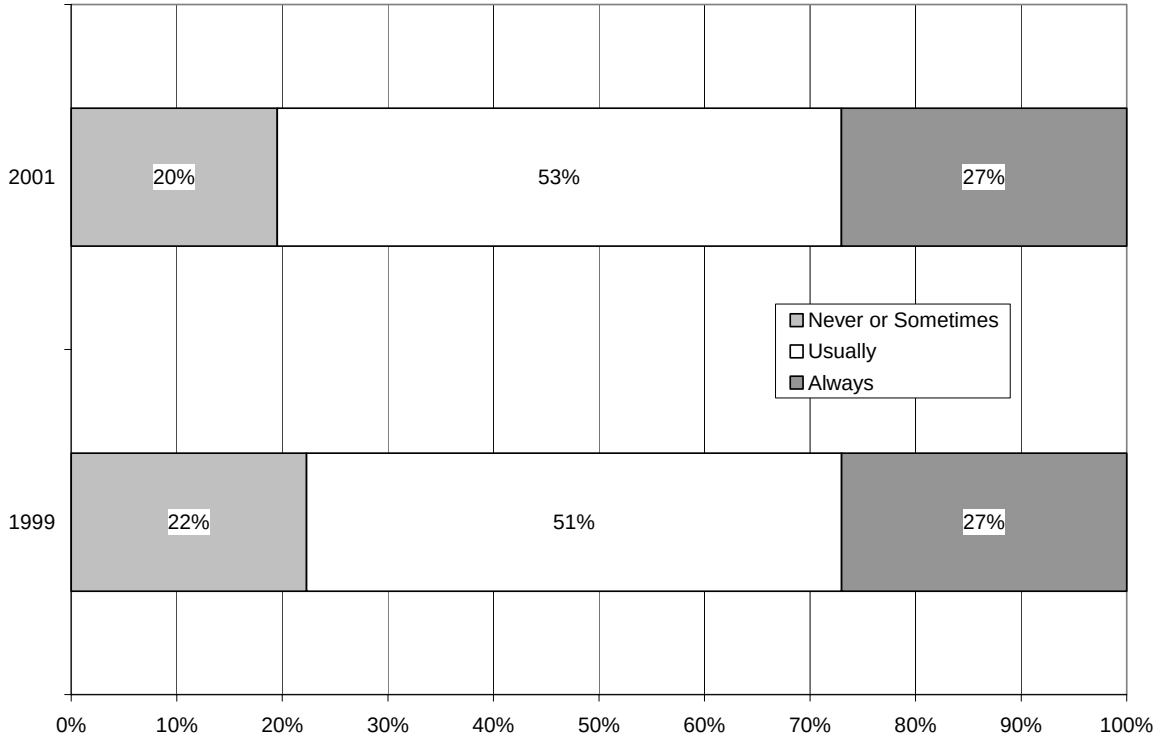
This composite aggregates results of four questions:

- When you called during regular office hours, how often did you get the help or advice you needed?
- How often did you get an appointment for regular or routine health care as soon as you wanted; when you need care right away for an illness or injury?
- How often did you get care as soon as you wanted?
- How often did you wait in the doctor's office or clinic more than 15 minutes past your appointment time to see the person you went to see?

There were no statistically significant differences between 1999 and 2001 STAR+PLUS responses to this composite. Twenty-seven percent of STAR+PLUS respondents in both survey years indicated they are "always" able to get care quickly, while about half indicated they are “usually” able to get care quickly. Approximately 20 percent reported they "never” or “sometimes" get care quickly.

As with STAR+PLUS, the percentages of both Medicaid and commercial respondents reporting that getting care quickly is not a problem were about the same in 2001 as they were in 1999. However, in both years, the percentages of both Medicaid and commercial respondents reporting no problem getting care quickly were close to twice as high as the percentage of STAR+PLUS respondents reported no problem getting care quickly.

Figure 4.3: Getting Care Quickly



Difference between 1999 and 2001 is not statistically significant at 0.321 level.

4.3.3 Member Satisfaction with Access to Care Coordination

THQA administered a 25-item survey to STAR+PLUS members receiving long-term care services to measure satisfaction with care coordination. The survey was developed by a workgroup of THQA staff, state staff and consumer advocates. In addition, a semi-structured, open-ended interview developed by the same group was conducted with members receiving long-term care services who were not eligible for Medicare in order to obtain more detailed information about satisfaction. The study period was September 1, 1999 – July 31, 2001. Surveys and interviews were conducted in members' homes.

Over 93 percent of duals and about two-thirds of Medicaid-only members find it easy to get a care coordinator to help them. Most also say it is easy to get long-term care services like attendant care, special equipment and therapies from their STAR+PLUS

HMO. However, members interviewed don't always know whom to call when their care coordinator changes or they change HMOs.

4.3.4 Provider Satisfaction with Access

THQA conducts an annual survey of provider satisfaction with Medicaid managed care. Because of the large number of providers who participate in both STAR and STAR+PLUS in Harris County, THQA does not administer separate provider surveys for the two programs.

Physicians responding to the 2001 survey indicated they do not believe Medicaid managed care has increased member access to other provider types or to services. Survey respondents believe that Medicaid managed care members do not benefit as fully from the programs as they possibly could due to several factors. These include lack of member understanding of the Medicaid managed care system, and language/communication barriers.

4.3.5 Utilization

Table 4.1 summarizes quarterly data from September 1999 through August 2001 on inpatient discharges, average inpatient hospital lengths of stay, and emergency room use.

Table 4.1: Summary of HMO-Reported Utilization Data

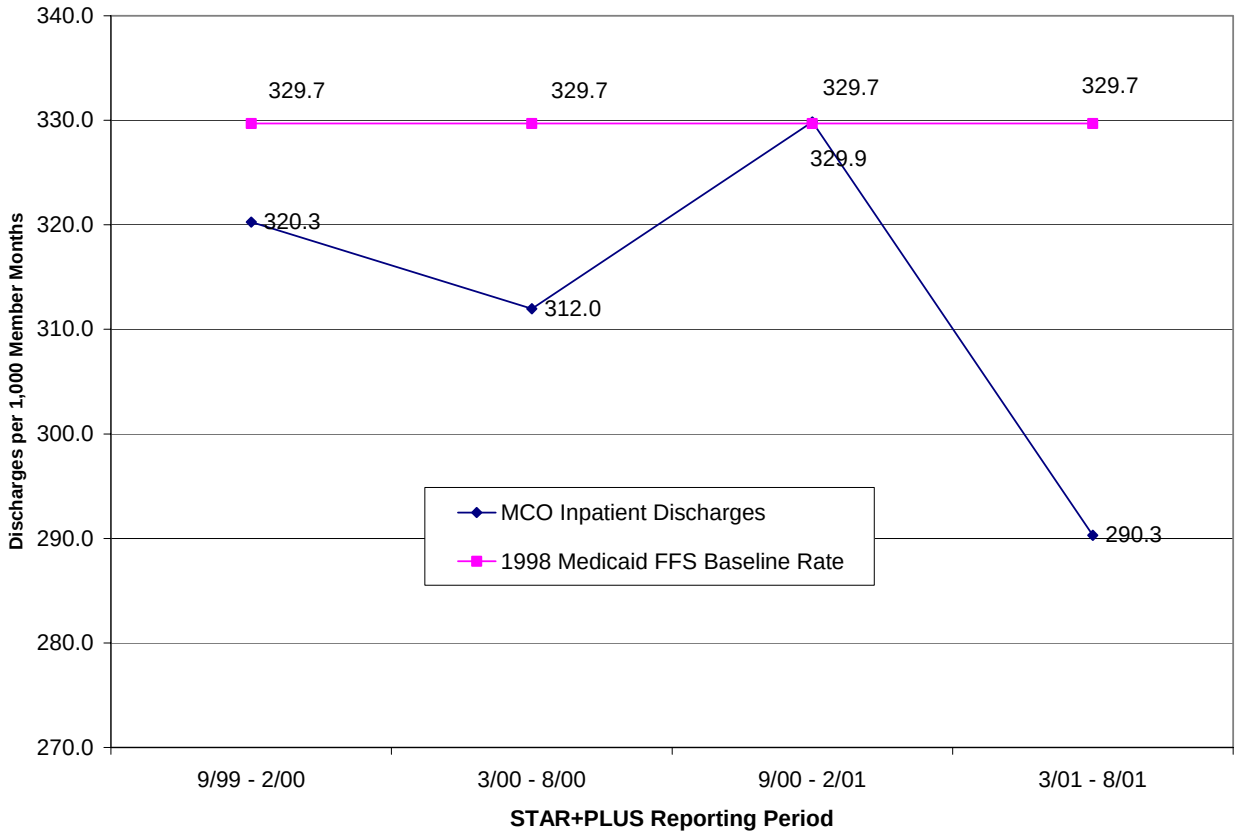
Reporting Period	Member months	Inpatient Discharges per 1,000 Member Months	Average Length of Stay in Days	Emergency Room Utilization per 1,000 Member Months
9/99-2/00	135,022	320.3	6.73	876.2
3/00-8/00	137,064	312.0	6.47	914.6
9/00-2/01	129,031	329.3	6.28	946.7
3/01-8/01	107,520	290.3	6.08	867.2

4.3.5.1 Inpatient Discharges

The rate of inpatient discharges reported by the STAR+PLUS HMOs dropped from just over 320 per 1,000 member months for the first reporting period to about 290 per 1,000 member months for the last reporting period. However, the rate for the third reporting period was the highest for the two-year period, interrupting an otherwise downward trend.

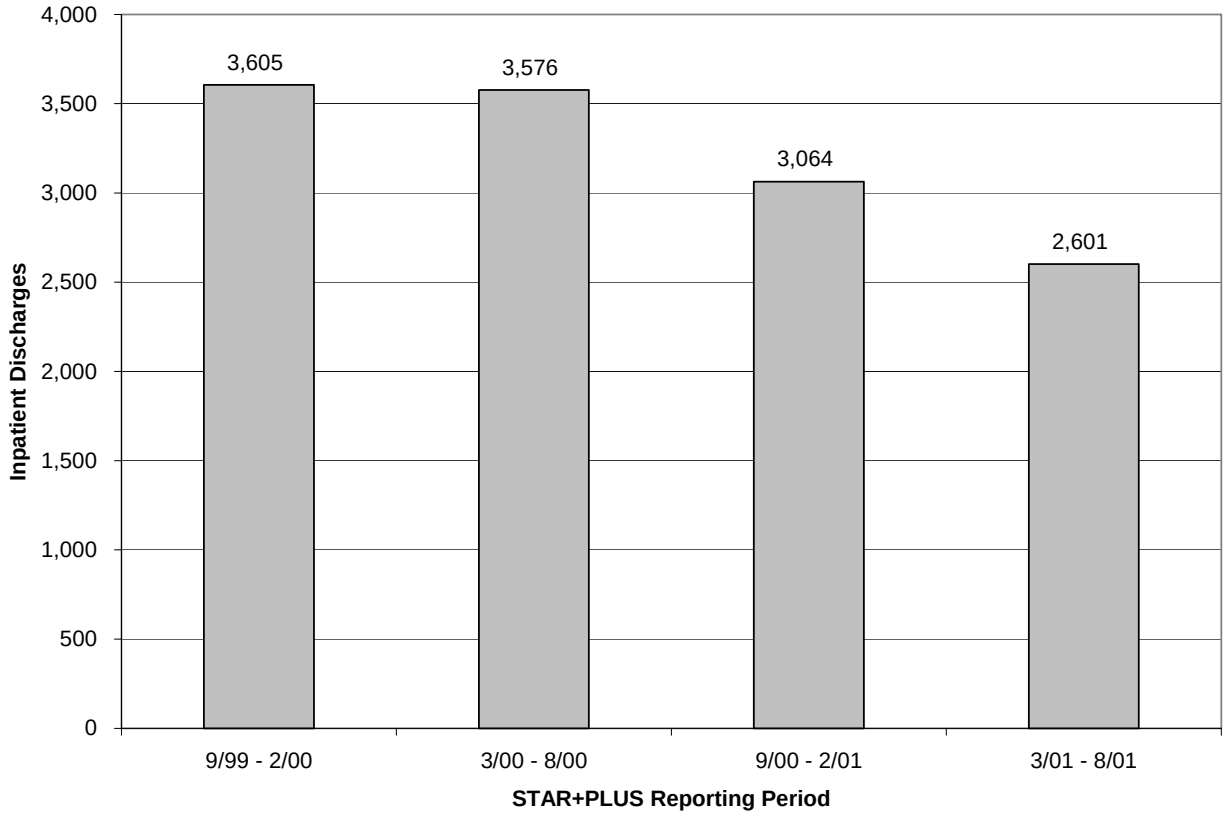
The overall rate of inpatient hospital discharges is lower under STAR+PLUS during the period September 1999-August 2001 than under the traditional program for the same population in the year preceding STAR+PLUS implementation. For each reporting period except one, the managed care rate is lower under STAR+PLUS than the 1998 annual rate in the traditional program. For the one reporting period in which the managed care rate is higher than the traditional program rate, the difference between the rates is extremely small.

Figure 4.4: Inpatient Discharges per 1,000 Member Months
STAR+PLUS versus SFY 1998 Traditional Program Baseline



The actual number of STAR+PLUS inpatient discharges dropped in each consecutive reporting period. The final reporting period shows about a one-third decrease in the number of discharges compared to the first reporting period, although the reasons for this drop are unclear.

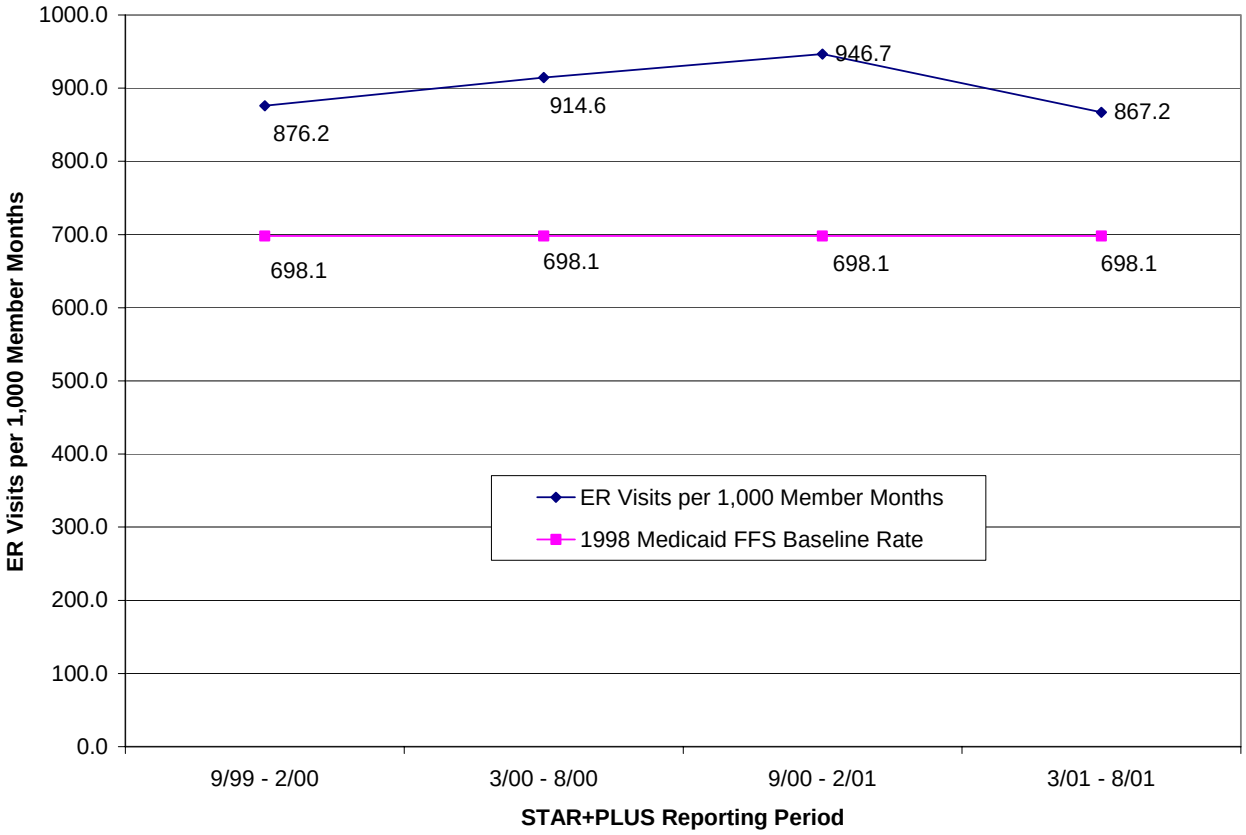
Figure 4.5: STAR+PLUS Inpatient Discharges



4.3.5.2 Emergency Room Visits

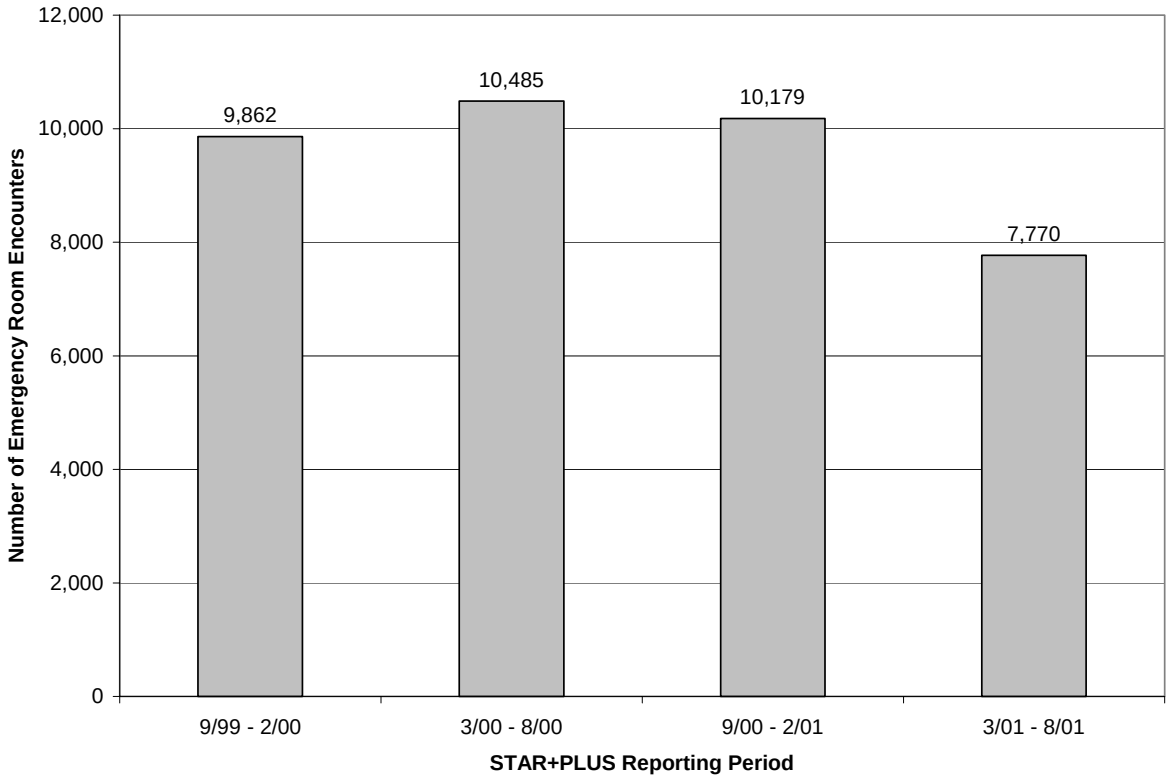
Emergency room utilization rates for STAR+PLUS were on an upward trend until the last reporting period, when the rate fell slightly below the rate of the first reporting period. In addition, STAR+PLUS emergency room rates were higher in every reporting period than the traditional program baseline rate.

Figure 4.6: Emergency Room Encounters per 1,000 Member Months STAR+PLUS versus SFY 1998 Traditional Program Baseline



The aggregate number of emergency room encounters rose in the second reporting period, declined slightly in the third reporting period, then declined significantly in the last reporting period. The decrease in the rate for the final reporting period is not as sharp as the decrease in the aggregate number of emergency room encounters due to a decrease in the number of member months, which fell from 129,031 (9/00 to 2/01) to 107,520 (3/01 to 8/01).

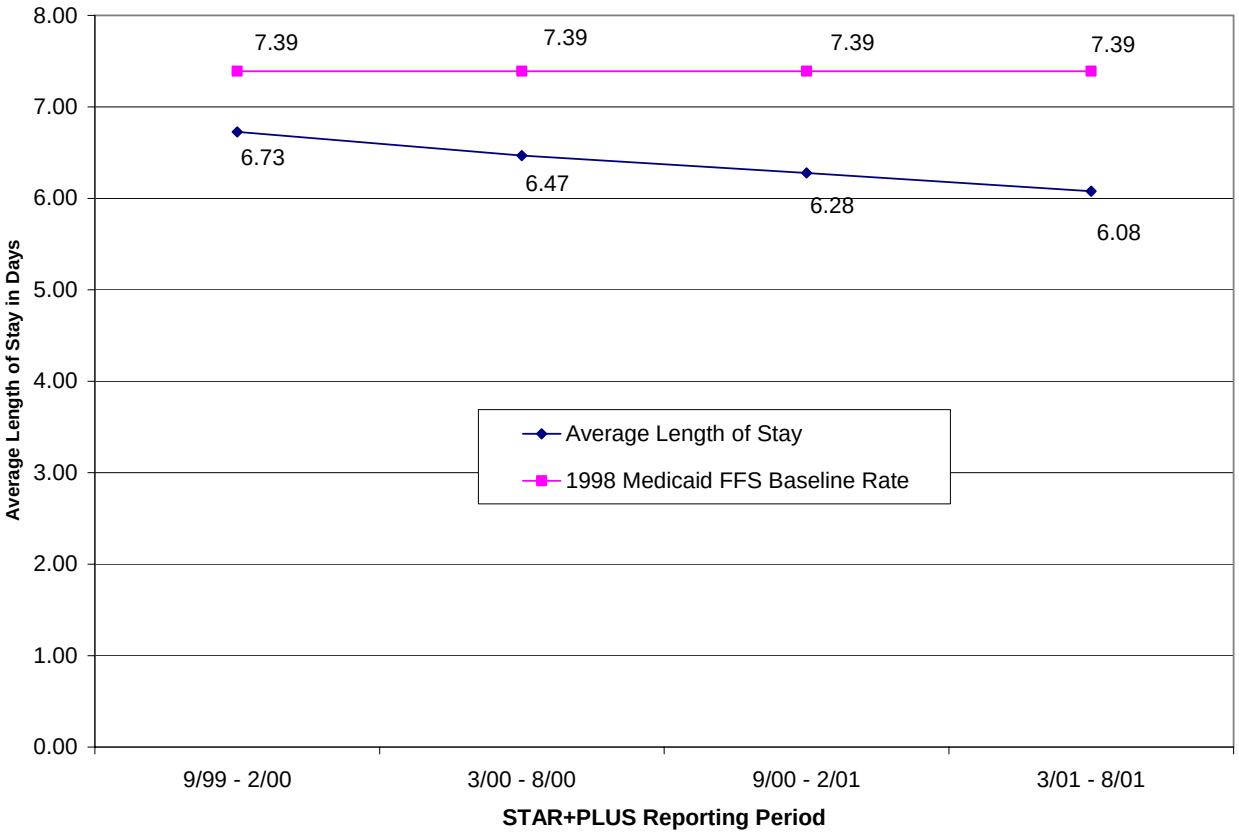
Figure 4.7: Number of STAR+PLUS Emergency Room Encounters



4.3.5.3 Average Length of Stay

The average length of stay in STAR+PLUS dropped in each reporting period. In addition, for each reporting period, the STAR+PLUS ALOS is lower than the traditional program baseline. During the first reporting period, the difference between the STAR+PLUS ALOS and the baseline was slightly more than half a day. By the final reporting period, the STAR+PLUS ALOS was more than a day lower than the baseline.

Figure 4.8: Average Length of Stay
STAR+PLUS versus SFY 1998 Traditional Program Baseline



4.4 Conclusions

Assessing STAR+PLUS member access to care is a challenge, given that reliable baselines were not established under the traditional Medicaid program and that no national managed care baselines specific to the aged and disabled population are available. Nevertheless, examining the access standards required of the STAR+PLUS HMOs and their compliance with those standards can provide some insight into the access to care that STAR+PLUS members have.

The access standards contained in the TDHS contract with STAR+PLUS HMOs are consistent with QARI standards. While these standards are not specific to aged and disabled populations, they are assumed to be good minimum standards for any population in managed care. Results of monitoring by the state's EQRO indicate that participating HMOs are meeting requirements related to 24-hour/7 day a week member access to the HMO, information needed to access services, and Spanish interpreters.

Responses to the CAHPS survey indicate that STAR+PLUS members are generally satisfied with their access to health care under the program. However, analysis of the responses and comparison with national benchmarks suggest some opportunity to improve satisfaction with access:

1. *Getting Needed Care*. While the majority of STAR+PLUS respondents for both years reported no problem getting needed care, the percentage reporting no problem dropped and the percentage reporting a small problem increased in 2001.(A factor that may have influenced the change in ratings for 2001 was the exit of one of the HMOs from the STAR+PLUS program.) In addition, the percentage of STAR+PLUS respondents giving the most favorable response is considerably lower than the percentages of Medicaid and commercial respondents giving the most favorable response.
2. *Getting Care Quickly*. Close to 80 percent of STAR+PLUS respondents indicated they always or usually get care quickly. However, a considerable minority (20 percent) indicated they never or sometimes get care quickly. In addition, the percentage of STAR+PLUS respondents giving the most favorable rating to this composite was only about half the percentages of both national comparison groups.

These should be construed not as areas in which the program is failing to ensure access to care but rather as opportunities to increase an already high overall level of member satisfaction.

Responses to the care coordination survey and interviews indicate that members are generally satisfied with their access to care coordination services and to long-term care services. While the overall picture of access to care coordination is positive, responses

suggest that additional member education regarding procedures for accessing care coordinators when the person responsible for coordinating care changes and when members change HMOs could be useful.

Provider satisfaction with access under STAR+PLUS was measured along with satisfaction of STAR providers, thus program-specific conclusions are difficult to draw. However, results do highlight possible areas for further inquiry. Survey respondents do not believe Medicaid managed care increases access to other providers or to services. They believe that members lack an understanding of managed care, and that this, combined with language and communication barriers, prevent members from benefiting as fully as possible from these programs.

While analysis of access standards and member satisfaction survey responses suggest that STAR+PLUS is basically ensuring access to care, analysis of utilization measures yields a less conclusive picture of access under STAR+PLUS. However, without analyzing individual medical records to determine such information as diagnoses, treatment or procedures provided, and individual responses to the care provided, it is difficult to make conclusive statements regarding appropriateness of inpatient hospital and emergency room utilization and hospital lengths of stay and what these utilization rates reflect vis-à-vis access to primary and preventive services. Further complicating the attempt to draw conclusions is the disabling and chronic nature of the health conditions common to a population such as that served by the STAR+PLUS program. Individuals who have disabling and chronic conditions might be expected to use hospital and emergency room services at a high rate despite good access to primary care.

Nevertheless, some statements can be made about utilization in STAR+PLUS and inferences made about areas for additional study. First, STAR+PLUS has generally lowered the rate of inpatient hospital discharges compared to the rate for this population in the year preceding the program's implementation. Assuming that better access to primary care reduces the need for inpatient hospitalization by preventing, reducing or delaying the worsening of chronic conditions, STAR+PLUS apparently ensured better access to primary care during its second waiver period than was ensured under the traditional program in 1998.

Second, emergency room utilization has been higher during the second STAR+PLUS waiver period than it was in the year prior to program implementation, although utilization declined toward the end of the waiver period. On the one hand, higher ER utilization in STAR+PLUS may say something about better access to ER services than was available under the traditional program. On the other hand, it may indicate a problem with access to primary and preventive services. Despite the drop toward the end of the waiver period, the rate of ER utilization in STAR+PLUS appears to point in the opposite direction of the rate of inpatient discharges, although as stated previously,

without more detailed information it is difficult to draw conclusions. Thus PPRI believes this is an area for additional study.

Third, average length of stay dropped consistently over the waiver period, and was lower under STAR+PLUS during this period than under the traditional program in 1998. This reduction could result from better care coordination and management of patient conditions, but once again, without more detailed information it is difficult to draw conclusions.

5 Quality of Care

5.1 Summary

Overall Member Satisfaction. Most STAR+PLUS members are satisfied with the program's health plans, providers and services, with reported levels of satisfaction changing very little from 1999 to 2001. STAR+PLUS survey results generally compare well with the results of two national comparison groups. There are four potential areas for improvement (two of which are discussed in the previous chapter). However, these should be construed not as areas in which the program is failing to ensure quality care but rather as opportunities to increase an already high overall level of member satisfaction.

Member Satisfaction with Care Coordination. Members are generally satisfied with care coordination services. However, survey and interview responses suggest that two potential areas for improvement exist: member perception of care coordinator responsiveness and member education regarding assessments, services, and care coordination. These improvement opportunities should be interpreted in the context of good overall satisfaction.

Member Satisfaction with Behavioral Health Services. Members are generally satisfied with their behavioral health services. They are also generally satisfied with outcomes of care, although to a lesser degree than with services. However, satisfaction with outcomes increased slightly over the last two years. The state may want to consider studying why satisfaction with outcomes is lower than satisfaction with services, but given good overall satisfaction, this is probably not a critical area for examination.

Provider Satisfaction. Conclusions about provider satisfaction primarily apply to Medicaid managed care overall rather than to STAR+PLUS specifically (except for that expressed by long-term care providers) due to survey methodology. Providers are generally satisfied with coverage and clinical aspects of Medicaid managed care, thus no indications of quality of care problems are reflected in the survey. However, providers are generally dissatisfied with administrative issues such as reimbursement and claims processes. Because persistent dissatisfaction with administrative aspects may eventually affect the care provided and continued program participation, this is an area requiring attention, particularly for long-term care providers.

Focused Studies. The depression focused study found that PCPs treating depression are generally following recommended guidelines for prescriptions, and that documentation of referrals to and communication with behavioral health specialists has

improved. Review of documentation of important treatment components showed mixed results, with increases in documentation of types and dosages of prescribed medications but decreased documentation of follow-up visits with patients receiving prescriptions and drug side effects. THQA recommended continuation of quality improvement efforts relating to PCP: documentation of depression treatment and outcomes; use of screening tool; patient education; communication with BH specialist; and follow-up for patients receiving prescriptions. The diabetes study found that most patients received prescription for medicines that are recommended for diabetes management. However, PCPs have low rates of documentation for important components of diabetes treatment, including screening tests, management plans, and patient education. THQA recommended quality improvement efforts to: improve PCP documentation rates of treatment and outcomes; continue studying outcomes of care; and track the impact of improvement efforts on treatment and documentation. While lack of documentation does not necessarily mean care was not provided, the state's ability to accurately assess quality of care depends on reliable documentation of treatment and outcomes. THQA's recommendations for depression and diabetes will likely improve the ability to conduct such assessments. To the degree that lack of documentation does reflect lack of care, THQA recommendations may also improve quality of care by making PCPs more aware of how their management of depression or diabetes differs from recommended treatment guidelines and by increasing PCP adherence to recommended guidelines.

5.2 Background and Methodology

The Institute of Medicine defines health care quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[7] Measuring quality has become an important objective in improving health care delivery in the United States. Until the proliferation of managed care of the 1990s, the hospital was the most common area for measuring quality. With more and more people receiving their health care benefits through managed care arrangements, the performance of HMOs is now being assessed and reported publicly. New efforts in the area of quality assurance for HMOs have sought to standardize how a health plan should calculate many performance measures in various areas, such as quality and utilization.[8] Standardizing performance measures can permit comparisons of health data from HMO to HMO as well as among state Medicaid programs.

[7] Lohr, K.N. Medicare: A Strategy for Quality Assurance, v I. Washington, DC: National Academy Pr; 1990:21.

[8] Spoeri, R. & Ullman, R. (1997). "Measuring and Reporting Managed Care Performance: Lessons Learned and New Initiatives. Annals of Internal Medicine. 127:726-732.

To assess quality of care provided under the STAR+PLUS program, PPRI:

- Reviewed member complaints
- Analyzed responses to member satisfaction surveys and compared results to national benchmarks
- Reviewed member satisfaction survey and interview results related to care coordination
- Reviewed member satisfaction survey results related to behavioral health services
- Reviewed provider satisfaction survey results
- Reviewed results of two focused studies, conducted by the state's EQRO, that examined depression and diabetes.

Member Complaints. PPRI analyzed complaint data for beginning in September 1999 through August 2001. The HMOs are required to keep a record of the complaints they receive, by logging each complaint received in person, by telephone, or in writing. The complaint logs serve both the HMOs and TDHS to help detect problem patterns. Once patterns are detected and analyzed, Birch and Davis and TDHS work to develop policy and procedural improvements to address the complaints and any reoccurring themes.

TDHS is in the process of modifying the complaint recording procedures. As a result, the format and content of the complaint data was inconsistent between the reporting periods as TDHS is working to implement the new complaint reporting system. With the complaint logs submitted by the HMOs, PPRI summarized the complaints into 5 general categories based on the earliest TDHS methodology for sorting complaints. The general categories that result from these efforts included:

- **Enrollment and Administrative Issues -** This category most often surrounded complaints regarding Member confusion or frustration with PCP selection or difficulties or problems associated with obtaining their HMO identification card
- **Billing Issues -** This category included complaint topics related to Member billing.
- **Access Issues -** This category included complaints dealing with access to care, such as a PCP and home health services. This category also included complaints such as delays or denials authorization for services as well as the inability to get prescriptions refilled.
- **Quality of Care -** This category primarily included patient perceptions of quality problems with providers, such as poor or inappropriate care as well as the courteousness of providers and their staff.
- **Other -** A general category designed to catch other complaints that did not fit into the previous four categories.

Complaints were taken from the complaint summary logs developed by the HMOs and sorted into the appropriate categories. Although some complaints were listed as a single entry in the STAR+PLUS HMO complaint logs, they could have contributed to one or more complaint categories. When a single complaint covered several areas of concern, such as Member inability to access care and a Member complaint about the perceived quality of care they received, PPRI counted complaint as two complaints: 1) as an access issue complaint and 2) as a quality of care complaint. Members with multiple problems or complaints were the exception and did not constitute a large number of the complaints received by the HMOs.

Overall Member Satisfaction. The Texas Health Quality Alliance (THQA) has measured STAR+PLUS member satisfaction annually since 1998 using the Consumer Assessment of Health Plans Survey (CAHPS) instrument. The CAHPS survey is used nationally in Medicaid, Medicare and commercial managed care. It asks members to rate their satisfaction with various aspects of their health care.

CAHPS results are reported separately for certain questions, and as a composite for certain other questions. Results reported separately include satisfaction with:

- Personal doctor
- Specialist
- Health plan
- Overall health care.

Results reported as composites of more than one question are satisfaction with:

- Getting needed care (4 questions)
- Getting care quickly (4 questions)
- Doctor communication (4 questions)
- Office staff courtesy (2 questions)
- Health plan customer service (3 questions).

Using THQA's data from the 1999 and 2001 STAR+PLUS CAHPS surveys, PPRI examined overall program results and changes between the two years in member-reported satisfaction for the questions and composites shown above. These two years were selected in order to compare the most recent survey from the first STAR+PLUS waiver period with the most recent survey from the second STAR+PLUS waiver period. T-tests were used to determine differences among response means from the survey, such as member ratings of their physician on a scale from 0 to 10. When categorical data were tested, chi-squares were employed. In both instances, differences that reached the level of ($p<0.05$) were determined as significant.

Because there were no clear guidelines available about cutoff points, averaging response questions, and protocols for missing data for determining the aggregate responses for each of the CAHPS questions, PPRI developed its own set of decision criteria that is available in Appendix X. PPRI attempted to model the format used by THQA and the Agency for Healthcare Quality and Research, the national agency that developed the CAHPS questionnaires. As a result, any comparisons to national data should be made cautiously.

In addition to comparing 1999 survey results to the 2001 results, PPRI compared the STAR+PLUS results for both years to selected National CAHPS Benchmark Database results for those two years. The National CAHPS Benchmark Database provides, among other data, nationwide average percentages of adults in Medicaid and in commercial managed care giving certain responses to the CAHPS questions and composites. It is important to note that adults in Medicaid managed care nationally are primarily the TANF and TANF-related population, as few states include aged and disabled individuals in their Medicaid managed care programs. Thus, comparisons between Medicaid adults nationally and STAR+PLUS should be made cautiously given the significant differences between the two populations.

Member Satisfaction with Care Coordination and with Behavioral Health Services. PPRI reviewed THQA-reported results of a survey and interviews that measured member satisfaction with care coordination and of two surveys that measured member satisfaction with behavioral health services.

Provider Satisfaction. PPRI reviewed THQA-reported results of a survey that measured satisfaction of providers participating in STAR and STAR+PLUS with Medicaid managed care.

Focused Studies. PPRI reviewed THQA-reported results of focused studies that examined treatment of depression and diabetes in STAR+PLUS.

5.3 Results

5.3.1 Member Complaints

Medicaid recipients have long been guaranteed the opportunity for a fair hearing before the state agency to protest the reduction or termination of benefits.[9] Greater patient protections were designed for Medicaid beneficiaries because many believe most Medicaid recipients have fewer skills to successfully advocate for themselves than their

[9] 42 U.S.C. § 1396a(a)(3).

commercial counterparts. Low literacy and reading skills of the typical Medicaid recipient can make developing or filing a written grievance or complaint especially vexing. Thus, providing multiple avenues and interfaces to permit Medicaid recipients to submit a complaint or grievance is especially critical. [10]

With a system for receiving and resolving complaints, Medicaid recipients and providers are assured that they have a forum that will hear their concerns. The primary purpose of the complaint process remains the resolution of individual or provider disputes.

5.3.2 STAR+PLUS Complaint Definition

Definitions for complaint and grievance vary widely across the country. While some states use the term complaint and grievance interchangeably, some categorize the two differently, often with grievance being more severe. Texas has sought to reduce any confusion between the two terms by defining disputes with the single term: Member complaint. The definition is taken from the Texas State Insurance Code, Section 20A.02. Member complaint is defined as:

- Any dissatisfaction expressed by a Member or a person acting on behalf of the member either orally or in writing to the health maintenance organization concerning any aspect of the health maintenance organization's operation, including but not limited to dissatisfaction with plan administration, or the way a service is provided. The term does not include misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the Member.[11]

5.3.3 Filing a Complaint in Texas

Medicaid recipients are encouraged to talk with the Member Services Department of their HMO first, but can begin the complaint process at a variety of interfaces. Most complaints are filed directly with the HMO or the Enrollment Broker. Members may also seek to resolve problems by calling the Starline. The Starline is a regional helpline for STAR and STAR+PLUS clients in Harris County which provides a basic level of assistance, such as answering simple questions and making referrals to the Enrollment Broker, the client's HMO, PCP or Care Coordinator, or other appropriate state or community resources. Inquiries or issues that cannot be handled quickly or easily by a Starline worker are transferred to an advocate. Data are gathered from the Starline to

[10] Rawlings-Sekunda, J. (January 1999) "Addressing Complaints and Grievances in Medicaid Managed Care." National Academy for State Health Policy.
[11] TDH Complaint Definitions [On-line]. Available : http://www.tdh.state.tx.us/hcf/mc/complaints/mccompdef.htm

track problems that should be addressed with the Enrollment Broker, HMOs, the local advisory committee, or other pertinent parties in the Harris County pilot. Data from the Starline were not available at the time of this report and were not incorporated into the subsequent findings.

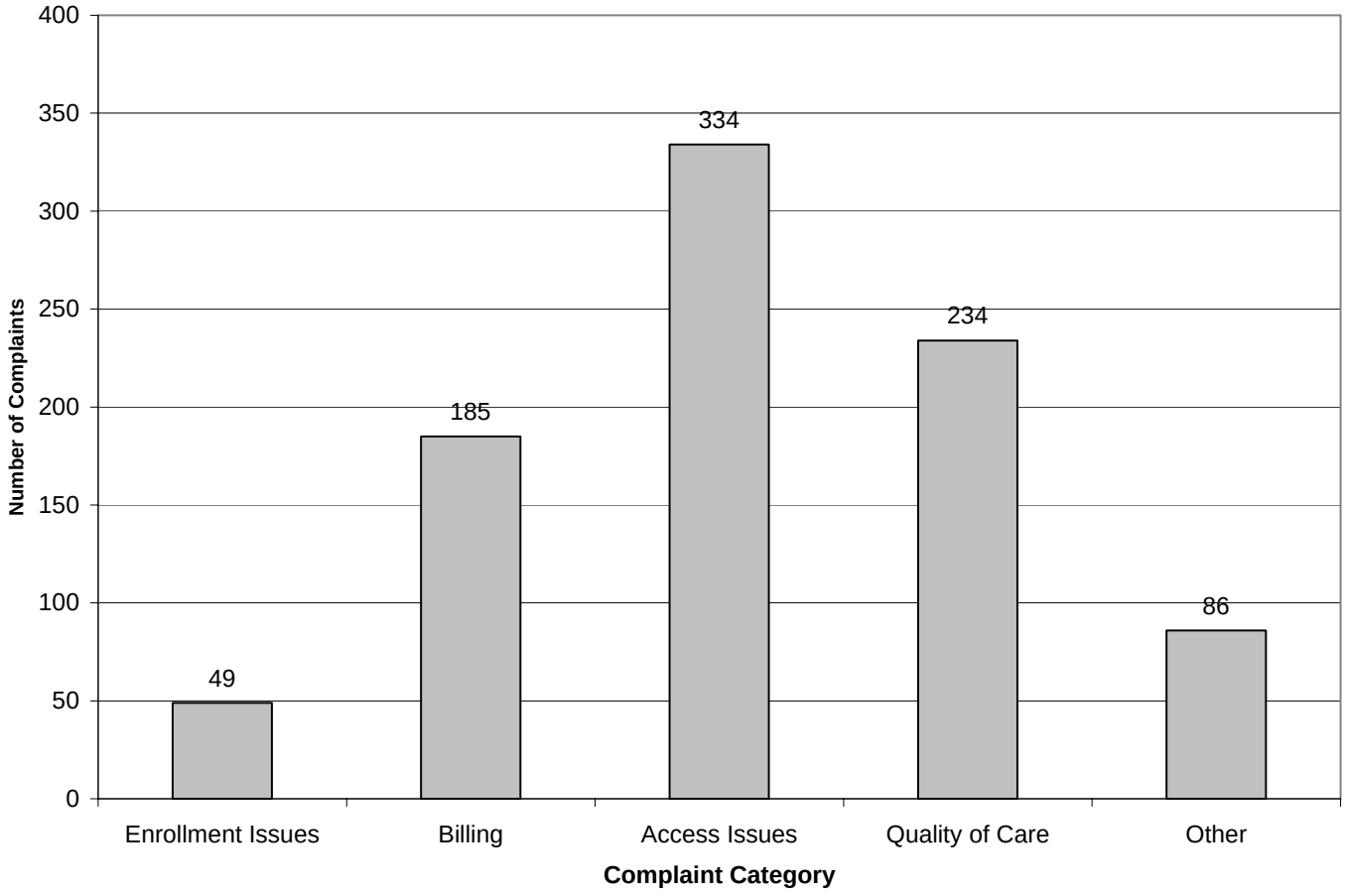
The Enrollment Broker maintains a client hotline for Medicaid recipient inquires. Complaints that are received by the Enrollment Broker are then passed on to the HMO for resolution. The Enrollment Broker provides Medicaid managed care recipients education and assistance with their selections among managed care plan options and the selection of a PCP, but does not address complaints associated with HMOs. The Enrollment Broker also reports all complaints received to TDHS to match with the MCO complaint reports. TDHS compares the complaint reports from the Enrollment Broker with the MCO complaint reports to assure that all complaints are resolved in a timely fashion.

The HMO contracts incorporate extensive requirements for complaint resolution. All complaints must be resolved in 30 days of receipt of the complaint. The HMOs typically involve staff within the HMO, such as billing, prior authorizations, etc., to investigate the complaint in the staff member's area of expertise. Medical issues of an urgent nature require quick responses. Medical complaints, such as denials of care, require clinical review and many times, a decision from the HMO's medical director. Medicaid recipients can request a fair hearing from the State at any point during the appeal process and do not have to exhaust the appeals process with the HMO before requesting a fair hearing.

5.3.4 Complaint Data

Figure 5.1 displays a summary of the 888 complaints received from the HMOs over the two-year reporting period. Access to care issues were the most frequently reported type of complaint. Approximately 38 percent of all STAR+PLUS complaints were related to access to care. Quality of care complaints followed with 26 percent of all reported complaints.

Figure 5.1: STAR+PLUS Member Complaints by Type : September 1999 through August 2001

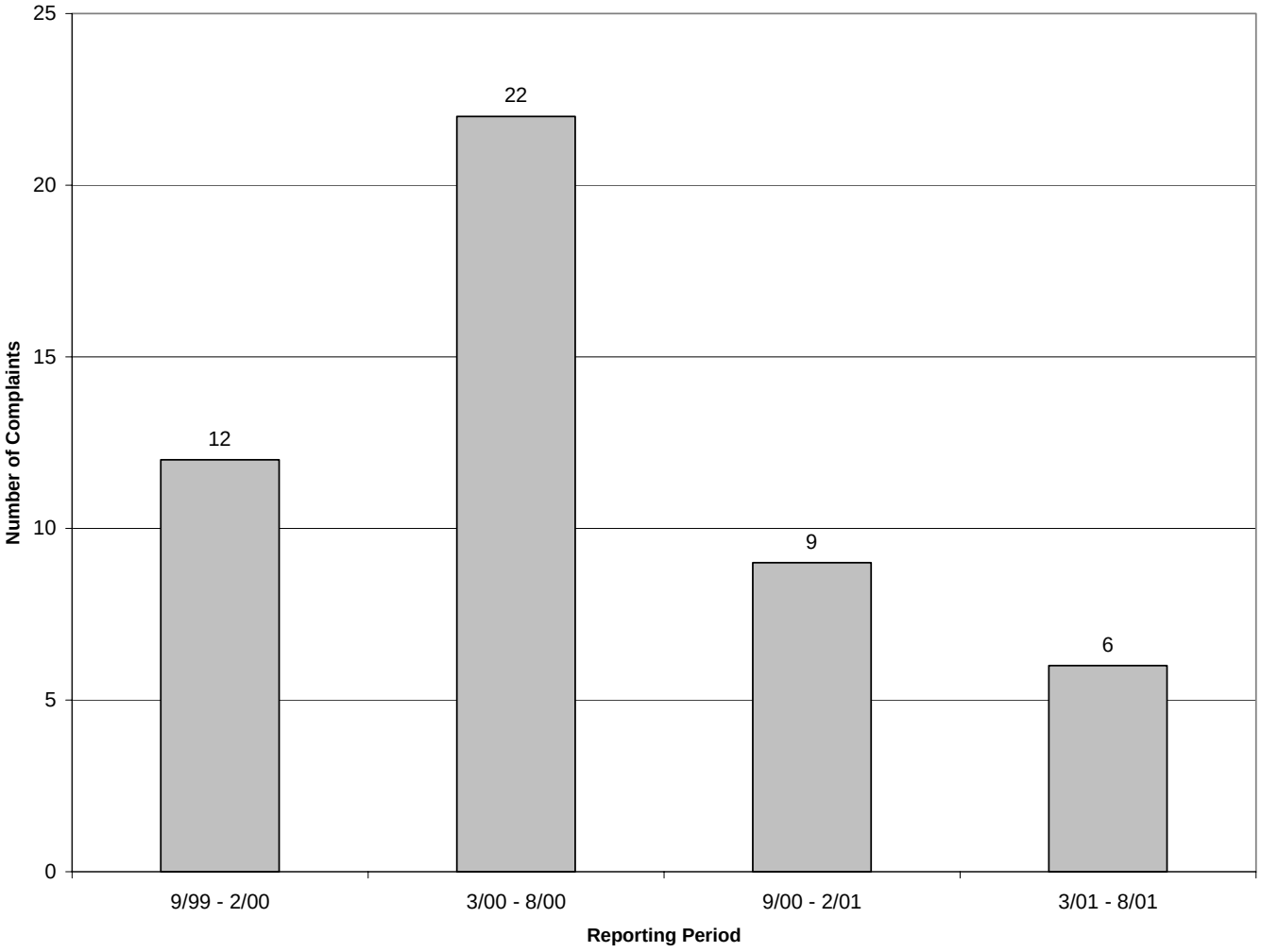


5.3.5 Enrollment and Administrative Issues

Enrollment and administrative issues are seemingly two very broad categories, but they both can be construed as accounting for how the HMO functions on a day to day basis. Enrollment problems are often the result of administrative snafus generally attributable to the State's Medicaid computer system and contractors. Many times, enrollment problems require administrative staff to remedy the problem. Many enrollment problems that ultimately reflect Member dissatisfaction with the HMO are often out of the immediate control of the HMO. The Medicaid managed care enrollment process in Texas is administered by an Enrollment Broker. Medicaid recipients who are required to participate in the STAR+PLUS program that do not choose a plan and/or PCP are assigned one of each by the Enrollment Broker. While computer algorithms attempt to assign Medicaid recipients to providers and plans they have a history with and within reasonable proximity to the recipient's residence, the match is not always agreeable to the Medicaid recipient. At times, a PCP may be unable to accept new patients, thus some STAR+PLUS members may have some difficulties selecting their PCP of choice and complain to the HMO.

The vast majority of enrollment problems seem to have abated as complaints of this nature were the lowest reported among the other categories. As STAR+PLUS members become increasingly more educated about managed care and earlier enrollment snafus that plagued the STAR and STAR+PLUS programs upon implementation have been eliminated, the number of enrollment-related complaints dropped over the two year period from a high of 22 between March 2000 and August 2000 to a low of 6 between March 2001 and August 2001. The low number of complaints seems to indicated that members are receiving their ID cards and receiving their PCP of choice for care within the STAR+PLUS network.

Figure 5.2: STAR+PLUS Member Administrative/Enrollment Complaints

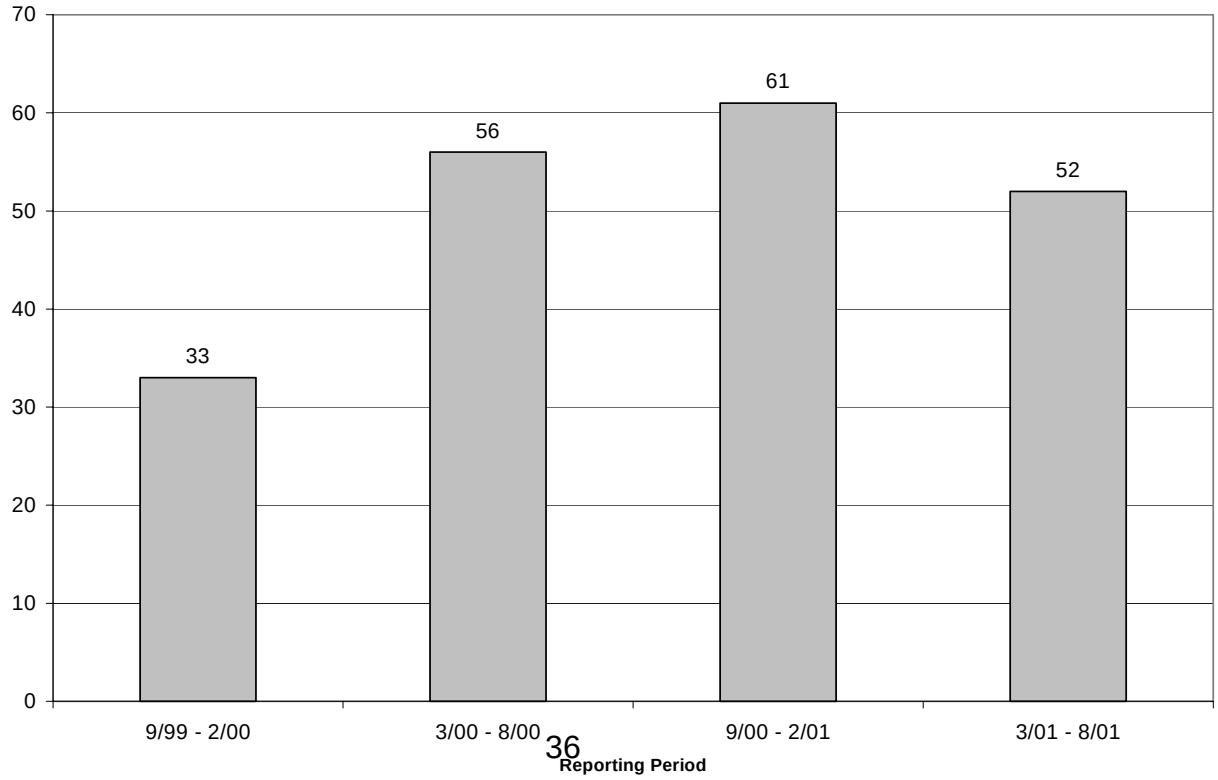


5.3.6 Billing Issues

Medicaid recipients may not be billed for any Medicaid covered service. Medicaid HMOs must accept the capitation rate from the State as payment in full for all Medicaid covered services as stipulated in the STAR+PLUS contract: "HMO and network providers are prohibited from billing or collecting any amount from a member" for Medicaid covered services.

Complaints analyzed by PPRI for this report seemed to be concentrated in one HMO that had 80 percent of all the complaints attributable to billing issues. The overwhelming majority of the complaints were simply raised from members who had been billed for deductibles or for "services rendered." It would seem that most of the billing problems would begin to abate as STAR+PLUS has been in operation since 1998 and providers should be more aware that they may not bill STAR+PLUS members for covered services. However, the volume of billing complaints remained stable during the two-year reporting period. Because the majority of these complaints seem to be isolated within one HMO, concentrated outreach with the HMO and its providers could reduce the frequency of complaint of this type.

Figure 5.3: STAR+PLUS Member Billing Complaints

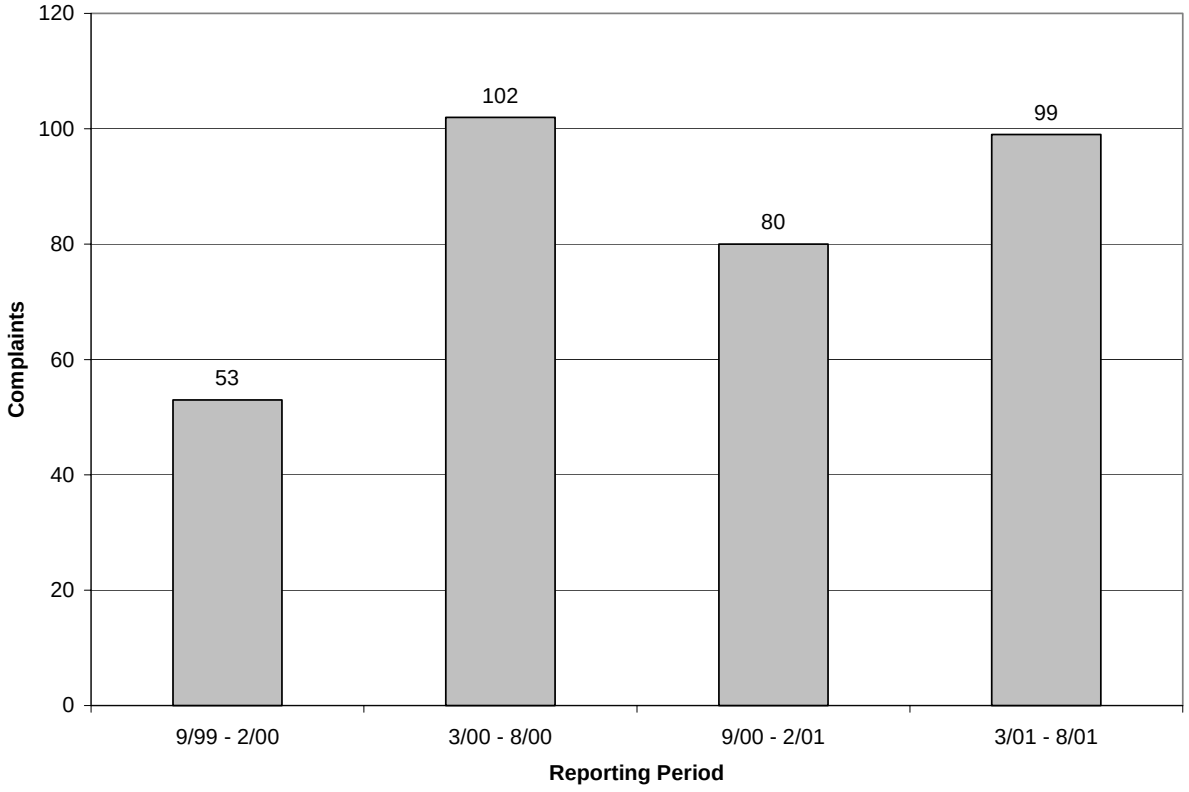


5.3.7 Access Issues

The STAR+PLUS contract contains several provisions to ensure recipient access to timely and adequate care. Access not only includes ability to see providers and receive services, but also information about how to access care, how to file a complaint, and Member rights.

Most of the time, STAR+PLUS members receive the care they need. However, when an HMO will pay only for care that is considered medically necessary, the potential for a disagreement exists. As a result, member complaints about access issues were the most common among the five complaint categories. STAR+PLUS members complained about a variety of access issues. A large portion of the access issues related around the inability to schedule appointments in a timely fashion with a provider and difficulties with authorizations and/or referrals for specialty care. While access problems can be a serious issue and raise concerns about care, further review of the complaint logs indicated that nearly all of the complaints were resolved by HMO staff in a timely fashion and do not seem to impede access to care.

Figure 5.4: STAR+PLUS Member Access Complaints

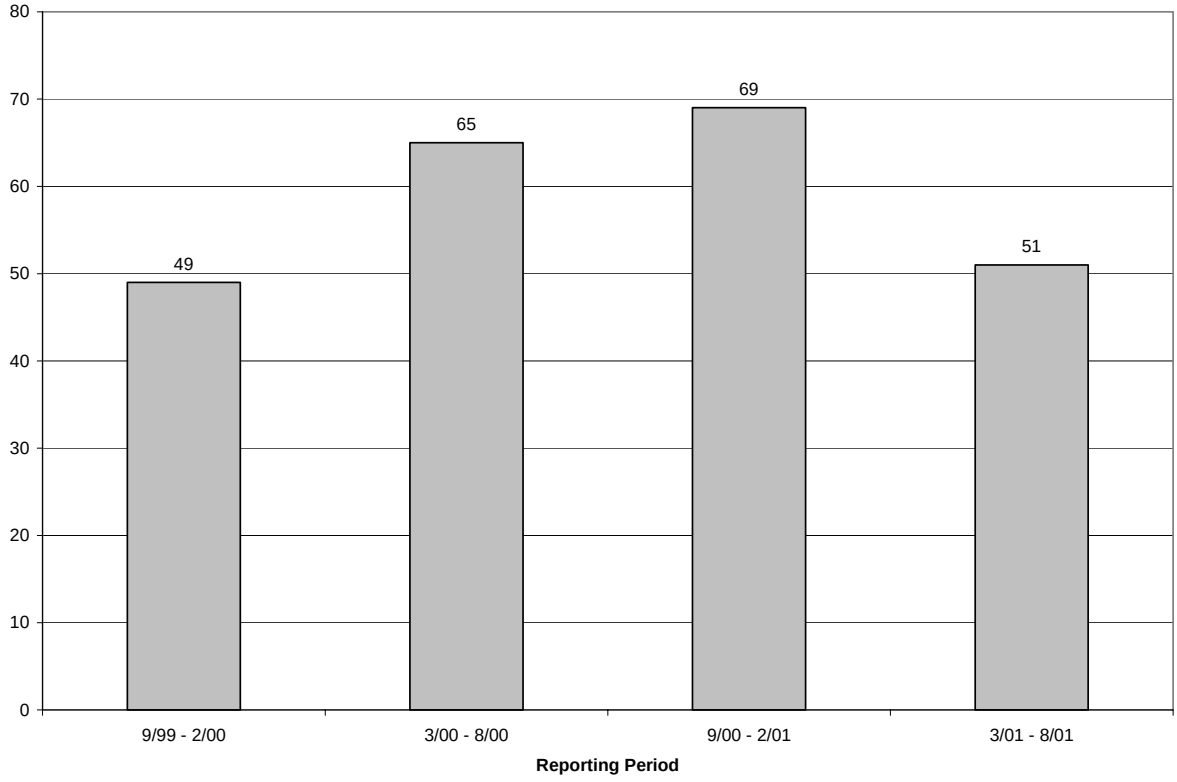


5.3.8 Quality of Care

Quality of care complaints of STAR+PLUS members are quite different than the technical quality of care indicators typically assessed in medical chart reviews. Typically, quality measures focus on process measures and clinical outcomes, such as immunizations and health screening rates. However, patient perceptions and experiences can also impact quality of care. STAR+PLUS Member quality complaints largely revolve around how well providers and office staff interact with the patients and their caregivers. STAR+PLUS Member perception of quality is an important facet of care because it can often influence patient compliance with a treatment regimen or instructions.[12]

Quality of care and treatment issues comprised 26 percent of all STAR+PLUS Member complaints. The number of Member complaints peaked between September 2000 and February 2001. A review of the Member complaints seemed to indicate that the majority of the complaints were associated with personality conflicts with the PCP or other provider.

Figure 5.5: STAR+PLUS Member Quality of Care Complaints

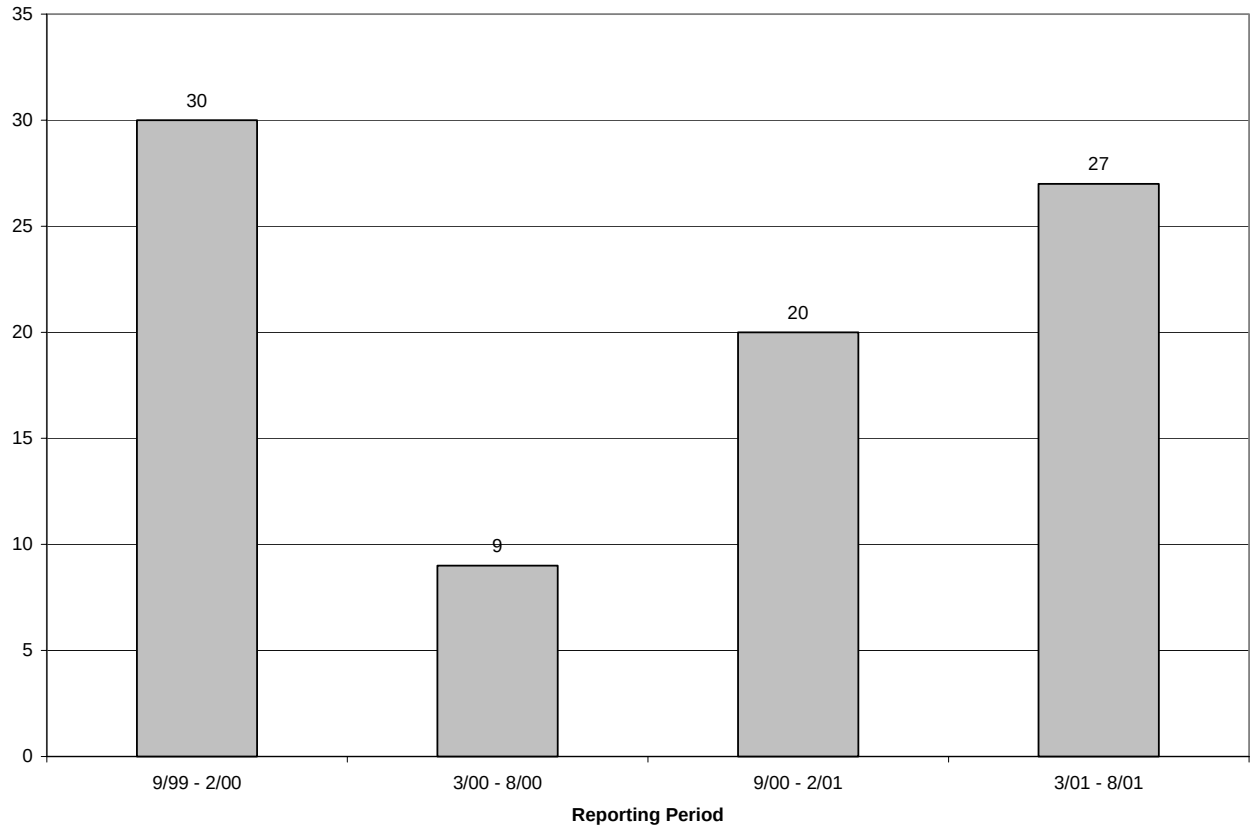


[12] States of Health (2001). Quality of Care: Giving Consumers a Say. 11(1).

5.3.9 Other (Unclassified) Issues

Unclassified complaints or "other" comprised 10 percent of all STAR+PLUS Member complaints. No particular theme emerged from the unclassified complaints indicating that there does not seem to be problems with the STAR+PLUS program in any of the areas outside the more descriptive categories. However, it is crucial to monitor complaints in this category to spot potential problems that might otherwise go unnoticed.

Figure 5.6: STAR+PLUS Member Other (Non-Categorized) Complaints

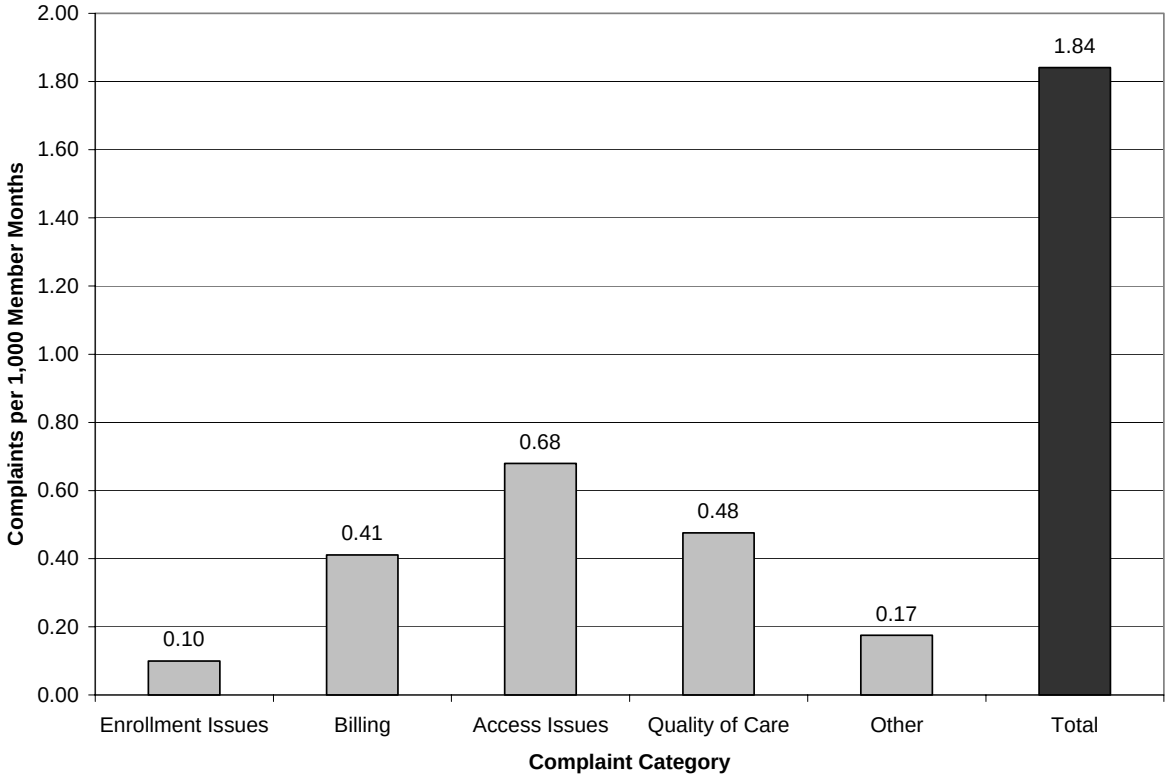


5.3.10 Complaints per Member Month

When comparing managed care data, the metric of member months is the most preferred and accurate way to report data. Because people join and leave the STAR+PLUS program throughout the year, it would be inaccurate to use the total membership from one point of the year. Furthermore, calculation of the rate of complaints can also provides the ability to compare data across other HMOs or Medicaid programs.

While the total number of Member Complaints received from STAR+PLUS members over the past two years may appear to be high, when converting the number of complaints into a rate of member months, the rate is actually quite low as indicated in Figure 5.7. The overall complaints per 1,000 member months was 1.84 for the two year reporting period. Each of the five complaint categories are also broken down into complaints per 1,000 member months, with each category remaining well below 1 complaint per 1,000 member months.

Figure 5.7: STAR+PLUS Member Complaints per 1,000 Member Months



5.3.11 Overall Member Satisfaction

The following chart summarizes results from the 1999 and 2001 STAR+PLUS CAHPS surveys and from the 1999 and 2001 National CAHPS Benchmark Database. For the composite ratings, the chart shows the percentage of STAR+PLUS respondents, adult Medicaid managed care respondents nationwide and adult commercial managed care respondents nationwide giving the most positive response. For the individual ratings, the chart shows the percentage of each group giving a 9 or 10 rating (on a scale of 0-10, where 10 = "best possible" and 0 = "worst possible").

Table 5.1: 1999 and 2001 CAHPS Results:
STAR+PLUS Compared To Adults in Medicaid Managed Care and Commercial Managed Care Nationwide

QUESTIONS	1999 STAR+PLUS	1999 ADULT MEDICAID	1999 ADULT COMMERCIAL	2001 STAR+PLUS	2001 ADULT MEDICAID	2001 ADULT COMMERCIAL
COMPOSITES						
Getting Needed Care	67	72	78	58	71	76
Getting Care Quickly	27	49	44	27	48	47
Doctor Communication	64	61	58	61	62	58
Office Staff Courtesy	74	68	65	75	67	64
Health Plan Customer Service		56	49		60	56
INDIVIDUAL RATINGS						
Personal Doctor	63	59	48	62	60	50
Specialist	64	59	54	68	61	55
Health Plan	50	51	37	55	48	37
Overall Health Care	57	53	46	56	53	47

5.3.11.1 Getting Needed Care and Getting Care Quickly

Results for these composites are discussed in the pervious chapter.

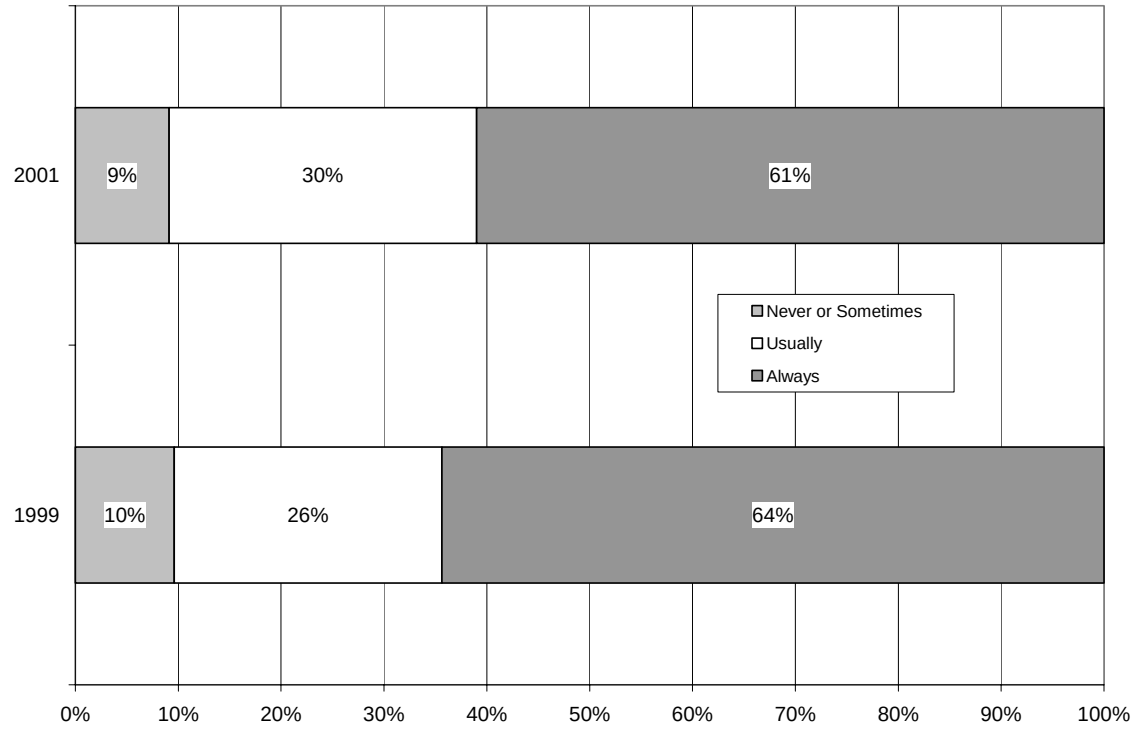
5.3.11.2 Doctor Communication

This composite aggregates results of four questions:

- How often did doctors or other health care providers listen carefully to you?
- How often did doctors or other health care providers explain things in a way you could understand?
- How often did doctors or other health care providers show respect for what you had to say?
- How often did doctors or other health care providers spend enough time with you?

STAR+PLUS ratings for both survey years were nearly the same; differences were not statistically significant. Over 60 percent of STAR+PLUS respondents reported that physicians and other health care providers "always" communicate well with them, and just over a quarter reported that providers “usually” communicate well. Only about 9 percent indicated that their health care providers "never” or “sometimes" communicate well with them.

Figure 5.8: Doctor Communication



Difference between 1999 and 2001 is not statistically significant at 0.200 level.

As with STAR+PLUS, the percentages of Medicaid and commercial respondents reporting that providers always communicate well were about the same in 2001 as they were in 1999. The percentage of STAR+PLUS members reporting that providers always communicate well was about the same as the percentages of both national groups giving this response.

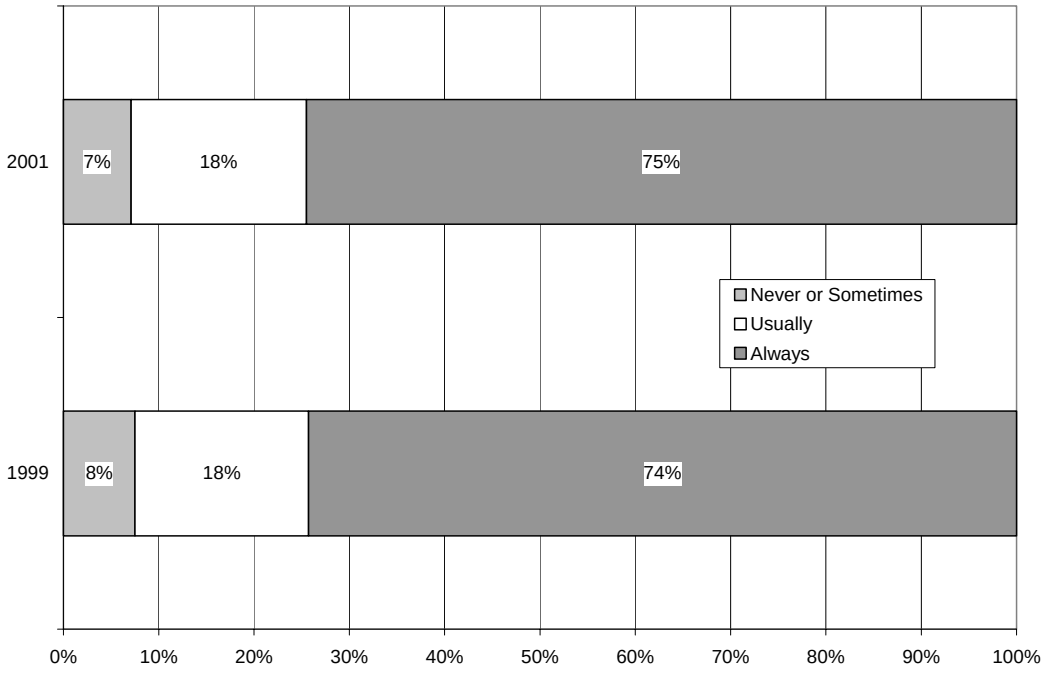
5.3.11.3 Courtesy, Respect and Helpfulness of Medical Office Staff

This composite aggregates results of two questions:

- How often did office staff at a doctor's office treat you with courtesy and respect?
- How often were office staff at a doctor's office as helpful as you thought they should be?

This composite was one of the most highly rated areas of the survey. The results from both survey years were nearly identical, with no statistically significant differences. Almost three-quarters of STAR+PLUS respondents in both years indicated that the medical office staff were “always” courteous and helpful, with another 18 percent indicating that staff are “usually” courteous and helpful.

Figure 5.9 Courtesy, Respect and Helpfulness of Medical Office Staff



Difference between 1999 and 2001 is not statistically significant at 0.117 level.

As with STAR+PLUS, the percentages of both Medicaid and commercial respondents indicating office staff are “always” courteous and helpful were about the same in 2001 as they were in 1999. The percentage of STAR+PLUS respondents giving this response was higher in both years than the percentages of both Medicaid and commercial respondents giving this response.

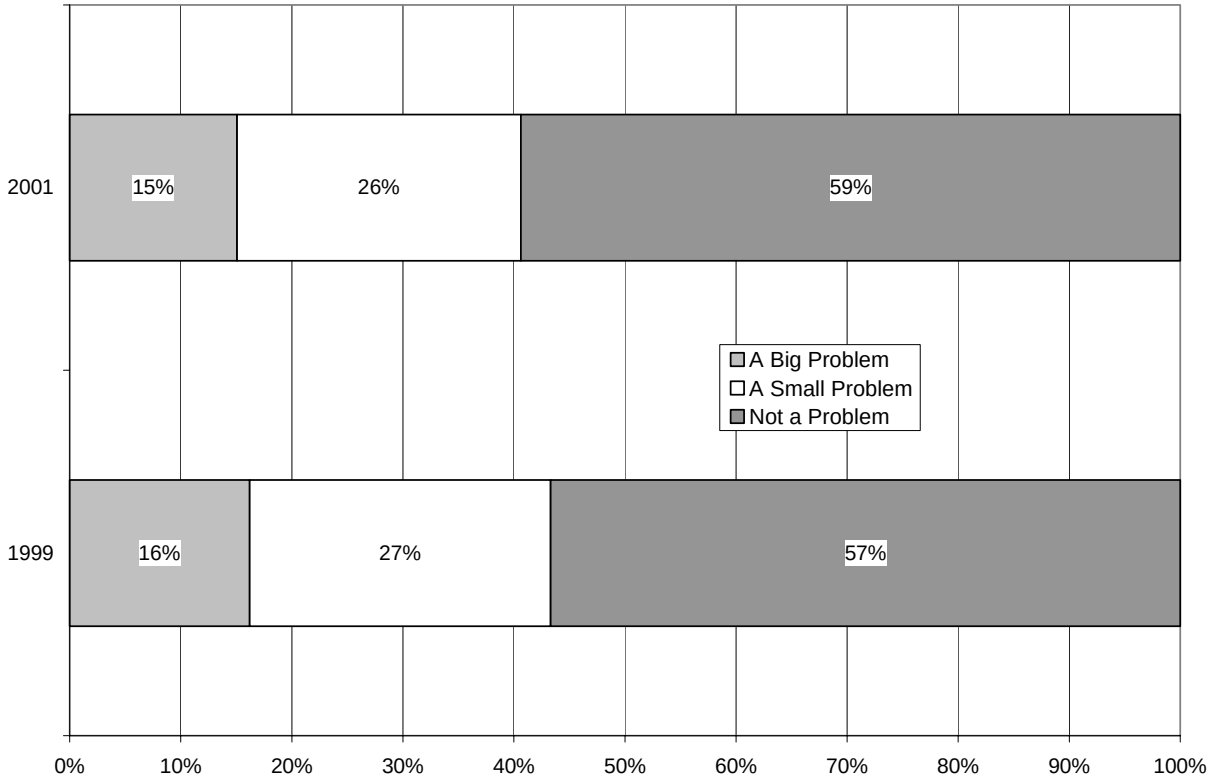
5.3.11.4 Health Plan Customer Service

This composite aggregates results of three questions:

- How much of a problem was it to find or understand information in the written materials?
- How much of a problem was it to get the help you needed when you called your health plan's customer service?
- How much of a problem did you have with paperwork for your health plan?

The percentages of both Medicaid and commercial respondents giving this composite the most favorable rating were somewhat higher in 2001 than in 1999. Nearly 60 percent of STAR+PLUS respondents in both survey years indicated having few problems with customer service, with no statistically significant differences. A small percent of respondents indicated having some problems with accessing customer service as 16 percent in 1999 and 15 percent in 2001 indicated that dealing with customer service was a "big problem."

Figure 5.10: Ratings of Health Plan Customer Service



Difference between 1999 and 2001 is not statistically significant at 0.646

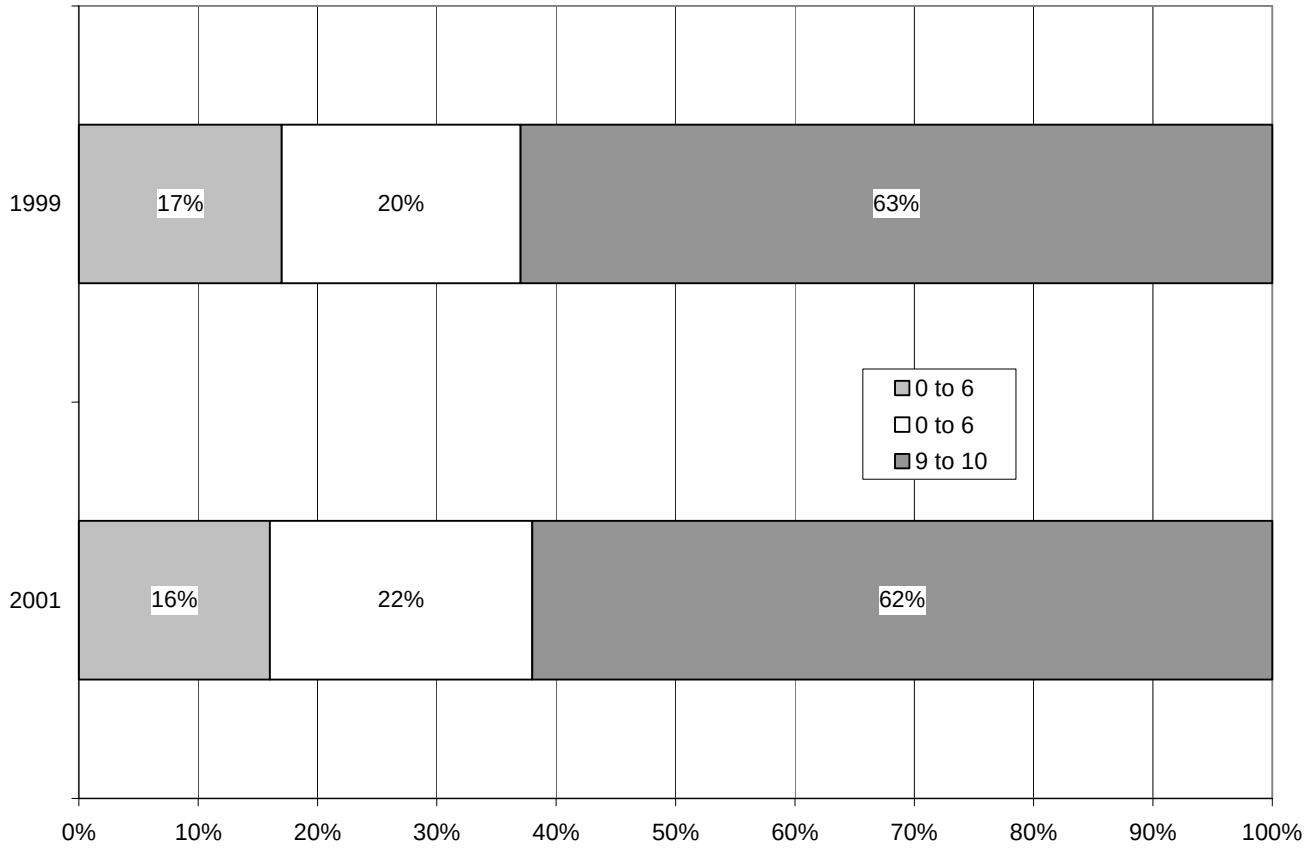
5.3.12 Satisfaction with Personal Doctor

The CAHPS survey asks respondents to rate their personal doctor on a scale from 0 to 10, with 0 being the worst possible doctor and 10 being the best possible doctor.

STAR+PLUS respondents rated their personal doctors very highly in both years. The average rating was 8.4 in both 1999 and 2001.

Over 60 percent of the STAR+PLUS respondents rated their personal doctor as a 9 or 10 in 1999 and in 2001, as illustrated in Figure 5.11. This was about the same as the percentage of Medicaid respondents giving a 9 or 10 rating, but higher than the percentage of commercial respondents giving these ratings.

Figure 5.12: Ratings of Personal Doctor



Difference between 1999 and 2001 is not statistically significant at 0.293

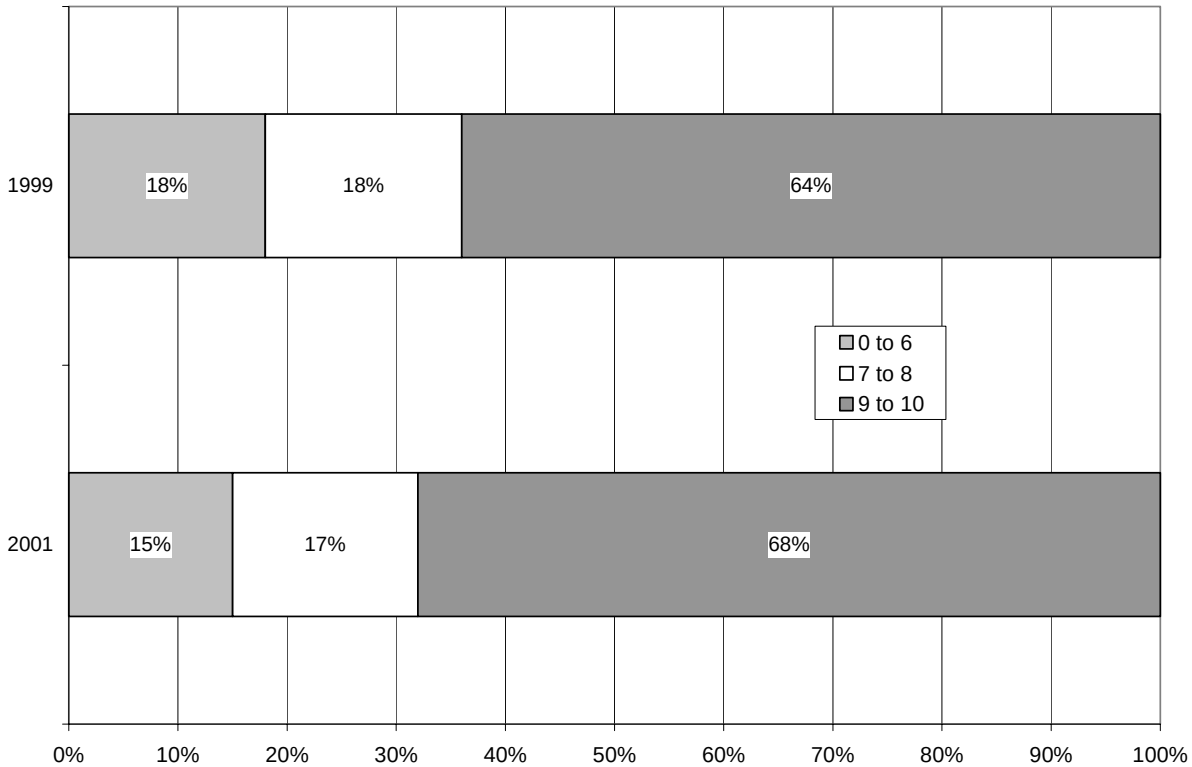
5.3.12.1 Satisfaction with Specialists

The CAHPS survey asks respondents to rate their specialists on a scale from 0 to 10, with 0 being the worst possible specialist and 10 being the best possible specialist.

STAR+PLUS respondents rated their specialists very highly in both years. The average rating was 8.4 in 1999 and 8.6 in 2001 (this increase is not statistically significant).

The majority of STAR+PLUS survey respondents in both years rated their specialists either 9 or 10, as illustrated in Figure 5.13. In both 1999 and 2001, the percentage of STAR+PLUS respondents rating their specialists 9 or 10 was higher than the percentages of Medicaid and commercial respondents giving their specialists those ratings.

Figure 5.13: Ratings of Specialist



Difference between 1999 and 2001 is not statistically significant at 0.088

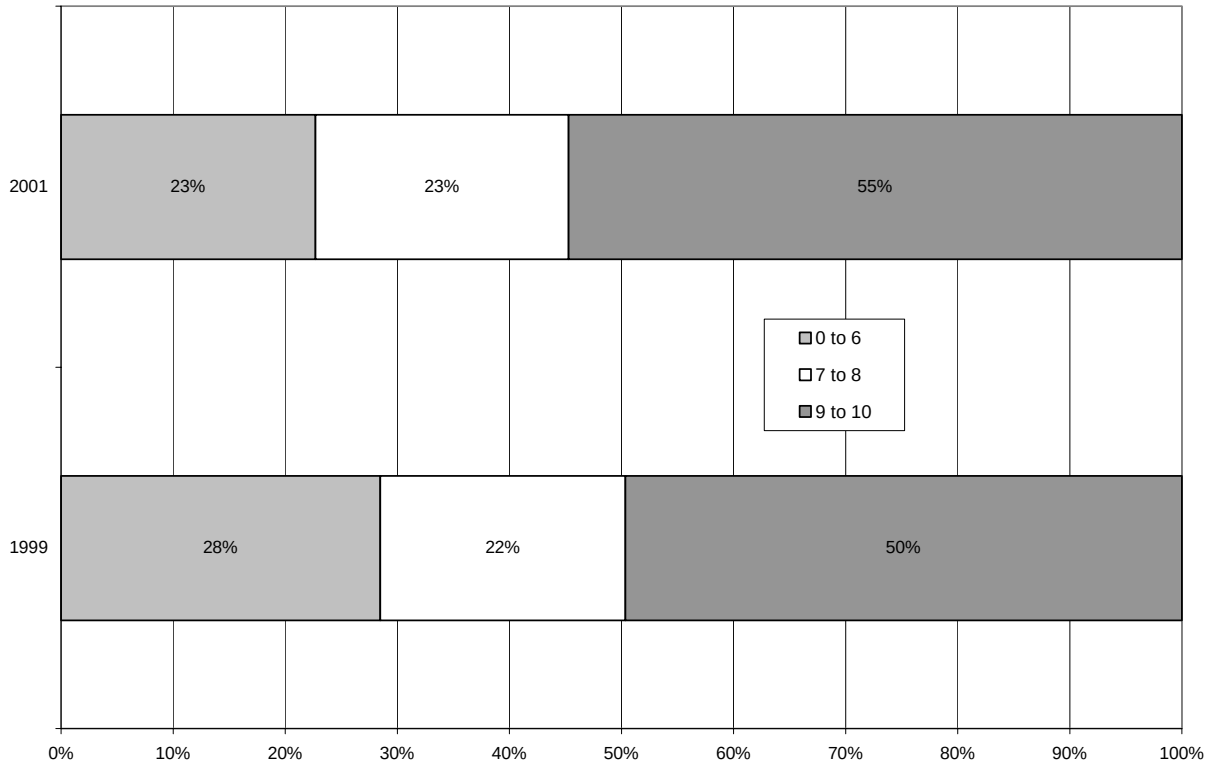
5.3.12.2 Satisfaction with Health Plan

The CAHPS survey asks respondents to rate their health plan on a scale from 0 to 10, with 0 being the worst possible health plan and 10 being the best possible health plan.

The majority of STAR+PLUS respondents rated their health plan highly in both years. Average STAR+PLUS health plan ratings rose from 7.5 in 1999 to 7.9 in 2001, a statistically significant increase ($p<0.01$).

Over half of STAR+PLUS respondents rated their health plan either 9 or 10, increasing from 50 percent in 1999 to 55 percent in 2001. The percentage giving the lowest ratings (0-6) dropped from 28 percent to 23 percent. In 1999, the percentages of STAR+PLUS and national Medicaid respondents giving their health plan the highest ratings were about the same, but in 2001 the STAR+PLUS percentage was slightly higher. For both years, a higher percentage of STAR+PLUS respondents than commercial respondents gave the highest ratings.

Figure 5.14: Satisfaction with Health Plan



Difference between 1999 and 2001 is statistically significant at 0.000 level.

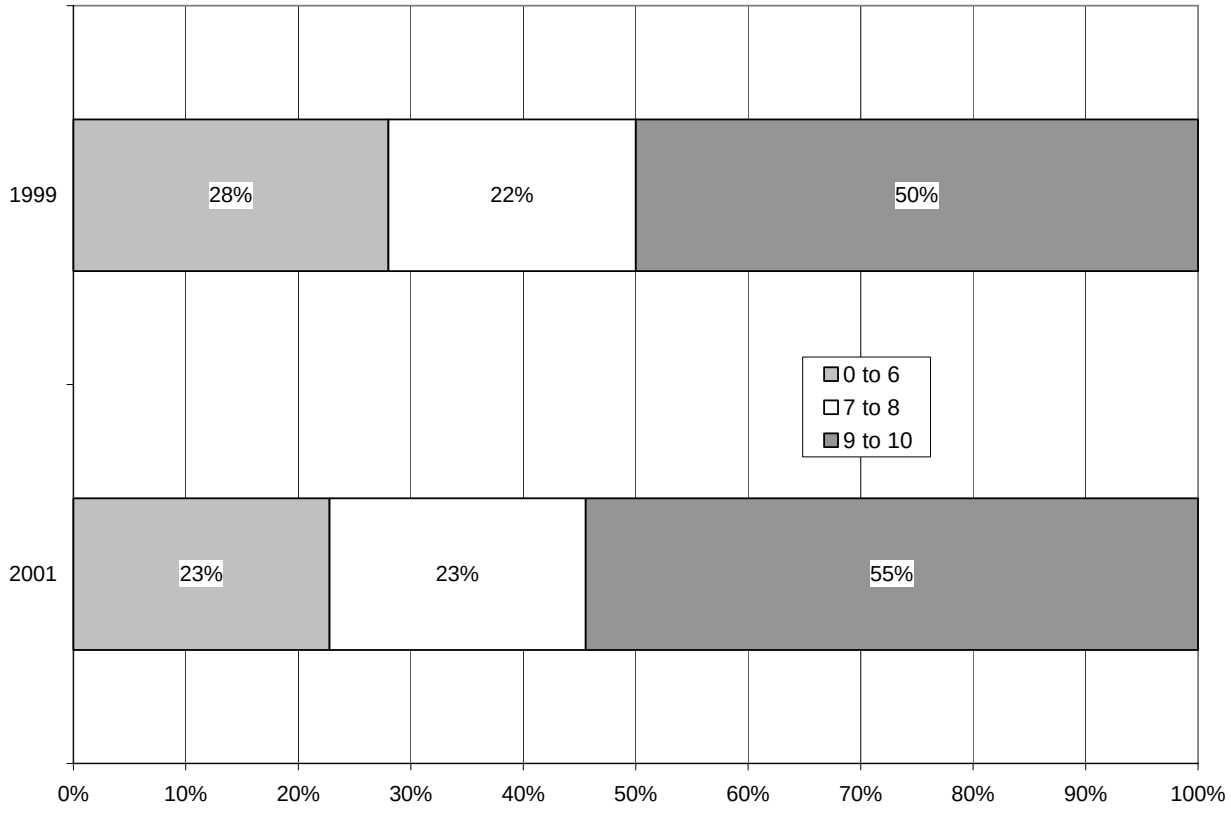
5.3.12.3 Satisfaction with Overall Health Care

The CAHPS survey asks respondents to rate their overall health care on a scale from 0 to 10, with 0 being the worst possible health care and 10 being the best possible health care.

Most STAR+PLUS respondents rated their overall health care very highly. The average rating was 8 in 1999 and 8.3 in 2001 (this increase is not statistically significant).

Over half of STAR+PLUS respondents rated their overall health care either 9 or 10 in both years, with 57 percent giving these ratings in 1999 and 56 percent giving these ratings in 2001. About 20 percent gave the lowest ratings (0-6) in both years. The percentage of STAR+PLUS respondents giving 9 or 10 ratings was similar to but slightly higher than the percentages of Medicaid respondents giving 9 or 10 ratings, and higher than the percentages of commercial respondents giving these ratings.

Figure 5.15: Satisfaction with Health Plan



Difference between 1999 and 2001 is statistically significant at 0.000 level.

5.3.13 Member Satisfaction with Care Coordination

THQA administered a 25-item survey to STAR+PLUS members receiving long-term care services to measure satisfaction with care coordination. The survey was developed by a workgroup of THQA staff, state staff and consumer advocates. In addition, a semi-structured, open-ended interview developed by the same group was conducted with members receiving long-term care services who were not eligible for Medicare in order to obtain more detailed information about satisfaction. The study period was September 1, 1999 – July 31, 2001. Surveys and interviews were conducted in members' homes.

Responses to the surveys and interviews indicate that:

- Most respondents rate care coordination as good, very good or excellent. Over 90 percent of duals and about 70 percent of Medicaid-only members are satisfied with how care coordinators solve problems. Interviewed members were about evenly split over the responsiveness of care coordinators.
- Over 93 percent of duals and about two-thirds of Medicaid-only members find it easy to get a care coordinator to help them. Most also say it is easy to get services like attendant care, special equipment and therapies from their STAR+PLUS HMO. However, members interviewed don't always know who to call when their care coordinator changes or they change HMOs.
- Almost two-thirds of duals and one-third of Medicaid-only members say a care coordinator helped them get non-STAR+PLUS services that they needed.
- Almost 80 percent of duals and 60 percent of Medicaid-only members say they are involved in decisionmaking about their care. Most interviewed members are familiar with the function and availability of care coordination, although they indicated that care coordinators sometimes miss opportunities to educate members about assessments, services and care coordination.

5.3.14 Member Satisfaction with Behavioral Health Services

STAR and STAR+PLUS members were surveyed during May-June 2001 to determine their satisfaction with behavioral health services. Few results were split by program, thus overall results are reported here and conclusions specific to STAR+PLUS are difficult to draw.

Adult enrollees aged 18-64 were surveyed using the short version (21 item) Mental Health/Alcohol and Drug Abuse Survey, which was developed by the Mental Health Statistics Improvement Program MHSIP) Policy Group under the sponsorship of the Center of Mental Health Services (CMHS) and the Substance

Abuse and Mental Health Service Administration (SAMHSA). Parents of child enrollees aged 6-17 were surveyed using an adapted version of the 37-item Youth Services Survey for Families (YSSF), which was developed as part of the State Indicator Project funded by the Center for Mental Health Services (CMHS).

Responses to the surveys indicate that:

- Respondents are generally satisfied with their behavioral health services. Over 80 percent satisfaction was reported for most questions. Adult satisfaction increased slightly over the previous year.
- Respondents are generally satisfied with outcomes of care, although to a lesser degree than with services. However, satisfaction with outcomes increased slightly over the last two years.

5.3.15 Provider Satisfaction

THQA conducts an annual survey of providers participating in STAR and STAR+PLUS about their satisfaction with various aspects of Medicaid managed care. Because of the large number of providers who participate in both programs in Harris County, THQA does not administer a separate survey for each program and results apply to Medicaid managed care overall instead of to each specific program. However, because long-term care providers do not participate in STAR, it is possible to separate their responses and obtain a subset of results specific to STAR+PLUS.

The 2001 survey found an overall provider satisfaction rating under 3.00 (on a 5-point scale, where 5 is the highest and 1 is the lowest). This rating, which is generally consistent across provider types, has been about the same for each survey since 1999. Most providers are generally satisfied with clinical care provided under Medicaid managed care as well as with covered services and health promotion and disease prevention efforts. However, they are generally dissatisfied with administrative aspects of Medicaid managed care. Primary care physicians and specialists are dissatisfied with the amount of paperwork required of them and with the levels of reimbursement they receive. Long-term care providers are dissatisfied with the levels of reimbursement they receive under STAR+PLUS as well as with the accuracy and timeliness of claims payments. Overall, long-term care providers are more dissatisfied with Medicaid managed care than are other provider types.

5.3.16 Focused Studies

THQA conducted two focused studies during the waiver period. The topics studied were:

- Depression
- Diabetes.

5.3.16.1 Depression Focused Study

THQA conducted a study of STAR+PLUS primary care physicans' (PCP) treatment of depression. The study, which was a follow-up to the previous year's study, looked at drug regimens, treatment patterns and PCP documentation for STAR+PLUS adults aged 21-64 with a diagnosis of depression recorded between September 1, 1999 and August 31, 2000.

The study found that:

- Just over 80 percent of patients were prescribed anti-depressants, and about half of these were also prescribed anti-anxiety medications. SSRIs and tricyclics were the most commonly-prescribed medications. Behavioral health providers tended to prescribe different medications than PCPS prescribed, possibly owing to differences in acuity of patients.
- Most PCPs prescribed medications at dosages that fall within recommended guidelines.
- While referrals are not required for STAR+PLUS members to access behavioral health services, PCPs documented referrals to BH specialist for about 25 percent of patients, a level about twice that of the previous year. In addition, documentation rates increased for PCP communication with BH providers.
- PCPs have low rates of medical record documentation for depression treatment. Documentation rates decreased from the previous year for follow-up visits with patients receiving prescriptions and drug side effects. However, documentation rates increased from the previous year for prescriptions and referrals to BH specialists.

THQA concluded that STAR+PLUS should continue to set goals and timeframes for quality improvement of PCP documentation of depression treatment and outcomes. THQA also concluded that STAR+PLUS should continue its quality improvement efforts regarding PCP use of a depression screening tool, patient education, communication with behavioral health specialists and follow-up for patients receiving prescriptions.

5.3.16.2 Diabetes Focused Study

THQA conducted a study of diabetes management that examined drug regimens and PCP documentation of important treatment components. The study included Medicaid-only STAR+PLUS members 18 and over with a diagnosis of diabetes recorded between September 1, 1999 and August 31, 2000.

The study found that:

- PCPs have low rates of documentation for diabetes treatment.
- Just under half of the patients had a test for glucose control. Almost 40 percent of these tests indicated inadequate glucose management, and only a third of these patients had a management plan.
- Only about a third of patients had a test for lipid management. For a significant number of those with poor test results, there was no evidence of a prescribed drug regimen.
- Not quite half of patients had a foot exam, about 20 percent had an eye exam and just under a quarter had a kidney exam.
- About 11 percent of patients received education about their condition and how to manage it.
- Over 95 percent of patients received prescriptions for recommended medications.

THQA concluded that STAR+PLUS should set goals and timeframes for improving PCP documentation rates of treatment and outcomes. THQA also concluded that the program should continue studying outcomes for this population as well as track the impact of improvement efforts on treatment and documentation.

5.4 Conclusions

The STAR+PLUS Member complaints do not seem to indicate significant problems with access or quality. Many disputes appear to arise because recipients are unfamiliar with what is or is not covered by their STAR+PLUS HMO. Also, a significant number of complaints also appear to arise through personality conflicts between STAR+PLUS members and their providers. With the STAR+PLUS HMOs averaging under 2 complaints per 1,000 Member months, the majority of STAR+PLUS members appear to have few formal complaints about the program. However, STAR+PLUS administrators should continue to closely monitor Member complaints to detect any access or quality problems in their nascent stages as well as continue to standardize the complaint process.

Most STAR+PLUS members who responded to the 1999 and 2001 CAHPS surveys indicated satisfaction with the aspects of their health care measured by the survey. In all but two areas of the survey, there were no statistically significant differences between 1999 to 2001. Of the two areas with differences between years, one (satisfaction with health plan) showed an improvement. In addition, for all but one area of the survey, the percentages of STAR+PLUS respondents giving the most favorable responses and ratings were similar to or higher than the percentages of adults in Medicaid managed care and commercial managed care nationally giving the most favorable responses and ratings.

However, comparison of the 1999 and 2001 STAR+PLUS surveys to one another and to national CAHPS benchmarks for those two years highlight four potential opportunities to improve overall member satisfaction. Two of these areas (Getting Needed Care and Getting Care Quickly) are discussed in the previous chapter. The other two are:

1. *Satisfaction with Health Plan*. Overall, STAR+PLUS respondents indicated satisfaction with their health plan. In fact, their level of satisfaction increased from 1999 to 2001, with the percentage giving the lowest ratings to this question dropping in 2001. Additionally, the percentage of STAR+PLUS respondents giving the most favorable ratings was as high or higher than the Medicaid and commercial percentages. Nevertheless, a considerable minority (close to a quarter) of respondents in 2001 gave the lowest ratings to this composite.
2. *Overall Health Care*. Most STAR+PLUS respondents reported high levels of satisfaction with their overall health care, and STAR+PLUS had a higher percentage of most favorable ratings for this question than either of the comparison groups did. Nevertheless, a considerable minority (20 percent) gave the lowest ratings on this question.

Because of the high levels of overall satisfaction expressed by STAR+PLUS respondents and the fact that STAR+PLUS survey results generally compare well with national Medicaid managed care and commercial managed care results, the issues identified above should not be construed as areas in which the program is failing to ensure member access to quality care. Instead, they should be viewed as opportunities for the state and participating health plans to implement strategies that will increase an already high level of member satisfaction with the program's plans, providers and services.

STAR+PLUS members are generally satisfied with care coordination services. However, survey and interview responses suggest that two potential areas for improvement exist:

1. Member perception of care coordinator responsiveness

2. Member education regarding assessments, services, and care coordination.

Again, given the level of overall satisfaction with care coordination, potential room for improvement in these areas does not suggest the existence of serious problems.

STAR+PLUS members are also generally satisfied with their behavioral health care. Satisfaction was somewhat higher for services than for outcomes. The state may want to consider studying why satisfaction with outcomes is lower than satisfaction with services. However, given the level of overall satisfaction, this is probably not a critical area for examination.

With the exception of those of long-term care providers, provider responses to the THQA satisfaction survey can only be used to draw conclusions about Texas Medicaid managed care in general. Because providers are generally satisfied with coverage and clinical aspects, with dissatisfaction concentrated around administrative aspects, PPRI believes that the current level of provider dissatisfaction does not reflect problems with quality of care provided under STAR+PLUS. However, because provider dissatisfaction with issues such as reimbursement and claims processes may eventually affect the care they provide as well as their continued participation in the program, STAR+PLUS should consider this an area requiring attention. This is particularly the case for long-term care providers.

Focused study results suggest some areas for quality improvement efforts specific to the studied conditions. The depression focused study found that most PCPs prescribed medications at dosages that fall within recommended guidelines. PCPs increased their documented rate of referrals to and communication with behavioral health specialists. They also improved their documentation of types and dosages of prescribed medications. However, they documented lower rates of other important treatment components such as follow-up visits with patients receiving prescriptions and drug side effects. THQA recommended that quality improvement follow-up include:

1. Continuing to set goals and timeframes for quality improvement of PCP documentation of depression treatment and outcomes
2. Continuing current quality improvement efforts regarding PCP use of a depression screening tool, patient education, communication with behavioral health specialists and follow-up for patients receiving prescriptions.

The diabetes focused study found that most patients received prescription for medicines that are recommended for diabetes management. However, PCPs have low rates of documentation for important components of diabetes treatment, including screening tests, management plans, and patient education. THQA recommended that quality improvement follow-up include:

1. Setting goals and timeframes for improving PCP documentation rates of treatment and outcomes
2. Continuing to study outcomes of STAR+PLUS PCP treatment of diabetes
3. Tracking the impact of improvement efforts on treatment and documentation.

The two focused studies analyzed the information that was available in patient medical records. While lack of documentation does not necessarily mean care was not provided, the state's ability to accurately assess quality of care depends on reliable documentation of treatment and outcomes. Following THQA's quality improvement recommendations for depression and diabetes will likely improve the ability to conduct such assessments. To the degree that lack of documentation does reflect lack of care, the THQA recommendations may also improve quality of care by making PCPs more aware of how their management of depression or diabetes differs from recommended treatment guidelines and by increasing PCP adherence to recommended guidelines.

6 Cost Effectiveness

6.1 Summary

Cost Effectiveness of the Waiver.

According to the data provided to PPRI by TDHS, the implementation of the STAR+PLUS program in Harris County indicated savings of approximately $123 million to the state during the waiver period. The cost effectiveness evaluation was calculated within the STAR+PLUS service area for the two years in which the area operated under the waiver (Waiver Year (WY) 1: Feb, 2000 – Jan, 2001 and; Waiver Year 2: Feb, 2001 – Jan, 2002). The STAR+PLUS program saved the state approximately $66 million in WY 1 and $56 million in WY 2. The estimated results are savings for the state that produced nearly a 17 percent reduction in state expenditures had the waiver not been in effect in Harris County.

6.2 Background and Methodology

As a condition of CMS waiver approval, 1915(b) waivers must be either cost neutral or must generate cost savings versus the traditional fee-for-service Medicaid program. PPRI conducted a study of the costs due to the implementation of the STAR+PLUS program in Harris County. The analysis compared costs incurred by the STAR+PLUS program for services had the waiver not been in effect. In calculating program costs, costs related to services, the vendor drug program, and administration were included.

TDHS classified managed care clients into major risk groups depending on the type of services they received. The evaluation of costs was carried out for each risk group within the service area for the two years in which the area operated under the waiver (Waiver Year 1: Feb, 2000 – Jan, 2001; Waiver Year 2: Feb, 2001 – Jan, 2002). The computations included some projected costs under the waiver. All data that were used in the analysis, including the projected rates for the different services, were provided to PPRI by the STAR+PLUS program.

In the STAR+PLUS program, both the HMO and the PCCM models were utilized. In addition, a number of SSI and SSI-related recipients remained in the traditional fee-for-service Medicaid program largely due to their being ineligible for services under STAR+PLUS program. A small portion of the fee-for-service component costs consisted of those incurred by clients prior to their enrollment in the above models.

The basic unit of analysis was a “member month” which was defined as the unit of measure related to each member for each month the member was enrolled in a managed care plan.

Members were classified by their STAR+PLUS eligibility as (a) Medicaid only clients and (b) Dual Eligible clients or duals, those eligible for both Medicare and Medicaid services. The PCCM model is available only to Medicaid only clients. The HMO clients were further classified into eight major risk groups based on the type of acute and long-term care they received:

Medicaid Eligible Only Clients

- Other Community Care (OCC): Clients at-home, can receive acute care and long-term care services
- Community Based Alternatives (CBA): Clients at-home, can receive acute care and long-term care services, clients have need profiles similar to Nursing Facility clients but needs are met with home-based or community-based services
- Nursing Facility (NF)- (Voluntary): Clients who reside in a nursing facility, can receive acute care and nursing facility services, and have chosen to join an HMO
- Nursing Facility (NF)- (Mandatory): Clients who reside in a nursing facility, can receive acute care and nursing facility services, and are required to join an HMO

Duals – Medicare and Medicaid Eligible Clients

- Other Community Care (OCC): Clients at-home, can receive long-term care services
- Community Based Alternatives (CBA): Clients at-home, can receive long-term care services, clients have need profiles similar to Nursing Facility clients but needs are met with home-based or community-based services
- Nursing Facility (NF)- (Voluntary): Clients who reside in a nursing facility, can receive nursing facility services, and have chosen to join an HMO
- Nursing Facility (NF)- (Mandatory): Clients who reside in a nursing facility, can receive nursing facility services, and are required to join an HMO

For each waiver year the cost to the state for all risk groups was estimated under each of the managed care models operating in the area as well as for the fee-for-service component. The total cost for services then was the sum of these costs. Added costs due to the implementation of managed care in the Vendor Drugs program and in administration were added to the cost for services to arrive at total costs under the waiver. Costs without the waiver were projected through for services had STAR+PLUS not been implemented.

Next, the rate of cost per member per month was calculated for each waiver year by dividing each total cost by its total number of member months for the waiver year. The without-waiver rate was utilized to project the total without-waiver costs for a number of member months comparable to the number under the waiver. The difference between this number and the total estimated costs under the waiver provided the estimated cost/savings due to the implementation of STAR+PLUS in Harris County.

6.3 Results

STAR+PLUS program savings exceeded $100 million during the waiver period. Data supplied by TDHS indicated that the STAR+PLUS program resulted in savings of $123 million had the waiver not been in effect in Harris County. The projected savings from the STAR+PLUS program are almost a 17 percent increase in savings from traditional fee-for-service Medicaid.

Table 6.1: STAR+PLUS Projected Costs and Waiver Savings

	Waiver Year 1	Waiver Year 2	Waiver Years 1 & 2
Member months	657,492	680,148	1,337,640
Est. costs without waiver	$361,540,694	$361,137,524	$722,678,218
Est. cost per member month	$549.88	$530.97	$540.26
Est. costs with waiver	$295,167,884	$304,883,143	$600,051,027
Est. cost per member month	$448.93	$448.26	$448.59
Est. savings under the waiver	**$66,372,810**	**$56,254,143**	**$122,627,191**
Est. savings per member month	**$100.95**	**$82.71**	**$91.67**

Over all, the cost analysis indicated positive savings due to the implementation of the STAR+PLUS program. However, it must be cautioned that the cost savings were calculated and supplied by TDHS. Due to time constraints and data limitations, PPRI did not independently validate all waiver assumptions and calculations and believes the cost effectiveness data are accurate.

7 Conclusions

7.1 Access to Care

It appears that STAR+PLUS is ensuring member access to services. Given the results of compliance monitoring for access standards and the generally high level of satisfaction expressed by STAR+PLUS members with access to services and care coordination, higher-than-baseline emergency room utilization does not appear to be a cause for alarm, although it may be a good area for additional study. Without detailed, patient-level information, measurement of aggregate utilization yields multiple possible interpretations. However, it is reasonable, given the positive results of the access standards and satisfaction analyses, to posit that reductions in inpatient discharges and ALOS may be due to better access to primary care, the availability of care coordination, and better management of patient conditions. While provider satisfaction with access under STAR+PLUS is difficult to assess on its own, the program may want to consider improvement efforts in member education. In addition, provider survey results appear to conflict with EQRO monitoring results relating to access to language interpreters. The program may want to explore further whether and to what extent language or communication barriers may exist.

7.2 Quality of Care

It appears that STAR+PLUS is generally ensuring an adequate level of quality in the services provided to its members but a number of steps can be taken to raise the level of quality. Member and provider satisfaction results indicate STAR+PLUS is ensuring quality of care, and while some areas for improvement exist they do not appear to be critical. To ensure continued participation of sufficient providers the program needs additional focus on provider satisfaction with administrative processes. In addition, focused study results highlight areas for improvement specific to care for depression and diabetes.

7.3 Cost Effectiveness

According to the data provided to PPRI by TDHS, the implementation of the STAR+PLUS program in Harris County indicated savings of approximately $123 million to the state during the waiver period. The cost effectiveness evaluation was calculated within the STAR+PLUS service area for the two years in which the area operated under the waiver (Waiver Year (WY) 1: Feb, 2000 – Jan, 2001 and; Waiver Year 2: Feb, 2001 – Jan, 2002). The STAR+PLUS program saved the state approximately $66 million in WY 1 and $56 million in WY 2. The estimated results are savings for the state that

produced nearly a 17 percent reduction in state expenditures had the waiver not been in effect in Harris County.

Over all, the cost analysis indicated positive savings due to the implementation of the STAR+PLUS program. However, it must be cautioned that the cost savings were calculated and supplied by TDHS. Due to time constraints and data limitations, PPRI did not independently validate all waiver assumptions and calculations and believes the cost effectiveness data are accurate.