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

***Submitted to:***

*The Texas Department of Human Services*

October 1999

Prepared by:

Steve Borders
Trish O'Day
Craig H. Blakely, MPH, Ph.D.
James Dyer, Ph.D.
Bodhini Jayasuriya, Ph.D.
Ramdas Menon, Ph.D.

Public Policy Research Institute
Texas A&M University

## Acknowledgements

We are very grateful for the support and generous assistance from individuals, organizations and state agencies that assisted with our research. We sincerely thank the Texas Department of Human Services and the Texas Health and Human Services Commission for their suggestions and expertise with the study design and the shaping of this report.

We also want to thank the states and organizations that provided valuable assistance and data for this project:

- The Texas Health Quality Alliance
- The State of Maryland
- The State of Massachusetts
- The State of Colorado
- The State of Washington
- The State of Delaware
- The State of Ohio
- The State of Florida
- The State of Minnesota
- The State of Tennessee

Thanks to the numerous interviewers and supervisors with the Survey Lab. Special thanks to:

- Steven Thigpen – Manager of the Survey Facility
- Steven Saldana – Assistant Manager of the Survey Facility
- Reade Sitton – Programmer
- Alicia Novoa – Manager of Data Entry

# TABLE OF CONTENTS

# I. Executive Summary

This report was prepared by the Public Policy Research Institute (PPRI) at Texas A&M University for the Texas Department of Human Services (TDHS). The federal Health Care Financing Administration (HCFA) requires an Independent Assessment of access, quality, and cost effectiveness of all 1915(b) waivers. The waiver was granted by HCFA to Texas for the time period of February 1998 to January 2000. This report provides for the Independent Assessment of the Texas STAR+PLUS Medicaid managed care 1915(b) waiver program.

## *A. Findings*

STAR+PLUS is Texas' first attempt to integrate acute and long-term care through a managed care delivery system on a mandatory basis for the aged and disabled Medicaid population. As with any new initiative, evaluation and trending may be limited or constrained by start-up issues, such as general Medicaid recipient and provider confusion, initially low enrollment numbers due to a phased-in enrollment process, difficulties reporting accurate and reliable data, and lag time in reporting.

With these caveats in mind, PPRI analyzed data collected by the STAR+PLUS program as well as data submitted by the STAR+PLUS managed care organizations (MCOs). PPRI also contacted other states currently operating or planning integrated acute and long-term care Medicaid managed care programs to assess current trends and compare experiences and contract requirements to the STAR+PLUS program. PPRI also administered a satisfaction survey to Supplemental Security Income (SSI) Medicaid recipients participating in the traditional fee-for-service program in the state and compared those findings to a previous satisfaction survey taken on STAR+PLUS Members

The following general findings emerged from these efforts:

**ACCESS TO CARE**

1. **The STAR+PLUS program has similar contract standards for access as other Medicaid managed care programs.** PPRI reviewed and assessed access standards of managed care contracts from Massachusetts, Colorado, and Washington.

2. **STAR+PLUS managed care organizations (MCOs) substantially met requirements for: 1) Health Services Availability, Accessibility, and Adequacy, 2) Access Performance Standards.** The Texas Health Quality Alliance (THQA) performed an onsite review of the STAR+PLUS MCOs. A synopsis of that report is included within.

3. **STAR+PLUS may have increased the number of providers participating in the Medicaid program.** Determining the exact number of providers participating in the STAR+PLUS program is difficult because providers often participate in more than one MCO. However, under the traditional, fee-for-service Medicaid program, the ratio of primary care providers (PCPs) to Medicaid Members was 1:38. In the STAR+PLUS program that ratio has improved to 1:12 for Access, 1:13 for Americaid, and 1:22 for HMO Blue.

4. **STAR+PLUS seems to be have decreased Member reliance on the emergency room.** Although not conclusive, STAR+PLUS Members appear to be using the emergency room on a less frequent basis than traditional fee-for-service Medicaid recipients. A five-quarter analysis of MCO utilization data of emergency room visits per 1,000 Member months indicated fewer visits than baseline fee-for-service rates.

5. **STAR+PLUS hospital inpatient discharges and average length-of-stay (ALOS) figures are approximately the same as Medicaid baseline fee-for-service data.** Analysis of MCO utilization data indicated discharge rates and ALOS from the STAR+PLUS program nearly identical to Medicaid baseline fee-for-service rates.

**QUALITY OF CARE**

6. **STAR+PLUS quality assurance reporting requirements differ from nationally accepted requirements.** Four out of the five states reviewed for this report require audited Health Plan Employer Data and Information Set (HEDIS) reporting from their contracted MCOs. The relatively short Medicaid eligibility cycle in Texas of less than 12 months does not lend itself to accurate HEDIS reporting. However, without HEDIS data, it will continue to be difficult to make comparisons of the STAR+PLUS program to Medicaid managed care programs in other states as well as commercial MCOs.

7. **Two of the 3 STAR+PLUS MCOs demonstrated strengths with care coordination.** A THQA onsite review of the STAR+PLUS MCOs found that care coordinators were appropriately assigned to Members who needed them. A synopsis of that report is included within.

8. **Two of the 3 STAR+PLUS MCOs were found to have weaknesses in their Quality Improvement Committees.** A THQA onsite review of the STAR+PLUS MCOs found no STAR+PLUS Members actively participating on MCO Quality Improvement Committees. A synopsis of that report is included within.

9. **STAR+PLUS MCO complaint data most likely represents an underestimate of complaints for both Members and providers.** While there is no indication that excessive complaints are a significant problem in

the STAR+PLUS program, data analyzed by PPRI suggest that ambiguity in the complaint reporting process has led to an underestimate of complaint counts.

10. **STAR+PLUS Members and those receiving services in traditional fee-for-service Medicaid seem equally positive about the care they receive.** PPRI surveyed fee-for-service Medicaid recipients and compared those results to an earlier STAR+PLUS satisfaction survey completed by THQA.

**COST EFFECTIVENESS**

11. **For the waiver period of February 1999 through January 2000, STAR+PLUS will result in an estimated $6 million in savings to the State had the waiver not been in effect.** PPRI analyzed the projected costs for each risk group without the waiver versus the actual and projected costs incurred for each risk group with the waiver.

## *B. Conclusions*

The Secretary of the Department of Health and Human Services granted the State of Texas a 1915(b) Medicaid managed care waiver for the STAR+PLUS program on the basis that the waiver is cost effective, efficient, and not inconsistent with the purposes of Title XIX.[1] As such, PPRI performed an independent assessment in each of the following areas to determine the STAR+PLUS program's compliance with meeting the requirements of the waiver:

**ACCESS TO CARE**

The STAR+PLUS program appears not to impede Member access to care as utilization rates are similar to those in fee-for-service Medicaid. In fact, access may even have been increased under the program by virtue of the lowering of the PCP to Member ratios that existed under fee-for-service Medicaid.

**QUALITY OF CARE**

STAR+PLUS Members appear to be equally satisfied with the care they receive as do those in fee-for-service Medicaid. Furthermore, the STAR+PLUS program appears to be providing excellent care coordination for those who require such services.

[1] Section 1915(b) Waiver Program, Independent Assessments: Guidance to States. (1998). Health Care Financing Administration.

## COST EFFECTIVENESS

The waiver has resulted in a $6 million savings to the State had the waiver not been in effect.

As a result of the Independent Assessment, PPRI believes the State has met or exceeded the requirements of the waiver for these three areas.

# II. Introduction

This report was prepared by the Public Policy Research Institute (PPRI) at Texas A&M University for the Texas Department of Human Services (TDHS). The federal Health Care Financing Administration (HCFA) requires an Independent Assessment of access, quality, and cost effectiveness of all 1915(b) waivers. The waiver was granted by HCFA to Texas for the time period of February 1998 to January 2000. This report provides for the Independent Assessment of the Texas STAR+PLUS Medicaid managed care 1915(b) waiver program.

STAR+PLUS is Texas' first attempt to integrate acute and long-term care through a managed care delivery system on a mandatory basis for the aged and disabled Medicaid population. As with any new initiative, evaluation and trending may be limited or constrained by start-up issues, such as general Medicaid recipient and provider confusion, initially low enrollment numbers due to a phased-in enrollment process, difficulties reporting accurate and reliable data, and lag time in reporting.

PPRI's assessment of the STAR+PLUS program was conducted over a six-month period, beginning in March of 1999 through August 1999. PPRI and TDHS worked together to select the following study areas to address the access, quality of care and relative cost of the STAR+PLUS program:

I. Access to Care

- TDHS contract requirements for access to care
- Provider capacity before and during the waiver
- Review of the MCO annual summary reports on Quality Improvement Plans
- Selected Managed Care Organization (MCO) utilization measures

II. Quality of Care

- TDHS contract requirements for quality
- Review of MCO Member complaints
- Review of MCO provider complaints
- Member satisfaction of care
- Member monthly plan changes

III. Cost Effectiveness

- Analysis and comparison of cost incurred under the STAR+PLUS program with the projected costs had the waiver not been in effect.

TDHS and PPRI met on several occasions to discuss potential areas and timeframes for this study. These areas were selected for review not only because of appropriateness, but were also driven by the realities of data availability.

# III. Overview of the STAR+PLUS Program

Across the country, Medicaid programs are increasingly turning to managed care organizations and systems to deliver services. As of June 1997, nearly 48% of the national Medicaid population was enrolled in managed care.[2] Texas Medicaid began enrolling recipients into managed care in 1993. Since that time, Texas has incrementally introduced Medicaid managed care to most of the metropolitan areas of the state. Only the Temporary Assistance for Needy Families (TANF) and TANF-related population were required to participate in this reform effort, called STAR (State of Texas Access Reform). However, a small population of Supplemental Security Income (SSI) recipients were permitted to voluntarily enroll in most managed care service areas. Starting in April 1998, the State began requiring SSI and SSI-related recipients to enroll in managed care to receive their Medicaid services. This pilot project, called STAR+PLUS, is limited to Harris County (Houston).

STAR+PLUS is designed to integrate delivery of acute and long-term care services through a managed care system. Approximately 55,000 SSI and SSI-related aged and disabled Medicaid recipients in Harris County are required to participate in STAR+PLUS to receive Medicaid services. Approximately 5,000 more may participate on a voluntary basis.

Participants choose from three managed care organizations, one that also offers Medicare managed care. An enhanced prescription drug benefit is available for Medicaid-eligible participants who choose the same MCO for both Medicare and Medicaid services. Children and some behavioral health clients have a primary care case management option in addition to the three MCO choices. Because the majority of STAR+PLUS recipients are enrolled in a MCO, this study primarily focuses on services and data from the STAR+PLUS MCOs.

The STAR+PLUS MCOs provide all Medicaid primary, acute, and long-term care services through one service delivery system. This includes ensuring each client has a primary care doctor. Other acute care services include specialists, home health, medical equipment, lab, x-ray, and hospital services. However, dually eligible enrollees continue to receive acute care services from the Medicare provider of their choice, and receive only long-term care services from the STAR+PLUS MCO. STAR+PLUS long-term care services include personal care services and adult day health services. The State's 1915(c) Community Based Alternatives waiver is included in the STAR+PLUS program. Clients who meet the medical necessity criteria to be in a nursing home choose between Community-Based Alternatives waiver services or nursing facility services. MCO

[2] Health Care Financing Administration (1997). "National Summary of Medicaid Managed Care Programs and Enrollment" [On-line]. Available: http://www.hcfa.gove/medicaid/trends97.htm

networks incorporate all of the above providers, including Medicaid significant traditional providers.

Recipients with complex medical conditions are assigned a care coordinator, an MCO employee who is responsible for coordinating acute and long-term care services. The care coordinator develops an individual plan of care with the recipient, family members, and providers, and can authorize services for the client.

There are challenges in serving dual eligibles and disabled Medicaid recipients in managed care. With the relative success of mandatorily enrolling children and families receiving TANF into Medicaid managed care programs, Texas chose to test the mandatory enrollment of the SSI population in managed care. The health needs of primarily younger and healthy TANF and TANF-related populations differ from those of the aged and disabled populations, which create challenges in trying to serve these individuals in typical managed care plans. While managed care has become the dominant vehicle of health care delivery in the United States, MCOs have primarily served healthy populations of workers with employer-sponsored insurance or children and pregnant women on Medicaid. Consequently, most MCOs lack experience dealing with the needs of disabled individuals and those with long-term care needs.

Conflicts between Medicare and Medicaid also pose significant challenges for serving dual eligibles. While the federal government provides funding for both Medicare and Medicaid, the operation of each program is vastly different. States have no involvement in administration or operation of the Medicare program, and funds for Medicare do not flow through states. On the other hand, states administer and operate their own Medicaid program. Guidelines are set by the federal government, using a mixture of state and federal funds that flow through the state. Medicare covers acute care services only, while Medicaid covers both acute and long-term care services. Dual eligibles are typically supposed to receive acute care from Medicare and long-term care from Medicaid. However, the overlap between certain acute and long-term care services results in a blurry distinction between some of the services offered by the two programs. In addition, virtually no coordination occurs between Medicare and Medicaid to help alleviate problems caused by differences or overlap in the programs.

# IV. Study Methodology

The Health Care Financing Administration granted a 1915(b) waiver to the State of Texas to implement the STAR+PLUS program in Harris County. As a condition of the waiver, the State is required to obtain an independent, third party assessment of the waiver program. The assessment must focus on access to care, quality of care, and cost effectiveness of the program.

Obtaining consistent and reliable data to fully analyze program effects and outcomes has been difficult because of the complexities associated with managed care and its administration. Although the State has substantially invested in developing a system (Texas Medicaid Administrative System) to fully evaluate the outcomes, cost, and quality of care of all Medicaid programs, outcomes-based management based on effective and reliable encounter data remains elusive. Much has already been developed, such as early phases of the new Compass 21 system for the State Medicaid Management Information System (MMIS), but even the ad hoc query platform for report development, scheduled to be operational in February 1999, is not yet available. The overall Compass 21 product, anticipated to start-up in late 1999 has been indefinitely delayed.

## *A. Access to Care*

PPRI project staff examined several sources of information to determine STAR+PLUS Member access:

- Project staff performed a review and summary of the TDHS MCO contract requirements. Staff also contacted several other state Medicaid programs that are currently planning or beginning acute and long-term integrated managed care programs that parallel the STAR+PLUS program. PPRI compared other state contract requirements for Member access to the STAR+PLUS program access requirements.
- Two sets of reports on Member access were also examined. On-site review results from a report by the Texas Health Quality Alliance (THQA) were reviewed. In addition, the MCO's self–reported activities on access monitoring were examined. A distillation of the information gathered from these reports is included in the PPRI assessment of Member assess.
- A limited number of utilization measures were also examined, such as hospital discharges and emergency room rates and compared to experiences under the traditional fee-for-service Medicaid program operating in other areas of the state.
- Finally, PPRI analyzed provider capacity both before and during the waiver, examining the number of acute care and long-term care providers participating in the traditional fee-for-service Medicaid program and STAR+PLUS.

## *B. Quality of Care*

Quality of care can be measured in a variety of ways. In managed care, examining encounter data is one of the most thorough measures of quality of care. However, encounter data was not available and examining encounter data was beyond the scope of this project. As such, PPRI examined the following quality of care indicators:

- Project staff examined TDHS MCO contract Quality Improvement (QI) requirements as well as results of an on-site review by THQA. PPRI also obtained contracts and other available resources from other state Medicaid programs and compared the QI requirements with those from the STAR+PLUS program.
- Both Member and provider complaints were also investigated. PPRI examined MCO reported complaints by category and frequency on a quarterly basis.
- PPRI conducted a survey to produce data that would allow for the comparison of respondents from the STAR+PLUS program to similar respondents receiving their health care in fee-for-service programs. THQA was commissioned to conduct a Member satisfaction survey of STAR+PLUS clients in the Harris County waiver area. To conduct the relevant analytical comparisons, PPRI conducted a similar survey of Medicaid SSI recipients receiving health services under the traditional fee-for-service model.

## *C. Cost-Effectiveness*

Without examining encounter data directly, it is difficult to conduct a true cost-effectiveness analysis. However, PPRI staff analyzed costs incurred by the Medicaid program under STAR+PLUS and compared those costs with costs based on the allocated upper payment limit (UPL) for services had the waiver not been in effect. In calculating these relative costs, those 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 (Waver Year (WY) 1: Feb, 1998 – Jan, 1999; WY2: Feb, 1999 – Jan, 2000). The computations for WY2, included some projected costs under the waiver. The STAR+PLUS program provided all the data, including the projections that were used in the analysis. The cost to TDHS of services rendered in the Harris service area was calculated with and without managed care for each of the waiver years.

# V. Access to Care

## *A. Overview*

Access to health care has long been a problem in the Medicaid fee-for-service environment. Citing low reimbursement rates and arduous administrative procedures, many providers chose not to participate in the Medicaid fee-for-service program. Managed care programs, such as STAR+PLUS, link each Medicaid recipient with a primary care provider (PCP). The PCP acts as the medical home and is responsible for 24-hour coverage when the STAR+PLUS recipient requires access to care. Recipients with complex medical conditions are assigned a care coordinator, an MCO employee who is responsible for coordinating acute and long-term care services. The care coordinator develops an individual plan of care with the recipient, family members and providers, and can authorize services for the client.[3]

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] Furthermore, for populations with chronic conditions, such as the STAR+PLUS population, Medicaid managed care is largely untested.

## *B. STAR+PLUS Access to Care Contract Requirements*

State requirements for access in the STAR+PLUS contract are detailed in section 7.9 - Primary Care Providers, 7.10 - Specialty Care Providers, and Appendix A - Standards for Quality Improvement: Standard XI - Standards for Availability and Accessibility. Contract provisions are consistent with national standards. QARI is a federally-developed set of standards, modeled on NCQA standards.

These contract requirements include PCP and specialist network capacity, ratio of Primary Care Providers (PCPs) to covered clients, 24 hour/7 day PCP accessibility, and distance and time requirements for PCPs and specialists access. The MCO 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, and

[3] Texas Health and Human Services Commission (1999). “Texas Medicaid in Perspective, Third Edition.”

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

- THSteps Medical Check-ups: within 90 days of new enrollment, except newborns whose mother is a MCO Member at the time of birth must be seen for a check-up at birth and within one to two weeks of birth, and in all cases, consistent with the American Academy of Pediatrics periodicity schedule.

Referrals to specialists must adhere to the following access guidelines:

- Urgent Care: within 24 hours of request,
- Routine Care: within 2 weeks of request, and
- Prenatal Care: within 2 weeks of request.

In addition, MCOs must have developed standards and methods to monitor waiting times in provider offices, telephone calls, and appointment wait times.

## *C. Other States' Requirements for Access to Care*

Other states reviewed have similar access standards; although, there are some minor differences. PPRI reviewed Medicaid managed care contracts from Massachusetts, Colorado, and Washington. For example, the STAR+PLUS contract requires PCPs to be available throughout the service area to ensure that no Member must travel more than 30 miles or 45 minutes, whichever is less. Massachusetts' proposed standard is a choice of two PCPs within 15 miles or 30 minutes. Both Massachusetts (yet-to-be-implemented) and Washington call for well visits within 30 days, as opposed to STAR+PLUS requirements for adult wellness exams within 8-10 weeks of request. The Colorado contract states adult, non-symptomatic well care physical exams must be scheduled in four months. The STAR+PLUS and Washington programs require urgent care visits within 24 hours Massachusetts and Colorado requirements specify within 48 hours.

## *D. THQA On-Site Review of Access to Care*

THQA reviewed 15 assessment areas in their 1999 on-site baseline, structure and process review survey in the Harris Service Delivery Area (SDA). The assessment areas were based on the Texas Department of Health (TDH) and TDHS contractual provisions, including the QARI standards. Two assessment areas were specific to access issues: (1) Health Services Availability, Accessibility, and Adequacy and (2) Access Performance Standards. These 15 assessment areas were reviewed at the same time for STAR and STAR+PLUS. In addition, the STAR+PLUS program had another four assessment areas unique to that program; Health Services Availability and Adequacy was one of these areas of review (see Table 5.3).

## 1. THQA Scoring

Table 5.1: Health Services Availability, Accessibility, and Adequacy

| MCO | SCORE | MAXIMUM SCORE POSSIBLE |
|---|---|---|
| HMO Blue | 185 | 189 |
| ACCESS | 184 | 189 |
| Americaid | 188 | 189 |

Table 5.2: Access to Care Performance Standards

| MCO | SCORE | MAXIMUM SCORE POSSIBLE |
|---|---|---|
| HMO Blue | 14 | 15 |
| ACCESS | 13 | 15 |
| Americaid | 15 | 15 |

Table 5.3: Health Services Availability and Adequacy (STAR+PLUS only)

| MCO | SCORE | MAXIMUM SCORE POSSIBLE |
|---|---|---|
| HMO Blue | 12 | 12 |
| ACCESS | 12 | 12 |
| Americaid | 12 | 12 |

On average, all three MCOs substantially met the requirements for these categories.

## 2. THQA Plan Summaries

### *ACCESS*

All STAR+PLUS necessary specialty services and facilities such as obstetrical care, prenatal care and education, trauma center, etc. are provided. All requested interpretive services are available. CNR Behavioral Health Organization (BHO) attempts to match patients with providers who speak their language, rather than using interpreters. Calls to the Member telephone numbers revealed that some plan representatives were not familiar with all benefits, services, and access standards (for example, how long a Member would wait to get a prenatal appointment).

In the STAR+PLUS program, Access staff described proactive care coordination activities. Community based services are being used as alternatives. Access has hired care coordinators based on training and experience with populations who have chronic and/or complex conditions.

***AMERICAID***

Documentation and information indicated that there is an adequate provider network of PCPs, specialists, significant traditional providers, and behavioral health providers to care for the membership over a physical, geographical, and cultural range of accessibility. Out of network and emergency care is available when necessary and access to community organizations are in place. Plans of care for Members with complex and chronic problems using a multidisciplinary team could not be verified by the THQA reviewers.

Americaid has developed standards for access to medical care for routine, urgent, and emergency situations. The MCO has established standards that are compatible with the TDHS contract regulations. Members can obtain behavioral health services after normal business hours and can receive care in alternative settings, such as in schools and homes.

An adequate number of care coordinators, specific to the STAR+PLUS program, are on the staff of the Medical Management Department with a supervisor strictly for the STAR+PLUS area. There are RN, LVN, and MSW coordinators and all have had adequate orientation and sensitivity training for this population. They work closely with discharge planners in the hospitals, Members and family members for determining levels of appropriate care.

***HMO BLUE***

The plan arranges for all health care services listed in the TDHS contract. The MCO provides services to all groups with special needs, including pregnant Members, and Members with disabilities, chronic or complex conditions. The MCO provides interpreters for those Members who need this service. The MCO contracts with AT&T for interpreter services.

STAR+PLUS Members have excellent access to providers and do not have to travel more than 30 miles or 45 minutes to access PCP services. CompCare, the BHO, contracts and works with the local Mental Health Mental Retardation agency.

The plan has policies and procedures for access to care, including emergency, urgent, and routine. Interviews with the providers reveal that they are aware of the plan’s standards. The medical chart verified that providers were compliant with the plan’s standards.

The firm which manages the STAR+PLUS product, Managed Care Solutions, has been in the long-term care business since 1988 and is considered one of the most experienced firms in that area of health care, according to an HMO Blue executive. The plan employs approximately 45 care coordinators, some of whom have specialized areas of concentration such as HIV or complex pediatric conditions. All care coordinators are either experienced MSW or RN level service providers. They are assisted by care coordination associates who handle telephone assistance, clerical duties, tracking of documentation and some Member outreach activities. The ratio of care coordinators to Members is dependent on the level of severity of the Member's condition.

Care coordinators, associates, and supervisors meet regularly to discuss appropriate options for the least restrictive and appropriate community based or home services. Records of these meetings were found in the documentation reviewed.

## *E. STAR+PLUS MCO Annual Quality Improvement Plan (QIP) Summary Reports: Access Monitoring Activities*

Each of the three STAR+PLUS plans has submitted an annual QIP summary report. These QIP summary reports detail quality improvement activities that have occurred during the prior year, based on each of the QARI standards. Regarding accessibility of care (QARI standard XI), HMO Blue's summary report states that an "access and availability study commenced in September 1998; the results will be reviewed and goals established in the QIP for next year". There was no formal monitoring of follow-up on broken/missed appointments. The HMO Blue Member services department is working toward a 95% call answering standard and an answer within 30 seconds.

Americaid's summary report, for STAR and STAR+PLUS, includes a quarterly evaluation of calls to their Service Center, with 8,674 total incoming calls reported for June 1998 and 13,071 for September 1998. Thirteen percent of calls were abandoned in June 1998, compared to 2.7 % in September 1998. Average time answered dropped from 2.01 minutes in June to 0.36 minutes in September. The average time queued dropped from 1.59 minutes in June to 0.16 minutes in September. Americaid also reported Member satisfaction survey results related to appointment wait times and stated that the objective to "measure PCP and high volume SCP providers' compliance with appointment access standards" was met.

Regarding accessibility of care, Access states that data is collected on an ongoing basis from Member services call statistics, including types of calls and PCP changes (no data included in summary report). Access noted that "activities for 1998 were targeted at implementing the administrative processes developed for health plan performance and assessment."

## *F. Provider Capacity*

While it is difficult to determine actual provider capacity in the STAR+PLUS program versus that of the traditional Medicaid fee-for-service, the number of providers participating in the Medicaid managed care program appear to have increased as indicated in Table 5.4.

Table 5.4 Provider Ratios of the STAR+PLUS MCOs as Compared to Fee-for-Service Medicaid in the Harris Service Area

| Provider Type | Fee-for-service Harris Service Delivery Area before STAR+PLUS | Access | Americaid | HMO Blue |
|---|---|---|---|---|
| Primary care physicians (PCPs) | 1655 | 926 | 644 | 391 |
| Specialists serving as PCPs[1] | N/A | 87 | 83 | 327 |
| Average Number of Members | 63328[2] | 12467[3] | 10125[3] | 15830[3] |
| Ratio of PCPs to Members | 1:38 | 1:12 | 1:13 | 1:22 |

[1] Members may request a specialist to serve as their PCP in the STAR+PLUS program.
[2] Average Number of Members = Total Member Months ÷ 12 (State Fiscal Year 1997)
[3] Average Number of Members = Total Member Months ÷ 15 (there were 15 months of data analyzed for this report).

While this chart shows encouraging trends in the number of physicians participating in the Medicaid program, these results should be interpreted cautiously. Providers participating in the STAR+PLUS program may limit the number of Medicaid Members they see. Furthermore, providers may, and usually do, participate in more than one MCO. The numbers of providers in Table 5.4 does not represent a unique number of providers participating in the STAR+PLUS program.

The number of long-term care providers in the traditional fee-for-service Medicaid program and the STAR+PLUS program is shown in Table 5.5. The STAR+PLUS program appears to have attracted more providers in each of long-term type provider category than existed in the fee-for-service program. Texas mandated that all long-term care providers providing Medicaid services as of State Fiscal Year (SFY) 1996 who were willing to accept MCO rates and meet credentialing

standards be given a contract to participate in the MCO network. Nearly all long-term care providers joined a MCO network.

Table 5.5: Long-Term Care Provider in the STAR+PLUS MCOs as Compared to Fee-for-Service Medicaid in the Harris Service Area

| Provider Type | Fee-for-service Harris Service Delivery Area before STAR+PLUS | Access | Americaid | HMO Blue |
|---|---|---|---|---|
| Adult Day Care | 23 | 28 | 29 | 27 |
| Nursing Homes | 56 | 45 | 46 | 57 |
| CBA Waiver | 49 | 100[1] | 118[1] | 142[1] |
| Primary Home Care | 51 | 68 | 62 | 125 |

[1] This number may include providers already counted under the Primary Home category

## *G. STAR+PLUS Utilization Rates*

Because of the scarcity of providers accepting Medicaid in the fee-for-service program, Medicaid recipients were often forced to get care where they could receive it. Many Medicaid recipients were relegated to receiving care at the hospital emergency rooms (ERs). Lack of a medical home and continuity of care encouraged frequent and inappropriate use of hospital emergency rooms for conditions such as flu-like symptoms, ear aches and minor infections. Furthermore, lack of adequate and effective preventive care frequently leads to higher hospitalization rates and longer lengths of stay. Because ER visits and inpatient stays can be a rough barometer of access in a managed care environment, the following three utilization measures were reviewed and analyzed:

- Inpatient Discharges
- Average length of stay (ALOS) of inpatient care
- Emergency Room (ER) utilization rates

Table 5.6 presents quarterly data on these three critical characteristics aggregated from data at the three MCOs: Total Inpatient Discharges/1,000 Member months (excluding mental health and chemical dependency), average length of stay in inpatient care (in days); and Emergency Room (ER) visits calculated as visits/1,000 Member months. The numbers used in this section of

the report were provided by the MCOs and all rates were calculated by PPRI staff using formula specified for Utilization Management Report (Physical Health)[5].

Table 5.6: Summary of Utilization Measures from the STAR+PLUS MCOs in Harris county

| Reporting Period | Member months | Inpatient Discharges per 1,000 Member Months | Average Length of Stay | Emergency Room Utilization per 1,000 Member Months |
|---|---|---|---|---|
| SFY 98 – Quarter 2 12/97 – 2/98 | 13,727 | 2000.1 | 1.74 | 348.8 |
| SFY 98 – Quarter 3 3/98 – 5/98 | 91,639 | 643.4 | 2.64 | 276.0 |
| SFY 98 – Quarter 4 6/98 – 8/98 | 104,408 | 503.3 | 5.02 | 614.1 |
| SFY 99 – Quarter 1 9/98 – 11/98 | 102,803 | 329.2 | 7.76 | 387.7 |
| SFY 99 – Quarter 2 12/98 – 2/99 | 104,896 | 300.3 | 7.40 | 321.3 |

Although reported in tables and graphs presented here, results from the following analysis should be interpreted cautiously. The benefits most often associated with managed care, such as more appropriate ER usage and lower ALOS, often take several years to materialize. Furthermore, PPRI was presented with limited data sets from TDHS that have not been audited or verified for accuracy by TDHS. Attempts to verify MCO utilization data for this report were unsuccessful. Furthermore, data from SFY 1998, quarter 2 contain information on a considerably smaller number of Members because of the phased-in enrollment period. Moreover, this "quarter" of data provided numbers from January to February 1998 because the State quarterly reporting period began prior to the STAR+PLUS program.

For comparative purposes, PPRI examined data from fee-for-service SSI and Medical Assistance Only (MAO) consumers from Harris County. Baseline rates were established for fee-for-service recipients. When referring to the following

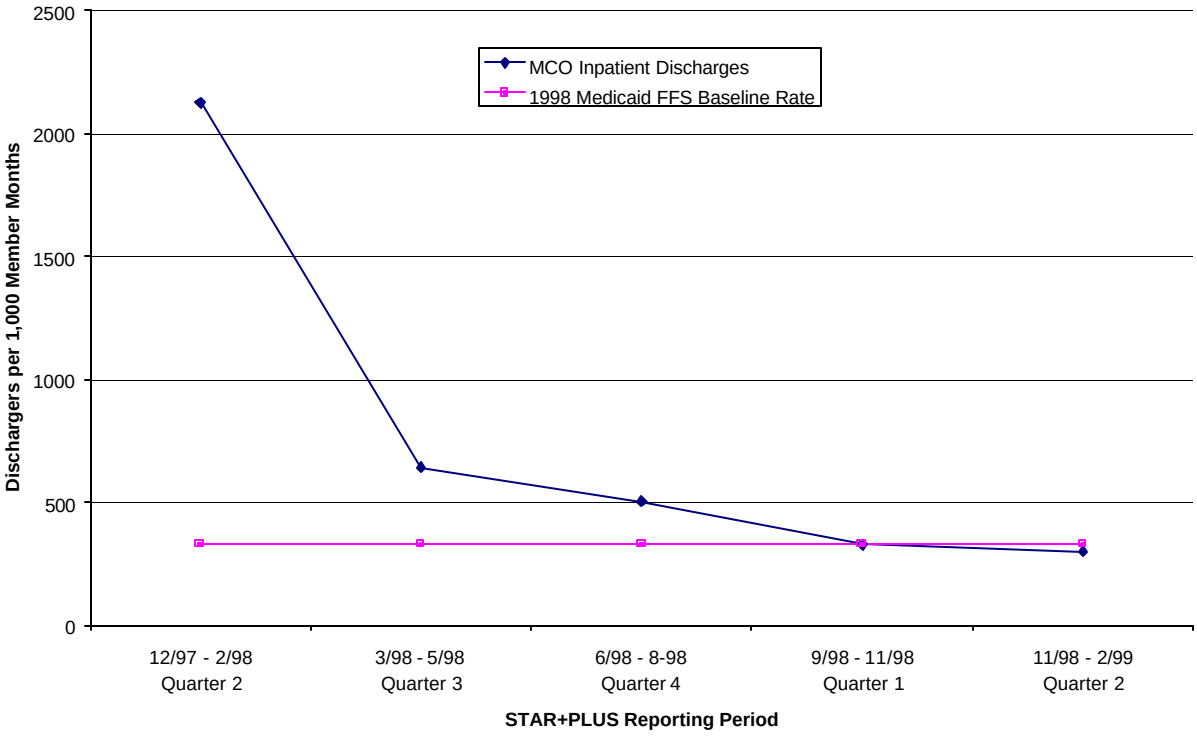
[5] *Utilization Management Report: Physical Health – State Fiscal Year, 1998.* 12/30/97.

graphs in each section, the fee-for-service data is presented as a baseline for comparison. The quarterly labels reported along the x-axis for Figures 5.1, 5.3, and 5.5 represent only the data reported for the STAR+PLUS MCOs.

### 1. Inpatient Discharges

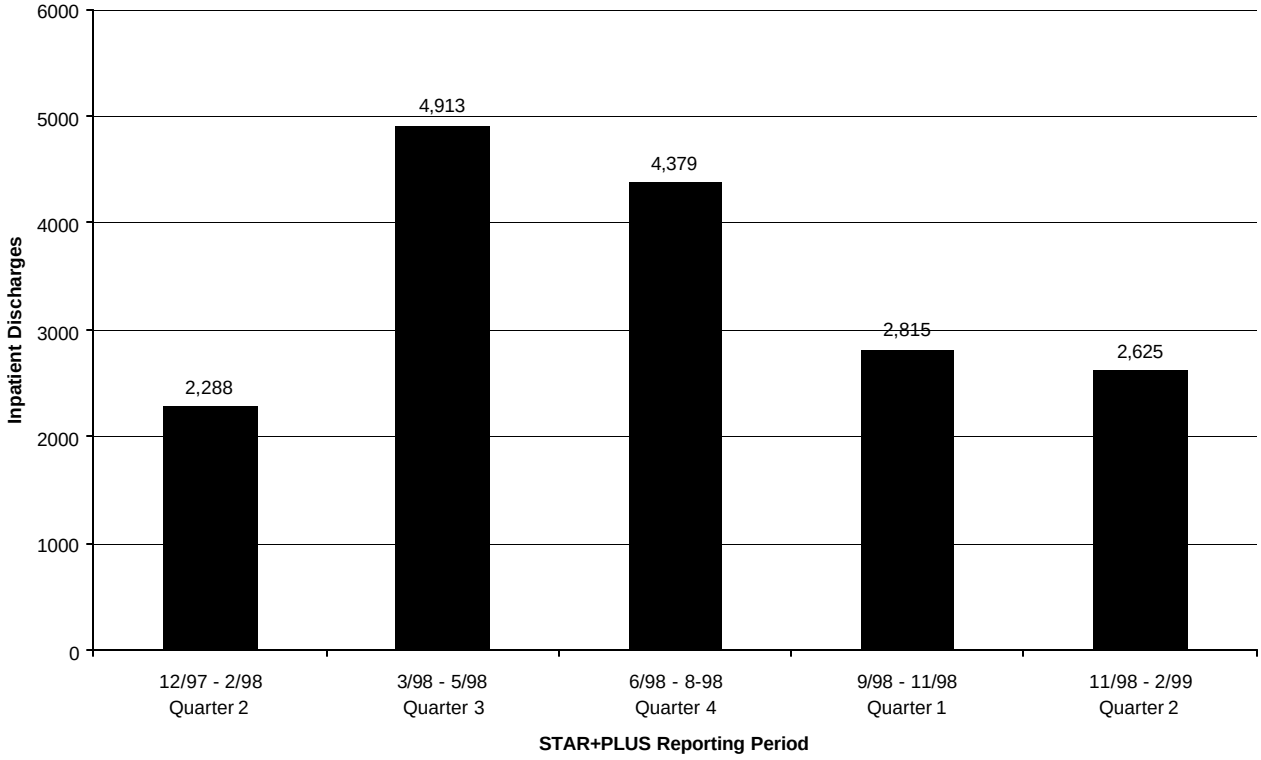
Excluding SFY 1998, Quarter 2, inpatient hospitalization discharges per 1,000 Member Months are fairly consistent with the baseline fee-for-service comparisons as indicated in Figure 5.1. Aggregated data from the STAR+PLUS MCOs show a consistent decline over the five quarter reporting period.

**Figure 5.1: Inpatient Discharges per 1,000 Member Months: STAR+PLUS MCOs versus SFY 1998 SSI FFS Baseline Data**




The MCO data report a sharp drop in discharges for the quarter one and quarter two in 1999 (see Figure 5.2 below). There was a 35% drop in discharges between the last quarter of 1998 and the first of 1999. In contrast, there was only a 2% drop in Member months during the same time frame.

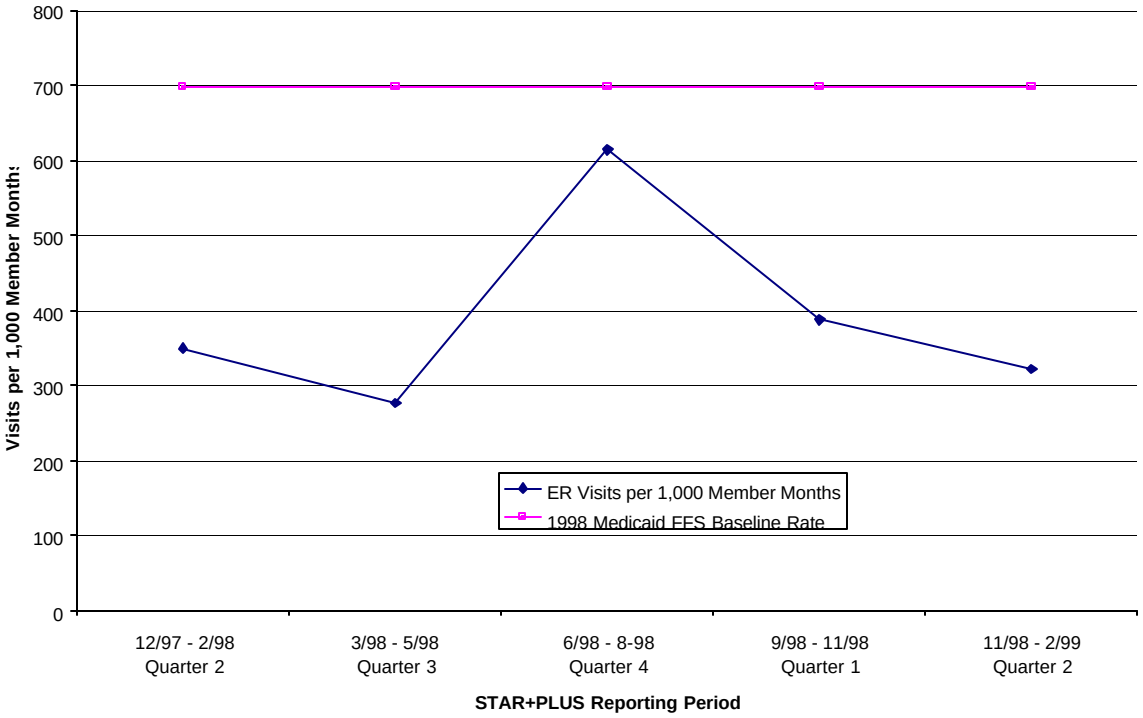
**Figure 5.2: STAR+PLUS Inpatient Discharges**




## 2. Emergency Room Visits

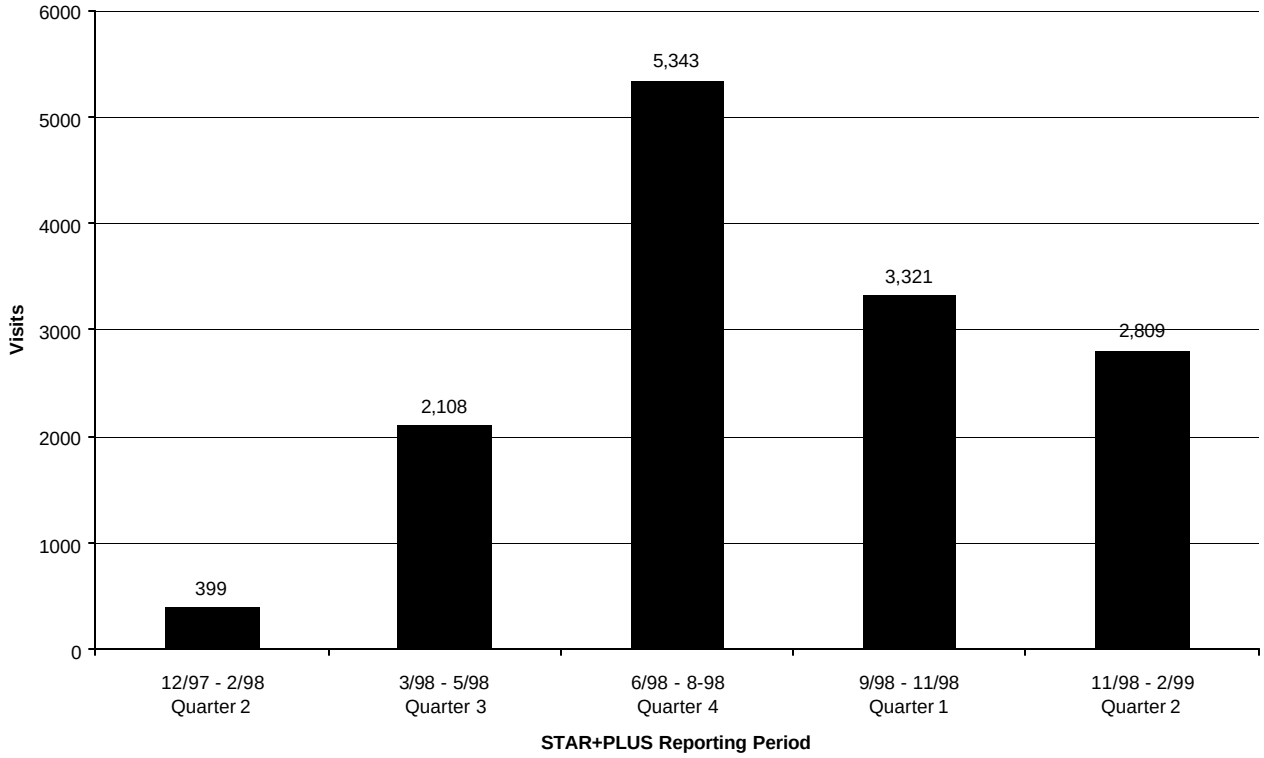
Decreasing emergency room use is a sign that managed care may be doing its intended work, preventing inappropriate usage of expensive emergency room services. Entrenched, decades-long patterns of inappropriate emergency room use can be difficult to break. Figure 5.3 shows encouraging trends in ER usage. The STAR+PLUS MCOs reported ER visits per 1,000 Member Months lower than the fee-for-service baseline rate for all five quarters. Indeed, the rates show a significant rise for the 4$^{th}$ quarter of 1998, but the rate subsides in SFY 1999 quarter 1 and 2.

**Figure 5.3: Emergency Room Visits per 1,000 Member Months: STAR+PLUS MCOs versus SFY 1998 SSI FFS Baseline Data**




SFY 1998 4th quarter reporting period contains a spike in ER usage for the STAR+PLUS MCOs as indicated in Figure 5.4. ER visits increased from 2,108 ER visits in SFY 1998 quarter 3 to 5,343 in SFY 1998 quarter 4, a 153% increase. In contrast, the number of Member months remained relatively stable during that time period, but did increase 14%. Two of the MCOs appear to have accounted for most of the increase and PPRI believes a strong possibility of reporting error exists for SFY 1998 quarter 4.

**Figure 5.4: STAR+PLUS Emergency Room Visits per Quarter - Aggregate of all MCOs**



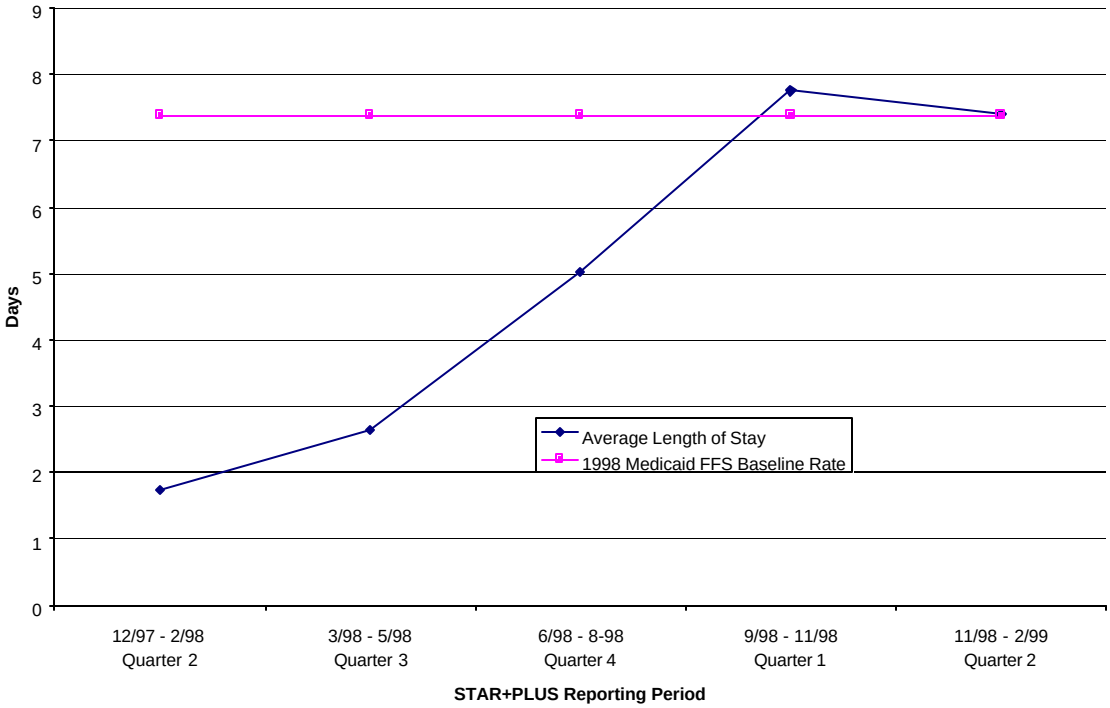

### 3. Average Length of Stay

As MCOs begin to learn more about the disabled population and are better able to manage the care of their Members, logic contends that average lengths of stay for inpatient hospitalizations would decline.

From Figure 5.5, there is no evidence of a decline in the average length of stay[6]. The ALOS for STAR+PLUS MCO Members increased sharply for the first three of the four quarters under examination and has leveled off at over 7 days per stay in the first two quarters of 1999. In comparison, among fee-for-service recipients, the average is nearly the same (7.39 days), thereby showing a convergence of ALOS patterns.

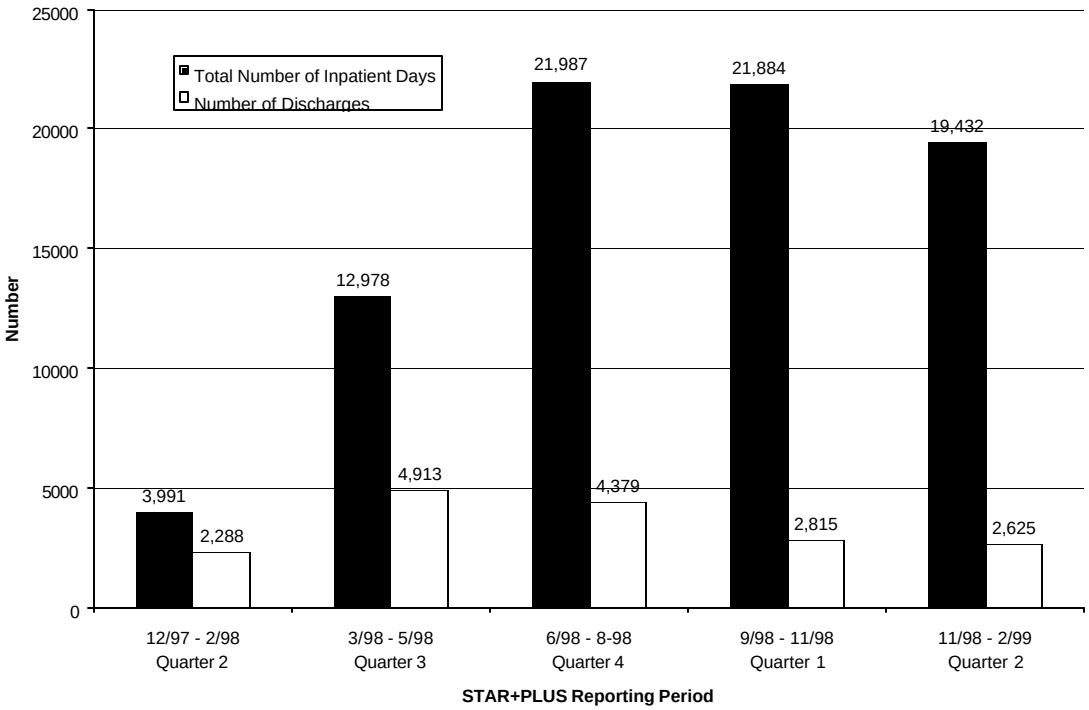
[6] ALOS is calculated by the formula: (Number of days/number of discharges).

**Figure 5.5: Average Length of Stay:**
**STAR+PLUS MCOs versus SFY 1998 SSI FFS Baseline Data**




The number of days has increased steadily in comparison to that of discharges, accounting for the increase in the ALOS. The caveats about the quality of the discharge data reported earlier continue to be an issue. At this point in time, PPRI could uncover no information that could shed light on these patterns.

**Figure 5.6: STAR+PLUS MCO Inpatient Days and Discharges**



*(This Page Left Intentionally Blank)*

# VI. Quality of Care

## *A. Overview*

State quality requirements are contained in the MCO contract. The goal of protecting and improving the health and satisfaction of Medicaid beneficiaries is addressed by the requirement for the MCOs to develop and implement a Quality Improvement Plan that objectively and systematically monitors and evaluates the quality and appropriateness of care and services to enrollees. Quality of care studies and related activities as well as pursuing opportunities for improvement on an ongoing basis, help to assure that the MCOs meet defined quality standards. Establishment of these standards and strategies serve to ensure and promote quality of care in MCOs serving STAR+PLUS enrollees.

## *B. STAR+PLUS Quality Improvement (QI) Contract Requirements*

STAR+PLUS contract requirements for quality improvement are found in Article XI, Quality Assurance and Quality Improvement Program. These requirements are based on federal regulations and, in particular, the Quality Assurance Reform Initiative (QARI) guidelines, developed by HCFA in 1993 as a guide for state Medicaid Managed Care programs.

Each contracted MCO must develop, maintain, and operate and submit a written Quality Improvement Plan (QIP) to the State, describing how it will accomplish activities specified in the modified QARI standards. Other QI contract requirements relate to notifying the State regarding subcontracting of QI requirements and the status of any accreditation by an external accrediting agency. In addition, the MCO must integrate behavioral health into their QIP activities and monitoring. Contractual QI reporting requirements include:

- selected focused health studies,
- annual QIP summary report, and
- medical record audits

All three MCOs have developed and submitted an approved-by-the-State QIP. The annual QIP summary reports detail quality improvement activities and processes that have occurred during the year, as well as self-assessment and "re-direction" comments.

## *C. Other States Requirement for QI*

The quality improvement program requirements in other states' Medicaid Managed Care programs were reviewed for comparison. MCO contract

documents from Colorado, Washington, and Florida show these states' similarities to the basic STAR program.

The Senior Care Options Program in Massachusetts and the Diamond State Cares Initiative in Delaware are more similar to STAR+PLUS; these two programs are in the planning stages and have not been implemented yet. The Massachusetts program, which aims to develop a geriatric managed care model, is targeted to begin in fall 1999. The Delaware project for elders and persons with disabilities may be implemented in late 2000.

The MCO quality assurance programs reviewed for this project share some basic tenets, which include:

- each MCO must have a formal internal quality assurance system,
- there must be a designated director of quality assurance and utilization review,
- MCO has an internal quality assurance committee with expertise in Quality Assurance, with appropriate representation, that meets regularly, keeps minutes, and reports to an MCO executive level,
- MCO must have a written quality assurance plan that describes the policies and procedures of the health plan's quality assurance system,
- MCO must have a formal process for receiving, procession, responding to and reporting Member complaints/grievances, MCO must have a plan for involving Members of the health plan in quality assurance activities, and
- The production of periodic quality assurance reports, which describe the results of the health plan's quality assurance activities, and actions taken by the health plan to address identified deficiencies in the quality of services provided to Members.

These basic requirements are really no different from requirements for MCOs serving commercial populations. Insurance regulatory agencies in most states adhere to these basic quality assurance provisions. Quality improvement standards for many states are often modeled on the National Committee for Quality Assurance (NCQA) Standards for Accreditation of Managed Care Organizations. In fact, the QARI guidelines developed by HCFA for state Medicaid managed care programs are very similar to the NCQA quality assurance standards.

The quality assurance/quality improvement requirements in both the STAR and STAR+PLUS contracts are consistent with these national standards. There are some differences, however, in related requirements; four out of the five states reviewed required audited HEDIS reporting from their contracted MCOs (usually a sub-set of the NCQA HEDIS measures). The fifth state, Delaware, mentions developing performance measures similar to certain HEDIS measures, such as mammography rates and influenza immunization rates. The STAR and STAR+PLUS contracts do not require HEDIS reporting; while this has been

explored by the state agencies involved (TDH, TDHS, and the HHSC) , the Texas experience of span of Medicaid eligibility and Member length of enrollment in an MCO (less than six months) does not lend itself to accurate HEDIS reporting. Most HEDIS measures require 12 months enrollment in a health plan. Many state Medicaid programs have a term of six months or one year guaranteed eligibility; Colorado, for example, has six months guaranteed eligibility.

Some states require the MCO to pay for and procure an external quality review. In Texas, the State procures the external quality review for all contracted Medicaid managed care organizations. The same is true for an independent survey of Member satisfaction.

Of particular interest are the two programs more similar to STAR+PLUS. The State of Massachusetts is currently developing a geriatric managed care model targeted for all Medicaid MassHealth Members aged 65 and over, who are dual eligibles. The program, Senior Care Options, is designed to encourage the participation of networks of health and social service providers that will be known as Senior Care Organizations. They will integrate all components of care for persons aged 65 and over who are dually eligible for Medicaid and Medicare. Enrollment will be voluntary.

The Senior Care Organizations will allow Medicaid and Medicare funds to be blended in order to provide services in the most appropriate, cost-effective manner and to improve health outcomes. Both Medicaid and Medicare payments can be used to provide services not covered under either FFS system.
The Delaware, Diamond State Cares Initiative, is similar to STAR+PLUS in that it will be a mandatory enrollment for elders and persons with disabilities. It will not, however, serve persons under age 18. As in STAR+PLUS, dual-eligibles will continue to receive care from Medicare as primary. There is no blending of Medicaid and Medicare funds as in the Massachusetts project. Diamond State Cares will have risk-adjusted rate categories for the first three years (for example, a separate rate category for persons with HIV/AIDS and a separate category for persons with late-stage AIDS) and the State will risk share the first three years for both profit and loss.

### 1. THQA On-site Review of QI

Review and analysis of certain reports provides insight into the status of each MCO’s compliance with State QI requirements. One of these reports is a report by THQA, the State’s Quality Monitor regarding an on-site, first-year, structure and process review of each STAR+PLUS MCO.

The on-site surveys were conducted by THQA in April 1999 in conjunction with the STAR review. This was a first year, baseline, structure and process review for the Harris MCOs.

THQA developed a STAR+PLUS specific evaluation tool for the on-site survey to address four assessment areas:

1. Member benefits and services education,
2. Health services availability and adequacy,
3. Member case coordination, and
4. Provider related processes

All the STAR+PLUS MCOs' scores reflect adequate structure to carry out contractual requirements. Scores for the STAR+PLUS review were as follows:

Table 6.1: MCO Onsite Review Scores

| MCO | Score | Highest Possible Score | Percent |
|---|---|---|---|
| HMO Blue | 147 | 150 | 98% |
| ACCESS | 149 | 150 | 99% |
| AMERICAID | 122 | 150 | 81% |

The QI related findings identified by the THQA include:

***HMO Blue***

*STRENGTHS*

1. Assessment instruments have been developed and are being used to identify Members with chronic disabilities.
2. Care coordinators are assigned to each STAR+PLUS Member identified as needing a care coordinator.
3. There is provider participation in the Plan's Quality Improvement Committee.
4. The plan developed "focus groups" to solicit input from Members.

*WEAKNESSES*

1. There are no members participating on the Executive Quality Improvement Committee.
2. Community based guidelines had little involvement from Plan providers.
3. Provider profiling has been targeted as an area by the Plan for improvement.

4. Twenty-four hour live voice access was not available and responses were not always appropriate.

***ACCESS***

*STRENGTHS*

1. The Plan's Member education program initiatives are innovative and comprehensive.
2. All required policies and procedures for Care Coordination are in place.
3. The Plan's providers have a proficient understanding of the difference between STAR and STAR+PLUS.
4. The Plan elicits provider satisfaction information that is beyond the State's requirements.

*WEAKNESSES*

1. The Plan's computer systems are unable to electronically interface with outside entities, such as TDH, TDHS, THQA, and providers, causing untimely data submissions.
2. The Plan's staff reported little provider involvement in the Quality Improvement Program.
3. The Plan does not have a signed contractual document or employee agreement with the Medical Director describing the participation in the State's fair hearing process.
4. The Plan reports communication difficulties between behavioral health specialists and PCPs.

***AMERICAID***

STRENGTHS

1. The MCO has a structured and comprehensive Member education program.
2. The MCO's outreach department is well trained and efficient.
3. There is a Director of Utilization Management solely for the STAR+PLUS Program.
4. Network providers receive on-going education and training in a consistent manner.

WEAKNESSES

1. Interviews with network providers revealed that not all provides are aware of the MCO's Quality Management Program and how to participate on the QM committees.

2. Policies and procedures are in place to address the benefits and services to minors. However, there was no evidence presented that the actual services are being provided to minors enrolled in the health plan.
3. There was no evidence presented that the MCO ensures that all Members discharged from inpatient psychiatric hospitalizations receive follow-up care within 7 days of discharge.

## *D. STAR+PLUS Member Complaints*

The STAR+PLUS MCO contract takes the definition of complaint from the Texas State Insurance Code, Section 20A.02. Complaint is defined as:

- Any dissatisfaction, expressed by a complainant orally or in writing to the HMO (MCO) with any aspect of the HMO's operation, including, but not limited to dissatisfaction with the plan administration; the way a service is provided; or disenrollment decisions. A complaint is not: 1) a misunderstanding or a misinformation that is resolved promptly by supplying appropriate information or clearing up the misunderstanding to the satisfaction of the Member (Medicaid beneficiary) or 2) an appeal of action taken by an HMO.

### 1. Other State Definitions of Disputes

PPRI surveyed other states to draw comparative data. Data was obtained either through direct contact from other state Medicaid programs or through data available via the World Wide Web. As Table 6.2 indicates, states vary in their methods of defining disputes. Also, the methods for reporting and resolving disputes varied across the states surveyed for this report.

Table 6.2: Definitions of Complaint and Grievance of Selected States

| State | No Distinction | Complaint "Verbal and/or Informal" | Grievance "Formal and/or written" | Notes |
|---|---|---|---|---|
| Texas | V | | | Complaint - Covers all disputes, formal and informal. Complaints must be resolved within 30 days of MCO receipt. |
| Tennessee | | V | V | Grievance must be filed within 30 days of notice from MCO. If grievance is filed within 10 days, MCO must maintain the same level of care[7] |
| Colorado | V | | | Complaint – all oral and written dissatisfaction. Must be filed within 30 days of adverse determination or beneficiary knowledge of problem.[8] |
| Maryland | V | | | Complaint - Covers all disputes, formal and informal.[9] |
| Ohio | | V | V | Complaint – information received by the state through their enrollment information center Grievance – problems and/or concerns identified by an enrollee and relayed to MCO either verbally or in writing[10] |

### 2. Filing a Complaint in Texas

The Texas Department of Human Services does not have a prescribed protocol for Medicaid recipients filing a complaint. Medicaid recipients are encouraged talk with the Member Services Department of the MCO first, but can begin the complaint process at a variety of interfaces. Most complaints are filed directly with the MCO 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 MCO, PCP or Care Coordinator, or other appropriate state or community resources. Inquiries or issues that cannot be handled quickly or easily

[7] Your Rights to Health Care Under TennCare. [On-line]. Available http://www.state.tn.us/health/tenncare/grievfrm.htm.
[8] State of Colorado Model HMO Contract. July 1998.
[9] Maryland Department of Mental Health and Mental Hygiene – Interview with Rosalie Koslof, Chief of Recipient Services.
[10] Ohio Department of Human Services. Managed Care Plan Progress Report: Statewide January – June 1998.

by a Starline worker are transferred to an advocate. Data are gathered from the Starline to track problems that should be addressed with the Enrollment Broker, MCOs, 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 MCO 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 MCOs. 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 MCO contracts incorporate extensive requirements for complaint resolution. All complaints must be resolved in 30 days of receipt of the complaint. The MCOs typically involve staff within the MCO, 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 MCO'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 MCO before requesting a fair hearing.

### 3. Complaint Data

Two factors may have affected the quantity and type, as well as the reliability and validity of the STAR+PLUS complaint data reviewed by PPRI. First, the STAR+PLUS program began in January of 1998. However, TDHS opted for a phased-in enrollment process. Therefore, Medicaid recipients who were required to enroll in the STAR+PLUS program were given three months to enroll before being automatically assigned to an MCO. The phase-in period allowed TDHS, the Enrollment Broker, and the STAR+PLUS MCOs to educate and inform Medicaid beneficiaries about the STAR+PLUS program so that they could make better choices of MCOs and PCPs. Only 5 % of the STAR+PLUS population was enrolled in a MCO when the program began in January of 1998.[11] The low number of managed care enrollees for the first three months, most likely contributed to a lower number of complaints than the MCOs would most likely experience with full enrollment.

Second, the state does not prescribe the MCO reporting protocol. Thus, plans have responded with varying strategies and reporting formats that are not directly

[11] Unpublished TDHS enrollment data.

comparable. PPRI believes the data provided by the MCOs reflects a significant under estimate of true complaint activities. Many complaints can easily be resolved by either the Enrollment Broker or the MCO and are not recorded. For example, PPRI investigated a limited dataset of complaints received by the Enrollment Broker taken from calls received from STAR+PLUS Members from January 1999 through May 1999. The Enrollment Broker hotline data indicated a significantly higher number of issues for the six month period than did the MCOs for the five quarters (15 months) of data examined for this report. While many of the contacts reported to the Enrollment Broker can not be directly classified as complaints, many of the issues could clearly be defined as complaints, such as:

- Member does not like PCP/specialist assignment
- Appointment delay - Inordinate delay in availability
- Waiting time in office is unreasonable
- PCP refused requested referral(s) or treatment
- Personality conflict or not happy with PCP
- Unhappy with PCP's staff

The Enrollment Broker recorded 16,718 contacts for the STAR+PLUS program during the six month period. [12] Over 600 of those contacts pertained to the six issues listed above, far surpassing the 303 complaints reported by the MCOs over the five quarter reporting period.

### 4. MCO Complaint Tracking

STAR+PLUS MCOs are required to keep a record of the complaints they receive. MCOs must log each complaint received in person, by telephone, or in writing. The complaint logs help both the MCO and TDHS detect problem patterns. Once patterns are detected and analyzed, the MCOs and TDHS work to develop policy and procedural improvements to address the complaints and any recurring themes.

Complaint logs must be submitted to TDHS each quarter as a contract deliverable. Each complaint log must contain the following information:

- The date upon which the complaint was filed
- A summary of the facts surrounding the complaint
- The date of resolution of the complaint
- An explanation of the procedure followed
- The outcome of the complaint process

Table 6.3 shows the various categories MCOs use to report complaints.

[12] THDS Unpublished data. SB 601 report January 1999 through May 1999.

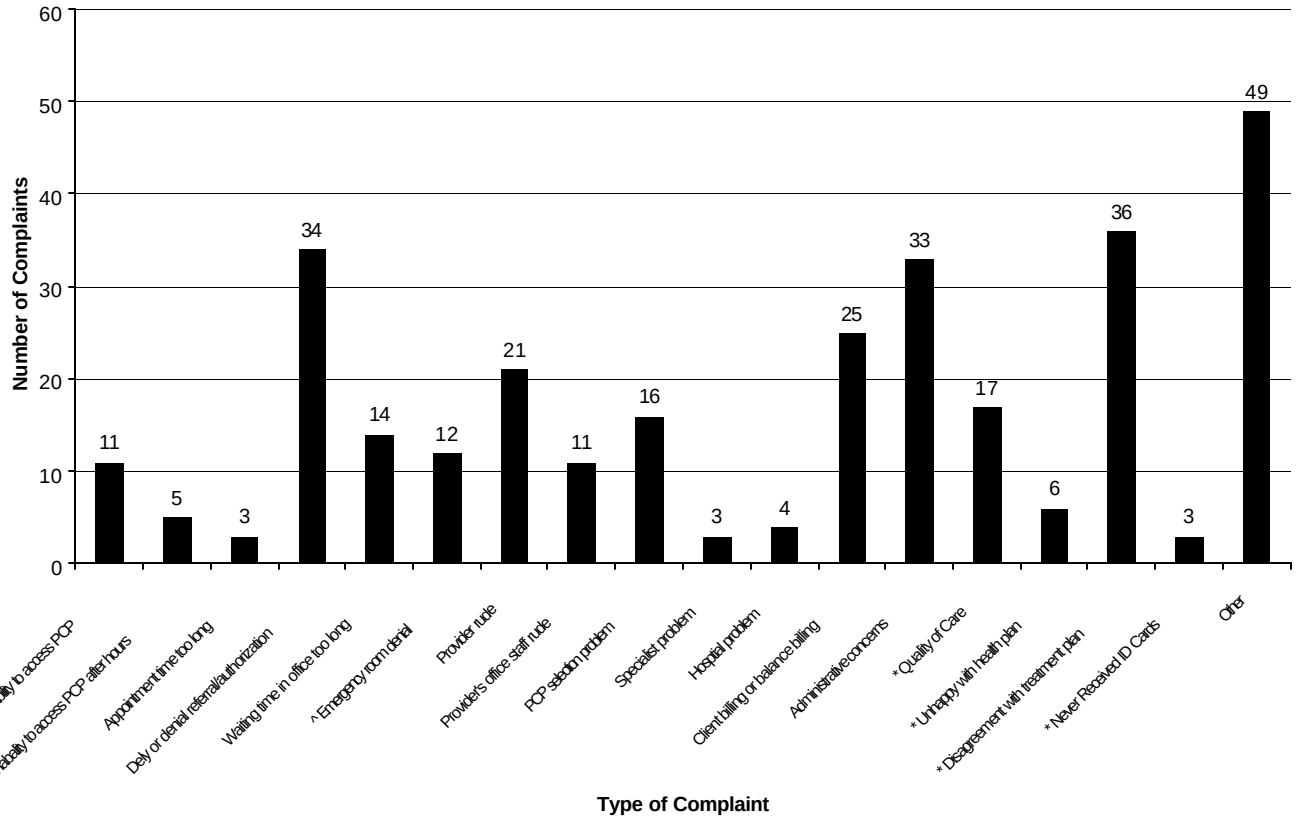
Table 6.3: MCO Complaint Categories

| Complaint Type |
|---|
| Inability to Access PCP |
| Inability to Access PCP After Hours |
| Appointment Time Too Long (Member cannot obtain an appointment in a reasonable amount of time) |
| Delay or Denial Referral/Authorization |
| Waiting Time in Office Too Long |
| Emergency Room Denial (MCO or PCP would not approve ER visit because of condition deemed inappropriate) |
| Rude Provider |
| Rude Office Staff of Provider |
| PCP Selection Problem |
| Specialist Problem |
| Hospital Problem |
| Client Billing or Balance Billing |
| * Administrative Concerns |
| * Quality of Care |
| * Unhappy with health plan |
| * Disagreement with treatment plan |
| * Never Received ID Cards |
| Other |

* Additional, self-reported categories by selected health plans. Categories not required by TDHS.

For this study, PPRI analyzed complaint data for a five quarter period, extending from December 1997 through February 1999. Figure 6.1 displays a summary of the 303 complaints received by the MCOs during this time period. STAR+PLUS recipients reported complaints across the spectrum of categories. The most frequently reported complaint type was “other” or non-classified type of complaint, representing 49 or 16% of all complaints. The second most frequently reported complaint was “Disagreement with treatment plan,” comprising 36 or 12% of all complaints. Disagreement with treatment plan is a self-reported category and is only reported by two of the three STAR+PLUS MCOs.

**Figure 6.1: STAR+PLUS Member Complaints by Type**




^ Emergency room denial = PCP and/or MCO would not authorize ER visit because care condition deemed inappropriate for ER
* Self-reported MCO complaints by select STAR+PLUS MCOs. Categories not required by TDHS

## 5. Complaint Analysis

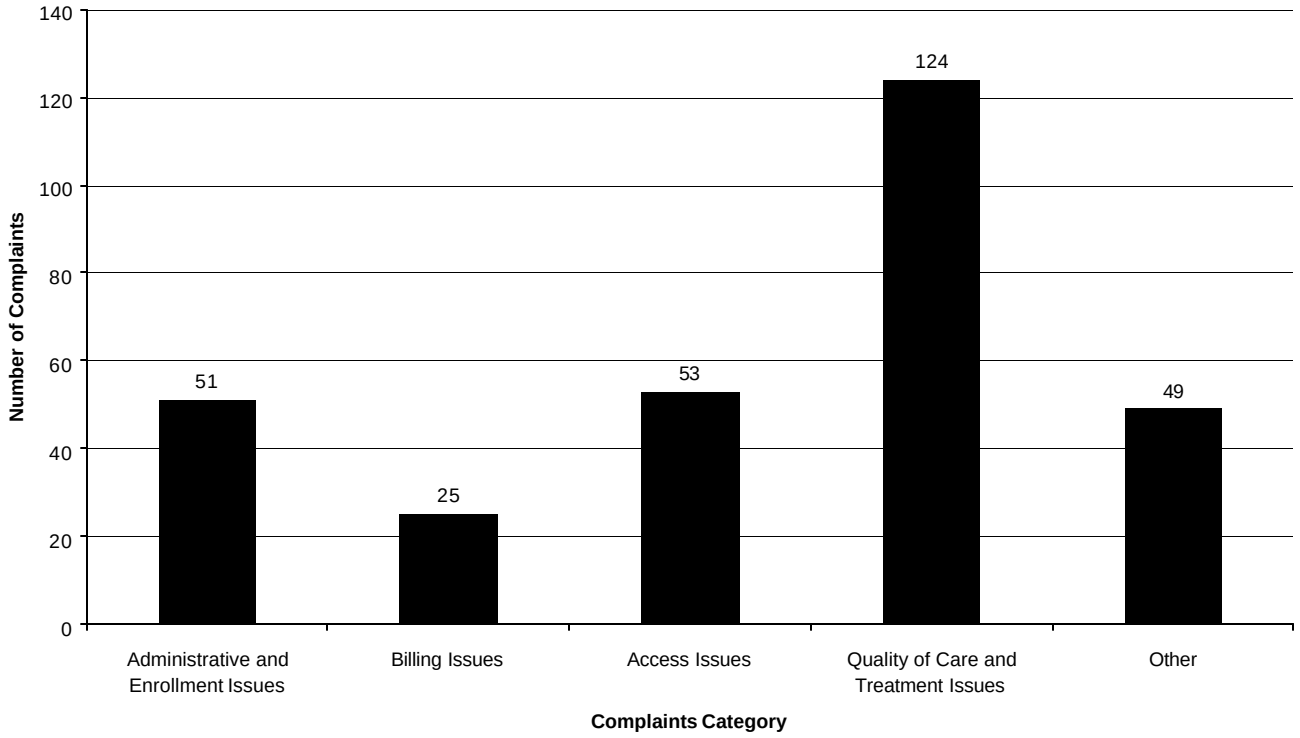
After researching complaint data from other Medicaid programs around the country and complaint reporting practices at the Texas Department of Insurance, PPRI categorized complaint data into one of five categories. Data reduction efforts were undertaken to simplify some analytical presentations and provide for more direct comparability with other Medicaid programs across the country.

TDHS has no written or formal definitions for classification of complaint types. MCOs have wide latitude to use their own classifications. Also, some complaint categories have rather ambiguous classifications, such as “PCP selection problem,” “specialist problem,” and “hospital problem.” As a result, it is extremely difficult to aggregate across MCOs without first reducing the data set to more generic categories. A content analysis of the TDHS and MCOs’ complaint categorization schemes led to PPRI developing the following analytical complaint categories:

- Enrollment/Administrative Issues
- Billing Issues
- Access Issues
- Quality of Care/Treatment Issues
- Other

Figure 6.2 displays the complaints as they are grouped by category. Quality of Care issues were the most frequently reported type of complaint. Approximately 41% of all STAR+PLUS complaints were related to quality of care issues. Access issues, administrative and enrollment issues, and other issues were reported at nearly the same rates, each comprising approximately 17% of all complaints. Billing issues were the most infrequently reported complaints, accounting for around 8% of all complaints.

**Figure 6.2: STAR+PLUS Memeber Complaints by Category (December 1997 through February 1999)**

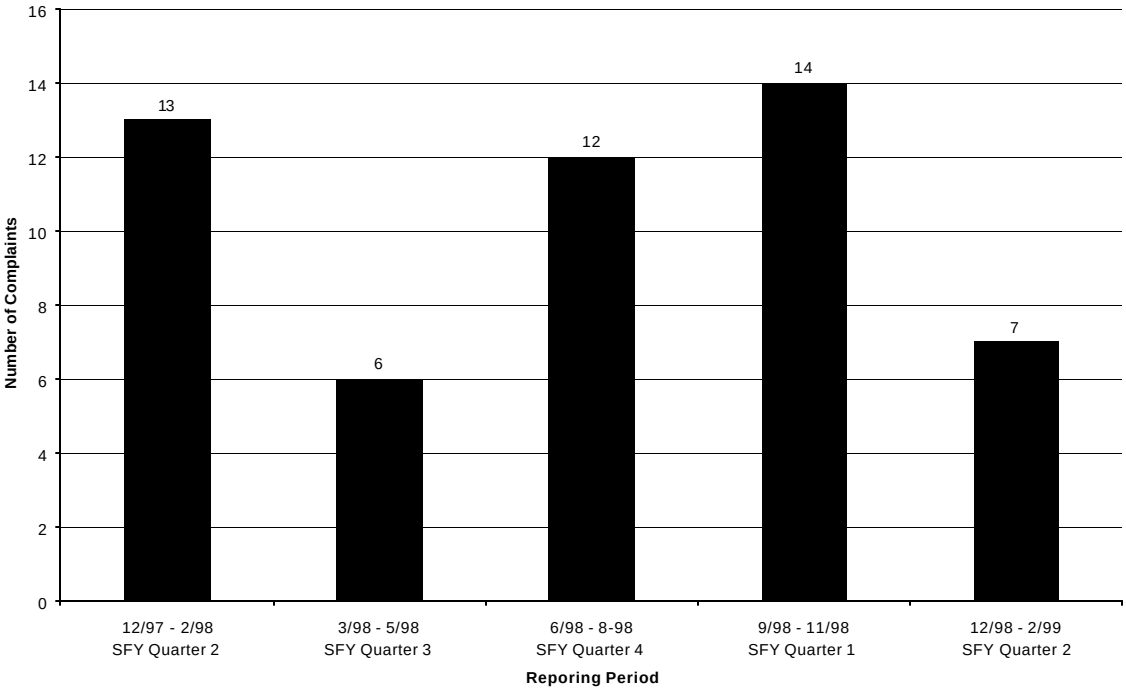


### a) Enrollment and Administrative Issues

Enrollment and administrative issues are seemingly two very broad categories, but they both can be construed as accounting for how the MCO 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 MCO are often out of the immediate control of the MCO. 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. Furthermore, PCPs in the STAR+PLUS program are limited to 1,500 Members, unless granted a special exemption by TDHS. 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 MCO.

No dominant theme emerged from review of the MCO complaint reports. Enrollment and administrative issues comprised 52 or 17% of all STAR+PLUS complaints over the five quarter reporting period and remained fairly consistent over time.

**Figure 6.3: STAR+PLUS Member Administrative/Enrollment Complaints**



### b) Billing Issues

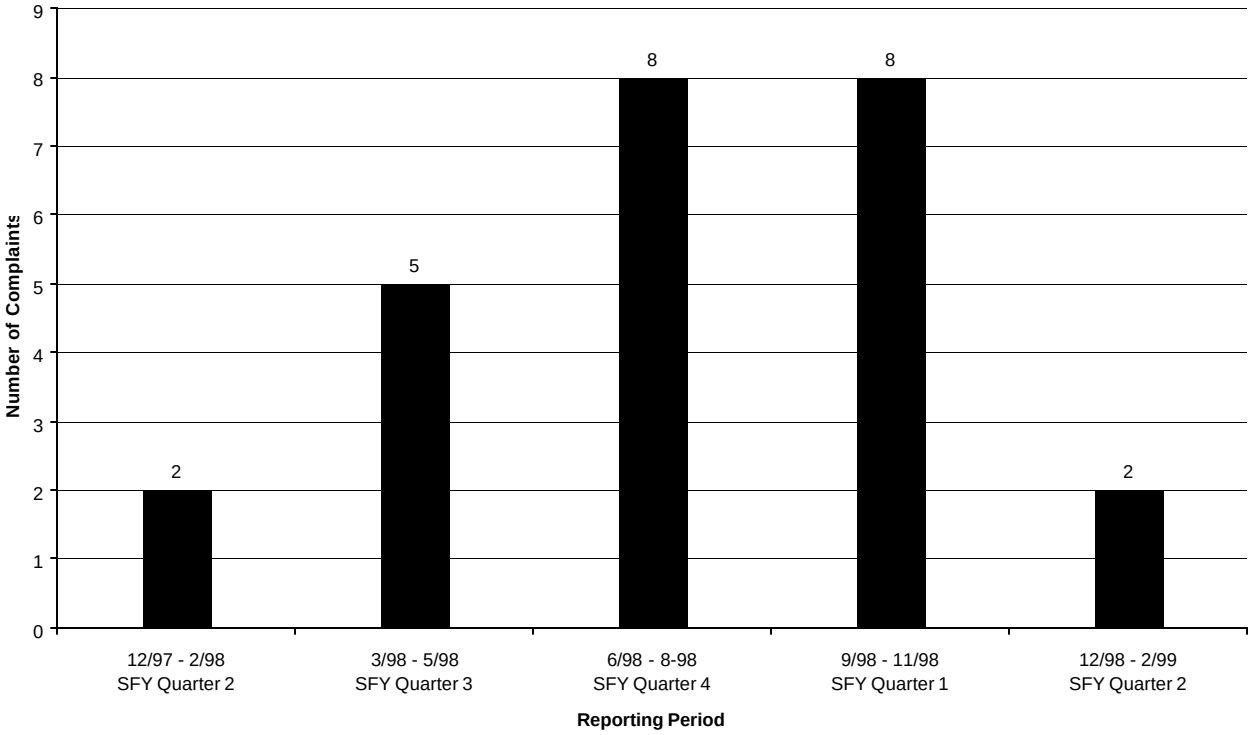
Medicaid recipients may not be billed for any Medicaid covered service. Medicaid MCOs must accept the capitation rate from the State as payment in full for all Medicaid covered services as stipulated in the MCO contract:

- HMO (MCO) and network providers are prohibited from billing or collecting any amount from a Member except for costs for health care services or long term care services not covered by this Contract, in which case the Member must be informed of such costs prior to providing non-covered services.

Complaints analyzed by PPRI for this report most often pertained to confusion over value-added services, such as dental procedures. Some STAR+PLUS MCOs offer limited dental benefits as a value-added benefit. It appears that some confusion exists with the dental value-added benefits and some STAR+PLUS recipients were billed for dental services they assumed were covered by the MCO.

Figure 6.4 illustrates the number of reported billing complaints from December 1997 to February 1999. Billing issues comprised only 10% of all complaints, the lowest of all complaint categories.

**Figure 6.4: STAR+PLUS Member Billing Complaints**

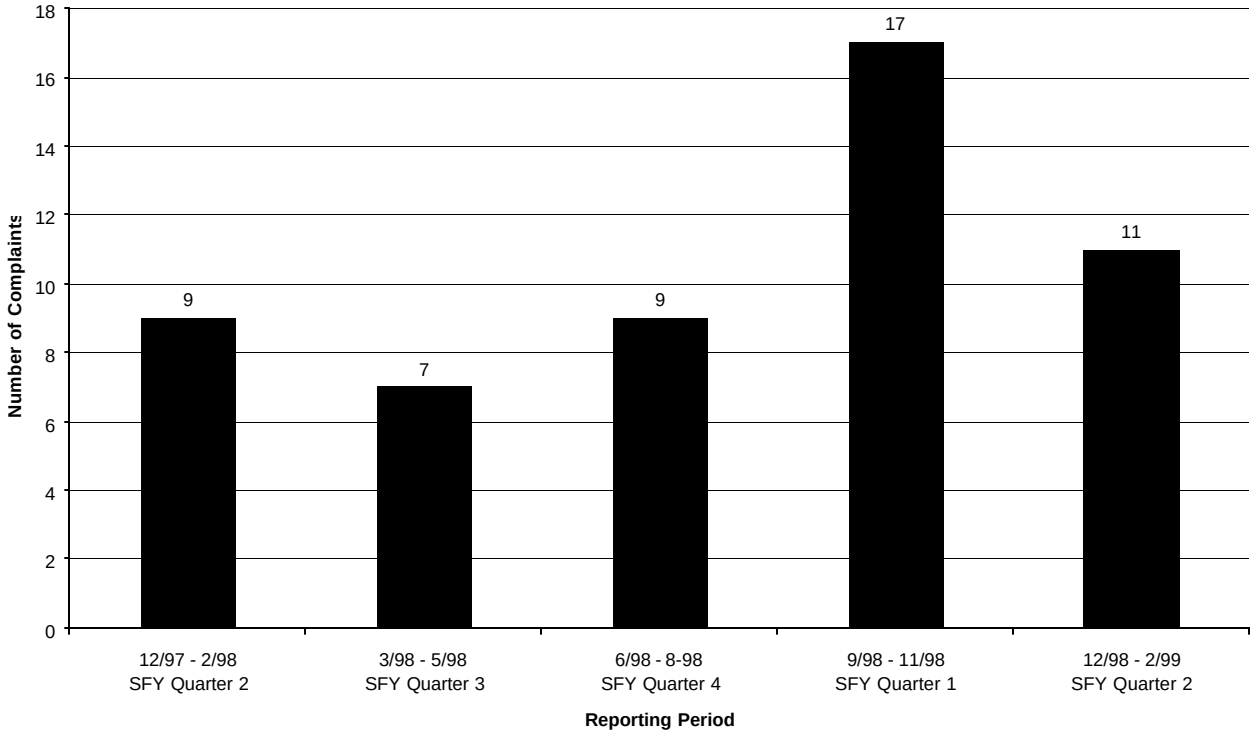


### c) Access Issues

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.

Many STAR+PLUS Members appeared to complain about MCO denials of authorizations for specialty care. Under the fee-for-service Medicaid program, recipients could self-refer for many types of specialty care. MCOs refer Members to specialty care only when the referral is deemed medically necessary and appropriate by the MCO. Becoming accustomed to seeking referrals for Medicaid services in managed care may be frustrating for some STAR+PLUS Members. However, the complaint data suggest that access does not appear to be a significant problem in the STAR+PLUS program, as access issues accounted for 53 or 17.5% of the reported complaints during the five quarter reporting period.

**Figure 6.5: STAR+PLUS Member Access Complaints**



## d) Quality of Care/Treatment Issues

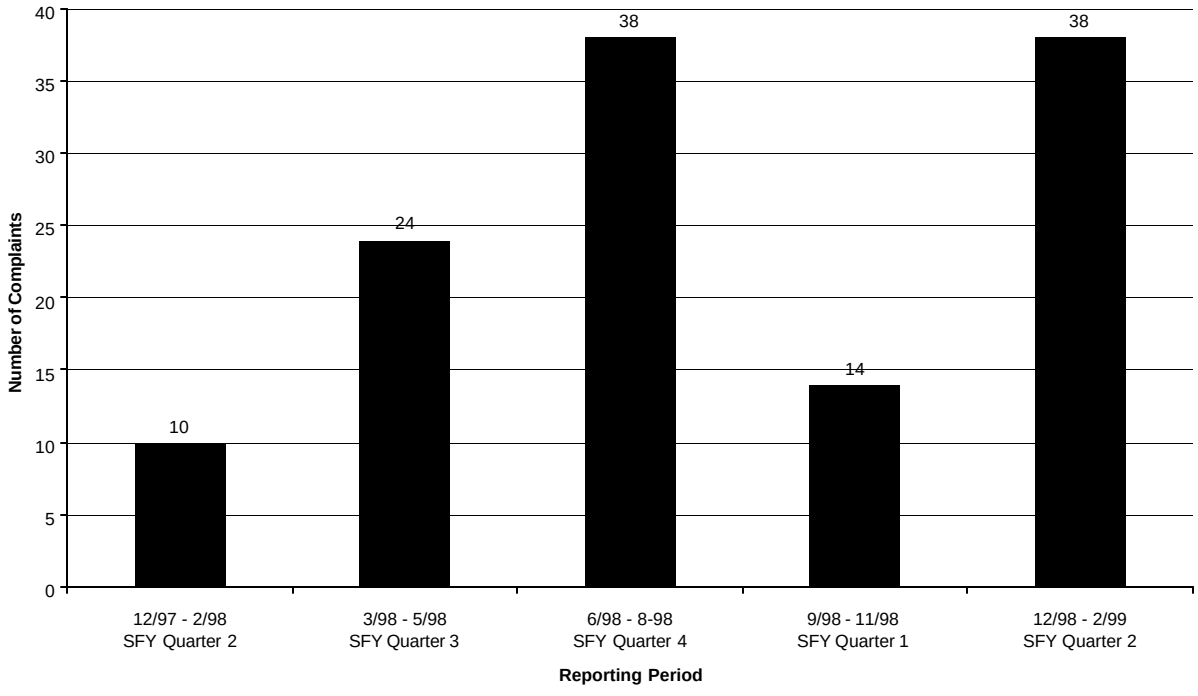
Quality of care complaints of STAR+PLUS Members are quite different than the technical quality of care indicators typically assessed in medical chart reviews. The distinct advantage of monitoring quality of care complaints is that it provides feedback in a more timely fashion than retrospective chart reviews, cutting the time to solve potentially dangerous or problematic situations.

Quality of care and treatment issue were the most frequently cited complaint by STAR+PLUS Members. Quality of care complaints comprised 41% of all reported complaints. Nearly 60% of the 124 quality of care complaints came from the categories that two MCOs voluntarily reported:

- Quality of care
- Unhappy with health plan
- Disagreement with treatment plan

Since the STAR+PLUS MCOs are voluntarily reporting such problems, this may indicate that the MCOs are cognizant of problems afflicting their Members and may be serious about correcting quality of care and treatment problems. No single type of quality problem stood out. Quality and treatment problems were reported across all types of providers, including hospitals, physicians, and ancillary providers.

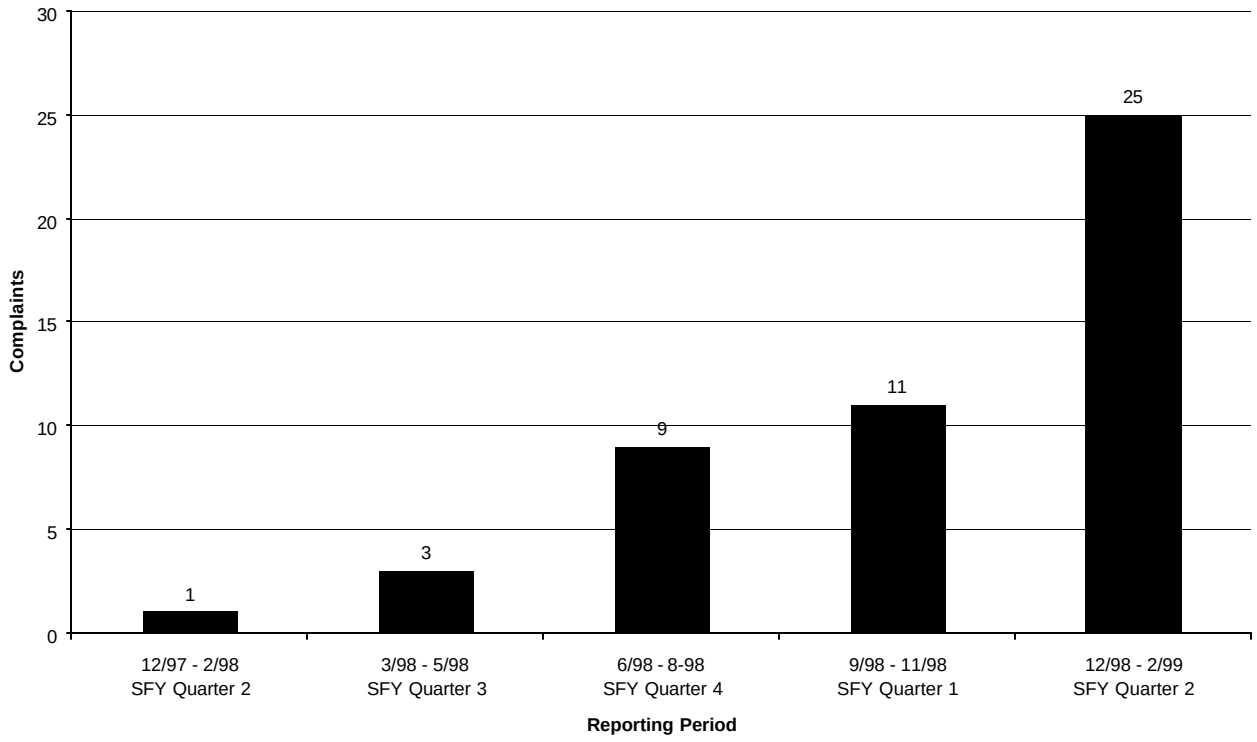
**Figure 6.6: STAR+PLUS Member Quality of Care/Treatment Issue Complaints**



## e) Other (Unclassified) Issues

Unclassified complaints comprised 16% of all STAR+PLUS Member complaints for the five-quarter reporting period. Despite making up only a fraction of the complaints during the reporting periods of 12/97 – 2/98 and 3/98 – 5/98, unclassified complaints grew to approximately 30% of all reported complaints during the reporting period of 12/98 – 2/99. While no single trend seemed to emerge from the unclassified complaint logs, STAR+PLUS administrators may want to create new categories of complaint types to better capture this data, especially as the this category has steadily risen over the past five quarters.

**Figure 6.7: STAR+PLUS Other (Non-categorized) Complaints**



## 6. Complaint Comparisons with Other States

PPRI obtained data on complaints from other states to provide a comparison of the number and types of complaints received from other Medicaid managed care programs around the nation. Because of the significant differences in Medicaid populations, geographic locations, complaint reporting practices, complaint and grievance definitions, and individual state Medicaid requirements, the comparisons drawn here between the STAR+PLUS program and the Maryland and Ohio Medicaid managed care programs should be interpreted cautiously. The comparisons illustrated here are designed to show general complaint rates in each state and should not be taken as indicative of capturing all managed care complaints.

Complaint data from each state was converted into complaints per Member month. Because people join and leave Medicaid MCOs throughout the year, it would be inaccurate to use the total membership from one point of the year. Therefore states use "Member months" to calculate the average number of Members during the year:

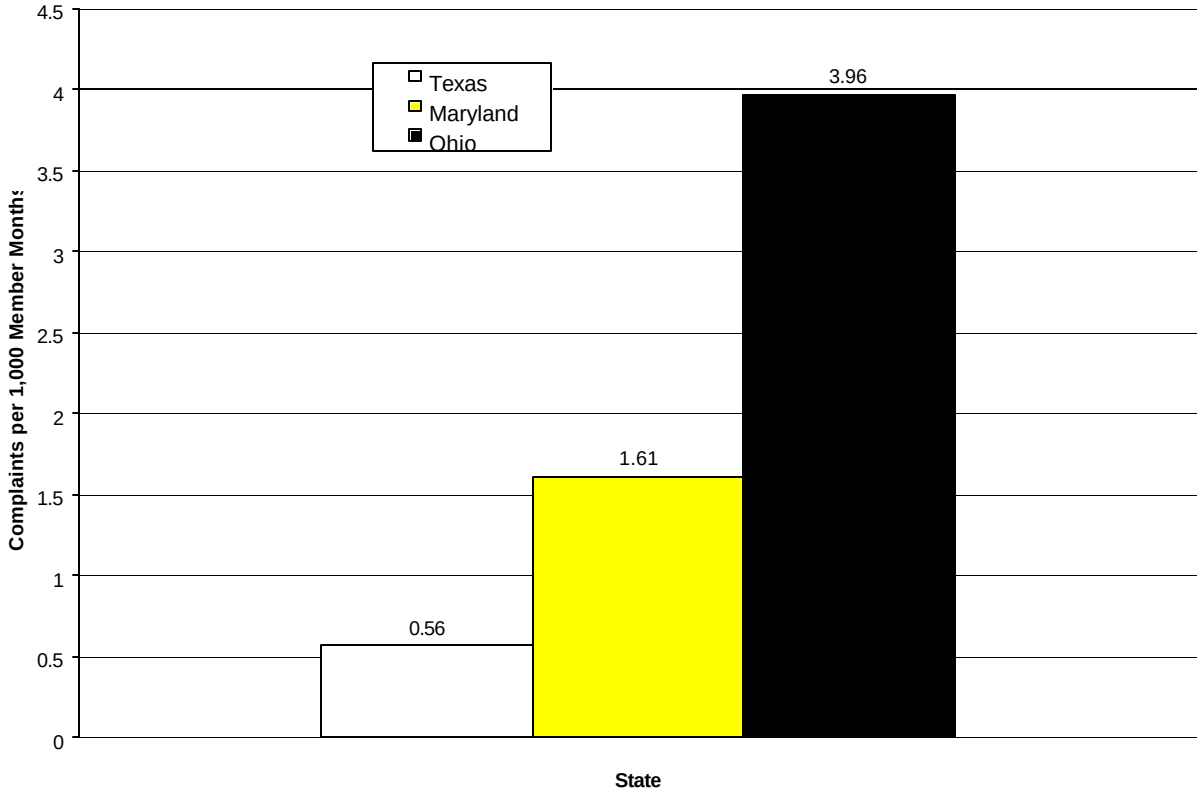
Current Year Member Months ÷ 12 = Average Member Months

To obtain comparable rates for comparative purposes, complaint data from each of the three states were developed into complaints per 1,000 Member months. The rate is derived from the following formula:

Number of Reported Complaints x 1,000 ÷ Average Member Months =
Complaints per 1,000 Member Months

The STAR+PLUS program reported fewer complaints per 1,000 Members per month than did either Maryland or Ohio. The STAR+PLUS program reported less than one Member complaint per 1,000 Member months as indicated in Figure 6.8. Again, these results should be interpreted cautiously. The complaint data received on the STAR+PLUS program was gathered on a much smaller population than either the Maryland or Ohio data. Also, the Maryland and Ohio programs primarily serve non-disabled Medicaid clients whose health needs and perceptions may be vastly different from those enrolled in the STAR+PLUS program.

**Figure 6.8: Comparisons of Member Complainst per 1,000 Member Months**




## *E. Provider Complaint Analysis*

Despite the widespread introduction of Medicaid managed care, little research exists on physician satisfaction and physician perceptions regarding the impact of Medicaid managed care on patient care. Physicians and other health care providers provide critical information about the STAR+PLUS program. Provider complaint reports cannot substitute as satisfaction surveys for physicians and other providers participating in the STAR+PLUS program, but they can provide insights into trends and difficulties providers face. MCOs are required to keep provider complaint logs similar to the Member complaint logs.

Complaint logs must be submitted to TDHS each quarter as a contract deliverable. Each complaint log must contain the following information:

- The date upon which the complaint was filed
- A summary of the facts surrounding the complaint
- The date of resolution of the complaint

- An explanation of the procedure followed
- The outcome of the complaint process

Despite the similarities of the provider and Member complaint reporting process, one substantial difference exists. MCOs are not required to categorize provider complaints. For purposes of this report, PPRI categorized quarterly complaints reported by the MCOs into seven categories:

- Billing problems and/or overdue payments
- Contracting
- Prior-authorization for payment
- Incorrect payment rate
- Member Assignment problems
- Authorization of Services for Member
- Other problems

The three STAR+PLUS MCOs reported a total of 81 provider complaints from December 1997 through February 1999. Complaint totals are broken out by each State Fiscal Year (SFY) quarter for each reporting period they were available. This count most likely underreports the number of provider complaints for the period. One MCO indicated having no "written complaints" for several quarters. Providers that may have called or communicated their complaint in some fashion other than a written format appear not to be reported. Also, complaint logs varied for each MCO, making analysis of the complaints difficult. One MCO provided excellent detail of each provider complaint, while another provided only scant information.

Complaints associated with administrative and business issues were overwhelmingly the most frequently reported complaints, consisting of 88% of all complaints. Billing problems and overdue payments were the most often reported complaint type, accounting for 41% of all complaints. Billing complaints typically dealt with providers who had submitted claims and had not received payment from the MCO. Providers also frequently cited difficulties with bills that were rejected because they lacked ”authorization for payment." Authorization problems can be expected as providers adjust from a retrospective payment system in fee-for-service where services are typically rendered and bills are submitted for payment to a prospective payment system in managed care where providers must seek authorization from the MCO before providing many types of specialty care and tests. Providers offered few complaints to the MCOs about difficulties obtaining authorization for services for their patients, which suggests that STAR+PLUS physicians feel that STAR+PLUS recipients are getting access to appropriate referral care and tests from their physicians. Figures 6.9 and 6.10 provide a summary of all provider complaints received between December 1997 and February 1999.

**Figure 6.9: STAR+PLUS Provider Complaints per Quarter**

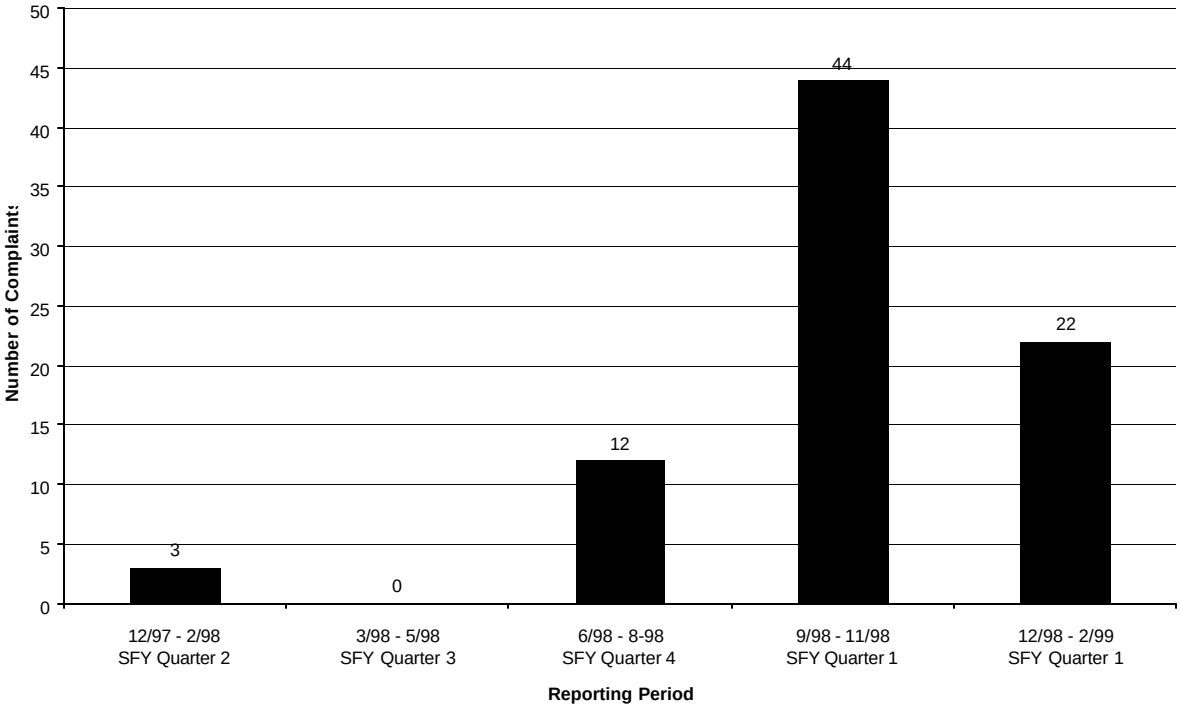
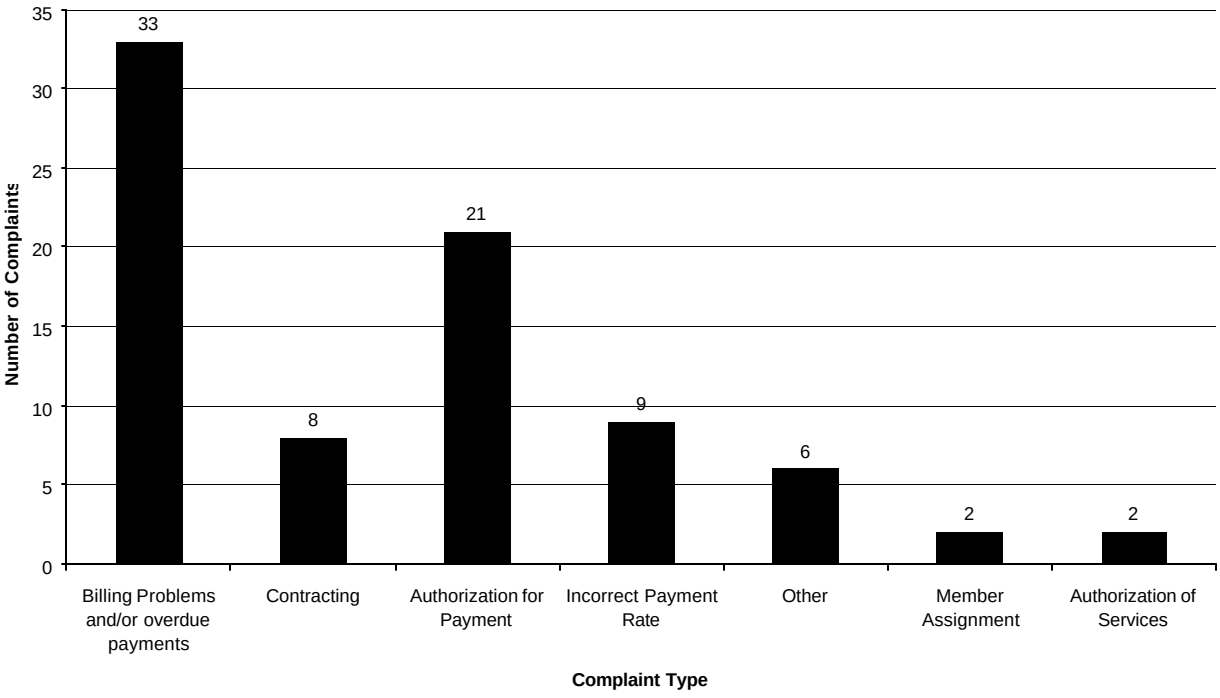



**Figure 6.10: STAR+PLUS Provider Complaints (December 1997 through February 1999)**



## *F. STAR+PLUS Member MCO Changes*

Unlike commercial and many other state Medicaid managed care programs, STAR+PLUS Members have the opportunity to change managed care plans on a monthly basis. The 1915(b) waiver stipulates that all participants required to join a managed care plan be afforded the opportunity to switch plans on a monthly basis.

Advocates contend that the best way to protect the well-being of individual enrollees is to ensure that they can effectively select among MCOs. Plan changes can disrupt continuity of care and may be an indication of dissatisfaction with a particular physician or MCO. Some argue that high rates of disenrollment provide an important signal to plan administrators that something is amiss with the MCO's practices.[13] However, a recent study completed of Medicaid recipients in Tennessee (TennCare) found that the primary reason that Medicaid enrollees switched plans was the desire to see a specific physician or another MCO. The report found that the majority of TennCare enrollees with chronic medical conditions did not switch MCOs when given the opportunity.[14] This seems to hold true for the STAR+PLUS program as indicated in Figures 6.11 and 6.12. While no trend is apparent in the STAR+PLUS Member MCO changes each month, the number of changes remains at or below 1% of the STAR+PLUS population each month. The highest number of plan changes came in September 1998 and January 1999, when 445 of the approximately 45,000 STAR+PLUS Members enrolled in a MCO switched plans.

[13] Schlesinger, M., Druss, B., & Thomas, T. No Exit? The Effect of Health Status on Dissatisfaction and Disenrollment from Health Plans. *Health Services Research*. Volume 31, Number 2. pp 547-571.

[14] Shifts in Enrollment in Managed Care Plans: A Survey of TennCare Enrollees (1998). Division of Health Care Services Evaluation.

**Figure 6.11: STAR+PLUS Member Requests for MCO Changes by Month**

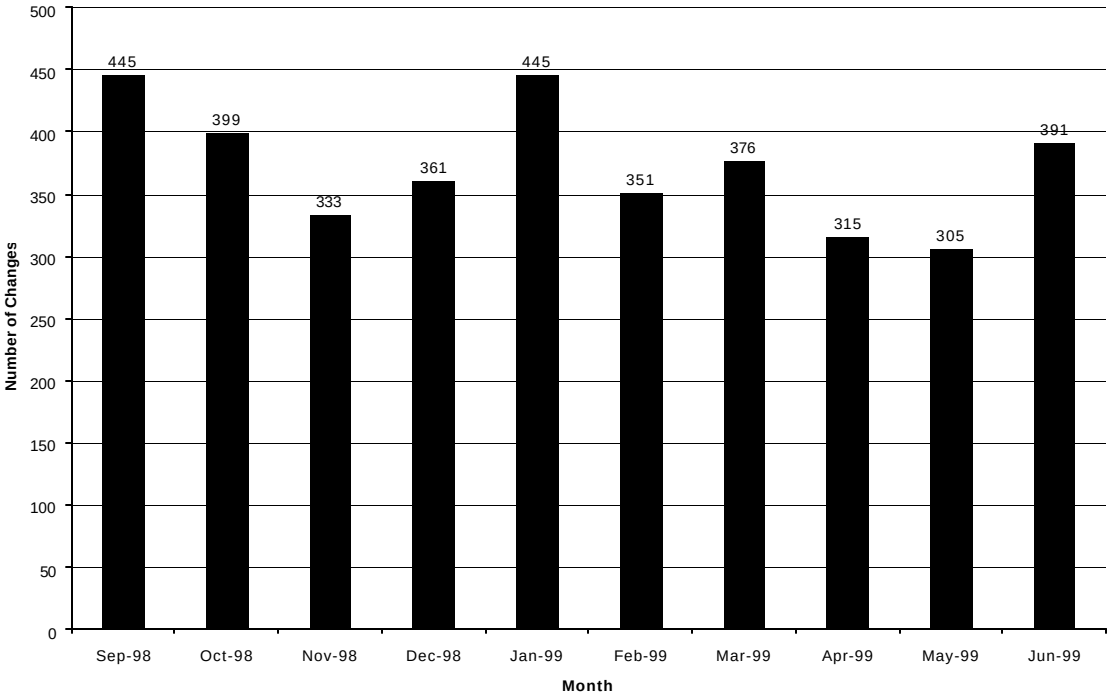
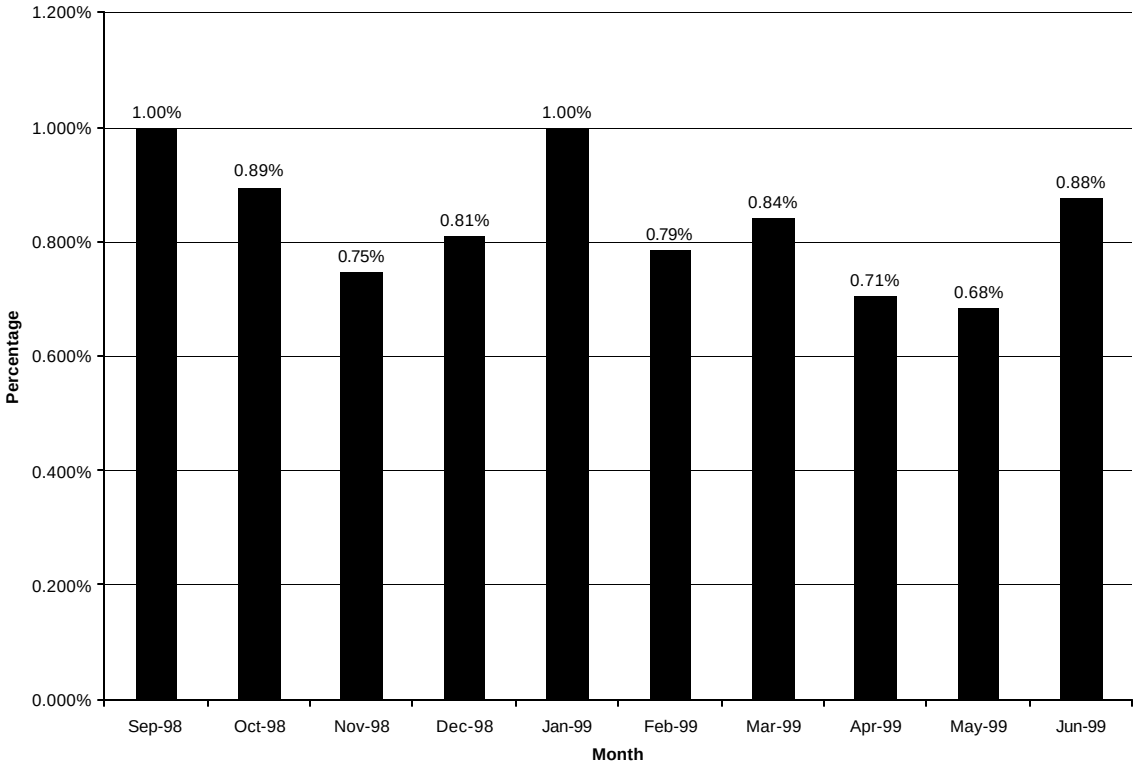



**Figure 6.12: STAR+PLUS Member Requests for MCO Changes as a Percentage of the STAR+PLUS Population**



## *G. Comparison Between STAR+PLUS And Fee-For-Service Member Satisfaction*

PPRI conducted a comparison survey for Member satisfaction in a non-managed care area (Dallas) in June and July 1999 using the Consumer Assessment of Health Plans (CAHPS) fee-for-service instrument. CAHPS is built on data gathered through focus groups and research about consumer needs for health care decision making. Similar to the Member satisfaction survey conducted by the Texas Health Care Quality Alliance (THQA) for STAR+PLUS Members, this comparison survey was split between adults and children (with parents or guardians completing the survey for the child).

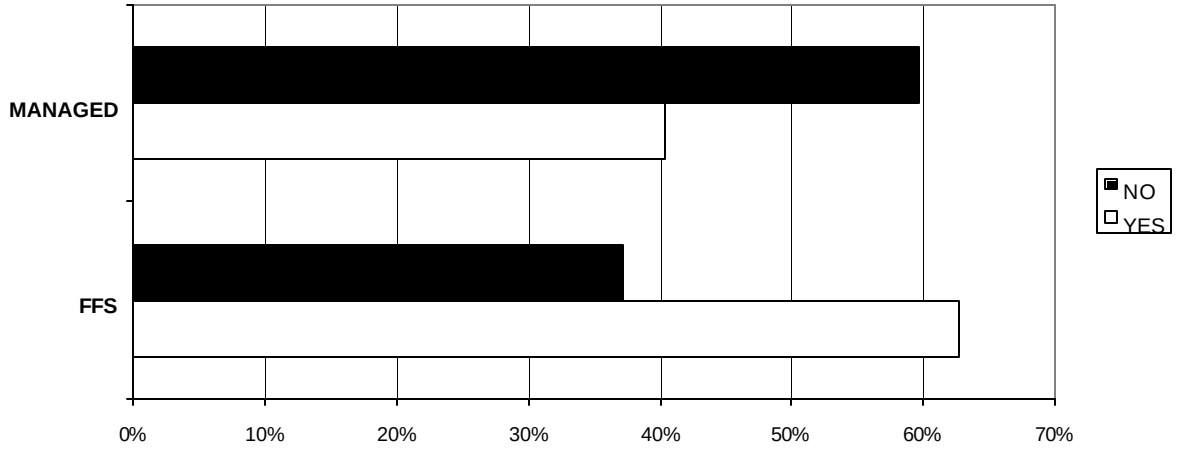
The CAHPS survey instruments used for the fee-for-service and managed care surveys differ somewhat due to differences in the two delivery systems. For example, the fee-for-service survey does not ask about satisfaction with a health plan. The age split for children and adults is slightly different in the two surveys, with THQA considering over age 15 as an adult, and PPRI using age 21. Only the common items from the surveys are considered in this analysis. Question numbers refer to the questions as numbered in the fee-for-service questionnaire (see Appendix D).

### 1. Findings on the comparison between fee-for-service and STAR+PLUS Adults

In general, responses to both the fee-for-service and STAR+PLUS surveys were quite positive. Few substantive differences were noted in the response patterns from the adult SSI clients in fee-for-service areas relative to those in the Houston STAR+PLUS pilot area.

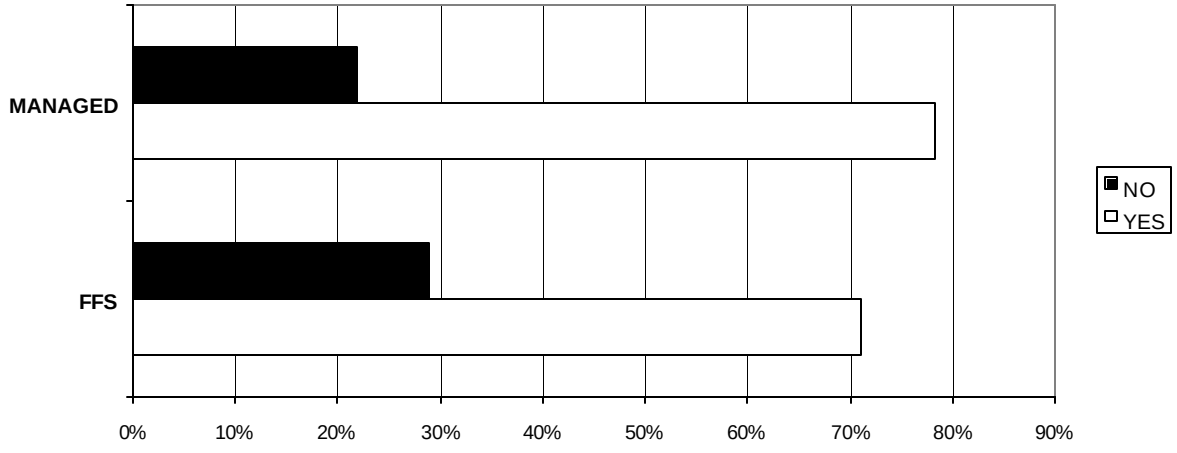
It appears that the only significant differences in responses from fee-for-service and STAR+PLUS respondents were directly related to differences in the structures of the delivery systems. The majority of fee-for-service patients had looked for a personal doctor or nurse in the previous year and the majority of those in managed care had not (Figure 6.13, 63% to 40% on Q2, sign<=.001). People in fee-for-service care were slightly less likely than those in managed care to have a personal doctor or nurse (Figure 6.14, 71% to 78% on Q4, sign<=.02). The fee-for-service clients were more likely to report using the emergency room at least once than were those in managed care (Figure 6.15, 38% compared to 23% on Q21, sign <=.001). None of the managed care patents reported using the emergency room more than one time, while 20 percent of FFS patients reported using it two or more times.

**Figure 6.13:**
**Q2 TRIED TO FIND PERSONAL DR/NURSE**



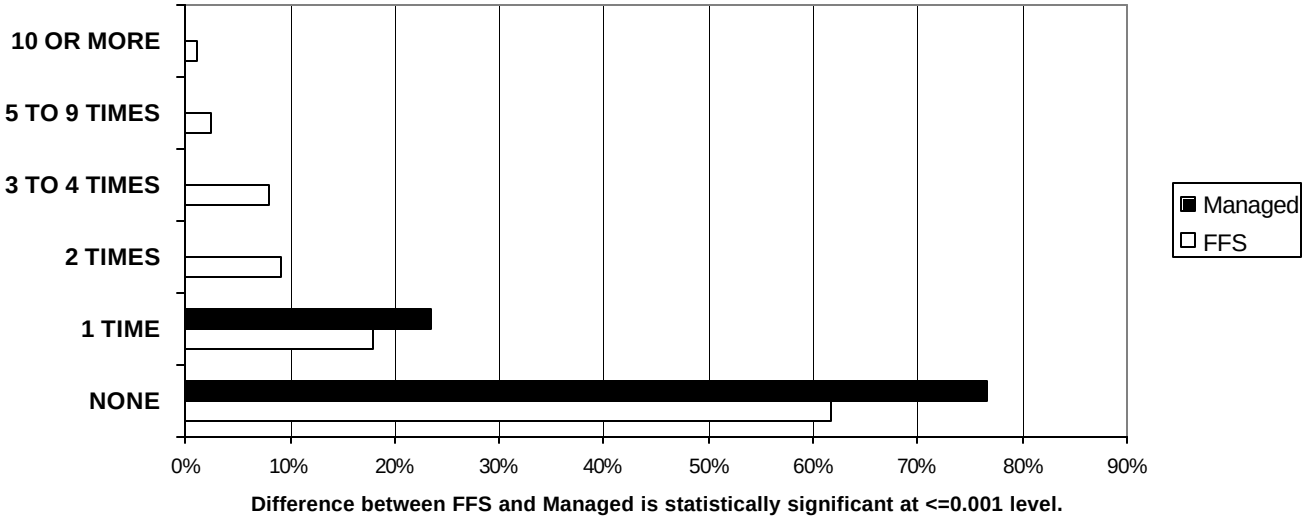

**Difference between FFS and Managed is statistically significant at <=0.001 level.**

**Figure 6.14:**
**Q4 ONE PERSON AS YOUR PERSONAL DR/NURSE**




**Difference between FFS and Managed is statistically significant at <=0.014 level.**

**Figure 6.15:**
**Q21 # OF TIMES EMERGENCY ROOM CARE**



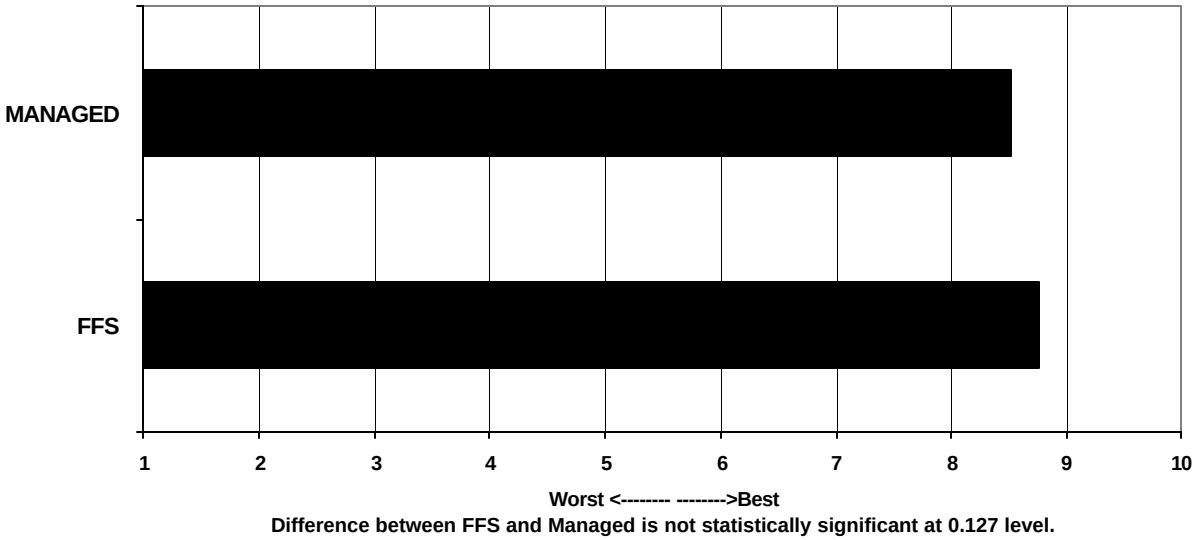

**Difference between FFS and Managed is statistically significant at <=0.001 level.**

### a) Personal doctor

Fee-for-service respondents were more likely to report trying to find a personal health care provider. Figure 6.14 suggests that those in the STAR+PLUS program are more likely to have an identifiable personal health care provider. This is a reasonable conclusion, since in STAR+PLUS, as in any managed care plan, must choose a PCP or one will be assigned to them.

The data presented in these two figures suggest that fee-for-service clients invest more effort in locating a regular provider, although less likely to report having a single provider. Managed care is structured so that Members have a PCP, so managed care Members are more likely to report having a personal doctor. Yet, nearly one quarter of the managed care recipients did not report that they had a single PCP. Among those who had a personal health care provider or PCP there was not an observable difference in the respondent ratings of the quality of their care (Figure 6.16, Q7, ns).

**Figure 6.16:**
**Q7 RATING OF PERSONAL DR/NURSE**

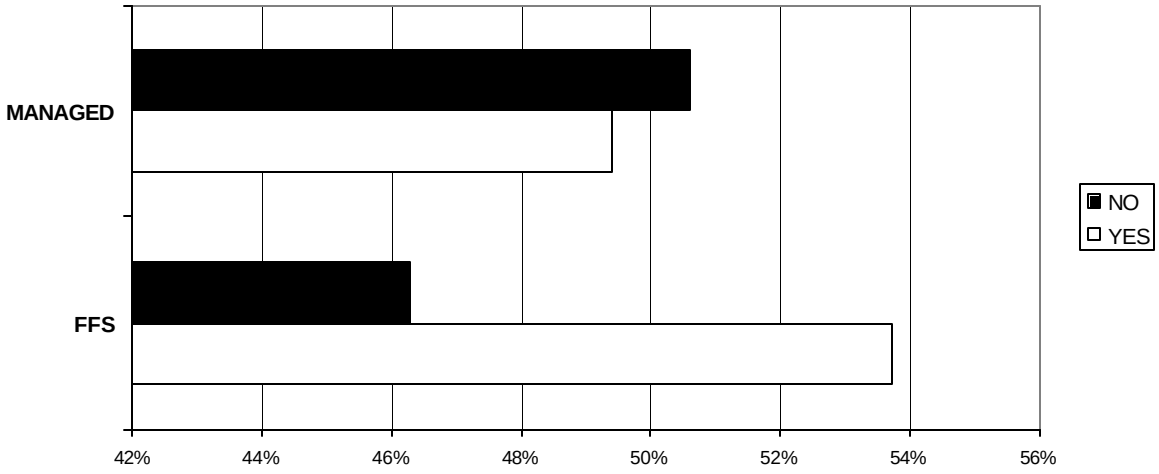



**Difference between FFS and Managed is not statistically significant at 0.127 level.**

## b) Self-Reported Health Care Services Utilization

In general, service utilization (self-reported by clients) did not differ appreciably between fee-for-service and managed care. There was no significant difference between FFS and managed care respondents in the number reporting needing a specialist (Figure 6.17, Q8, 54% vs. 49%, ns.). Very few Medicaid SSI recipients in either service delivery setting reported attempting to contact their provider for health care advice (fewer than 2%).

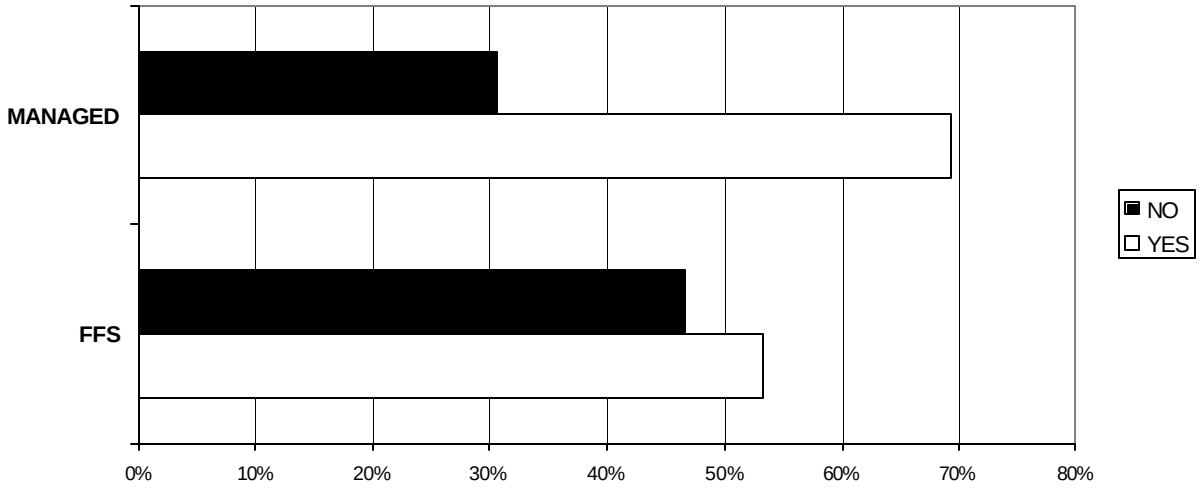
**Figure 6.17:**
**Q8 THOUGHT NEEDED A SPECIALIST**




**Difference between FFS and Managed is not statistically significant at 0.196 level.**

A significantly lower number of fee-for-service respondents than managed care respondents reported trying to see their doctor (Figure 6.18, Q16,53% and 69%, sign<=.001) These data suggest that STAR+PLUS Members were somewhat more likely to report accessing health care services during the preceding six month window than were those in comparable fee-for-service areas in Texas. STAR+PLUS Members were considerably less likely to report emergency room contacts during the preceding six months than their fee-for-service counterparts (see Figure 6.15, Q21, sign<=.001). No STAR+PLUS Members reported multiple emergency room contacts, while nearly 20% of the fee-for-service recipients reported more than one emergency room visit during the six month period immediately preceding the survey.

**Figure 6.18:**
**Q16 TRY TO SEE DR. FOR ILLNESS LAST 6 MONTHS**




**Difference between FFS and Managed is statistically significant at <=0.001 level.**

## c) Provider Satisfaction Ratings

Ratings of satisfaction with providers did not differ significantly between fee-for-service and STAR+PLUS respondents. Aspects of interaction with providers were rated using one of two scales. One scale asked respondents to rate the aspect of care from 0 to 10, with 10 reflecting the most positive response. The other scale asked respondents to rate the aspect of care from 0 to 4, with 4 being the maximum positive score. For questions with a 10 point scale, only one received a score of less than 8. For questions using the 4 point scale, neither group's average rating was below 3.3.

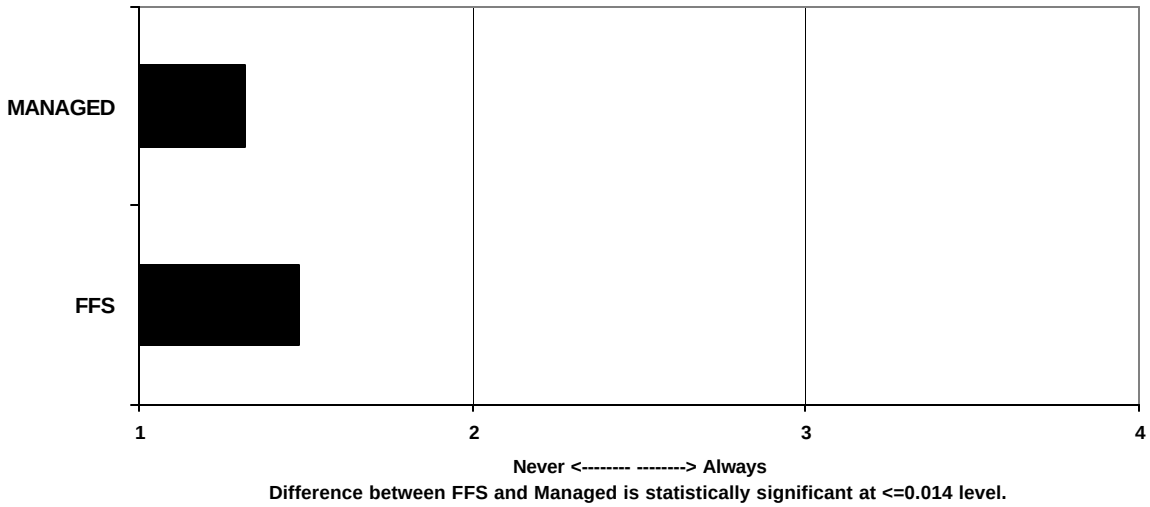
Respondents were asked to rate their interactions with their provider and staff. Most of the differences between ratings given by fee-for-service and managed

care respondents were not statistically significant. For example, no differences were noted on whether the provider:

- treated the respondents with courtesy and respect;
- was viewed as helpful;
- almost always listened to what the recipient had to say;
- explained things in an understandable way;
- showed respect for what the recipient had to say,
- spent enough time with the recipient, and
- involved the recipient in the decision making process to the degree they wished to participate.

Statistically significant differences between fee-for-service and STAR+PLUS responses resulted from one question on the surveys. The fee-for-service patents were slightly more likely to indicate frequently having a hard time speaking with or understanding the doctor (Figure 6.19, Q27, FFS-1.48, MC-1.32, p<.02).

**Figure 6.19:**
**Q27 HARD TIME SPEAKING WITH OR UNDERSTANDING**




## d) Summary of Adult Findings

In general, these findings indicate that STAR+PLUS clients and comparable fee-for-service clients are similarly satisfied with the care they receive from Medicaid. Results also indicate that the managed care recipients are more likely to have recently seen their provider for routine care and less likely to have visited the emergency room on multiple occasions.

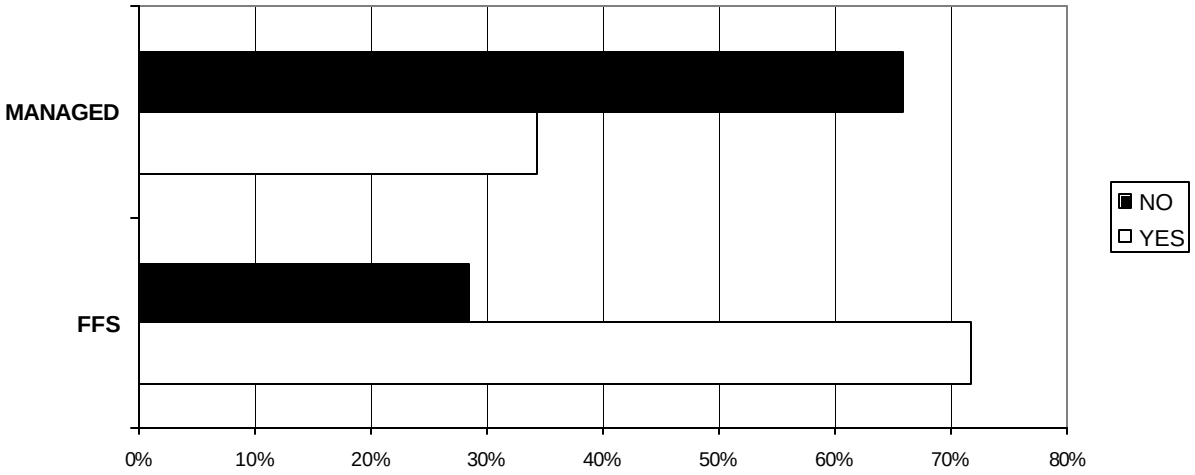
## 2. Findings on the comparison between fee for service and STAR+PLUS Children

In general, responses from parents with children served in fee-for-service and in STAR+PLUS are quite similar. Where differences do exist, they do not indicate a pattern of advantage for either system.

### a) Personal doctor

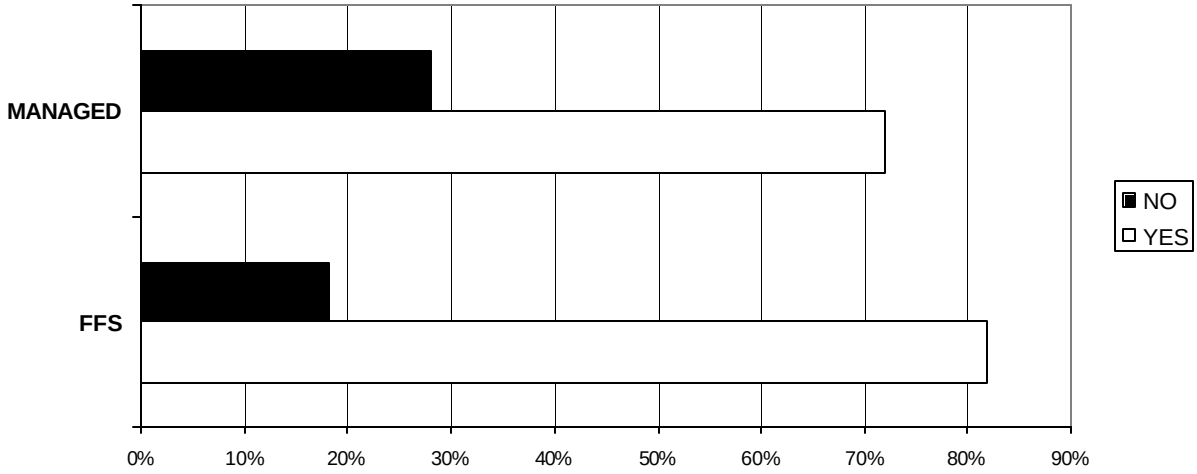
Parents of children in fee-for-service were much more likely than those in STAR+PLUS to indicated they had tried to find a personal doctor or nurse (Figure 6.20,72% to 34% on Q2, sign<=.001). Those in fee-for-service were slightly more likely to report having someone they think of as a personal doctor or nurse (Figure 6.21, 82% to 72% on Q4, sign<=.002). Parents of those in fee-for-service were somewhat more likely to think their child needed to see a specialist (Figure 6.22,58% to 46% on Q9, sign<=.001).

**Figure 6.20:**
**Q2 TRY TO FIND PERSONAL DOC OR NURSE FOUR CHILD**



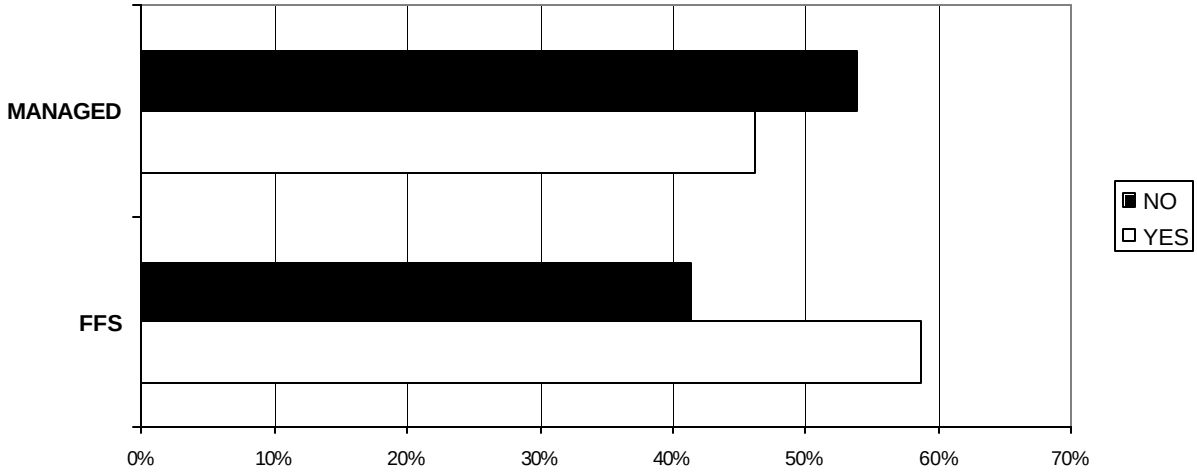

**Difference between FFS and Managed is statistically significant at <=0.001 level.**

**Figure 6.21**
**Q4 DO YOU HAVE 1 PERSON YOU THINK OF PERS DOC**




**Difference between FFS and Managed is statistically significant at <=0.002 level.**

**Figure 6.22**
**Q9 THOUGHT CHILD NEEDED TWO SEE SPECIALIST**

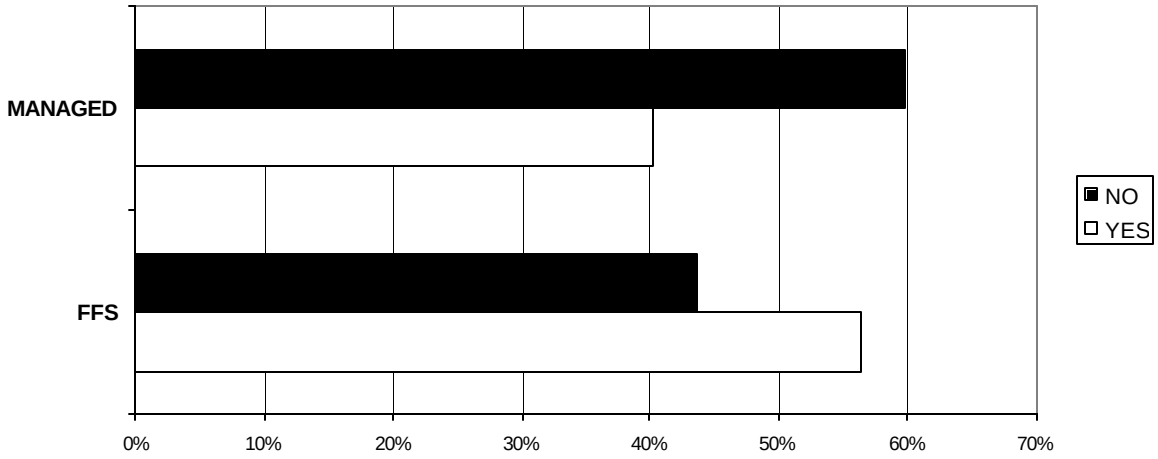



**Difference between FFS and Managed is statistically significant at <=0.001 level.**

### b) Access to and Availability of Health Services

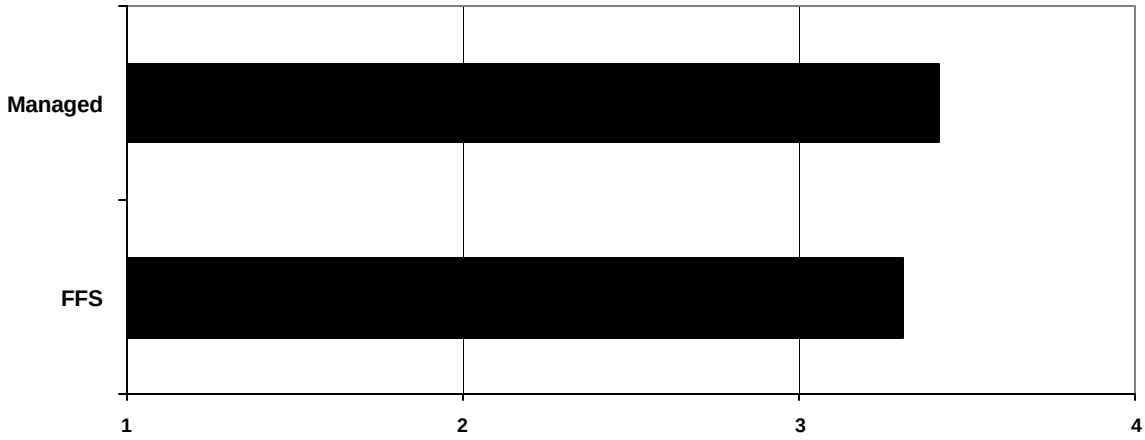
Parents in the fee-for-service sample were somewhat more likely than those in STAR+PLUS to say they had tried to see a doctor right away for care (Figure 6.23, 56% to 40% on Q17, sign<=.001). Those who tried to see a doctor right away were equally likely to be seen as soon as they wanted, with over half in each system reporting "always" (Figure 6.24, Q18) There was a slight tendency for fee-for-service to go to the doctor more often. (Figure 6.25, Q23, sign<=.03).

**Figure 6.23:**
**Q17 DID YOU TRY TO SEE DOC RIGHT AWAY FOR CARE**




**Difference between FFS and Managed is statistically significant at <=0.002 level.**

**Figure 6.24:**
**Q18 HOW OFTEN DID YOU SEE DOC AS SOON AS WANT**




**Never<-------- --------> Always**
**Difference between FFS and Managed is not statistically significant at 0.243 level.**

### c) Provider Satisfaction Ratings

Ratings of satisfaction with providers did not differ significantly between fee-for-service and STAR+PLUS respondents. Aspects of interaction with providers were rated using one of two scales. One scale asked respondents to rate the aspect of care from 0 to 10, with 10 reflecting the most positive response. The other scale asked respondents to rate the aspect of care from 0 to 4, with 4 being the maximum positive score. For questions with a 10 point scale, only one question received a mean score of less than 8. For questions using the 4 point scale, neither group's average rating was below 3.3.

Respondents were asked to rate their interactions with their provider and staff. Most of the differences between ratings given by fee-for-service and STAR+PLUS respondents were not statistically significant.

There were statistically significant differences on the following questions, but these differences are probably not large enough to indicate an important divergence (Please See Appendix for the graphs below):

- overall rating of child's health care (Q42, FFS-8.7, Managed-8.2, sign<=.003),
- child's health plan (Q60, FFS-8.8, Managed-8.2, sign<=.0001),
- how often have a hard time speaking with the doctor (Q28, FFS-1.30, Managed-1.4, sign<=.05).

Responses to most questions indicated little difference in reported satisfaction with STAR+PLUS. Differences in responses to the following questions were found not to be not statistically significant:

- rating of the child's doctor or nurse (Q18),
- how often did the child get the care when wanted (Q20),
- how often were they treated with respect (Q25),
- how often was the staff as helpful as should be (Q26),
- how often carefully listened (Q27),
- how often explain so understand (Q34),
- how often spend enough time (Q36),
- how often involve parents in decisions (Q39),
- how often parent got interpretation when needed (Q44),
- and how often the child got an explanation (Q46).

### d) Summary of child survey findings

Both STAR+PLUS and fee-for-service parents appear equally satisfied with the care their children are receiving in the Medicaid program. There were few statistically significant differences and those differences that did exist are probably not substantively important. It appears that neither fee-for-service or STAR+PLUS produces a different level of consumer satisfaction.

# VII. Cost Effectiveness

## A. Introduction

As a condition of HCFA 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 with costs based on the allocated upper payment limit (UPL) 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, 1998 – Jan, 1999; Waiver Year 2: Feb, 1999 – Jan, 2000). 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.

## B. Background

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) Medicare/ Medicaid clients[15]. The PCCM model was 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 Only

- Other Community Care (OCC): Clients at-home, can receive acute care and long-term care services

[15] A description of these classifications is provided in the Methodology report of this project, ----?

- 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

Medicare/ Medicaid 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

Under the above scenario, the analysis of the cost effectiveness can be broadly explained as follows. 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 the Upper Payment Limit (UPL) 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.

## C. Evaluation of Cost

Tables 1-4 in Appendix A provide a detailed break-down of the cost analysis. The total estimated cost[16] for each waiver year and the corresponding Member months are presented in Table 7.1 below.

**Table 7.1: Estimated Saving Under Managed Care**

| | Waiver Year 1 | Waiver Year 2 | Waiver Years 1 & 2 |
|---|---|---|---|
| Member months without waiver (Yr total) | 745,656 | 779,184 | 1,524,840 |
| Est. costs without waiver ($) | 302,662,263 | 344,126,366 | 646,788,629 |
| Est. cost per Member month per month ($) | 405.90 | 441.65 | 424.17 |
| Member months under waiver (Yr total) | 733,148 | 740,042 | 1,473,190 |
| Est. costs under waiver ($) | 299,552,806 | 319,273,778 | 618,826,584 |
| Est. cost per Member month per month ($) | 408.58 | 431.43 | 420.06 |
| Est. cost w/o waiver for comparable MM ($) | 297,585,258 | 326,839,314 | 624,880,342 |
| Est. savings under the waiver ($) | -1,967,548 | 7,565,536 | 6,053,758 |
| Est. savings per Member month per month ($) | -2.68 | 10.22 | 4.11 |

## D. Assumptions and Limitations

- The Upper Payment Limit (UPL) rates for services that were used in computing the without-waiver costs were those initially agreed upon between HCFA and DHS. According to DHS, these rates were computed using incorrect data that overstated the fee-for-service costs. Consequently, it should be noted that the savings posted above may be slightly exaggerated.
- Vendor drug program costs included only those costs that were directly due to the change in policy from the implementation of managed care. Specifically, these constituted cost of unlimited prescriptions for PCCM clients over 21 years of age and Medicaid Only at-home MCO clients over 21.

[16] The total cost reflects only those additional Vendor Drug or Administrative costs due to the implementation of managed care. They do not include the costs of those items that did not change due to managed care.

- Administrative costs that were included in the total costs were those due to the change in policy, just as in the case of vendor drug costs. Thus, it was assumed that other administrative costs incurred in the waiver years were not affected by the implementation of managed care.

## *E. Summary of Findings*

The above analysis shows a projected additional cost of $1.9 million due to the implementation of managed care in the first waiver year (February 1998 through January 1999). This corresponds to a rate of $2.68 per Member per month. In the second waiver year, managed care posted a saving of seven and a half million dollars. The rate of savings here was $10.22 per Member per month.

For the combined two years, the implementation of STAR+PLUS resulted in estimated savings of $6 million, which converts to approximately $4 per Member per month. STAR+PLUS may have resulted in some savings to the State, but these savings were less than one percent of the cost for the combined two years.

# VIII. Conclusions and Recommendations

Effective program evaluation is critical to the success and future of the STAR+PLUS program. Despite data limitations, it appears that the STAR+PLUS program was able to focus on improving access to care, reducing costs and improving quality during the first two years of the waiver.

## *A. Access to Care*

In general, MCOs with commercial business or with Medicaid contracts in other service areas of the state were able to start up evaluative and monitoring activities related to access a bit quicker than start-up MCOs. Future state or independent reviews should have the benefit of more evaluation data to review and analyze. The State is appropriately notifying each STAR+PLUS MCO regarding the THQA on-site survey results as part of the renewal review process, asking each MCO to respond with a corrective action plan, if appropriate, prior to renewal.

Provider capacity appears to have increased under the STAR+PLUS program, but an unduplicated count of providers is difficult to obtain with current data.

- **Recommendation -** Provider capacity may need to be evaluated in the context both of the STAR and STAR+PLUS programs in the Harris Service Area, rather than STAR+PLUS alone since MCOs participate in both programs. Furthermore, the State should consider appropriating more resources to develop data systems or methods to reliably track the number of providers participating in the Medicaid managed care program to assess both attrition and an accurate number of providers on a quarterly or yearly basis.

No clear evidence emerged suggesting that access to care has been restricted in the STAR+PLUS program. Review of certain indicators of access, such as selected utilization management tables, indicated some positive trends, but were largely inconclusive. While the rates of inpatient discharges and emergency room use did appear to decline over several quarters from the implementation of the STAR+PLUS program, these findings are inconclusive. Overall utilization management data was questionable and has not been validated.

- **Recommendation -** TDHS must establish a system of validating contract deliverables, such as the utilization management tables. Furthermore, MCOs must dedicate adequate resources and systematically coordinate with TDHS to developing higher quality, accurate contract deliverables. The State's current efforts to streamline the Utilization Management tables for State Fiscal Year 2000 MCO reporting should help by streamlining reporting requirements. Focusing on a few reports, selected for appropriateness of the STAR+PLUS population, and insisting on correct and timely submissions from the

contracted MCOs should enhance data quality and afford TDHS the information to make any necessary program changes.

In the absence of data, the onsite reviews by THQA were very helpful. The STAR+PLUS MCOs received high marks in the areas of: 1) Health Services Availability, Accessibility, and Adequacy, and 2) Access Performance Standards.

- **Recommendation -** Onsite monitoring provides some of the only real evidence of MCO behavior and compliance with the contract requirements in the STAR+PLUS program. TDHS should continue to invest in quality monitoring, especially since obtaining reliable and accurate encounter data remains a significant obstacle to measuring quality and access.

## *B. Quality of Care*

Despite a lack of reliable and comprehensive data, there is no indication that the STAR+PLUS program has quality of care problems. Attempts to produce comparative analyses of the STAR+PLUS program to other commercial and Medicaid managed care programs were unsuccessful because of STAR+PLUS's unique quality assurance reporting requirements. Four out of five states reviewed for this report require audited Health Employer Data Information Set (HEDIS) reporting for their contracted MCOs. Many commercial MCOs also report HEDIS data which enables groups such as the Texas Health Care Information Council to assess that information and develop MCO report cards.

- **Recommendation -** TDHS should consider using nationally accepted reporting standards, such as HEDIS. HEDIS measure reporting will not be appropriate for Texas Medicaid Managed Care and the STAR+ Program as long as the average span of eligibility remains six months. In the absence of guaranteed eligibility or lock-in periods, the STAR+PLUS Program should continue to hone and streamline quality measures, with a goal of an efficient, effective, trim set of HEDIS-like performance measures, adapted for Texas, that can be maintained over time for trending purposes.

The STAR+PLUS care coordinators appear to be doing an excellent job for the chronically ill and disabled Members who need their assistance the most. A THQA analysis found that two out of the three MCO's care coordinator were appropriately assigned to Members who required their assistance.

- **Recommendation -** Again, onsite monitoring provides some of the only real evidence of MCO behavior and compliance with the contract requirements in the STAR+PLUS program. TDHS should continue to invest in quality monitoring, especially since obtaining reliable and accurate encounter data remains a significant obstacle to measuring quality and access.

The STAR+PLUS complaint data likely underestimates complaints from both Members and providers. While there was no indication that complaints represent significant problems in the STAR+PLUS program, ambiguity in the reporting process created several problems. Complaints that are taken by the Enrollment Broker are frequently not forwarded to the MCO because they appear to be resolved over the telephone. Complaints that are forwarded to the MCO by the Enrollment Broker are difficult to track. Furthermore, complaint categories set up by TDHS have no written definitions.

- **Recommendation -** TDHS must establish a more effective system for tracking complaints. Furthermore, MCOs must dedicate adequate resources and systematically coordinate with TDHS to assure that all MCOs are developing high quality, accurate complaint deliverables. TDHS might consider a system to assign a unique identifier to each complaint, so that complaints may be more easily tracked from receiving through the resolution process. TDHS might also consider standardization of the complaint reporting process, clearly defining each of the complaint categories, providing training, coordination, and support to ensure more accurate reporting. Finally, TDHS should require all MCOs to add the following categories to their complaint reporting: Value-Added Services, Administrative Concerns, Quality of Care, Unhappy with Health Plan, Disagreement with Treatment Plan, and Never Received ID Card. Furthermore, because the default process appears to impact Member complaints, the State should periodically evaluate the default system to ensure that correct assignments are made and that the State's goals for access are being achieved.

STAR+PLUS Members and those receiving services in traditional fee-for-service Medicaid are similarly satisfied with the care they receive from Medicaid. STAR+PLUS Members indicated that they have seen their provider for routine care more recently than did their fee-for-service counterparts. Furthermore, STAR+PLUS Members also reported that they were less likely to visit the emergency room on multiple occasions, a finding that is consistent with the analysis reported from the utilization management tables.

- **Recommendation -** Managed care and fee-for-service comparisons are interesting, yet the State has not gathered any pre and post-implementation satisfaction ratings on the same Members. In future studies, the State may want to consider surveying Medicaid clients before they enter managed care systems and again after those clients have had some experience in managed care to provide direct comparisons of Medicaid managed care to fee-for-service.

In general, the SSI population has a high incidence of mental illness. Complaint data should therefore reflect some proportion of behavioral health services. However, both Member and provider complaints from the behavioral health arena were virtually non-existent.

- **Recommendation -** THQA is planning a review of behavioral health services, but additional evaluation of behavioral health services may be needed.

## *C. Cost-Effectiveness*

For the waiver period of February 1999 through January 2000, STAR+PLUS will save an estimated $6 million over State costs had the waiver not been in effect. PPRI analyzed the projected costs for each risk group without the waiver versus the actual and projected costs incurred for each risk group with the waiver.