

**The Children's Health Insurance Program in  
Texas:  
The Established Enrollee Survey Report  
Fiscal Year 2006**

**Measurement Period:  
December 2005 – April 2006**

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**Submitted:  
July 2, 2006**

**Final Submitted:  
November 13, 2006**

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# Overview

<b>Report Title:</b>	<b>The Children's Health Insurance Program in Texas: The Established Enrollee Survey Report for Fiscal Year 2006</b>
<b>Prepared by:</b>	<b>The Institute for Child Health Policy University of Florida</b>
<b>Measurement Period:</b>	<b>December 2005 – April 2006</b>
<b>Date Submitted by EQRO:</b>	<b>July 2, 2006</b>
<b>Final Submitted by EQRO:</b>	<b>November 13, 2006</b>

## Purpose

The purpose of this report is to present the results of telephone-based consumer satisfaction surveys conducted from December 2005 through April 2006 with the parents of children enrolled in the Children's Health Insurance Program (CHIP) in Texas during fiscal year 2006. More specifically, the intent of this report is to:

- describe the sociodemographic characteristics and health statuses of children enrolled in CHIP for 12 months or longer;
- document the presence of a usual source of care;
- describe parental satisfaction with their children's health care;
- describe the need and availability of specialty care for established enrollees;
- compare the parental satisfaction scores of managed care organizations (MCOs) participating in CHIP; and
- identify the impact of policy changes implemented since fiscal year 2004 on families' satisfaction levels with CHIP in Texas.

## Summary of Major Findings

There are some specific areas in which the results of the fiscal year 2006 established enrollee survey are very similar to those of the fiscal year 2004 survey. Areas of similarity include the following:

- As in the fiscal year 2004 survey, overall reported need for specialized therapies was low. Less than one percent of respondents reported their child needed home health care, three percent reported their child needed specialized medical equipment, four percent reported that their child needed physical, occupational, or speech therapy, and seven percent reported that their child needed mental health therapy.
- Overall, 40 percent of children needed care, tests, or treatment. This is similar to the 41 percent of children who were reported to need care, tests, or treatment in the fiscal year 2004 survey.
- While there are no specific standards about what would constitute an acceptable score for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey composite scores, a score of 75 points was used to indicate that families "usually" or "always" had positive experiences with a particular composite. Using this criterion, overall, CHIP performed well in the areas of Getting Needed Care (85 points), Doctor's Communication (89 points), Doctor's Office Staff (88 points), Health Plan Customer Service (90 points), Obtaining Prescription Medication (94 points), Obtaining Specialized Services

(78 points), Shared Decision Making (81 points), and Getting Needed Information (82 points). However, improvement is needed in the areas of Getting Care Quickly (66 points), Relationship with a Personal Doctor or Nurse (68 points), and Care Coordination (70 points). Results are very similar to those in the fiscal year 2004 report with the exception of one score - Obtaining Specialized Services. There was an overall improvement in respondent rating with the score increasing from 71 points in 2004 to 78 points in 2006.

- The CAHPS Health Plan Survey composite results for children with special health care needs (CSHCN) and children without special health care needs are very similar and within four points for seven of the 11 composite scores, including Getting Needed Care, Doctor's Communication, Office Staff, Prescription Medication, Specialized Services, Shared Decision Making, and Getting Needed Information. Since these analyses were not conducted for the fiscal year 2004 survey report, there is no comparative data.
- There was some variation in the CAHPS Health Plan Survey composite scores among the four racial/ethnic groups. Caregivers who were categorized as Other, non-Hispanic had the lowest scores for seven of the 11 composite scores. Since these analyses were not conducted for the fiscal year 2004 survey report, there is no comparative data.
- In both fiscal year 2004 and fiscal year 2006, there were significant differences between the MCOs in their performance on the CAHPS Health Plan Survey clusters after controlling for enrollee health status and race/ethnicity. For fiscal year 2006, Amerigroup, Parkland, and Community First performed significantly worse than the reference MCO (the MCO with the highest score for the cluster) in at least ten of the 11 CAHPS Health Plan Survey clusters in the multivariate analyses. In fiscal year 2004, Amerigroup, Parkland, El Paso First, and Superior (in CSA 7 and CSA 11) performed significantly worse than the reference MCO in at least six of the nine CAHPS clusters.

There are some specific areas in which the results of the fiscal year 2006 survey differ from that of the fiscal year 2004 survey. These areas include the following:

- Sixty-five percent of the children in families who responded to the Established Enrollee Survey were Hispanic. This is larger than the 59 percent of Hispanic families who responded to the survey in fiscal year 2004.
- Twenty-two percent of children were identified as having a special health care need based on the CSHCN Screener. This figure is two percentage points higher than the 20 percent of children identified as having a special health care need in the fiscal year 2004 survey; however, the difference is not statistically significant.
- Overall, 86 percent of respondents reported their child has a personal doctor or nurse. This is higher than the 81 percent of respondents who reported their child had a usual source of care in the fiscal year 2004 survey.
- Overall, 22 percent of respondents reported their child needed to see a specialist in the past six months. This is slightly lower than the 25 percent of respondents to the 2004 survey who reported their child needed to see a specialist.
- Of those children who needed to see a specialist, 66 percent of respondents reported obtaining a referral to specialty care was not a problem. This is lower than the 72 percent who indicated obtaining a referral was not a problem in the fiscal year 2004 survey.

## **EQRO Recommendations**

The Texas Health and Human Services Commission (HHSC) may wish to consider the following strategies when developing future policy regarding health insurance for children from low-income families:

- **Strategies to increase performance related to getting care quickly, caregivers' relationship with child's personal doctor or nurse, and care coordination should be explored.** Each of these areas overall fell below the 75 point criterion. Strategies should be developed to address deficiencies in these areas, including: (1) reviewing MCO provider panels to ensure adequate numbers of providers, (2) reviewing authorization procedures to ensure that care can be rendered quickly, and (3) reviewing policies that impact the doctor-patient relationship.
- **Strategies to address differences in MCO performance should be considered.** Some significant differences exist among MCOs in performance on the CAHPS Health Plan Survey clusters. Three MCOs performed significantly worse than the highest performing MCOs for ten or more clusters. Two of the three MCOs also performed poorly in the fiscal year 2004 report. A review should be conducted with these MCOs to develop a plan to address consumer satisfaction.
- **Specifically monitor the quality of care provided to CSHCN.** The HHSC routinely monitors the care that CSHCN receive in CHIP. In the past, this monitoring was included in reports examining overall CHIP quality of care. Beginning in July 2006, HHSC implemented CSHCN-specific reporting to focus specifically on this vulnerable population of children. The monitoring will include CHIP and Medicaid and will address access to specialty care.

## Introduction

Assessing parental satisfaction and their experiences with their children's health care is an important measure of the quality of children's health care.<sup>1</sup> Studies have shown that satisfaction ratings reflect parent expectations of their child's health care and provide implicit ratings of parents' judgment about the overall delivery of their child's health care services.<sup>2,3</sup> Parental satisfaction with child health care is also known to be associated with positive health care behaviors such as adhering to treatment plans and appropriate use of preventive health care services.<sup>4</sup>

The Texas Health and Human Services Commission (HHSC) contracted with the Institute for Child Health Policy (IHP) to evaluate parents' experiences and satisfaction with their children's health care while enrolled in the Children's Health Insurance Program (CHIP). Parents of children enrolled in CHIP for 12 months or longer were interviewed using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 3.0.<sup>5</sup> The interviews were conducted between December 2005 and April 2006. Parental experiences and satisfaction with CHIP are assessed every two years, and the last report is from fiscal year 2004 - "Child Health Insurance Program in Texas: The Established Enrollee CAHPS Survey Report for SFY 04."

Since fiscal year 2004, the State of Texas implemented several major policy changes, including:

- asset testing for children with families with incomes at or above 150 percent of the Federal Poverty Level (FPL);
- change to collecting the first month's premium on initial enrollment but not at renewal;
- restoration of benefits, including hospice care services, skilled nursing care, tobacco cessation programs, vision care, chiropractic services, and behavioral health services;
- increased behavioral health benefits, including increases in inpatient and outpatient mental health benefits, increases in inpatient and outpatient substance abuse benefits, and the addition of medically necessary inpatient detoxification/stabilization services; and
- reinstated collection of cost sharing obligations for families using the following criteria:
  - families at 133-150 percent of FPL paying \$25 per six-month enrollment period per family;
  - families at 151-185 percent of FPL paying \$35 per six-month enrollment period per family; and
  - families at 186-200 percent of FPL paying \$50 per six-month enrollment period per family.

After these additional policy changes were implemented, the number of children enrolled in CHIP in Texas declined from 359,734 in August 2004 to 294,189 in April 2006—over 18 percent. This is in addition to the 29 percent enrollment drop that occurred between September 2003 and July 2004. These figures were calculated using CHIP enrollment files provided to IHP.

The purpose of this report is to present the results of telephone-based consumer satisfaction surveys conducted from December 2005 through April 2006 with the parents of children enrolled in CHIP in Texas during fiscal year 2006. More specifically, the intent of this report is to:

- describe the sociodemographic characteristics and health status of children enrolled in CHIP for 12 months or longer;
- document the presence of a usual source of care;
- describe parents' experiences and satisfaction with their children's health care;
- describe the need and availability of specialty care for established enrollees;

- compare the scores on the CAHPS Health Plan Survey of managed care organizations (MCOs) participating in CHIP; and
- identify the impact of policy changes implemented since fiscal year 2004 on families' satisfaction levels with CHIP in Texas.

## Methods

### *Sample Selection Procedures*

A stratified random sample of families was selected to participate in this survey, which is called the Established Enrollee Survey. To be eligible for inclusion in the sample, the child had to be enrolled in CHIP in Texas for 12 continuous months in the past year. This criterion was chosen to ensure that the family had sufficient experience with the program to respond to the questions. The sample was stratified to include representation from the 13 CHIP MCOs.

A target was set of 3,900 completed telephone surveys. This sample size was selected to (1) provide a reasonable confidence interval for the survey responses and (2) to ensure there was a sufficient sample size to allow for comparisons between MCOs. The Established Enrollee Survey is comprised of many different types of questions, and the confidence interval information provided is based on selected items with uniformly distributed responses. The information presented is provided as a “worst case” guideline only. Using a 95 percent confidence interval, the responses provided in the tables and figures are within  $\pm 1.55$  percentage points of the “true” response.<sup>6</sup> The “true” response is the response that would be obtained if there were no measurement error. The stratification strategy along with the number of complete interviews is depicted in **Table 1**.

**Table 1. CHIP in Texas MCO Stratification Strategy**

Survey Areas	Completed Interviews (N=3,904)
Amerigroup	300
El Paso First	300
Community First	300
Cook Children’s	300
Driscoll	300
FIRSTCARE	301
Mercy	300
Parkland	300
Seton	301
Texas Children’s	300
Superior	300
Superior EPO	301
UTMB	301
<b>TOTAL</b>	<b>3,904</b>

Attempts were made to contact 9,504 families. Using the contact information provided, 78 percent of families were located and 20 percent refused to participate. The response rate was 68 percent and the cooperation rate was 78 percent.<sup>7</sup> These contact, refusal, response, and participation

rates are comparable to those obtained with other low-income families in Medicaid and in State Children's Health Insurance Programs.<sup>8,9,10</sup> There were 3,904 completed surveys.

Using the following characteristics, survey responders were compared to those who could not be located and to those who were located but refused to participate: child race/ethnicity, gender, age, and family income. No significant differences were found between survey responders and those not located or refusing to participate. Due to random sample selection procedures and the lack of significant differences between responders and non-responders on key sociodemographic indices, the results of this survey are believed to be generalizable to the larger group of established enrollees.

## **Data Sources**

Two data sources were used in these analyses. First, the Enrollment Broker for CHIP in Texas provided enrollment files to ICHP. These files were used to (1) identify the children who met the sample selection criteria, (2) obtain contact information for the families, and (3) compare the sociodemographic characteristics of survey participants compared to those not located or those refusing to participate. Second, telephone survey data from families whose children were enrolled in CHIP in Texas for 12 months or longer in fiscal year 2006 were used. These surveys were conducted in December 2005 through April 2006.

## **Measures**

The Established Enrollee Survey is comprised of the following sections: (1) a household listing table containing questions about the number of people in the household, their relationship to the child enrolled in CHIP, and their insurance and health status, (2) questions about the presence of a usual source of care for the child, (3) the Consumer Assessment of Healthcare Providers and Systems Health Plan Survey 3.0 (described below), (4) the Children With Special Health Care Needs (CSHCN) Screener, (5) a series of questions about family members' employment status and access to employer-based health insurance, and (6) demographic questions. The survey instrument is comparable to the instrument used to survey established enrollees during fiscal year 2004; however, some survey questions were eliminated to assist in decreasing survey administration time and increasing response rates.

The household listing table was developed originally for use in the Florida KidCare evaluation and adopted for use in CHIP in Texas. It was developed in consultation with survey-design experts from Mathematica and the Urban Institute. The question series has been used in approximately 30,000 surveys conducted with families of Medicaid recipients and CHIP enrollees in Texas, Florida, and New Hampshire.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 3.0 Medicaid module with supplemental questions addressing care for CSHCN was used to assess families' satisfaction with their children's health care.<sup>11</sup> CAHPS Health Plan Survey reporting composites, which are scores that combine results for closely related survey items, were used to provide comprehensive yet concise results for multiple survey questions.<sup>12</sup> Psychometric analyses indicate that the composite scores are a reliable and valid measure of member experiences.<sup>13,14</sup> Composite scores were obtained using the CAHPS Health Plan Survey items to address parents' experiences with (1) getting needed care, (2) getting care quickly, (3) doctor's communication, (4) interactions with the doctor's office staff, (5) health plan customer service, (6) obtaining prescription medicine, (7) getting specialized services for their children, (8) having a personal doctor or nurse,



(9) shared decision making, (10) getting needed information, and (11) coordination of their child's care. For the fiscal year 2006 survey, there are 11 CAHPS Health Plan Survey composite scores instead of the nine composite scores included in the fiscal year 2004 survey report. The composite score for family-centered care has been further subdivided into three scores: having a personal doctor or nurse, shared decision making, and getting needed information. Using this composite scoring method, a mean score was calculated for each of the 11 areas that could range from 0 to 100 points with higher scores indicating greater satisfaction.

The CSHCN Screener was adapted from questions used on the National Health Interview Survey and the Questionnaire for Identifying Children with Chronic Conditions. The CSHCN Screener was used to determine if the child had special health care needs. The CSHCN Screener uses information reported by the respondent to assess whether the child (1) has activity limitations when compared to other children of his or her age, (2) needs or uses medications, (3) needs or uses specialized therapies such as physical therapy, (4) has an above-routine need for the use of medical, mental health, or educational services, or (5) needs or receives treatment or counseling for an emotional, behavioral, or developmental problem.<sup>15</sup> For each of these areas, the respondent is also asked if the child has limitations, medication dependency, or uses/needs services because of a condition that has lasted or is expected to last for 12 months or longer. The CSHCN Screener is based on the following Maternal and Child Health Bureau definition:

CSHCN are children "who have or are at elevated risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount not usually required by children."<sup>16</sup>

If the child had one or more of the consequences listed above due to a condition that had lasted or was expected to last for 12 months or longer, then he or she was considered to have special health care needs.

The question series about employment, access to employer-based coverage, and sociodemographic characteristics were developed by ICHP and have been used in more than 25,000 surveys with Medicaid and CHIP enrollees in Texas and in Florida. The items were adapted from questions used in the National Health Interview Survey,<sup>17</sup> the Current Population Survey,<sup>18</sup> and the National Survey of America's Families.<sup>19</sup> On average, the entire Established Enrollee Survey took 28 and one-half minutes to complete, less than the 45 minutes it took to complete the fiscal year 2004 version of the survey.

Individuals could refuse to respond to particular items or indicate that they did not know the answer to particular questions. These responses are indicated by the categories "refused" and "don't know." These responses occurred in less than one percent of the cases. Individuals could also provide additional open-ended responses not covered by pre-existing survey categories. If these responses could be meaningfully grouped in a single category, they were grouped under a single heading. Items that could not be meaningfully grouped together were noted as "Other." The items were initially grouped into meaningful categories when possible by a Research Assistant. The groupings were then reviewed by a Research Coordinator and the Project Director before they were finalized.

## ***Survey Data Collection Techniques***

Letters written in English and Spanish were sent to all potential participants in the sample explaining the purpose of the study and requesting their participation. The Bureau of Economic and Business Research (BEER) at the University of Florida conducted the telephone surveys using computer-assisted-telephone-interviewing (CATI). Calls were made in English and in Spanish from 10 a.m. Central Time to 9 p.m. Central Time, 7 days a week. Calls were rotated throughout the morning, afternoon, and evening using the Sawtooth Software System in order to maximize the likelihood of reaching the enrollees.

A minimum of 40 attempts were made to reach a family, and if the family was not reached after that time, the software system selected the next individual on the list. Bad phone numbers were sent to a company that specializes in locating individuals, and any updated information was loaded back into the software system. Additional attempts were made to reach the family using the updated contact information. No financial incentives were offered to participate in the surveys. The respondent was selected by asking to speak to the person in the household who was most knowledgeable about the child's health and health care. The respondent also was asked to confirm that the child had been enrolled in CHIP for at least 12 months and was currently enrolled at the time of the interview.

Historically, there has been concern that telephone surveys are biased in that they do not include responses from populations that do not have phones. This is a particularly important issue with Medicaid recipients who may not have telephone service due to low incomes. However, research has shown that "transient" telephone households—those who have lost or gained telephone service in the recent past—are similar demographically to households without telephone service.<sup>20</sup> In an attempt to understand potential sources of bias in this survey, respondents were asked questions about their telephone service in the past six months. Five percent of responding families reported their household had not had a phone in the past six months. For those who had interrupted service, 56 percent reported that they were without telephone service due to cost.

Those with transient telephone service were compared with individuals who reported no break in telephone service across several demographic factors, including race, gender, education, and household type. There were some statistically significant differences found among families with continuous phone service and transient phone service. Analysis indicated a slightly higher percentage of Hispanics (5 percent) and Black, non-Hispanics (5 percent) who reported interruptions in telephone service in the past six months compared to White, non-Hispanics (4 percent) and Other, non-Hispanics (4 percent) ( $X^2=21.57$ ,  $p=0.010$ ). This may indicate some potential bias in results in that slightly fewer Hispanic and Black, non-Hispanic respondents than expected may be included in the survey.

Analysis also showed a higher percentage of individuals with some college education (6 percent) who reported interruptions in telephone service in the past six months compared to individuals with a high school diploma (4 percent) and those with an associate's degree (1 percent) ( $X^2=28.68$ ,  $p=0.001$ ). This may indicate some potential bias in results in that slightly fewer individuals with some college education may be included in the survey than expected.

Finally, Chi-square results indicated a higher percentage of single parent households (6 percent) who reported interruptions in telephone service in the past six months compared to two parent

households (4 percent) ( $X^2=94.44$ ,  $p=0.000$ ). This may indicate some potential bias in results in that slightly fewer single parent households may be included in the survey than expected.

## **Data Analysis**

Descriptive statistics, Chi-square tests, and logistic regression models, calculated using STATA Version 8, were used in this report.<sup>21</sup> Descriptive results for each item by MCO are provided to HHSC.

## **Results**

### **Demographics**

The demographic characteristics of families with children who are enrolled in CHIP in Texas are important to assess. Research has shown that disparities exist among racial and ethnic groups in pediatric health care with regard to access to health care,<sup>22</sup> obtaining a usual source of health care,<sup>23</sup> and satisfaction with health care providers.<sup>24,25</sup> One study, primarily focusing on disparities in children's access to medical care among Hispanics, showed that Hispanic children experience difficulties accessing care that is not fully explained by parent's social or economic status or the child's health-related quality of life.<sup>26</sup> Due to the rich diversity evident among the population in the State of Texas and the importance of ensuring accessible health care for children from low-income families, assessing demographic characteristics of CHIP in Texas enrollees is essential.

The demographic characteristics of respondents who participated in the 2006 Established Enrollee Survey are displayed in **Table 2**. Sixty-five percent of the children in families who responded to the Established Enrollee Survey were Hispanic. This is larger than the 59 percent of Hispanic families who responded to the survey in fiscal year 2004. This difference is statistically significant ( $X^2=57.19$ ,  $p=0.000$ ). For fiscal year 2006, the next largest racial/ethnic group was White, non-Hispanic, which consisted of 21 percent of children whose families participated in the survey. Black, non-Hispanic children comprised eight percent of the total population while children classified as Other, non-Hispanic comprised six percent of the total number surveyed.

Sixty-six percent of CHIP enrollees resided in two-parent families while 33 percent of enrollees lived in single parent households. The majority of respondents were married (64 percent) with the next two highest categories for marital status of respondents being single (15 percent) and divorced (10 percent).

Survey results indicated some variability in respondent educational status. Thirty-two percent of respondents reported having less than a high school education, 31 percent reported obtaining a diploma or GED, 21 percent reported some college or vocational training, and 14 percent reported having an associate's degree or higher. This can be compared to the educational attainment of the respondents in the fiscal year 2004 survey. In fiscal year 2004, 45 percent of respondents reported having less than a high school education, 16 percent reported obtaining a diploma or GED, 29 percent reported some college or vocational training, and 11 percent reported having an associate's degree or higher. The differences in educational attainment are statistically significant ( $X^2=333.41$ ,  $p=0.000$ ).

The average age of children whose families responded to the survey was 11 years ( $\pm$  4.35 years). This is similar to the average age of enrollees whose caregivers responded to the fiscal year 2004 survey. Fifty-three percent of the children whose families responded to the survey were male while 47 percent were female.

**Table 2. Demographic Characteristics of CHIP Families Participating in the Established Enrollee Telephone Survey**

<b>Respondent Demographics</b>	<b>N=3904</b>	<b>Percent</b>
<b>Child Race/Ethnicity</b>		
White, non-Hispanic	804	20.59
Black, non-Hispanic	311	7.97
Hispanic	2,547	65.24
Other, non-Hispanic	242	6.20
<b>Respondent Marital Status</b>		
Married	2,506	64.19
Unmarried partner	61	1.56
Divorced	382	9.78
Separated	248	6.35
Single	580	14.86
Widowed	113	2.89
Don't Know	3	0.08
Refused	11	0.28
<b>Household Type</b>		
Single parent	1,271	32.56
Two parent	2,578	66.03
Not a parent	8	0.20
Don't Know	27	0.69
Refused	20	0.51
<b>Respondent Education</b>		
Less than High School	1264	32.38
High School Diploma or GED	1,212	31.05
Some Vocational/College	837	21.44
AA Degree or Higher	558	14.29
Don't Know	22	0.56
Refused	11	0.28
<b>Mean Age Of Child/Standard Deviation</b>		
	11.42 (+4.35)	
<b>Child Gender</b>		
Male	2,067	52.95
Female	1,834	46.98
Don't Know <sup>1</sup>	1	0.03
Refused <sup>1</sup>	2	0.05

<sup>1</sup> Respondents answered “don’t know” or “refused” to provide information regarding the child’s gender, and the surveyor/researcher was unable to make a determination of gender based on the child’s name.

## ***Health Status***

Often quality of care assessments are reported for children as a group without considering their health status. However, children with special health care needs (CSHCN) comprise a unique group who may be more susceptible to adverse health outcomes than healthy children if there are variations in the quality of their health care. Recent estimates from the 2001 National Survey of CSHCN indicate that 13 percent of children in the United States have a special health care need.<sup>27</sup> Previous estimates of the percentages of these children range from 15 percent to 25 percent of the populations studied, depending on the definition of CSHCN used.<sup>28,29,30,31</sup> Despite differences in how they are identified or in the populations studied, CSHCN require close monitoring to ensure that they have access to high quality health care.<sup>32,33</sup>

As previously described, the CSHCN Screener was used to identify the presence of special health care needs among the children who were enrolled in CHIP using information reported by the parent or primary caregiver. Based on the CSHCN Screener results, 22 percent of children were identified as having a special health care need. This figure is two percentage points higher than the 20 percent of children identified as having a special health care need in the fiscal year 2004 survey; however, the difference in percentages is not statistically significant ( $X^2=1.33$ ,  $p=0.248$ ).

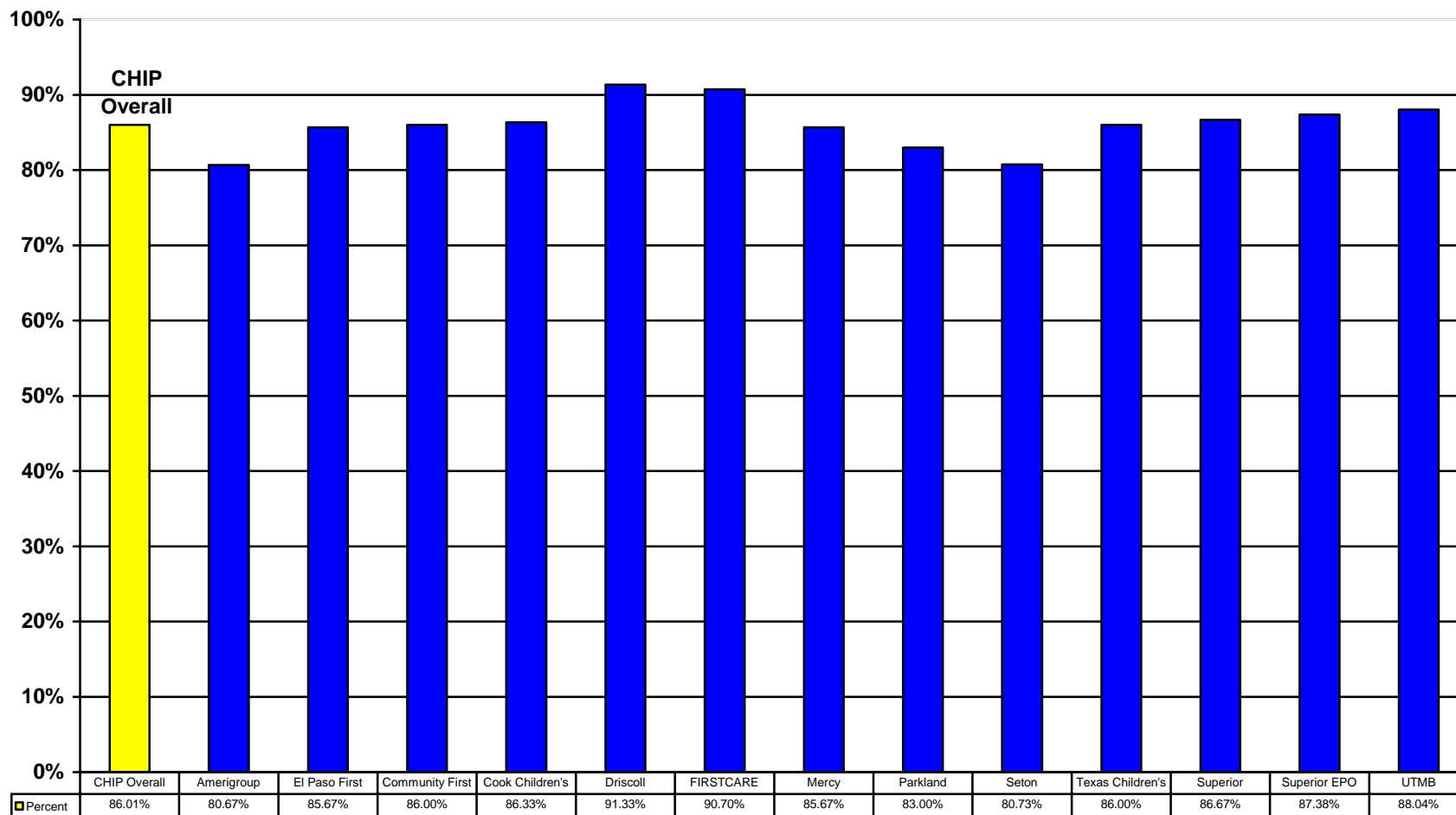
Established enrollees in CHIP in Texas represented a higher percentage of CSHCN than might be expected based on the national population estimates cited above.<sup>34</sup> Furthermore, the National Survey of Children with Special Health Care Needs 2001 (again using the CSHCN Screener) estimates that 12 percent of children in Texas have a special health care need. This finding is not surprising because parents might elect to enroll their children in CHIP based on the children's needs for health care services.

## ***Usual Source of Care***

Having a usual source of care—a particular person or place to which a child goes for sick and preventive care—facilitates the timely and appropriate use of pediatric services.<sup>35,36</sup> Research has shown that children without a usual source of care can be at risk for adverse health outcomes, including not receiving needed immunizations.<sup>37</sup> Some studies have also suggested that an identified usual source of care can reduce emergency department visits.<sup>38,39</sup>

Information is presented in this section using questions from the CAHPS Health Plan Survey about the presence of a personal doctor or nurse as a usual source of care. Overall, 86 percent of respondents reported their child has a personal doctor or nurse (See **Table 3**). This is higher than the 81 percent of respondents who reported their child had a usual source of care in the fiscal year 2004 survey. This difference is statistically significant ( $X^2=45.41$ ,  $p=0.000$ ). There is some variation in the percent of children with a personal doctor or nurse by MCO (See **Figure 1**). Respondents receiving services through Driscoll and FIRSTCARE report the highest percentage of children with a personal doctor or nurse—both 91 percent. For the fiscal year 2004 report, FIRSTCARE was also the plan with the highest percent of children with a personal health care provider. Ninety-one percent of children served through FIRSTCARE had a personal provider. Respondents receiving services through Seton and Amerigroup report the lowest percentage of children with a personal doctor or nurse—both 81 percent.

Figure 1. Percentage of Established Enrollees with a Personal Doctor or Nurse by MCO (Using the CAHPS Health Plan Survey)



**Table 3** provides a breakdown of the types of health care providers named as a personal doctor or nurse. Eighty-five percent of respondents reporting their children had a personal doctor or nurse reported the provider was a general doctor. The category general doctor includes both family doctors and pediatricians. Nine percent of respondents reported the personal doctor or nurse was a specialty physician. Five percent of respondents indicated the personal doctor or nurse was a physician's assistant or a nurse.

Respondents who reported their children had a personal doctor or nurse also provided information on the length of time their child had been seen by this person. Thirty-three percent reported seeing their child's doctor for five years or more. Thirty-three percent of respondents reported their child had been with their usual health care provider from two to five years. Thirteen percent of respondents reported their child had been with their usual source of care between one and two years, and 18 percent reported their child had seen their designated health care provider for less than one year.



**Table 3. Usual Source of Care**

Usual Source of Care	N=3904	Percent
<b>Do you have one person you think of as your child's personal doctor or nurse?</b>		
Yes	3,358	86.01
No	514	13.17
Don't Know	26	0.67
Refused	6	0.15
<b>Is this person a general doctor, a specialist doctor, a physician's assistant or a nurse? (N=3,358)<sup>2</sup></b>		
General doctor (Family practice or general pediatrician)	2,866	85.35
Specialist doctor	286	8.52
Physician's assistant	102	3.04
Nurse	60	1.79
Don't Know	39	1.16
Refused	5	0.15
<b>How many months or years has your child been going to his/her personal doctor or nurse? (N=3,358)</b>		
Less than 6 months	319	9.50
At least 6 months but less than 1 year	297	8.84
At least 1 year but less than 2 years	445	13.25
At least 2 years but less than 5 years	1,119	33.32
5 years or more	1,097	32.67
Don't Know	46	1.37
Refused	35	1.04
<b>Using any number from 0 to 10, where 0 is the worst personal doctor or nurse possible and 10 is the best personal doctor or nurse possible, what number would you use to rate your child's personal doctor or nurse? (N=3,358)</b>	8.92 ( $\pm$ 1.44)	
<b>Did your child have the same personal doctor or nurse before you joined this health plan? (N=3,358)</b>		
Yes	1,703	50.71
No	1618	48.18
Don't Know	32	0.95
Refused	5	0.15
<b>Since you joined this health plan, how much of a problem, if any, was it to get a personal doctor or nurse for your child you are happy with? (N=2,201)</b>		
A big problem	172	7.81
A small problem	334	15.17
Not a problem	1,673	76.01
Don't Know	10	0.45
Refused	12	0.55

<sup>2</sup> The number of parents responding to individual items will vary from the total number of surveys conducted primarily because of "skip sequences" in the survey. A "skip sequence" means that some items have particular sequences where questions are only asked based on responses to other questions.

## ***Parent Satisfaction with Their Children's Health Care – Descriptive Results***

The importance of parent experiences and satisfaction with their children's health care was described in the introductory section of this report. **Table 4** lists the mean composite scores for the 11 CAHPS Health Plan Survey parental satisfaction domains for the CHIP in Texas Program overall and by MCO. These are descriptive results only. The domains include:

- 1) Getting needed care,
- 2) Getting care quickly,
- 3) Doctor's communication,
- 4) Doctor's office staff,
- 5) Health plan customer service,
- 6) Obtaining prescription medicine,
- 7) Getting specialized services for their children,
- 8) Relationship with personal doctor or nurse,
- 9) Shared decision making,
- 10) Getting needed information, and
- 11) Coordination of their child's care.

As previously noted for the fiscal year 2006 survey, there are 11 CAHPS Health Plan Survey composite scores instead of the nine composite scores included in the fiscal year 2004 survey report. The composite score for family-centered care has been further subdivided into three scores: relationship with personal doctor or nurse, shared decision making, and getting needed information.

The composite scores are presented in **Table 4**. Shading is used to designate the MCOs with the lowest and highest score for each domain. Also, as previously described, each composite score can range from 0 to 100 with 100 indicating a perfect score.

Overall, CHIP in Texas fared very well in eight out of 11 domains scoring at or above 75 points out of a possible 100 points. Parents' ratings of the program with regard to getting care quickly, relationship with personal doctor or nurse, and care coordination were less favorable. The composite score for getting care quickly was 66 points. The score for relationship with personal doctor or nurse was 68 points, and the score for care coordination was 70 points out of a possible 100 points.

While the program fared very well in the remaining composite categories, the scores regarding parents' experiences in obtaining prescription medication for their children and in parents' experiences with health plan customer service (scoring 94 points and 90 points, respectively) are worth noting. These very positive results are very similar to the results reported from the 2004 satisfaction survey in which the score for parents' experiences in obtaining prescription medication for their children was 95 points and the score for parents' experiences with health plan customer service was 89 points.

Although the mean of the composite scores are fairly positive overall, the standard deviations (s.d. - not shown) are broad for some of the domains, indicating variability in the responses. The greatest variability among MCO domain scores was found in parents' experiences with coordination of their child's care (s.d.  $\pm 46$ ) and relationship with a personal doctor or nurse (s.d.  $\pm 46$ ).

The CAHPS Health Plan Survey composite scores reveal variability among MCO performance. Driscoll had the highest scores in five of the 11 composites: parents' experiences with how well doctors communicate; parents' experiences with courtesy, respect, and helpfulness of office staff; parents' experiences with health plan customer service; prescription medicine; and care coordination. FIRSTCARE had the highest scores for three of the 11 composites: parents' experiences with getting needed care, parents' experiences with getting care quickly, and shared decision making. Amerigroup had the lowest score of all MCOs for seven domains: parents' experiences with getting needed care; parents' experiences with how well doctors communicate; parents' experiences with courtesy, respect, and helpfulness of office staff; parents' experiences with health plan customer service; relationship with personal doctor or nurse; shared decision making; and getting needed information.

**Table 4** also provides a comparison of the overall CHIP CAHPS Health Plan Survey composite scores with the composite scores for Florida's KidCare program. The results for the two programs are very similar and within three points for eight of the 11 composite scores, including getting needed care, getting care quickly, doctors' communication, office staff, specialized services, shared decision making, getting needed information, and care coordination. However, CHIP in Texas scored appreciably higher on health plan customer service—almost 13 points higher. CHIP in Texas also scored five points higher than Florida KidCare in obtaining prescription medication. The Texas composite score for having a personal doctor or nurse was almost 12 points lower than that of the Florida program.

**Table 5** provides a comparison of the composite scores of caregivers of children with special health care needs and the scores of caregivers of children with no special health care need. The table also provides a comparison of composite scores among the four primary racial/ethnic groups. The results for CSHCN and children with no special health care needs are very similar and within four points for seven of the 11 composite scores, including getting needed care, doctor's communication, office staff, prescription medication, specialized services, shared decision making, and getting needed information. However, for relationship with personal doctor or nurse, the CSHCN score was 17 points higher than that of children with no special health care need. Also, the CSHCN score for getting care quickly was seven points higher than that of children with no reported health care need. Caregivers of children with no special health care need rated health plan customer service four points higher than parents of CSHCN, and caregivers of CSHCN rated care coordination five points higher than caregivers of children without special health care needs.

There was some variation in the CAHPS Health Plan Survey composite scores among the four racial/ethnic groups as displayed in **Table 5**. Caregivers who were categorized as Other, non-Hispanic had the lowest scores for seven of the 11 composite scores. This group consistently had the lowest rating for the following composite scores: getting care quickly, doctor's communication, helpfulness of office staff, relationship with personal doctor or nurse, shared decision making, obtaining specialized services, and getting needed information. Scores were appreciably lower than the mean overall score, ranging from five to nineteen points lower than the overall program mean. Caregivers who were categorized as Black, non-Hispanic had the lowest scores for three of the 11 composites, including getting needed care, health plan customer service, and care coordination. The variance in the composite scores for Black, non-Hispanics from the mean overall composite score was small—ranging from one to five points.

**Table 4. Descriptive Results - Average CAHPS Health Plan Survey Cluster Scores: Parent Satisfaction with Their Children's Health Care**

<b>MCOs</b>	<b>Getting Needed Care</b>	<b>Getting Care Quickly</b>	<b>Doctor's Communication</b>	<b>Office Staff</b>	<b>Customer Service</b>	<b>Prescription Medication</b>	<b>Specialized Services</b>	<b>Personal Doctor</b>	<b>Shared Decision Making</b>	<b>Getting Needed Information</b>	<b>Care Coordination</b>
<b>CHIP Overall</b>	84.86	65.93	88.77	88.31	89.50	93.79	77.66	67.56	81.02	82.36	69.61
<b>Florida KidCare</b>	84.09	66.91	87.33	88.31	76.71	88.77	74.59	79.48	78.88	83.00	69.43
<b>Amerigroup</b>	80.19	63.04	84.91	84.02	85.50	92.35	72.14	62.41	72.26	74.60	75.00
<b>El Paso First</b>	84.93	62.33	87.98	89.00	92.90	93.64	81.08	65.27	79.30	83.88	66.35
<b>Community First</b>	83.94	63.11	87.02	84.49	89.52	89.56	74.39	64.71	76.13	81.65	67.86
<b>Cook Children's</b>	84.04	71.02	89.16	89.46	86.50	95.20	66.45	64.88	77.86	85.63	66.67
<b>Driscoll</b>	88.54	68.35	91.55	92.98	93.13	96.81	87.50	67.67	83.97	84.10	78.57
<b>FIRSTCARE</b>	89.00	71.80	90.61	90.59	89.10	94.28	84.09	74.02	86.07	86.26	72.03
<b>Mercy</b>	87.60	59.30	90.02	91.70	92.08	94.35	79.73	76.89	85.49	87.85	76.92
<b>Parkland</b>	83.56	60.44	86.94	85.20	89.31	91.52	67.71	68.13	79.17	76.87	63.10
<b>Seton</b>	84.22	69.01	89.76	88.88	86.61	92.76	75.00	63.32	81.39	84.06	66.67
<b>Texas Children's</b>	87.32	64.43	87.14	84.46	91.78	94.25	75.27	67.34	84.90	80.89	75.58
<b>Superior</b>	81.90	66.96	88.50	88.07	87.57	94.66	81.03	69.02	81.48	76.34	69.79
<b>Superior EPO</b>	85.37	69.40	90.83	90.78	89.25	94.44	89.02	67.78	81.80	86.02	48.64
<b>UTMB</b>	83.78	67.18	89.44	88.11	90.72	94.41	70.99	66.67	82.34	84.50	68.03

**Table 5. Descriptive Results - Average CAHPS Health Plan Survey Cluster Scores: Parent Satisfaction with Their Children's Health Care**

<b>MCOs</b>	<b>Getting Needed Care</b>	<b>Getting Care Quickly</b>	<b>Doctor's Communication</b>	<b>Office Staff</b>	<b>Customer Service</b>	<b>Prescription Medication</b>	<b>Specialized Services</b>	<b>Personal Doctor</b>	<b>Shared Decision Making</b>	<b>Getting Needed Information</b>	<b>Care Coordination</b>
<b>CHIP Overall</b>	84.86	65.93	88.77	88.31	89.50	93.79	77.66	67.56	81.02	82.36	69.61
<b>CSHCN</b>	82.41	71.24	90.01	89.91	86.38	91.25	76.90	80.68	81.24	83.85	72.09
<b>No Special Health Care Need</b>	85.71	64.09	88.34	87.76	90.54	95.02	78.92	63.78	80.86	81.58	67.25
<b>White, non-Hispanic</b>	85.07	63.97	88.82	87.97	90.64	93.53	80.90	68.97	81.08	81.84	69.51
<b>Black, non-Hispanic</b>	83.98	73.85	91.30	91.80	86.58	94.58	73.89	65.47	81.20	85.35	65.00
<b>Hispanic</b>	85.95	66.18	89.19	88.03	89.23	92.56	82.26	69.34	82.66	82.77	85.59
<b>Other, non-Hispanic</b>	84.43	54.89	79.90	77.34	89.27	95.05	58.33	54.85	76.04	76.23	74.00

## ***Parent Experience and Satisfaction with Their Children’s Health Care – Multivariate Results***

Experiences and satisfaction with health care can be influenced by factors such as the enrollee’s health status<sup>40</sup> and sociodemographic characteristics.<sup>41</sup> Therefore, we compared parental scores for each of the previously described CAHPS Health Plan Survey clusters for each MCO after controlling for child health and sociodemographic characteristics.

The following health and sociodemographic variables were used in the logistic regression models:

- (1) Whether the child had a special health care need as measured by the CSHCN Screener. The reference group<sup>42</sup> was children with no special needs.
- (2) The child’s race/ethnicity was characterized as White, non-Hispanic; Black, non-Hispanic; Hispanic; or Other, non-Hispanic. The reference group is White, non-Hispanic.

To select a reference group for the MCOs, the MCO with the highest score for each CAHPS Health Plan Survey cluster was selected. The purpose of the reference group is to provide a point of comparison. The results of each MCO are compared to the results of the highest scoring MCO for each cluster after controlling for the children’s race/ethnicity and health status. The MCOs can have scores that are significantly lower than or not significantly lower than the MCO serving as the reference.

The outcome variable was the odds that the child would usually or always have positive experiences for each cluster. A score of 75 points or higher was used to indicate that the experience was usually or always positive.

**Table 6** contains a summary of the logistic regression results for each cluster. The reference MCO is indicated using the abbreviation “Ref.” For MCOs with scores that are not significantly different from the reference MCO, the abbreviation “NS” is used. For MCOs scoring significantly lower than the reference MCO after considering the covariates in the model, a “-” is used. The complete logistic regression results showing the odds ratios and confidence intervals are contained in Appendix A.

For the descriptive analyses, FIRSTCARE had the highest score for the *Getting Needed Care* cluster. After controlling for enrollee health status and race/ethnicity, the scores for Getting Needed Care were not significantly different for Texas Children’s, Mercy, Driscoll, and Superior EPO. Enrollees in the remaining MCOs had odds of usually or always getting needed care that were 36 to 63 percent less than those of enrollees in FIRSTCARE.

For the *Getting Care Quickly* cluster, FIRSTCARE had the highest score. After controlling for enrollee health status and race/ethnicity, Cook Children’s, Texas Children’s, Seton, Driscoll, Superior, UTMB, and Superior EPO were not significantly different in their scores from the reference group. Enrollees in the remaining MCOs had odds of usually or always getting care quickly that were 38 to 50 percent less than those of enrollees in FIRSTCARE.

**Table 6. Logistic Regression Results – CAHPS Health Plan Survey Cluster Scores: Differences Between MCOs in Parental Satisfaction Controlling for Child Race/Ethnicity and Health Status**

MCOs	Getting Needed Care	Getting Care Quickly	Doctor's Communication	Office Staff	Customer Service	Prescription Medication	Specialized Services	Personal Doctor	Shared Decision Making	Getting Needed Information	Care Coordination
<b>Amerigroup</b>	-	-	-	-	-	-	-	-	-	-	NS
<b>El Paso First</b>	-	-	NS	NS	NS	NS	NS	-	NS	NS	NS
<b>Community First</b>	-	-	-	-	-	-	-	-	-	-	NS
<b>Cook Children's</b>	-	NS	NS	-	-	NS	-	-	-	NS	NS
<b>Driscoll</b>	NS	NS	Ref	Ref	Ref	Ref	NS	-	NS	-	Ref
<b>FIRSTCARE</b>	Ref	Ref	NS	NS	-	NS	NS	NS	Ref	NS	NS
<b>Mercy</b>	NS	-	NS	NS	NS	NS	NS	Ref	NS	Ref	NS
<b>Parkland</b>	-	-	-	-	-	-	-	-	-	-	-
<b>Seton</b>	-	NS	NS	NS	-	-	NS	-	NS	NS	NS
<b>Texas Children's</b>	NS	NS	NS	-	NS	NS	NS	-	NS	-	NS
<b>Superior</b>	-	NS	NS	-	-	NS	NS	-	NS	-	NS
<b>Superior EPO</b>	NS	NS	NS	NS	NS	NS	Ref	-	NS	NS	NS
<b>UTMB</b>	-	NS	NS	-	NS	NS	-	-	NS	NS	NS

Key: "Ref" = reference MCO; "NS" = not significant; "-" = score significantly lower than reference.

Driscoll had the highest score for the *Doctor's Communication* cluster. After controlling for race/ethnicity and health status, the scores for children in El Paso First, Cook Children's, FIRSTCARE, Mercy, Seton, Texas Children's, Superior, Superior EPO, and UTMB were not significantly different than those of children in Driscoll. Children in the other MCOs had odds of usually or always having positive doctor communication that were 35 to 50 percent less than those of children in the reference MCO.

Driscoll also had the highest score for the *Doctor's Office Staff* cluster. All other MCOs had significantly lower scores compared to the reference MCO, except El Paso First, FIRSTCARE, Mercy, Seton, and Superior EPO.

Driscoll had the highest score for the *Health Plan Customer Service* cluster. Amerigroup, Community First, Cook Children's, FIRSTCARE, Parkland, Seton, and Superior had significantly lower scores than Driscoll. The scores for the other MCOs were not significantly different than the reference MCO.

Driscoll also had the highest score for the *Obtaining Prescription Medication* cluster. Four MCOs had significantly lower scores for this cluster compared to the reference MCO after controlling for the covariates in the model. Those MCOs were Amerigroup, Community First, Parkland, and Seton.

Superior EPO had the highest score for the *Obtaining Specialized Services* cluster. Amerigroup, Community First, Cook Children's, Parkland, and UTMB had significantly different scores from Superior EPO after controlling for child race/ethnicity and health status. These enrollees had odds of usually or always obtaining specialty services that were 70 to 79 percent less than those of children in Superior EPO.

Mercy had the highest score for the *Personal Doctor or Nurse* cluster. Only one other MCO had scores that were not significantly different (FIRSTCARE). All other MCOs had scores that were significantly lower than that of Mercy. The scores were from 33 to 52 percent lower than that of Mercy.

FIRSTCARE had the highest score for the *Shared Decision Making* cluster. Amerigroup, Community First, Parkland, and Cook Children's had significantly different scores from FIRSTCARE after controlling for child race/ethnicity and health status. The scores were from 49 to 64 percent lower than that of FIRSTCARE.

Mercy had the highest score for *Getting Needed Information*. Six MCOs had significantly lower scores for this cluster compared to the reference MCO after controlling for covariates in the model. Those MCOs were Texas Children's, Driscoll, Amerigroup, Community First, Parkland, and Superior.

Driscoll had the highest score for the *Care Coordination* cluster. Only one other MCO had a score that was significantly different (and lower) than Driscoll. Parkland had a care coordination score that was 64 percent lower than that of Driscoll after controlling for child race/ethnicity and health status.



### Specialty Services

The implementation of managed care for children, particularly those with special health care needs, sometimes raises questions about potential barriers to health care services.<sup>43</sup> The impact of managed care is of particular concern for children with complex physical or emotional disorders who may require many specialty services. Relatively healthy children may also require specialty services for acute conditions at various times.

**Table 7** shows the percentage of respondents reporting their children needed to see a physician specialist. Overall, 22 percent of respondents reported their child needed to see a specialist in the past six months. This is slightly lower than the 25 percent of respondents to the 2004 survey who reported that their child needed to see a specialist. There was some variation among health plans regarding the percent of children who needed to see a specialist. Respondents with children served by El Paso First reported the highest percentage of children needing to see a specialist (27 percent) and respondents with children served by Seton and Superior EPO reported the lowest percentage (19 percent each).

Of those children who needed to see a specialist, 66 percent of respondents reported obtaining a referral to specialty care was not a problem. This is lower than the 72 percent who indicated obtaining a referral was not a problem in the fiscal year 2004 survey. This difference is statistically significant ( $X^2=12.63, p=0.006$ ). For fiscal year 2006, 21 percent of respondents reported they had a “small” problem obtaining care and 11 percent of respondents reported experiencing a “big” problem when trying to secure a needed specialist for their child. Respondents with children who were provided care by Community First had the highest percentage of respondents who reported a “big” problem in accessing specialist care (20 percent). Respondents with children served by FIRSTCARE had the lowest percentage (3 percent) who reported a “big” problem in accessing specialist care.

**Table 7. Families’ Experiences with Specialty Care**

Specialist Care	N=3904	Percent
<b>In the last six months, did you or a doctor think your child needed to see a specialist?</b>		
Yes	857	21.95
No	3,040	77.87
Don't Know	5	0.13
Refused	2	0.05
<b>In the last six months, how much of a problem, if any, was it to get a referral to a specialist that your child needed to see? (N=857)</b>		
A big problem	98	11.44
A small problem	180	21.00
Not a problem	567	66.16
Don't Know	6	0.70
Refused	6	0.70

**Table 7. Families' Experiences with Specialty Care (Continued)**

Specialist Care	N=3904	Percent
<b>In the last six months, did your child see a specialist?</b>		
Yes	756	19.36
No	3,127	80.10
Don't Know	21	0.54
Refused	0	0.00
<b>Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate your child's specialist?</b>	8.83 ( $\pm$ 1.75)	
<b>In the last six months, was the specialist your child saw most often the same doctor as your child's personal doctor? (N=756)</b>		
Yes	231	30.56
No	511	67.59
Don't Know	9	1.19
Refused	5	0.66

Information regarding the percentage of respondents reporting their children needed specialized treatments or therapies such as home health care; specialized medical equipment or devices; special therapy such as physical, occupational, or speech therapy; or mental health therapy is provided in **Table 8**. As in the fiscal year 2004 survey, overall reported need for specialized therapies was low. Less than one percent of respondents reported their child needed home health care, three percent reported their child needed specialized medical equipment, and four percent reported that their child needed physical, occupational, or speech therapy. The highest percentage of respondents reported their child needed mental health therapy. Seven percent of respondents reported they attempted to obtain treatment or counseling for their child for an emotional, developmental, or behavioral problem. These percentages are similar to the percentages of respondents reporting their children needed specialized therapies in the fiscal year 2004 survey.

**Table 8** also provides information regarding respondents' experiences with obtaining needed specialized treatment, equipment, or therapies for their child. These numbers are provided as general descriptions only. This study was not designed as a focus study of children requiring specialized services. Due to the small percentages of children requiring these services, it is difficult to draw any conclusions about the experiences families reported in obtaining these services.

**Table 8. Families' Experiences with Specialized Services**

<b>Specialized Services</b>	<b>N=3904</b>	<b>Percent</b>
<b>In the last six months, did you need someone to come into your home to give home health or assistance for your child?</b>		
Yes	17	0.44
No	3,882	99.44
Don't Know	3	0.08
Refused	2	0.05
<b>In the last six months, how much of a problem, if any, was it to get these home health services for your child through your child's plan? (N=17)</b>		
A big problem	3	17.65
A small problem	4	23.53
Not a problem	10	58.82
Don't Know	0	0.00
Refused	0	0.00
<b>Did anyone from your child's health plan, doctor's office, or clinic help you with this problem? (N=7)</b>		
Yes	4	57.14
No	3	42.86
Don't Know	0	0.00
Refused	0	0.00
<b>In the last six months, did you get or try to get any specialized medical equipment or devices for your child such as a walker, a wheelchair, a nebulizer, feeding tubes, or oxygen equipment?</b>		
Yes	103	2.64
No	3,797	97.26
Don't Know	2	0.05
Refused	2	0.05
<b>In the last six months, how much of a problem, if any, was it to get special medical equipment for your child? (N=103)</b>		
A big problem	7	6.80
A small problem	16	15.53
Not a problem	80	77.67
Don't Know	0	0.00
Refused	0	0.00
<b>Did anyone from your child's health plan, doctor's office, or clinic help you with this problem? (N=23)</b>		
Yes	14	60.87
No	7	30.43
Don't Know	2	8.70
Refused	0	0.00

**Table 8. Families' Experiences with Specialized Services (Continued)**

<b>Specialized Services</b>	<b>N=3904</b>	<b>Percent</b>
<b>In the last six months, did you get or try to get special therapy for your child such as physical, occupational, or speech therapy?</b>		
Yes	145	3.71
No	3,754	96.16
Don't Know	3	0.08
Refused	2	0.05
<b>In the last six months, how much of a problem, if any, was it to get special therapy for your child? (N=145)</b>		
A big problem	20	13.79
A small problem	30	20.69
Not a problem	95	65.52
Don't Know	0	0.00
Refused	0	0.00
<b>Did anyone from your child's health plan, doctor's office, or clinic help you with this problem? (N=50)</b>		
Yes	26	52.00
No	24	48.00
Don't Know	0	0.00
Refused	0	0.00
<b>In the last six months, did you get or try to get treatment or counseling for your child for an emotional, developmental, or behavioral problem?</b>		
Yes	255	6.53
No	3,645	93.37
Don't Know	2	0.05
Refused	2	0.05
<b>In the last six months, how much of a problem, if any, was it to get this treatment or counseling for your child? (N=255)</b>		
A big problem	46	18.04
A small problem	45	17.65
Not a problem	163	63.92
Don't Know	1	0.39
Refused	0	0.00
<b>Did anyone from your child's health plan, doctor's office, or clinic help you with this problem? (N=91)</b>		
Yes	31	34.07
No	60	65.93
Don't Know	0	0.00
Refused	0	0.00

**Table 8. Families' Experiences with Specialized Services (Continued)**

Specialized Services	N=3904	Percent
<b>In the last six months, did your child get care from more than one kind of health care provider or use more than one kind of health care service?</b>		
Yes	434	11.12
No	3,445	88.24
Don't Know	21	0.54
Refused	4	0.10
<b>In the last six months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services? (N=434)</b>		
Yes	239	55.07
No	192	44.24
Don't Know	3	0.69
Refused	0	0.00

### ***Access to Needed Care***

Research has shown that disparities exist in access to needed health care for children with regard to race, ethnicity, socioeconomic status, and disability status.<sup>44, 45</sup> The National Survey of Children with Special Health Care Needs Chart Book reports that 18 percent of children with special health care needs were reported to need at least one health care service which they did not obtain in the past year. The report further cites that services needed but not obtained are most common among poor children (of whom 32 percent were reported to not receive at least one service they needed).

**Table 9** shows information regarding the percentage of children who needed care, tests, or treatment and their experiences obtaining care. Overall, 40 percent of children needed care, tests, or treatment. This is similar to the 41 percent of children who were reported to need care, tests, or treatment in the fiscal year 2004 survey. Of the children who needed these services, 79 percent reported that obtaining needed care was not a problem. This is slightly lower than the 83 percent of respondents who reported that it was not a problem to obtain needed care in the fiscal year 2004 survey. Children served by Community First and Superior reported the most problems obtaining care compared to other MCOs. Approximately 28 percent of respondents in these health plans reported either a “big” or “small” problem in obtaining needed care for their children.

**Table 9** also provides information about the percentage of children who needed approval from their MCO for care, tests, or treatment and their experiences obtaining approval. Overall, 18 percent of children needed approval from their MCO—similar to the 17 percent of children who needed approval in the 2004 survey. Statistical testing indicates that the one percentage point difference is not statistically significant ( $X^2=4.29$ ,  $p=0.232$ ). Of those who needed approval, 65 percent reported that obtaining approval was not a problem, 24 percent reported that obtaining approval was a “small” problem, and 11 percent reported that obtaining approval was a “big” problem. These results can be compared to those of fiscal year 2004 in which 67 percent of respondents reported that obtaining approval was not a problem, 24 percent reported that obtaining approval was a “small” problem, and 9 percent reported that obtaining approval was a “big” problem.

**Table 9. Access to Needed Care**

<b>Access to Needed Care</b>	<b>N=3904</b>	<b>Percent</b>
<b>In the last six months, did you or a doctor believe your child needed any care, tests, or treatment?</b>		
Yes	1,162	39.60
No	1,753	59.75
Don't Know	13	0.44
Refused	6	0.20
<b>In the last six months, how much of a problem, if any, was it to get the care, tests, or treatment for your child that you or your doctor believed necessary? (N=1,162)</b>		
A big problem	63	5.42
A small problem	177	15.23
Not a problem	915	78.74
Don't Know	2	0.17
Refused	5	0.43
<b>In the last six months, did your child need approval for any care, tests, or treatment?</b>		
Yes	539	18.37
No	2,356	80.30
Don't Know	33	1.12
Refused	6	0.20
<b>In the last six months, how much of a problem, if any, were delays in your child's health care while you waited for approval from your child's health plan? (N=539)</b>		
A big problem	57	10.58
A small problem	127	23.56
Not a problem	352	65.31
Don't Know	2	0.37
Refused	1	0.19

## Summary and Recommendations

There are some specific areas in which the results of the fiscal year 2006 established enrollee survey are very similar to those of the fiscal year 2004 survey. Areas of similarity include the following:

- As in the fiscal year 2004 survey, overall reported need for specialized therapies was low. Less than one percent of respondents reported their child needed home health care, three percent reported their child needed specialized medical equipment, four percent reported that their child needed physical, occupational, or speech therapy, and seven percent reported that their child needed mental health therapy.
- Overall, 40 percent of children needed care, tests, or treatment. This is similar to the 41 percent of children who were reported to need care, tests, or treatment in the fiscal year 2004 survey.
- While there are no specific standards about what would constitute an acceptable score for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey composite scores, a score of 75 points was used to indicate that families “usually” or “always” had positive experiences with a particular composite. Using this criterion, overall, CHIP performed well in the areas of Getting Needed Care (85 points), Doctor’s Communication (89 points), Doctor’s Office Staff (88 points), Health Plan Customer Service (90 points), Obtaining Prescription Medication (94 points), Obtaining Specialized Services (78 points), Shared Decision Making (81 points), and Getting Needed Information (82 points). However, improvement is needed in the areas of Getting Care Quickly (66 points), Relationship with a Personal Doctor or Nurse (68 points), and Care Coordination (70 points). Results are very similar to those in the fiscal year 2004 report with the exception of one score - Obtaining Specialized Services. There was an overall improvement in respondent rating with the score increasing from 71 points in 2004 to 78 points in 2006.
- The CAHPS Health Plan Survey composite results for children with special health care needs (CSHCN) and children without special health care needs are very similar and within four points for seven of the 11 composite scores, including Getting Needed Care, Doctor’s Communication, Office Staff, Prescription Medication, Specialized Services, Shared Decision Making, and Getting Needed Information. Since these analyses were not conducted for the fiscal year 2004 survey report, there is no comparative data.
- There was some variation in the CAHPS Health Plan Survey composite scores among the four racial/ethnic groups. Caregivers who were categorized as Other, non-Hispanic had the lowest scores for seven of the 11 composite scores. Since these analyses were not conducted for the fiscal year 2004 survey report, there is no comparative data.
- In both fiscal year 2004 and fiscal year 2006, there were significant differences between the MCOs in their performance on the CAHPS Health Plan Survey clusters after controlling for enrollee health status and race/ethnicity. For fiscal year 2006, Amerigroup, Parkland, and Community First performed significantly worse than the reference MCO (the MCO with the highest score for the cluster) in at least ten of the 11 CAHPS Health Plan Survey clusters in the multivariate analyses. In fiscal year 2004, Amerigroup, Parkland, El Paso First, and Superior (in CSA 7 and CSA 11) performed significantly worse than the reference MCO in at least six of the nine CAHPS Health Plan Survey clusters.

There are some specific areas in which the results of the fiscal year 2006 survey differ from that of the fiscal year 2004 survey. These areas include the following:

- Sixty-five percent of the children in families who responded to the Established Enrollee Survey were Hispanic. This is larger than the 59 percent of Hispanic families who responded to the survey in fiscal year 2004.
- Twenty-two percent of children were identified as having a special health care need based on the CSHCN Screener. This figure is two percentage points higher than the 20 percent of children identified as having a special health care need in the fiscal year 2004 survey; however, the difference is not statistically significant.
- Overall, 86 percent of respondents reported their child has a personal doctor or nurse. This is higher than the 81 percent of respondents who reported their child had a usual source of care in the fiscal year 2004 survey.
- Overall, 22 percent of respondents reported their child needed to see a specialist in the past six months. This is slightly lower than the 25 percent of respondents to the 2004 survey who reported their child needed to see a specialist.
- Of those children who needed to see a specialist, 66 percent of respondents reported obtaining a referral to specialty care was not a problem. This is lower than the 72 percent who indicated obtaining a referral was not a problem in the fiscal year 2004 survey.

### EQRO Recommendations

The Texas Health and Human Services Commission (HHSC) may wish to consider the following strategies when developing future policy regarding health insurance for children from low-income families:

- **Strategies to increase performance related to getting care quickly, caregivers' relationship with child's personal doctor or nurse, and care coordination should be explored.** Each of these areas overall fell below the 75 point criterion. Strategies should be developed to address deficiencies in these areas, including: (1) reviewing MCO provider panels to ensure adequate numbers of providers, (2) reviewing authorization procedures to ensure that care can be rendered quickly, and (3) reviewing policies that impact the doctor-patient relationship.
- **Strategies to address differences in MCO performance should be considered.** Some significant differences exist among MCOs in performance on the CAHPS Health Plan Survey clusters. Three MCOs performed significantly worse than the highest performing MCOs for ten or more clusters. Two of the three MCOs also performed poorly in the fiscal year 2004 report. A review should be conducted with these MCOs to develop a plan to address consumer satisfaction.
- **Specifically monitor the quality of care provided to CSHCN.** The HHSC routinely monitors the care that CSHCN receive in CHIP. In the past, this monitoring was included in reports examining overall CHIP quality of care. Beginning in July 2006, HHSC implemented CSHCN-specific reporting to focus specifically on this vulnerable population of children. The monitoring will include CHIP and Medicaid and will address access to specialty care.



## Appendix A. Logistic Regression Results for the CAHPS Health Plan Survey Cluster Scores

(Yellow highlights indicate significant differences between the MCO scores and the reference group)

Odds of Usually or Always Getting Needed Care (MCO Reference = FIRSTCARE)

need1	Odds Ratio	Robust Std. Err.	z	P> z	[95% Conf. Interval]	
shcn	.5957937	.0544757	-5.66	0.000	.4980435	.7127292
hispanic	1.01318	.1073564	0.12	0.902	.8231774	1.247038
black	1.371354	.240344	1.80	0.072	.9726749	1.933443
other	1.039609	.1922843	0.21	0.834	.7234916	1.49385
cook	.5809427	.1262262	-2.50	0.012	.3794773	.8893665
seton	.6436305	.1410983	-2.01	0.044	.4188264	.9890976
txchild	.72809	.1643993	-1.41	0.160	.467722	1.133398
mercy	.8036058	.1892595	-0.93	0.353	.5064938	1.275005
driscoll	.9392386	.221794	-0.27	0.791	.5912501	1.492041
parkland	.5307256	.1157172	-2.91	0.004	.3461606	.8136966
commfirst	.6343619	.1399834	-2.06	0.039	.4116273	.9776199
elpaso	.5674894	.1249557	-2.57	0.010	.3685796	.8737438
superior	.5151706	.1118621	-3.05	0.002	.3366081	.7884561
utmb	.5133538	.1121543	-3.05	0.002	.3345428	.7877381
ameri	.3672594	.0786436	-4.68	0.000	.2413791	.5587869
epo	.6759054	.1519585	-1.74	0.081	.4350278	1.050158

Odds of Usually or Always Getting Care Quickly (MCO Reference = FIRSTCARE)

quick1	Odds Ratio	Robust Std. Err.	z	P> z	[95% Conf. Interval]	
shcn	1.21196	.1030271	2.26	0.024	1.025956	1.431686
hispanic	.72432	.0694393	-3.36	0.001	.6002432	.8740448
black	.7231116	.110568	-2.12	0.034	.5358604	.9757959
other	.5888642	.1004902	-3.10	0.002	.4214605	.8227604
cook	.8761494	.162241	-0.71	0.475	.6094764	1.259504
seton	.95149	.181684	-0.26	0.795	.6544402	1.38337
txchild	.7047994	.1287174	-1.92	0.055	.4927319	1.008139
mercy	.5018678	.0933194	-3.71	0.000	.3485888	.7225457
driscoll	.8362627	.1533563	-0.98	0.330	.5837768	1.19795
parkland	.6078592	.1120778	-2.70	0.007	.4235038	.8724661
commfirst	.5204074	.0975256	-3.49	0.000	.3604344	.7513819
elpaso	.52152	.097303	-3.49	0.000	.3617907	.7517693
superior	.7373343	.1357953	-1.65	0.098	.5139231	1.057866
utmb	.7106156	.1314356	-1.85	0.065	.4945342	1.021111
ameri	.6174474	.1138468	-2.62	0.009	.4301827	.8862311
epo	.9200233	.1672278	-0.46	0.647	.6442884	1.313764

Odds of Usually or Always Having Positive Experience With Doctor's Communication  
(MCO Reference = Driscoll)

doctor1	Odds Ratio	Robust Std. Err.	z	P> z	[95% Conf. Interval]	
shcn	1.04512	.0954466	0.48	0.629	.8738353	1.24998
hispanic	.7920799	.0830307	-2.22	0.026	.6449719	.9727409
black	.9672941	.1630843	-0.20	0.844	.6950999	1.346077
other	.4953951	.087808	-3.96	0.000	.3500076	.7011741
cook	.6893023	.1395983	-1.84	0.066	.4634718	1.02517
firstcare	.9868093	.2016858	-0.06	0.948	.661094	1.473002
seton	.8097972	.1685076	-1.01	0.311	.5385835	1.217586
txchild	.7656483	.152695	-1.34	0.181	.5179314	1.131844
mercy	.9676903	.1966517	-0.16	0.872	.6497665	1.441171
parkland	.5050286	.0994776	-3.47	0.001	.3432822	.742986
commfirst	.6546844	.1315148	-2.11	0.035	.4416115	.9705628
elpasso	.7781772	.1573203	-1.24	0.215	.5235947	1.156543
superior	.7723119	.1564869	-1.28	0.202	.5191837	1.148853
utmb	.7743305	.1576362	-1.26	0.209	.5195662	1.154016
ameri	.5875583	.116114	-2.69	0.007	.3988738	.8654987
epo	1.017204	.2071392	0.08	0.933	.6824534	1.516154

Odds of Usually or Always Having Positive Experience With Doctor's Office Staff  
(MCO Reference = Driscoll)

officel	Odds Ratio	Robust Std. Err.	z	P> z	[95% Conf. Interval]	
shcn	.9058463	.0841552	-1.06	0.287	.7550503	1.086759
hispanic	.7800033	.0837952	-2.31	0.021	.631906	.9628095
black	1.091182	.1929445	0.49	0.622	.7715897	1.543149
other	.6335703	.1157563	-2.50	0.012	.4428701	.9063864
cook	.6392808	.1359823	-2.10	0.035	.4213388	.9699558
firstcare	.8065304	.1725209	-1.01	0.315	.5303279	1.226583
seton	.6900281	.1509841	-1.70	0.090	.4493829	1.059539
txchild	.6033827	.1256372	-2.43	0.015	.4011941	.9074678
mercy	.9658508	.2091644	-0.16	0.873	.6317919	1.476543
parkland	.5629594	.1173471	-2.76	0.006	.3741509	.8470465
commfirst	.5064834	.105676	-3.26	0.001	.3364844	.7623694
elpasso	.6724961	.1425169	-1.87	0.061	.4439163	1.018775
superior	.6145305	.1289472	-2.32	0.020	.4073197	.9271532
utmb	.6356222	.1355781	-2.12	0.034	.4184445	.9655176
ameri	.477321	.0985575	-3.58	0.000	.3184593	.71543
epo	.8619945	.1842265	-0.69	0.487	.5670021	1.310462

Odds of Usually or Always Having Positive Experience With Health Plan Customer Service  
(MCO Reference = Driscoll)

custserv1	Odds Ratio	Robust Std. Err.	z	P> z	[95% Conf. Interval]	
shcn	.6181043	.0612315	-4.86	0.000	.5090247	.7505588
hispanic	1.253795	.1403043	2.02	0.043	1.006872	1.561274
black	1.393735	.2574999	1.80	0.072	.9703231	2.001908
other	1.334022	.276572	1.39	0.164	.8885672	2.002791
cook	.4934444	.1184652	-2.94	0.003	.308236	.7899383
firstcare	.5805169	.141509	-2.23	0.026	.3600168	.936067
seton	.4211831	.1021587	-3.56	0.000	.2618247	.6775343
txchild	.7642077	.1952763	-1.05	0.293	.463133	1.261006
mercy	.7351679	.1933275	-1.17	0.242	.4390819	1.230913
parkland	.5363988	.1343191	-2.49	0.013	.3283517	.8762669
commfirst	.5327108	.1297476	-2.59	0.010	.3305005	.8586397
elpaso	.7766467	.2030865	-0.97	0.334	.465202	1.296598
superior	.5697323	.1391282	-2.30	0.021	.3530271	.9194617
utmb	.7533272	.1900544	-1.12	0.262	.4594485	1.235181
ameri	.360217	.0868842	-4.23	0.000	.2245198	.5779279
epo	.6285674	.1565263	-1.86	0.062	.3858203	1.024044

Odds of Usually or Always Having Positive Experience Obtaining Prescription Medication  
(MCO Reference = Driscoll)

pm21	Odds Ratio	Robust Std. Err.	z	P> z	[95% Conf. Interval]	
shcn	.5128453	.0721517	-4.75	0.000	.3892527	.6756801
hispanic	.6154911	.1190689	-2.51	0.012	.4212636	.8992691
black	.5177546	.1413886	-2.41	0.016	.3031639	.8842404
other	.5885658	.1876509	-1.66	0.096	.3150712	1.099465
cook	.6981221	.2960798	-0.85	0.397	.3040389	1.603
firstcare	.5116522	.202037	-1.70	0.090	.2359714	1.109405
seton	.4424862	.1802876	-2.00	0.045	.1991059	.9833662
txchild	.5241302	.2129018	-1.59	0.112	.2364183	1.161977
mercy	.6528908	.2715677	-1.03	0.305	.2889257	1.475349
parkland	.3859783	.1498876	-2.45	0.014	.1803078	.8262499
commfirst	.3120905	.1190228	-3.05	0.002	.1477936	.6590305
elpaso	.5265526	.2118973	-1.59	0.111	.2392754	1.158739
superior	.7654903	.32813	-0.62	0.533	.3304222	1.773414
utmb	.5991907	.2547141	-1.20	0.228	.2604485	1.378505
ameri	.4115199	.1596676	-2.29	0.022	.1923663	.8803445
epo	.5733357	.2320022	-1.37	0.169	.2593985	1.267216

Odds of Usually or Always Having Positive Experience Obtaining Specialty Services  
(MCO Reference = Superior EPO)

speciall	Odds Ratio	Robust Std. Err.	z	P> z	[95% Conf. Interval]	
shcn	1.002551	.2210196	0.01	0.991	.650808	1.544401
hispanic	1.050161	.2650457	0.19	0.846	.6403605	1.722214
black	1.772611	.7866721	1.29	0.197	.7427732	4.230294
other	.5898611	.2399872	-1.30	0.194	.2657267	1.309376
cook	.210012	.1135847	-2.89	0.004	.0727567	.6061992
firstcare	.6015376	.3572123	-0.86	0.392	.1878417	1.926343
seton	.3856451	.2199149	-1.67	0.095	.1261213	1.179199
txchild	.4045285	.2331849	-1.57	0.116	.1307031	1.252024
mercy	.4639819	.2713475	-1.31	0.189	.1474682	1.459835
driscoll	.7022991	.4138149	-0.60	0.549	.221294	2.228818
parkland	.2591094	.1557796	-2.25	0.025	.0797501	.8418514
commfirst	.2891657	.1556048	-2.31	0.021	.1007167	.8302184
elpaso	.5684442	.328972	-0.98	0.329	.1828426	1.767251
superior	.3261159	.1897217	-1.93	0.054	.1042739	1.019925
utmb	.2724654	.1578058	-2.24	0.025	.0875618	.8478289
ameri	.3001359	.1650218	-2.19	0.029	.1021662	.8817156

Odds of Usually or Always Having a Personal Doctor or Nurse (MCO Reference = Mercy)

perdocl	Odds Ratio	Robust Std. Err.	z	P> z	[95% Conf. Interval]	
shcn	1.791094	.1581741	6.60	0.000	1.506425	2.129557
hispanic	1.376363	.1220837	3.60	0.000	1.156728	1.637701
black	1.35185	.194504	2.10	0.036	1.019666	1.792253
other	1.246943	.1938099	1.42	0.156	.9194883	1.691014
cook	.5214748	.0961055	-3.53	0.000	.3633797	.7483522
firstcare	.8312609	.1587438	-0.97	0.333	.5717228	1.208618
seton	.5329648	.0975188	-3.44	0.001	.3723494	.7628628
txchild	.6204139	.1152099	-2.57	0.010	.4311364	.8927881
driscoll	.6010966	.1098115	-2.79	0.005	.4201867	.8598965
parkland	.612084	.1132069	-2.65	0.008	.4259695	.8795155
commfirst	.5054857	.0924991	-3.73	0.000	.3531401	.7235536
elpaso	.5523647	.1003746	-3.27	0.001	.3868542	.7886868
superior	.6720153	.1245625	-2.14	0.032	.4673081	.9663957
utmb	.6229917	.1157801	-2.55	0.011	.4328031	.8967556
ameri	.4780392	.0878558	-4.02	0.000	.3334468	.685331
epo	.5994125	.1105735	-2.77	0.006	.4175464	.8604919

Odds of Usually or Always Having Positive Experience with Shared Decision Making  
(MCO Reference = FIRSTCARE)

decision1	Odds Ratio	Robust Std. Err.	z	P> z	[95% Conf. Interval]	
shcn	1.076028	.1419265	0.56	0.579	.8309053	1.393465
hispanic	.9248241	.149098	-0.48	0.628	.6742647	1.268492
black	1.207569	.3204434	0.71	0.477	.7178524	2.031369
other	.9504458	.2741752	-0.18	0.860	.5399843	1.672914
cook	.5136584	.159301	-2.15	0.032	.2796991	.943317
seton	.7958199	.2660814	-0.68	0.495	.4132536	1.532544
txchild	.79396	.2610177	-0.70	0.483	.4168335	1.512289
mercy	.9665959	.3323477	-0.10	0.921	.4926899	1.89634
driscoll	.8482356	.2747665	-0.51	0.611	.4495616	1.600456
parkland	.4860661	.1553146	-2.26	0.024	.2598409	.9092494
commfirst	.489467	.1530906	-2.28	0.022	.2651509	.9035533
elpasso	.7244537	.242935	-0.96	0.336	.3754677	1.397812
superior	.6229624	.1996662	-1.48	0.140	.3323858	1.167565
utmb	.7297486	.2396533	-0.96	0.337	.3833842	1.389032
ameri	.3652892	.1136026	-3.24	0.001	.1985723	.6719781
epo	.6452438	.2052278	-1.38	0.168	.3459304	1.203536

Odds of Usually or Always Getting Needed Information (MCO Reference = Mercy)

infol	Odds Ratio	Robust Std. Err.	z	P> z	[95% Conf. Interval]	
shcn	1.127954	.1587096	0.86	0.392	.8560965	1.486142
hispanic	.6381067	.1171479	-2.45	0.014	.4452706	.9144555
black	.9077825	.2610995	-0.34	0.737	.5166023	1.595171
other	.5671973	.1653532	-1.95	0.052	.3203214	1.004343
cook	.5798453	.2072624	-1.52	0.127	.2877763	1.16834
firstcare	.592797	.2170796	-1.43	0.153	.2892011	1.2151
seton	.6681742	.2526665	-1.07	0.286	.3184288	1.402061
txchild	.4910189	.1646998	-2.12	0.034	.2544394	.9475719
driscoll	.4793221	.1645025	-2.14	0.032	.2446226	.9392005
parkland	.380475	.1261405	-2.91	0.004	.198666	.728666
commfirst	.4162015	.1428668	-2.55	0.011	.2123817	.8156241
elpasso	.6698154	.2297336	-1.17	0.243	.341987	1.3119
superior	.3674384	.125924	-2.92	0.003	.1877029	.7192799
utmb	.5338426	.1895568	-1.77	0.077	.2661758	1.070676
ameri	.2443492	.0792046	-4.35	0.000	.1294489	.4612364
epo	.5424224	.1895566	-1.75	0.080	.2734477	1.075972

Odds of Usually or Always Having Positive Experience With Care Coordination  
(MCO Reference = Driscoll)

coordcarl	Odds Ratio	Robust Std. Err.	z	P> z	[95% Conf. Interval]	
shcn	1.165001	.2021303	0.88	0.379	.8291653	1.636861
hispanic	1.120274	.2254111	0.56	0.572	.755185	1.661863
black	2.314003	.8299727	2.34	0.019	1.145671	4.673775
other	2.49238	1.211589	1.88	0.060	.9612364	6.462464
cook	.4073312	.1893115	-1.93	0.053	.1638109	1.012867
firstcare	.6282421	.2961077	-0.99	0.324	.2494207	1.58242
seton	.4511641	.2190152	-1.64	0.101	.1742301	1.168277
txchild	.62026	.3182543	-0.93	0.352	.2268944	1.695601
mercy	.9442745	.5161121	-0.10	0.916	.3234872	2.756382
parkland	.3592224	.1755112	-2.10	0.036	.1378726	.935942
commfirst	.4441085	.2082844	-1.73	0.084	.1771252	1.113519
elpasso	.5369386	.2635511	-1.27	0.205	.2051732	1.405169
superior	.5648756	.2742677	-1.18	0.239	.2181039	1.462993
utmb	.5085429	.239724	-1.43	0.151	.2018721	1.281088
ameri	.6313444	.309247	-0.94	0.348	.2417287	1.648938
epo	.4537818	.2087008	-1.72	0.086	.1842329	1.117704

## Endnotes

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- <sup>5</sup> U.S. Agency for Healthcare Research and Quality (AHRQ) has changed the name "CAHPS" to encompass the overall program. As a result, changes have been made in this report to reflect changes made by AHRQ, and "CAHPS Version 3.0" has been renamed as "CAHPS Health Plan Survey 3.0." Please see [https://www.cahps.ahrq.gov/CAHPS\\_UsageGuide.asp](https://www.cahps.ahrq.gov/CAHPS_UsageGuide.asp) for these changes.
- <sup>6</sup> All statistical analyses, including survey responses, are measured with error. This can be offset by gathering more data (repeatedly or from more people in the population of interest). The "true" response can also be thought of as the actual response or the response we would get from the survey if there was no error or if no mistakes were made. Another way of looking at this is to take a question such as "Do you have one person you think of as your child's personal doctor or nurse?" In this survey, 86.01 percent of respondents replied "yes" to this question. Due to our confidence interval, we can say that we are 95 percent certain that between 82.61 and 79.95 percent of the population would actually reply "yes" to this question.
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- <sup>11</sup> National Committee for Quality Assurance. 2002. *HEDIS 2003: Specifications for Survey Measures*. Washington, D.C.
- <sup>12</sup> U.S. Agency for Healthcare Research and Quality. 2002. *Article 8: CAHPS Reporting Composites and Global Ratings, CAHPS Survey and Reporting Kit*.
- <sup>13</sup> McGee, J., D. E. Kanouse, S. Sofaer, J. L. Hargraves, E. Hoy, and S. Kleimann. 1999. "Making Survey Results Easy to Report to Consumers: How Reporting Needs Guided Survey Design in CAHPS. Consumer Assessment of Health Plans Study." *Medical Care* 37 (3 suppl.): MS32-MS40.
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- <sup>17</sup> Centers for Disease Control and Prevention, National Center for Health Statistics. *National Health Interview Survey*. See <http://www.cdc.gov/nchs/nhis.htm> for information.
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