

**The Texas STAR Managed Care Organization
and
Primary Care Case Management
Child Enrollee CAHPS[®] Health Plan Survey
Report
Fiscal Year 2007**

**Measurement Period:
December 2006 – April 2007**

Prepared by

**Texas External Quality Review Organization
Institute for Child Health Policy
University of Florida
Gainesville, Florida**

**Submitted:
July 30, 2007**

**Final Submitted:
August 10, 2007**

**Revised Final Submitted:
August 13, 2007**

Table of Contents

Overview	1
Introduction	4
Methods	4
Sample Selection Procedures	4
Data Sources	7
Measures	7
Survey Data Collection Techniques	8
Data Analysis	9
Results	9
Demographics	9
Health Status	12
Personal Doctor	12
Parent Satisfaction with Their Children’s Health Care – Descriptive Results	16
Parent Satisfaction with Their Children’s Health Care – Multivariate Results	19
Specialty Services	22
Access to Needed Care	26
Transitioning to Adult Care	27
Summary and Recommendations	30
Appendix A. Logistic Regression Results for the CAHPS® Health Plan Survey Cluster Scores	32
Notes	36

Table of Tables

Table 1. Survey Stratification Strategy	5
Table 2. Demographic Characteristics of STAR MCO/PCCM Families Participating in the CAHPS® Health Plan Survey	11
Table 3. STAR MCO and PCCM Program Child Enrollee’s Personal Doctor	15
Table 4. Descriptive Results - Average CAHPS® Health Plan Survey Cluster Scores: Parent Satisfaction with Their Children’s Health Care	18
Table 5. Logistic Regression Results – CAHPS® Health Plan Survey Cluster Scores: Differences Between MCOs in Parental Satisfaction Controlling for Child Race/Ethnicity, Health Status, and Respondent Education	21
Table 6. Families’ Experiences with Specialty Care	23
Table 7. Families’ Need for Specialized Services	24
Table 8. Access to Needed Care	27
Table 9. Transitioning from Child to Adult Care	28

Table of Figures

Figure 1. Percentage of STAR MCO/PCCM Child Enrollees with a Personal Doctor or Nurse by MCO/MCO SDA (Using the CAHPS® Health Plan Survey)	13
---	----

Overview

Report Title:	The Texas STAR Managed Care Organization and Primary Care Case Management Child Enrollee CAHPS® Health Plan Survey Report for Fiscal Year 2007
Measurement Period:	December 2006 – April 2007
Date Submitted by EQRO:	July 30, 2007
Final Submitted by EQRO:	August 10, 2007
Revised Final Submitted:	August 13, 2007

Purpose

The purpose of this report is to present the results of telephone surveys conducted with caregivers of children enrolled in two Texas Medicaid Programs: (1) the STAR Managed Care Organization (MCO) Program and (2) the Primary Care Case Management (PCCM) Program. This report provides results from surveys fielded from December 2006 through April 2007 and focuses on children enrolled during fiscal year 2006. Specifically, the intent of this report is to:

- describe the socio-demographic characteristics and health status of children enrolled in the STAR MCO and PCCM Programs,
- document the presence of a personal doctor,
- describe caregivers' satisfaction with their child's health care,
- describe the need and availability of specialty care for enrollees,
- document counseling for issues related to the transition from pediatric to adult care for adolescents with special health care needs, and
- compare the satisfaction scores of caregivers with children enrolled in the PCCM Program and caregivers with children enrolled in the managed care organizations (MCOs) participating in the STAR MCO Program.

Summary of Major Findings

- The majority of children in both programs whose families responded to the survey were Hispanic—54 percent for STAR and 58 percent for PCCM Program enrollees.
- Sixteen percent of children enrolled in the STAR MCO Program and 17 percent of children enrolled in the PCCM Program were identified as having a special health care need using the Children with Special Health Care Needs (CSHCN) Screener, which is higher than the general population estimate of 12 percent in Texas (also obtained using the CSHCN Screener on the National Survey of CSHCN).
- Overall, 84 percent of STAR MCO Program respondents and 87 percent of PCCM Program respondents reported their child had a specific person—a personal doctor or nurse—who provided their child's health care. This person was most often a general doctor (79 percent in both programs).
- While there are no specific standards or national data for what would constitute an acceptable score for the CAHPS® Health Plan Survey composites, 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 the STAR MCO Program and the PCCM Program performed well in 7 of the 11 CAHPS® Health Plan Survey composites. However, improvements are needed in

the areas of *Getting Needed Care* (65 points in STAR and 69 points in PCCM), *Getting Care Quickly* (63 points in STAR and 67 points in PCCM), *Personal Doctor or Nurse* (48 points in STAR and 61 points in PCCM), and *Care Coordination* (66 points in STAR and 67 points in PCCM). In general, composite scores for the PCCM Program were higher than the scores for the STAR MCO Program. The only exception to this is the *Obtaining Prescription Medicine* composite where the STAR MCO Program's score was 0.4 points higher than the score for the PCCM Program.

- There were some significant differences between the MCOs in their performance on the CAHPS[®] Health Plan Survey composites after controlling for child enrollee health status, race/ethnicity, and respondent education status. In the multivariate analyses, Parkland Community had significantly lower scores in six of the seven CAHPS[®] Health Plan Survey domains with significant results in the regressions. Superior – Travis and Community First had significantly lower scores in five of the seven CAHPS[®] Health Plan Survey domains with significant results in the regressions.
- Overall, 19 percent of respondents with children enrolled in the STAR MCO Program and 20 percent of respondents with children enrolled in the PCCM Program reported their child needed to see a specialist in the past six months. Twenty-seven percent of STAR respondents and 24 percent of PCCM respondents reported they had a “small” problem obtaining care, and 13 percent of STAR respondents and 10 percent of PCCM respondents reported experiencing a “big” problem when trying to obtain a needed specialist for their child.
- Overall reported need for specialized services—such as home health care, medical equipment, physical therapy, or mental health services—was very low. The need for such services ranged from two to seven percent in the STAR MCO Program and from one to eight percent in the PCCM Program. The majority of respondents reported obtaining these specialized services was “not a problem.”
- Sixteen percent of STAR MCO Program respondents and 11 percent of PCCM Program respondents reported their children needed approval from their MCO for care, tests, or treatment. Of those who needed approval, the majority (65 percent for STAR and 58 percent for PCCM) reported that obtaining needed care was “not a problem”.
- Families of adolescents with a special health care need often received care from doctors who only treat children (58 percent in the STAR MCO Program and 52 percent in the PCCM Program). Parents indicated that although doctors and other health care providers rarely discussed issues relating to their child's transition to adult care, they would have found this type of discussion helpful.

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 receiving Medicaid.

- **Strategies to increase performance related to *Getting Needed Care*, *Getting Care Quickly*, *Personal Doctor or Nurse*, and *Care Coordination* should be explored.** All of these domains fell below the 75 point criterion for both the STAR MCO and PCCM Programs. Strategies should be developed to address deficiencies in these areas, including: (1) reviewing MCO provider panels to ensure adequate numbers of and access to primary and specialty care providers, (2) reviewing procedures that facilitate connections for children and families with needed services and resources, and (3) reviewing authorization procedures to ensure that care can be rendered quickly. In addition, the American Academy of Pediatrics (AAP) has training programs related to providing a medical home, which include components that discuss issues related to families' positive experiences with their child's personal doctor.

- **Monitor care of children with special health care needs in the program.** A higher percentage of children with special health care needs are enrolling in the program than what one might expect based on state estimates (16 percent of children enrolled in the STAR MCO Program and 17 percent of children enrolled in the PCCM Program compared to 12 percent in the general Texas population). Based on this finding, HHSC might consider increasing emphasis on monitoring the quality of care for these children by using ongoing indicators specifically addressing CSHCN and/or focus studies. Families of adolescents with a special health care need are not getting the support they need from their doctors and other health care providers for their child's upcoming transition from pediatric to adult care. Although many of these adolescents are receiving care from pediatricians, their doctors are not discussing important issues such as the child's changing health care needs or obtaining insurance for their child as they become an adult. Most parents indicated this type of discussion would be helpful.

Introduction

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

The purpose of this report is to present the results of telephone surveys with caregivers of children enrolled in two Texas Medicaid Programs: (1) the Texas Medicaid Managed Care Program known as the STAR MCO Program and (2) the Texas Medicaid Managed Care Program known as the Primary Care Case Management (PCCM) Program. This report provides results from surveys fielded from December 2006 through April 2007 and focuses on children enrolled during fiscal year 2006. Specifically, the intent of this report is to:

- describe the socio-demographic characteristics and health status of children enrolled in the STAR MCO Program and the PCCM Program,
- document the presence of a personal doctor,
- describe caregivers' satisfaction with their child's health care,
- describe the need and availability of specialty care for enrollees,
- document counseling for issues related to the transition from pediatric to adult care for adolescents with special health care needs, and
- compare the satisfaction scores of caregivers with children enrolled in the PCCM Program to those of caregivers with children enrolled in the managed care organizations (MCOs) participating in the STAR MCO Program.

Methods

Sample Selection Procedures

A stratified random sample of families was selected to participate in two surveys. To be eligible for inclusion in the sample, the child had to be enrolled in either the Texas STAR MCO Program or the PCCM Program September 2005 expansion area for nine continuous months in the past year.⁵ This criterion was chosen to ensure the family had sufficient experience with the program to respond to the questions. The sample was stratified to include representation from the PCCM Program and the eight STAR MCOs. Two MCOs—Amerigroup and Superior—were further sub-divided by Service Delivery Area (SDA). There were a total of 13 strata for the STAR MCO Program and one stratum for the PCCM Program (See **Table 1**).

For the STAR MCO Program, a target was set to complete 3,900 telephone surveys. There were 3,906 completed surveys for STAR respondents. The target for the PCCM Program was 600 telephone surveys and 600 surveys were completed. This sample size was selected to (1) provide a reasonable confidence interval for the survey responses and (2) to ensure the sample was sufficiently large to allow for comparisons between MCOs and with the PCCM Program. The confidence interval information provided is based on a hypothetical item with a uniformly distributed response. The information presented is provided as a "worst case" guideline only. Using a 95 percent confidence interval, the responses provided within the tables and figures are within ± 1.75 percentage points of the "true" responses for the enrollees of the STAR MCO Program.⁶ The "true" response is the response that would

be obtained if there were no measurement error. The confidence interval for the PCCM Program enrollee responses is ± 4.00 percentage points. The stratification strategy along with the number of complete interviews is shown in **Table 1**.

Table 1. Survey Stratification Strategy

Survey Areas	Completed Interviews (N=4,506)
Amerigroup	
Dallas SDA	300
Harris SDA	300
Tarrant SDA	301
Travis SDA	300
Community First	300
Community Health Choice	300
El Paso First	303
FIRSTCARE	300
Parkland Community	302
Superior	
Bexar SDA	300
El Paso SDA	300
Travis SDA	300
Texas Children's	300
STAR TOTAL	3,906
PCCM	600
PCCM TOTAL	600

For the STAR MCO Program, an average of 6.21 attempts was made per phone number to contact the enrollees. The response rate was 60 percent and the cooperation rate was 72 percent.⁷ These response and cooperation rates are comparable to those obtained with other low-income families in Medicaid.^{8, 9, 10}

For the PCCM Program enrollees, there was an average of 6.87 attempts made per phone number to contact the enrollees. The response rate was 53 percent and the cooperation rate was 63 percent.

Survey responders were compared to those who could not be located and to those who were located but refused to participate on the following characteristics: enrollee race/ethnicity, gender, and age. There were significant differences between survey responders, those not located, and those refusing to participate in the STAR MCO and PCCM samples. Most of the significant differences between survey responders, those not located, and those refusing to participate were related to racial/ethnic groups and age. Specifically, the following significant differences were found:

- In 6 of the 13 STAR MCO/SDA samples, the Black, non-Hispanic racial/ethnic group (compared to the White, non-Hispanic racial/ethnic group) was less likely to be located and to respond to the survey. These STAR MCO/SDA samples included Amerigroup – Dallas, Amerigroup – Harris, Community Health Choice, Parkland Community, Superior – Bexar, and Superior – El Paso.
- In the Amerigroup – Dallas, El Paso First, and Superior – El Paso samples, the Hispanic racial/ethnic group (compared to the White, non-Hispanic racial/ethnic group) was less likely to be located and to respond to the survey. In contrast, the Hispanic racial/ethnic group (compared to

the White, non-Hispanic racial/ethnic group) was more likely to be located and to respond to the survey in the Amerigroup – Tarrant sample.

- In the Community Health Choice sample, the Other, non-Hispanic racial/ethnic group (compared to the White, non-Hispanic racial/ethnic group) was less likely to be located and to respond to the survey.
- In 4 of the 13 STAR MCO/SDA samples, those with children 0 through 5 years of age (compared to those with children 15 through 17 years of age) were less likely to be located and to respond to the survey. These STAR MCO/SDA samples included Amerigroup – Dallas, Community First, Parkland Community, and Superior – El Paso.
- In the PCCM sample, the Black, non-Hispanic racial/ethnic group (compared to the White, non-Hispanic racial/ethnic group) was less likely to be located and to respond to the survey.

Due to these significant differences between survey responders, those not located, and those refusing to participate, weights were developed for the STAR MCO and PCCM samples.

The weights developed consisted of three components.¹¹ First, a base sampling weight for each child with a completed survey was calculated. The base sampling weight relied on the probability of selection in a stratified random sampling for the STAR MCO Program where representations from 13 STAR MCO/SDAs were included. For the PCCM Program, the base sampling weight relied on the probability of selection in a simple random sampling. Second, base sampling weights were adjusted to compensate for those who could not be located and those who were located but refused to participate. The adjustment factors were derived by modeling the probability of a sampled STAR MCO or PCCM enrollee's parent responding to the survey as a function of the following characteristics: enrollee race/ethnicity, gender, and age.¹² Third, post-stratification techniques were used to adjust for any remaining discrepancies between the estimated number of child beneficiaries and the total number of child beneficiaries enrolled in 13 STAR MCO/SDAs or in the PCCM Program September 2005 expansion area. For the STAR MCO Program, post-stratification adjustments were conducted at the MCO level and relied on the following characteristics: enrollee age and race/ethnicity. Distributions of these enrollee characteristics were obtained from the information found in the Fiscal Year 2006 enrollment files for the STAR MCO Program. For the PCCM Program, post-stratification adjustments were conducted at the program level and relied on the following characteristics: enrollee age and race/ethnicity. Distributions of these enrollee characteristics were obtained from the information found in the Fiscal Year 2006 enrollment files for the PCCM Program September 2005 expansion area.

Data Sources

Two primary data sources were used to prepare this report. First, a third party administrator provided enrollment files for the STAR MCO Program and the PCCM Program to the Institute for Child Health Policy (IHP). These files were used to (1) identify the families who met the sample selection criteria, (2) obtain contact information for the families, and (3) compare the socio-demographic characteristics of survey participants to those not located or those refusing to participate. Second, telephone survey data from caregivers of children who were enrolled in the STAR MCO Program and the PCCM Program September 2005 expansion area for nine months or longer in fiscal year 2006 were used. These surveys were conducted from December 2006 through April 2007.

Measures

The STAR MCO/PCCM Child Enrollee CAHPS[®] Health Plan Survey takes less than 30 minutes to complete and includes the following sections:

- (1) the Consumer Assessment of Healthcare Providers and Systems Health Plan Survey 3.0,¹³
- (2) the Children With Special Health Care Needs (CSHCN) Screener,
- (3) a series of questions about issues related to moving from pediatric to adult care for children with special health care needs, and
- (4) demographic questions.

Families' satisfaction with their children's health care was assessed using the Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) Health Plan Survey 3.0.¹⁴ Specifically, the Medicaid module with supplemental questions addressing care for CSHCN was used. 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.¹⁵ Psychometric analyses indicate that the composite scores are a reliable and valid measure of member experiences.^{16,17} 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) child's personal doctor or nurse, (9) shared decision making, (10) getting needed information, and (11) coordination of their child's care. Using this composite scoring method, a mean score was calculated for each of the 11 areas; the score 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 (NHIS) and the Questionnaire for Identifying Children with Chronic Conditions (QuICCC). The CSHCN Screener is used to determine if a child has special health care needs. The CSHCN Screener uses information reported by the respondent to assess whether a 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.¹⁸ 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 a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.”¹⁹

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.

Parents and caregivers who have children 11 years of age and older identified by the CSHCN Screener to have a special health care need were asked an additional set of questions about their child’s transition from pediatric to adult care. Issues surrounding this transition include the changing medical needs of the child, the child taking charge of his/her own health care, and changes in insurance. Families were asked if their child’s doctors and other health care providers had discussed these issues with them. These questions were adapted from the SLAITS National Survey of Children with Special Health Care Needs II.²⁰

The demographic section, which includes questions regarding socio-demographic characteristics, was developed by ICHP and has 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,²¹ the Current Population Survey,²² and the National Survey of America’s Families.²³

Survey respondents were allowed the opportunity to refuse to respond to particular items or indicate they did not know the answer to particular questions. These responses are indicated by the categories “refused” and “do not know.” These responses most frequently occurred at rates that ranged between 0.0 -1.2 percent of responses in the STAR sample and at rates that ranged between 0.0 -1.4 percent of responses in the PCCM sample. Individuals could also provide additional, open-ended responses not covered by pre-existing survey categories.

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 (BEBR) 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 maximum number of 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. A maximum of 30 attempts were made to reach the families of PCCM and STAR MCO enrollees. Bad phone numbers were sent to a company that specializes in locating individuals. Any updated information was loaded back into the software system, and attempts were made to reach the family using the updated contact information. No financial incentives were offered to participate in the surveys. 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 either the STAR MCO Program or the PCCM Program for at least nine 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, due to low incomes, may not have telephone service. 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.²⁴ 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. Ten percent of responding families in the PCCM Program and nine percent in the STAR MCO Program reported their household had not had a phone in the past six months. For both PCCM and STAR enrollees who had interrupted service, the majority reported they were without telephone service due to cost (70 percent of PCCM families and 69 percent of STAR MCO families). For both PCCM and STAR respondents, those with transient telephone service were compared with individuals who reported no break in telephone service across several demographic factors, including respondent race/ethnicity, gender, education, and marital status. In the PCCM sample, logistic regression was not statistically significant. In the STAR MCO sample, those who are married (compared to those who are divorced, separated, or widowed) were less likely to report interruptions in telephone service and those with some vocational or college education (compared to those who were not high school graduates) were more likely to report interruptions in telephone service in the past six months. This may indicate some potential bias in the STAR MCO satisfaction results.

Data Analysis

Descriptive statistics were calculated using SPSS[®] Version 14.0. Chi-square tests and logistic regression models, calculated using STATA[®] Version 8, were used in this report. Descriptive results for each item for STAR MCO and PCCM samples are provided to HHSC.

Results

Demographics

The demographic characteristics of families with children who are enrolled in Medicaid programs in Texas are important to assess. Studies have shown that disparities exist among racial and ethnic groups in pediatric health care with regard to access to health care,²⁵ obtaining a usual source of health care,²⁶ and satisfaction with health care providers.^{27, 28} One study, which focused on disparities in children’s access to medical care among Hispanics, revealed that Hispanic children experience difficulties accessing care that are not fully explained by parents’ social or economic status or the child’s health-related quality of life.²⁹ Due to the rich diversity within the population in the State of Texas, which includes a high percentage of Hispanic children, assessing demographic characteristics of child Medicaid enrollees is necessary.

Table 2 displays the demographic characteristics of respondents who participated in the 2007 STAR MCO/PCCM Child Enrollee CAHPS[®] Health Plan Survey. The majority of children in both programs whose families responded to the survey were Hispanic—54 percent for STAR and 58 percent for PCCM. The next largest racial/ethnic group for children enrolled in the PCCM Program was White, non-Hispanic (25 percent) followed by Black, non-Hispanic (11 percent). A small minority of PCCM respondents reported Other, non-Hispanic (less than one percent) as their child’s racial/ethnic group. After Hispanic, the next largest racial/ethnic group for children enrolled in the STAR MCO Program was Black, non-Hispanic (21 percent) followed by White, non-Hispanic (17 percent). A small minority of STAR respondents reported Other, non-Hispanic (two percent) as their child’s racial/ethnic group. Although the largest racial/ethnic group for children in both programs was Hispanic, there were twice as many STAR MCO enrollees as PCCM enrollees who were Black, non-Hispanic.

The majority of children whose families responded to the survey resided in two-parent families (56 percent for STAR; 59 percent for PCCM). Forty-two percent of STAR MCO Program households were headed by a single parent while 39 percent of PCCM Program households were single-parent households. For the STAR MCO Program, the largest category of marital status for respondents was married (44 percent) with the next three largest categories being single (31 percent), unmarried partner (10 percent), and divorced (7 percent). For PCCM respondents, the marital status results were slightly different. The largest category of marital status for respondents was married (51 percent) with the next two largest categories being single (22 percent) and divorced (10 percent). Separated and unmarried partner were reported in equal percentages (seven percent).

Respondent educational status was very similar between the two programs. The largest group in both programs earned less than a high school education (44 percent of STAR MCO enrollee caregivers and 42 percent PCCM enrollee caregivers). The next largest group earned a high school diploma or GED (29 percent of STAR MCO caregivers and 31 percent of PCCM caregivers). Fifteen percent of STAR enrollees' caregivers and 17 percent of PCCM enrollees' caregivers earned some college or vocational credits. A small minority earned an Associate's Degree or higher (10 percent in the STAR MCO Program and 9 percent in the PCCM Program).

The average age of children was 7.10 years (std. err. = ± 0.10 years) in the STAR MCO Program and 7.52 years (std. err. = ± 0.21 years) in the PCCM Program. The children's genders for both STAR MCO and PCCM Programs were almost equally distributed.

Table 2. Demographic Characteristics of STAR MCO/PCCM Families Participating in the CAHPS® Health Plan Survey¹

Respondent Demographics		STAR MCO		PCCM	
		N	Percent	N	Percent
Child Race/ Ethnicity	Refused	10,436	0.90%	375	0.0%
	Do not know	58,861	5.10%	43,666	5.2%
	White, non-Hispanic	191,472	16.50%	212,494	25.3%
	Black, non-Hispanic	248,635	21.40%	93,058	11.1%
	Hispanic	632,827	54.40%	487,028	57.9%
	Other, non-Hispanic	20,638	1.80%	3,915	0.5%
	Total	1,162,869	100.00%	840,537	100.0%
Respondent Marital Status	Refused	3,667	0.3%	3,504	0.4%
	Do not know	880	0.1%	1,951	0.2%
	Married	510,717	43.9%	425,126	50.6%
	Unmarried partner	110,890	9.5%	60,479	7.2%
	Divorced	79,870	6.9%	80,028	9.5%
	Separated	70,975	6.1%	61,798	7.4%
	Single	357,733	30.8%	185,136	22.0%
	Widowed	28,136	2.4%	22,514	2.7%
Total	1,162,869	100.0%	840,537	100.0%	
Household Type	Refused	6,828	0.6%	6,433	0.8%
	Do not know	14,754	1.3%	13,371	1.6%
	Single parent household	487,989	42.0%	326,093	38.8%
	Two parent household	647,367	55.7%	492,324	58.6%
	Not a parent	5,932	0.5%	2,316	0.3%
	Total	1,162,869	100.0%	840,537	100.0%
Respondent Education	Refused	3,797	0.3%	6,396	0.8%
	Do not know	14,658	1.3%	6,035	0.7%
	Less than high school	514,526	44.2%	354,128	42.1%
	High school diploma or GED	341,898	29.4%	260,348	31.0%
	Some vocational/college	175,829	15.1%	140,332	16.7%
	AA degree or higher	112,161	9.6%	73,297	8.7%
	Total	1,162,869	100.0%	840,537	100.0%
Child Mean Age	Weighted Mean	7.10		7.52	
	Standard Error	0.10 (N=3,906)		0.21 (N=600)	
Child Gender	Refused	547	0.0%	0	0.0%
	Do not know	1,967	0.2%	0	0.0%
	Male	585,869	50.4%	437,111	52.0%
	Female	574,486	49.4%	403,426	48.0%
	Total	1,162,869	100.0%	840,537	100.0%

¹ Due to the weighting and carrying percentages out to only one decimal place, there may be very small differences in total numbers and percentages that result from rounding.

Health Status

Quality of care assessments are often 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 than healthy children to adverse outcomes from variations in the quality of their health care. Estimates from the 2001 National Survey of CSHCN indicate that 13 percent of children in the United States have a special health care need.³⁰ 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.^{31, 32, 33, 34} Despite differences in how they are identified in the populations studied, CSHCN require close monitoring to ensure that they have access to high quality health care.^{35, 36}

As previously described, the CSHCN Screener was used to identify the presence of special health care needs among the children who were enrolled in Texas Medicaid programs using information reported by the parent or primary caregiver. Based on the CSHCN Screener results, 16 percent of children enrolled in the STAR MCO Program and 17 percent of children enrolled in the PCCM Program were identified as having a special health care need. Of the total pool of children for the STAR MCO Program, 84 percent were healthy, 11 percent had one condition consequence as the result of their special needs, 4 percent had two condition consequences, and 1 percent had all three condition consequences. For children enrolled in the PCCM Program, 83 percent were classified as having no health care conditions, 13 percent had one condition consequence as the result of their special needs, 3 percent had two condition consequences, and 1 percent had all three condition consequences. Rates of CSHCN enrolled in both the STAR MCO Program and the PCCM Program were higher than the overall national population estimates cited above.³⁷ 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. Enrollment rates are expected to be higher for children with special health needs because parents may seek to enroll their children in Medicaid based on the increased need for health care services. Therefore, one might expect to find a higher percentage of CSHCN in Medicaid or any other health insurance program when compared to an overall population estimate.

Personal Doctor

Having a usual source of care—a particular person or place a child goes to for sick and preventive care—facilitates the timely and appropriate use of pediatric services.^{38, 39} Research has shown that children without a usual source of care can be at risk for adverse health outcomes, including not receiving needed immunizations.⁴⁰ Some studies have also suggested that an identified usual source of care can reduce emergency department visits^{41, 42}

Information presented in this section is based on the responses to questions from the CAHPS® Health Plan Survey about the presence of a *personal doctor or nurse* as a usual source of care. Parents were asked questions about the availability of a personal doctor or nurse (a usual person as the source of care), the type of personal doctor their child sees, and the longevity of that relationship.

Overall, 87 percent of respondents with a child enrolled in the PCCM Program and 84 percent of respondents with a child enrolled in the STAR MCO Program reported that their child has a personal doctor or nurse (See **Table 3**). There is some variation in the percent of children with a personal doctor or nurse by MCO and SDA (See **Figure 1**). Respondents with children receiving services through Superior – El Paso and Texas Children’s report the highest percentage of children with a personal doctor or nurse (89 percent). Respondents receiving services through Superior – Travis report the lowest percentage of children with a personal doctor or nurse (71 percent).

Figure 1. Percentage of STAR MCO/PCCM Child Enrollees with a Personal Doctor or Nurse by MCO/MCO SDA (Using the CAHPS® Health Plan Survey)

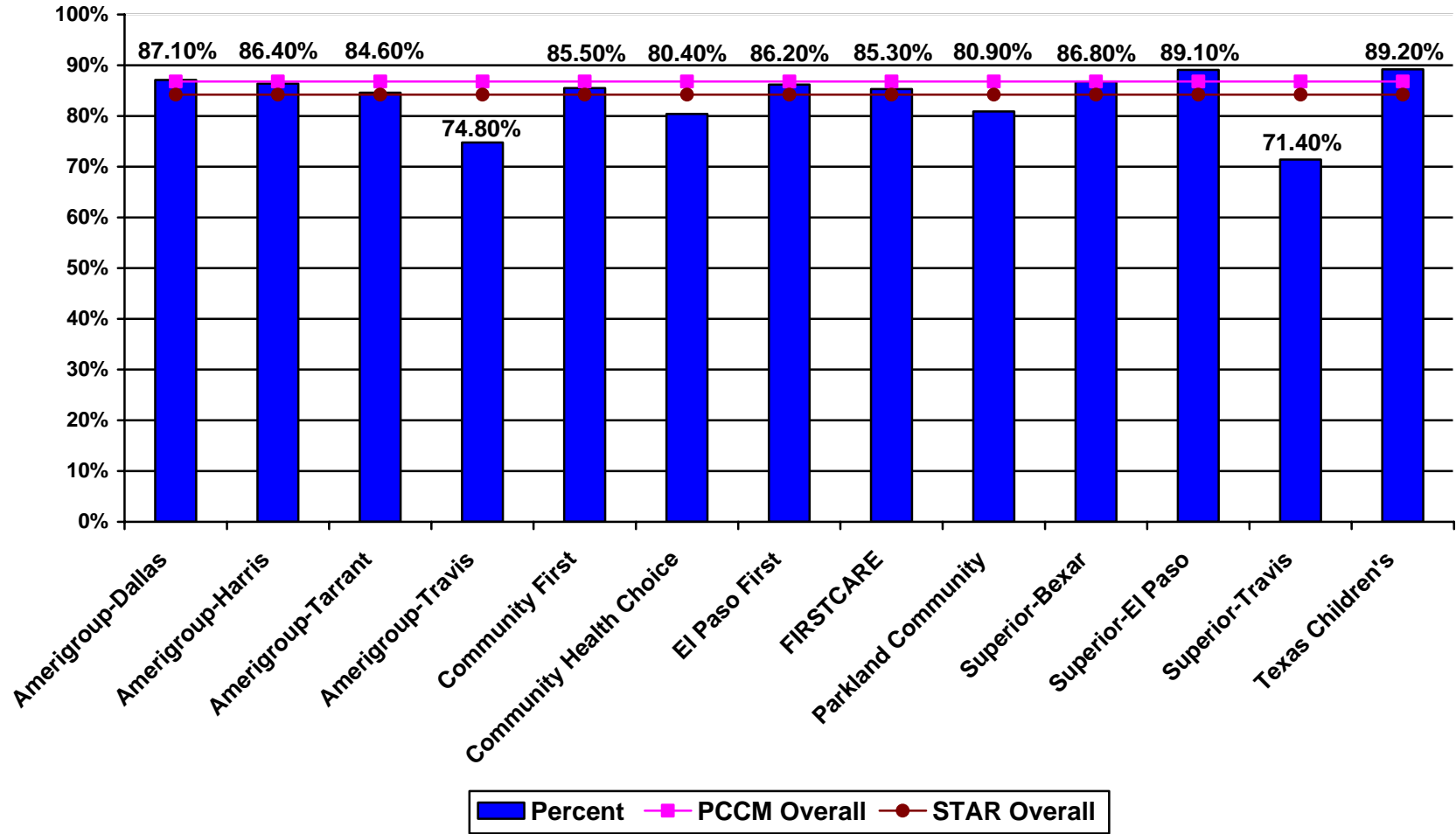


Table 3 also provides a breakdown of the type of health care provider named as a personal doctor or nurse. In both programs, 79 percent of respondents whose children had a personal doctor or nurse reported the provider was a general doctor. The category “general doctor” includes both family doctors and pediatricians. Eleven percent of STAR MCO respondents and 10 percent of PCCM respondents reported their child’s personal doctor or nurse was a specialty physician. Seven percent of STAR respondents and nine percent of PCCM respondents indicated their child’s 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. A high percentage of respondents with children enrolled in both programs reported longevity with their child’s provider. Thirty-four percent of STAR MCO Program respondents reported their child had been with this personal doctor or nurse from two to five years and 36 percent of PCCM Program respondents reported their child had the same provider for that length of time. Twenty-six percent of STAR respondents reported seeing their child’s doctor for five years or more while 31 percent of PCCM respondents reported their child had the same doctor for over five years. Therefore, 60 percent of children enrolled in the STAR MCO Program and 67 percent of those enrolled in the PCCM Program had a relationship with their personal doctor lasting two years or more.

The majority of respondents from both programs reported that it was not a problem to get a personal doctor for their child that they are happy with (79 percent of respondents whose children were enrolled in the STAR MCO Program and 83 percent of respondents whose children were enrolled in the PCCM Program).

Table 3. STAR MCO and PCCM Program Child Enrollee's Personal Doctor²

Personal Doctor		STAR MCO		PCCM	
		N	Percent	N	Percent
Do you have one person you think of as your child's personal doctor or nurse?	Refused	2,492	0.2%	2,061	0.2%
	Do not know	6,558	0.6%	2,835	0.3%
	Yes	979,031	84.2%	729,209	86.8%
	No	174,788	15.0%	106,431	12.7%
	Total	1,162,869	100.0%	840,537	100.0%
Your child's personal doctor - is this person a general doctor, specialist doctor, or a nurse?	Refused	4,873	0.5%	2,316	0.3%
	Do not know	22,202	2.3%	13,009	1.8%
	General doctor	776,898	79.4%	576,627	79.1%
	Specialist	109,514	11.2%	70,617	9.7%
	Physician's assistant	35,043	3.6%	43,149	5.9%
	Nurse	30,500	3.1%	23,491	3.2%
	Total	979,031	100.0%	729,209	100.0%
How many months or years has your child been going to their personal doctor or nurse?	Refused	6,449	0.7%	2,055	0.3%
	Do not know	17,258	1.8%	10,259	1.4%
	Less than 6 months	67,826	6.9%	36,039	4.9%
	At least 6 months but less than 1 year	106,255	10.9%	56,326	7.7%
	At least 1 year but less than 2 years	196,394	20.1%	134,763	18.5%
	At least 2 years but less than 5 years	334,864	34.2%	263,942	36.2%
	5 years or more	249,985	25.5%	225,825	31.0%
	Total	979,031	100.0%	729,209	100.0%
Since you joined your 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?	Refused	1,955	0.3%	0	0.0%
	Do not know	3,075	0.5%	6,276	1.8%
	A big problem	58,353	8.8%	23,736	6.6%
	A small problem	78,130	11.7%	31,642	8.8%
	Not a problem	523,443	78.7%	296,057	82.8%
	Total	664,955	100.0%	357,711	100.0%

² Due to the weighting and carrying percentages out to only one decimal place, there may be very small differences in total numbers and percentages that result from rounding.

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

The importance of parent satisfaction with their children's health care was described previously in this report. **Table 4** provides the mean scores for the 11 CAHPS® Health Plan Survey parental satisfaction composites, or clusters, for the PCCM and the STAR MCO Programs overall. Mean composite scores are also provided for the STAR MCO Program by MCO and MCO SDA. The following results are descriptive. The 11 CAHPS® Health Plan Survey domains are as follows:

- 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 Medication,*
- 7) *Obtaining Specialty Services,*
- 8) *Personal Doctor or Nurse,*
- 9) *Shared Decision Making,*
- 10) *Getting Needed Information, and*
- 11) *Care Coordination.*

Both the lowest and highest score for each domain in **Table 4** are shaded. As previously described, each of the domains had a possible score ranging from 0 to 100.

Overall, the STAR MCO Program and the PCCM Program fared very well in 7 out of 11 domains, scoring at or above 75 points out of a possible 100 points. A score of 75 points indicates that the respondents' experiences were usually or always positive. These domains were the same for both programs: *Doctor's Communication, Doctor's Office Staff, Health Plan Customer Service, Obtaining Prescription Medication, Obtaining Specialty Services, Shared Decision Making, and Getting Needed Information.* The highest scores were for *Obtaining Prescription Medication*, where the mean score was 92.8 in the PCCM Program and 93.2 in the STAR MCO Program. Parents' ratings of the two programs with regard to *Getting Needed Care, Getting Care Quickly, Personal Doctor or Nurse, and Care Coordination* were less favorable. The lowest scores were for the *Personal Doctor or Nurse* composite. Although the PCCM Program mean was only 60.7 out of 100 points, it was still 12.3 points higher than the STAR MCO mean of 48.4 points.

With the exception of the personal doctor domain, the CAHPS® composite scores showed little variation between the PCCM and STAR MCO Programs. In general, composite scores for the PCCM Program were higher than the scores for the STAR MCO Program. The only exception to this is the score for *Obtaining Prescription Medication*, where the STAR MCO Program's score was 0.4 points higher than the score for the PCCM Program. In general, the differences between PCCM and STAR MCO scores were 1) greatest with the *Personal Doctor or Nurse* composite (as discussed before, PCCM scores were 12.3 points higher than the STAR MCO scores for this domain), 2) smallest in the *Care Coordination* composite (PCCM scores were 1.0 points higher than the STAR MCO scores for this domain), and 3) between 2.8 and 6.9 points for the remaining eight domains.

There is some variability in MCO performance within the STAR MCO Program. The highest composite scores were distributed between five MCOs/SDAs. Superior – El Paso scored the highest of all the plans in four domains: *Health Plan Customer Service, Obtaining Prescription*

Medication, Personal Doctor or Nurse, and Care Coordination. El Paso First scored the highest in three domains (*Doctor's Communication, Doctor's Office Staff, and Getting Needed Information*), Community Health Choice scored the highest in two domains (*Getting Needed Care and Shared Decision Making*), and FIRSTCARE and Amerigroup – Tarrant had the highest score in one domain each (*Obtaining Specialty Services and Getting Care Quickly*, respectively).

The lowest scores were concentrated in three MCOs/SDAs. Amerigroup – Harris had the lowest score for four domains: *Getting Care Quickly, Doctor's Communication, Shared Decision Making, and Getting Needed Information.* Superior – Travis had the lowest score in three domains: *Health Plan Customer Service, Obtaining Prescription Medication, and Care Coordination.* Amerigroup – Travis had the lowest score in two domains (*Obtaining Specialty Services and Personal Doctor or Nurse*) and Amerigroup – Tarrant and Parkland Community had the lowest scores in one domain each (*Getting Needed Care and Doctor's Office Staff*, respectively).

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

CAHPS® Cluster Scores / PCCM & STAR MCO	Getting Needed Care	Getting Care Quickly	Doctor's Communication	Doctor's Office Staff	Health Plan Customer Service	Obtaining Prescription Medication	Obtaining Specialty Services	Personal Doctor or Nurse	Shared Decision Making	Getting Needed Information	Care Coordination
PCCM Overall	69.3	67.4	88.8	91.3	90.3	92.8	82.5	60.7	81.0	84.8	67.3
STAR MCO Overall	64.8	63.1	86.0	85.9	85.7	93.2	76.3	48.4	76.8	77.9	66.3
Amerigroup-Dallas	67.3	63.7	86.2	88.2	87.3	93.2	71.6	47.5	73.1	74.9	64.3
Amerigroup-Harris	60.5	59.6	84.2	84.1	88.2	95.5	75.8	52.0	68.7	71.2	77.5
Amerigroup-Tarrant	58.9	67.7	86.2	88.5	86.1	92.3	78.4	47.0	76.3	78.3	56.4
Amerigroup-Travis	64.8	64.3	85.7	85.0	77.7	91.3	71.0	41.4	73.7	79.7	69.1
Community First	68.1	60.1	85.7	85.3	81.6	92.8	75.9	48.9	76.3	79.5	70.4
Community Health Choice	73.9	62.8	86.3	86.8	87.7	94.8	76.5	44.1	84.4	80.0	69.6
El Paso First	69.1	61.6	90.1	88.9	89.7	90.6	78.6	53.3	83.3	85.3	67.9
FIRSTCARE	65.6	66.7	88.0	88.8	89.5	94.3	86.5	55.0	81.9	85.0	72.0
Parkland Community	65.6	61.8	84.9	81.9	81.8	91.8	73.4	45.7	80.0	77.5	63.5
Superior-Bexar	63.8	62.9	87.1	86.6	86.5	93.9	73.9	54.9	80.1	79.6	67.4
Superior-El Paso	69.9	63.2	88.0	86.9	93.6	96.2	75.3	58.1	81.0	81.6	78.5
Superior-Travis	63.1	63.3	85.8	82.0	77.4	89.0	81.0	42.8	75.4	77.1	52.2
Texas Children's	65.2	63.0	85.7	86.3	87.7	94.5	75.6	46.1	75.7	79.6	73.1

Note: The MCOs/SDAs with the highest and lowest scores for each domain are shaded.

Parent Satisfaction with Their Children’s Health Care – Multivariate Results

Satisfaction with health care can be influenced by factors such as the enrollee’s health status and socio-demographic characteristics.^{43, 44} Therefore, we compared parental satisfaction with care for each of the previously described CAHPS® Health Plan Survey composite scores for each MCO after controlling for child health and socio-demographic characteristics.

The following health and socio-demographic variables were used in the logistic regression models:

- (1) The child’s health status regarding the presence of a special health care need as measured by the CSHCN Screener (the reference group is no special needs⁴⁵),
- (2) The child’s race/ethnicity characterized as White, non-Hispanic; Black, non-Hispanic; Hispanic; and Other, non-Hispanic (the reference group is White, non-Hispanic), and
- (3) The caregivers’ educational level characterized as less than a high school education, a high school diploma or GED, some college or vocational school, or a college degree (the reference group is having less than a high school education).

A reference group for the MCOs was selected by using the MCO with the highest score for each CAHPS® Health Plan Survey composite. The purpose of the reference group is to provide a point of comparison for all other MCO scores. Therefore, the results of each MCO are compared to the results of the highest-scoring MCO for each cluster after controlling for the child’s race/ethnicity, health status, and parent education. The MCOs can have scores that are significantly lower than or not significantly different from the MCO serving as the reference.

The outcome variable was the likelihood 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 5 contains a summary of the logistic regression results for 7 of the 11 CAHPS® composites. Logistic regressions for the remaining four CAHPS® composites (*i.e.*, *Obtaining Specialty Services*, *Shared Decision Making*, *Getting Needed Information*, and *Care Coordination*) were not statistically significant and are not presented in **Table 5**. 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 logistic regression results showing the coefficient estimates and confidence intervals for 7 of the 11 CAHPS® composites are contained in Appendix A.

In the descriptive analyses, Community Health Choice had the highest score for the *Getting Needed Care* cluster. After controlling for enrollee health status and race/ethnicity, as well as parental education, the score for Parkland Community was significantly lower than the score for the reference MCO in the *Getting Needed Care* cluster.

For the *Getting Care Quickly* cluster, Amerigroup – Tarrant SDA had the highest score. After controlling for parental educational status, enrollee health status, and race/ethnicity, Community First, El Paso First, and Superior in the Bexar SDA had scores significantly lower than the scores for the reference group in the *Getting Care Quickly* cluster.

El Paso First had the highest score for the *Doctor's Communication* cluster. After controlling for child race/ethnicity, health status, and parental education, the ratings provided by families of children served by Amerigroup – Harris, Community First, Parkland Community, Superior – Travis, and Texas Children's were significantly lower than those of children served by El Paso First.

El Paso First also had the highest score for the *Doctor's Office Staff* cluster. After controlling for parental educational status, enrollee health status, and race/ethnicity, Amerigroup – Harris, Community First, Parkland Community, and Superior in the Travis SDA had scores that were significantly lower than the scores for the reference group in the *Doctor's Office Staff* cluster.

Superior – El Paso had the highest score for the *Health Plan Customer Service* cluster. After controlling for child race/ethnicity, health status, and parental education, the ratings provided by families of children served by Amerigroup – Dallas, Amerigroup – Travis, Community First, Community Health Choice, Parkland Community, Superior – Bexar, and Superior – Travis had significantly lower scores than the scores for Superior – El Paso in the *Health Plan Customer Service* cluster.

Superior – El Paso again had the highest score for the *Obtaining Prescription Medication* cluster. The only MCOs with scores significantly lower than the reference MCO were El Paso First, Parkland Community, and Superior – Travis.

Finally, Superior in the El Paso SDA had the highest score for the *Personal Doctor or Nurse* cluster. After controlling for parental educational status, enrollee health status, and race/ethnicity, Amerigroup – Tarrant, Amerigroup – Travis, Community First, Community Health Choice, Parkland Community, Superior – Travis, and Texas Children's had scores that were significantly lower than the scores for the reference group in the *Personal Doctor or Nurse* cluster.

Table 5. Logistic Regression Results – CAHPS® Health Plan Survey Cluster Scores: Differences Between MCOs in Parental Satisfaction Controlling for Child Race/Ethnicity, Health Status, and Respondent Education

CAHPS® Cluster Scores / PCCM & STAR MCO	Getting Needed Care	Getting Care Quickly	Doctor's Communication	Doctor's Office Staff	Health Plan Customer Service	Obtaining Prescription Medication	Personal Doctor or Nurse
Amerigroup-Dallas	NS	NS	NS	NS	-	NS	NS
Amerigroup-Harris	NS	NS	-	-	NS	NS	NS
Amerigroup-Tarrant	NS	Ref	NS	NS	NS	NS	-
Amerigroup-Travis	NS	NS	NS	NS	-	NS	-
Community First	NS	-	-	-	-	NS	-
Community Health Choice	Ref	NS	NS	NS	-	NS	-
El Paso First	NS	-	Ref	Ref	NS	-	NS
FIRSTCARE	NS	NS	NS	NS	NS	NS	NS
Parkland Community	-	NS	-	-	-	-	-
Superior-Bexar	NS	-	NS	NS	-	NS	NS
Superior-El Paso	NS	NS	NS	NS	Ref	Ref	Ref
Superior-Travis	NS	NS	-	-	-	-	-
Texas Children's	NS	NS	-	NS	NS	NS	-

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

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.⁴⁶ 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 6 provides information on the percentage of respondents reporting that their children needed to see a physician specialist. Overall, 19 percent of children enrolled in the STAR MCO Program and 20 percent of children enrolled in the PCCM Program reported their child needed to see a specialist in the past six months. There was some variation among health plans/SDAs. Respondents whose children were served by Community First reported the highest percentage of children who needed to see a specialist (25 percent) and respondents whose children were served by Amerigroup – Harris reported the lowest percentage of children who needed to see a specialist (13 percent).

Of those children who needed to see a specialist, 59 percent of STAR MCO Program respondents and 64 percent of PCCM Program respondents reported that obtaining a referral for specialty care for their child was “not a problem.” Twenty-seven percent of STAR respondents and 24 percent of PCCM respondents reported they had a “small” problem obtaining care for their child while 13 percent of STAR MCO respondents and 10 percent of PCCM respondents reported experiencing a “big” problem when trying to obtain a referral for a needed specialist for their child. Respondents with children who were provided care by Amerigroup – Travis had the largest percentage who reported a “big” problem getting a referral for a specialist (27 percent) followed by Parkland Community (23 percent) and Superior – Travis (20 percent). This means that one fifth to one quarter of the respondents had a “big” problem obtaining specialty care. Respondents with children enrolled in Amerigroup – Tarrant and Community Health Choice were the least likely to report a “big” problem in accessing specialist care (seven percent each).

Table 6. Families' Experiences with Specialty Care³

Specialty Care		STAR MCO		PCCM	
		N	Percent	N	Percent
In the last 6 months, did you or a doctor think your child needed to see a specialist?	Refused	1,590	0.1%	0	0.0%
	Do not know	2,204	0.2%	2,051	0.2%
	Yes	225,212	19.4%	170,736	20.3%
	No	933,863	80.3%	667,749	79.4%
	Total	1,162,869	100.0%	840,537	100.0%
In the past 6 months, how much of a problem, if any, was it to get a referral to see a specialist that your child needed to see?	Refused	0	0.0%	0	0.0%
	Do not know	2,475	1.1%	4,018	2.4%
	A big problem	29,562	13.1%	17,127	10.0%
	A small problem	60,533	26.9%	41,200	24.1%
	Not a problem	132,642	58.9%	108,391	63.5%
	Total	225,212	100.0%	170,736	100.0%
In the last 6 months, did your child see a specialist?	Refused	758	0.1%	0	0.0%
	Do not know	4,259	0.4%	1,708	0.2%
	Yes	207,583	17.9%	191,749	22.8%
	No	950,269	81.7%	647,080	77.0%
	Total	1,162,869	100.0%	840,537	100.0%
In the last 6 months, was the specialist your child saw most often the same doctor as your child's personal doctor?	Refused	208	0.1%	0	0.0%
	Do not know	2,486	1.2%	2,586	1.3%
	Yes	79,203	38.2%	78,278	40.8%
	No	125,685	60.5%	110,885	57.8%
	Total	207,583	100.0%	191,749	100.0%

Table 7 provides 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. Overall, the reported need for specialized therapies was low. The need for specialized services ranged between two and seven percent of children enrolled in the STAR MCO Program and between one and eight percent of children enrolled in the PCCM Program. Of the specialized services, the need for home health care was the lowest (two percent in the STAR MCO Program and less than one percent in the PCCM Program). The service that was most needed was treatment or counseling for an emotional, behavioral, or developmental problem (seven percent in the STAR MCO Program and eight percent in the PCCM Program).

Table 7 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 number of children in the original (unweighted) sample

³ Due to the weighting and carrying percentages out to only one decimal place, there may be very small differences in total numbers and percentages that result from rounding.

requiring these services, it is difficult to draw any conclusions about the experiences families reported in obtaining these services.

Table 7. Families' Need for Specialized Services⁴

Specialized Services		STAR MCO		PCCM	
		N	Percent	N	Percent
In the last 6 months, did you need someone to come into your home to give home health care or assistance for your child?	Refused	0	0.0%	0	0.0%
	Do not know	1,194	0.1%	0	0.0%
	Yes	20,281	1.7%	3,899	0.5%
	No	1,141,394	98.2%	836,638	99.5%
	Total	1,162,869	100.0%	840,537	100.0%
In the last 6 months, how much of a problem, if any, was it to get these home health services for your child through your child's health plan?	Refused	0	0.0%	0	0.0%
	Do not know	216	1.1%	0	0.0%
	A big problem	1,275	6.3%	0	0.0%
	A small problem	4,197	20.7%	0	0.0%
	Not a problem	14,593	72.0%	3,899	100.0%
	Total	20,281	100.0%	3,899	100.0%
Did anyone from your child's health plan, doctor's office, or clinic help you with this problem?	Refused	0	0.0%	0	0.0%
	Do not know	0	0.0%	0	0.0%
	Yes	3,728	68.1%	0	0.0%
	No	1,744	31.9%	0	0.0%
	Total	5,472	100.0%	0	0.0%
Did you get or try to get any special medical equipment for your child such as a wheelchair, nebulizer, feeding tube, or oxygen equipment?	Refused	0	0.0%	0	0.0%
	Do not know	105	0.0%	0	0.0%
	Yes	66,503	5.7%	62,137	7.4%
	No	1,096,261	94.3%	778,400	92.6%
	Total	1,162,869	100.0%	840,537	100.0%
In the last 6 months, how much of a problem, if any, was it to get the special medical equipment for your child?	Refused	119	0.2%	0	0.0%
	Do not know	326	0.5%	0	0.0%
	A big problem	5,366	8.1%	1,778	2.9%
	A small problem	8,757	13.2%	12,738	20.5%
	Not a problem	51,935	78.1%	47,622	76.6%
	Total	66,503	100.0%	62,137	100.0%

⁴ Due to the weighting and carrying percentages out to only one decimal place, there may be very small differences in total numbers and percentages that result from rounding.

Table 7. Families' Need for Specialized Services (Continued)⁵

Did anyone from your child's health plan, doctor's office, or clinic help you with this problem?	Refused	0	0.0%	0	0.0%
	Do not know	0	0.0%	0	0.0%
	Yes	8,275	58.6%	10,960	75.5%
	No	5,849	41.4%	3,556	24.5%
	Total	14,123	100.0%	14,515	100.0%
In the last 6 months, did you get or try to get special therapy for your child, such as physical, occupational, or speech therapy?	Refused	55	0.0%	0	0.0%
	Do not know	1,292	0.1%	0	0.0%
	Yes	63,611	5.5%	42,989	5.1%
	No	1,097,910	94.4%	797,548	94.9%
	Total	1,162,869	100.0%	840,537	100.0%
In the last 6 months, how much of a problem, if any, was it to get special therapy for your child?	Refused	421	0.7%	0	0.0%
	Do not know	174	0.3%	415	1.0%
	A big problem	9,941	15.6%	5,298	12.3%
	A small problem	12,812	20.1%	8,200	19.1%
	Not a problem	40,264	63.3%	29,076	67.6%
	Total	63,612	100.0%	42,989	100.0%
Did anyone from your child's health plan, doctor's office, or clinic help you with this problem?	Refused	0	0.0%	0	0.0%
	Do not know	0	0.0%	0	0.0%
	Yes	13,904	61.1%	6,907	51.2%
	No	8,848	38.9%	6,591	48.8%
	Total	22,752	100.0%	13,498	100.0%
In the last 6 months, did you get or try to get treatment or counseling for your child for an emotional, behavioral, or developmental problem?	Refused	260	0.0%	0	0.0%
	Do not know	886	0.1%	0	0.0%
	Yes	78,487	6.7%	63,390	7.5%
	No	1,083,235	93.2%	777,147	92.5%
	Total	1,162,869	100.0%	840,537	100.0%
In the last 6 months, how much of a problem, if any, was it to get the treatment or counseling your child needed through his/her health plan?	Refused	0	0.0%	0	0.0%
	Do not know	0	0.0%	868	1.4%
	A big problem	13,645	17.4%	6,089	9.6%
	A small problem	22,881	29.2%	16,105	25.4%
	Not a problem	41,962	53.5%	40,329	63.6%
	Total	78,487	100.0%	63,390	100.0%

⁵ Due to the weighting and carrying percentages out to only one decimal place, there may be very small differences in total numbers and percentages that result from rounding.

Table 7. Families' Need for Specialized Services (Continued)⁶

Did anyone from your child's health plan, doctor's office, or clinic help you with this problem?	Refused	0	0.0%	0	0.0%
	Do not know	347	0.9%	0	0.0%
	Yes	15,379	42.1%	10,937	49.3%
	No	20,800	56.9%	11,256	50.7%
	Total	36,526	100.0%	22,193	100.0%

Access to Needed Care

Table 8 contains information regarding the percentage of children sampled from the STAR MCO Program and the PCCM Program who needed care, tests, or treatment and their experiences obtaining care. Overall, for the STAR MCO Program, 32 percent of respondents reported their children needed care, tests, or treatment. For the PCCM Program, 34 percent of respondents reported their children needed health services. Of the children who needed these services, the majority of respondents (70 percent for STAR; 76 percent for PCCM) reported obtaining needed care was “not a problem.” Families with children served by Superior – Travis, Parkland Community, and Texas Children’s reported the most problems obtaining care compared to other MCOs. Superior – Travis had the largest percentage of respondents who reported that it was a “big” problem to get care for their children (17 percent). Additionally, 17 percent had a “small” problem obtaining care and 66 percent said it was “not a problem.” Parkland Community and Texas Children’s had the smallest percentage of respondents who indicated that getting needed care was “not a problem” (60 percent and 61 percent, respectively). Although a small minority in these health plans said getting needed care was a “big” problem (five percent and 11 percent, respectively), close to one third (32 percent and 28 percent, respectively) had a “small” problem obtaining needed care.

Table 8 also provides information about the percentage of children who needed approval from their MCO for care, tests, or treatment and their experiences obtaining approval. Sixteen percent of respondents with children enrolled in the STAR MCO Program reported their children needed approval from their MCO. Of those who needed approval, 65 percent reported that delays in obtaining approval were “not a problem,” 23 percent reported that delays obtaining approval were a “small” problem, and 12 percent reported that delays obtaining approval were a “big” problem. In comparison, of those children in the PCCM Program who needed approval (11 percent), 58 percent of their caregivers reported that delays obtaining approval were “not a problem,” 23 percent reported they were a “small” problem, and 20 percent reported they were a “big” problem. The PCCM Program findings should be viewed cautiously because only 60 respondents in the original (unweighted) sample reported prior approval for their child’s care was necessary.

⁶ Due to the weighting and carrying percentages out to only one decimal place, there may be very small differences in total numbers and percentages that result from rounding.

Table 8. Access to Needed Care

Access to Needed Care		STAR MCO		PCCM	
		N	Percent	N	Percent
In the last 6 months, did you or a doctor believe your child needed any care, tests, or treatment?	Refused	959	0.1%	1,187	0.2%
	Do not know	6,169	0.6%	3,560	0.5%
	Yes	308,598	32.4%	235,827	33.9%
	No	635,568	66.8%	455,516	65.4%
	Total	951,293	100.0%	696,090	100.0%
In the last 6 months, how much of a problem, if any, was it to get tests or treatment for your child that you or a doctor believed necessary?	Refused	0	0.0%	0	0.0%
	Do not know	3,058	1.0%	1,781	0.8%
	A big problem	24,337	7.9%	12,725	5.4%
	A small problem	66,603	21.6%	42,206	17.9%
	Not a problem	214,600	69.5%	179,115	76.0%
	Total	308,598	100.0%	235,827	100.0%
In the last 6 months, did your child need approval from your health plan for any care, tests, or treatment?	Refused	1,228	0.1%	0	0.0%
	Do not know	9,660	1.0%	11,593	1.7%
	Yes	150,667	15.8%	78,805	11.3%
	No	789,737	83.0%	605,691	87.0%
	Total	951,293	100.0%	696,090	100.0%
In the last 6 months, how much of a problem, if any, were delays in your health care while you waited approval from your child's health plan?	Refused	208	0.1%	0	0.0%
	Do not know	719	0.5%	0	0.0%
	A big problem	17,280	11.5%	15,577	19.8%
	A small problem	34,767	23.1%	17,954	22.8%
	Not a problem	97,693	64.8%	45,275	57.5%
	Total	150,667	100.0%	78,805	100.0%

Transitioning to Adult Care

Caregivers of CSHCN who were 11 years of age and older were asked questions about how their doctors and other health care providers are preparing them for transition from pediatric to adult care. **Table 9** includes information on (1) the percentage of children who were receiving care from pediatricians, (2) whether their doctors and other health care providers have discussed important issues about the child's transition to adult care, and (3) whether their parents would have found such a discussion helpful.

As more children with a chronic health condition or disability are surviving into adulthood, the need for a seamless transition into an adult health care setting is growing. Access to quality and uninterrupted health care is essential for the health of these adolescents. Many adolescents will age out of their pediatric facilities between the ages of 18 to 21. Retaining insurance coverage as they become adults can be difficult. Private health insurance is often through the parents and ends between the ages of 18 and 23. Title V public funding typically ends at age 21; the eligibility for Supplemental Security Income becomes more stringent, resulting in the loss of Medicaid coverage, and Medicaid benefits may change even if eligibility is retained.⁴⁷ Additionally, youth with special health care needs are often not used to taking care of their own health care needs or coordinating their own care.⁴⁸ The

need to address these issues was incorporated into the Healthy People 2010 objective that encouraged states to create a service system to meet the complex needs of CSHCN.⁴⁹

Of the respondents who care for CSHCN 11 years of age and older, more than half indicated their child received care from a pediatrician (58 percent in the STAR MCO Program and 52 percent in the PCCM Program). Of those whose child received care from a pediatrician, 22 percent from the STAR Program and 10 percent from the PCCM Program noted their pediatrician has discussed with them finding doctors who treat adults.

Of the other issues included in the survey, doctors and other health care providers were more likely to have discussed the child's changing health care needs as they become an adult (48 percent of respondents whose child was enrolled in the STAR MCO Program and 43 percent of respondents whose child was enrolled in the PCCM Program). Doctors and other health care providers were less likely to have discussed obtaining insurance coverage as the child becomes an adult (13 percent in the STAR Program and 14 percent in the PCCM Program). These rates are similar to rates found using data from the 2001 National Survey of Children with Special Health Care Needs.⁵⁰ Analyses showed that those children who were identified as having a medical home or a usual source of care were more likely to have discussed transitional issues with their doctors. This highlights the importance of the personal doctor's role in transitioning youth with special health care needs from pediatric to adult care.

Although the lack of such a discussion was the norm with all issues, the majority of parent respondents indicated a desire for this type of discussion. Very few doctors and other health care providers discussed obtaining insurance for the child during the transition to adulthood, but this discussion would have been helpful to 79 percent of STAR MCO respondents and 77 percent of PCCM respondents. Seventy-two percent of STAR MCO respondents and 63 percent of PCCM respondents reported that a discussion on their child's changing health care needs during the transition to adulthood would have been helpful.

Table 9. Transitioning from Child to Adult Care^{7,8}

Transitioning to Adult Care		STAR MCO		PCCM	
		N	Percent	N	Percent
Do any of your child's doctors or health care providers treat only children?	Refused	0	0.0%	0	0.0%
	Do not know	2,586	3.2%	2,899	4.7%
	Yes	46,577	58.4%	32,162	51.6%
	No	30,590	38.4%	27,218	43.7%
	Total	79,752	100.0%	62,279	100.0%
Have any of your child's doctors talked to you about having your child eventually see doctors or other health care providers who treat adults?	Refused	0	0.0%	0	0.0%
	Do not know	152	0.3%	0	0.0%
	Yes	10,033	21.5%	3,188	9.9%
	No	36,391	78.1%	28,974	90.1%
	Total	46,577	100.0%	32,162	100.0%

⁷ Due to the weighting and carrying percentages out to only one decimal place, there may be very small differences in total numbers and percentages that result from rounding.

⁸ These questions were only asked if the respondent's child was 11 years of age or older and they had a special health care need as identified by the CSHCN Screener.

Table 9. Transitioning from Child to Adult Care (Continued)^{9,10}

Would a discussion about doctors who treat adults have been helpful to you?	Refused	475	1.3%	0	0.0%
	Do not know	530	1.5%	0	0.0%
	Yes	20,878	57.4%	9,608	33.2%
	No	14,509	39.9%	19,366	66.8%
	Total	36,391	100.0%	28,974	100.0%
Have your child's doctors or other health care providers talked to you or your child about his/her health care needs as he/she becomes an adult?	Refused	784	1.0%	0	0.0%
	Do not know	0	0.0%	1,689	2.7%
	Yes	38,065	47.7%	26,813	43.1%
	No	40,904	51.3%	33,777	54.2%
	Total	79,752	100.0%	62,279	100.0%
Would a discussion about your child's changing health care needs have been helpful to you?	Refused	0	0.0%	0	0.0%
	Do not know	219	0.5%	2,160	6.4%
	Yes	29,232	71.5%	21,178	62.7%
	No	11,453	28.0%	10,438	30.9%
	Total	40,904	100.0%	33,777	100.0%
Has anyone discussed with you how to obtain or keep some type of health insurance coverage as your child becomes an adult?	Refused	0	0.0%	0	0.0%
	Do not know	894	1.1%	0	0.0%
	Yes	10,537	13.2%	8,785	14.1%
	No	68,321	85.7%	53,494	85.9%
	Total	79,752	100.0%	62,279	100.0%
Would a discussion about health insurance have been helpful to you?	Refused	475	0.7%	0	0.0%
	Do not know	784	1.1%	1,187	2.2%
	Yes	53,632	78.5%	41,212	77.0%
	No	13,430	19.7%	11,095	20.7%
	Total	68,321	100.0%	53,494	100.0%
How often do your child's doctors or other health care providers encourage him/her to take responsibility for health care needs, such as taking medication, understanding his/her health, or following medical advice?	Refused	383	0.5%	1,689	2.7%
	Do not know	625	0.8%	0	0.0%
	Never	9,735	12.2%	6,852	11.0%
	Sometimes	11,102	13.9%	9,560	15.4%
	Usually	12,863	16.1%	18,942	30.4%
	Always	45,045	56.5%	25,236	40.5%
	Total	79,752	100.0%	62,279	100.0%

⁹ Due to the weighting and carrying percentages out to only one decimal place, there may be very small differences in total numbers and percentages that result from rounding.

¹⁰ These questions were only asked if the respondent's child was 11 years of age or older and they had a special health care need as identified by the CSHCN Screener.

Summary and Recommendations

The major findings of this survey are as follows:

- The majority of children in both programs whose families responded to the survey were Hispanic – 54 percent for STAR MCO Program enrollees and 58 percent for PCCM Program enrollees.
- Sixteen percent of children enrolled in the STAR MCO Program and 17 percent of children enrolled in the PCCM Program were identified as having a special health care need using the Children with Special Health Care Needs (CSHCN) Screener, which is higher than the general population estimate of 12 percent in Texas (also obtained using the CSHCN Screener on the National Survey of CSHCN).
- Overall, 84 percent of STAR MCO Program respondents and 87 percent of PCCM Program respondents reported their child had a specific person—a personal doctor or nurse—who provided their health care. This person was most often a general doctor (79 percent in both programs).
- While there are no specific standards or national data for what would constitute an acceptable score for the CAHPS® Health Plan Survey composites, 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 the STAR MCO Program and the PCCM Program performed well in 7 of the 11 CAHPS® Health Plan Survey composites. However, improvements are needed in the areas of *Getting Needed Care* (65 points in STAR and 69 points in PCCM), *Getting Care Quickly* (63 points in STAR and 67 points in PCCM), *Personal Doctor or Nurse* (48 points in STAR and 61 points in PCCM), and *Care Coordination* (66 points in STAR and 67 points in PCCM). In general, composite scores for the PCCM Program were higher than the scores for the STAR MCO Program. One exception to this is the *Obtaining Prescription Medicine* composite where the STAR MCO Program’s score was 0.4 points higher than the score for the PCCM Program.
- There were some significant differences between the MCOs in their performance on the CAHPS® Health Plan Survey composites after controlling for child enrollee health status, race/ethnicity, and respondent education status. In the multivariate analyses, Parkland Community had significantly lower scores in six of the seven CAHPS® Health Plan Survey domains with significant results in the regressions. Superior – Travis and Community First had significantly lower scores in five of the seven CAHPS® Health Plan Survey domains with significant results in the regressions.
- Overall, 19 percent of respondents with children enrolled in the STAR MCO Program and 20 percent of respondents with children enrolled in the PCCM Program reported their child needed to see a specialist in the past six months. Twenty-seven percent of STAR respondents and 24 percent of PCCM respondents reported they had a “small” problem obtaining care, and 13 percent of STAR MCO respondents and 10 percent of PCCM respondents reported experiencing a “big” problem when trying to obtain a needed specialist for their child.
- Overall reported need for specialized services, such as home health care, medical equipment, physical therapy, or mental health services, was very low. The need for such services ranged between two and seven percent in the STAR MCO Program and between one to eight percent in the PCCM Program. The majority of respondents reported that obtaining these specialized services was “not a problem.”
- Sixteen percent of STAR MCO Program respondents and 11 percent of PCCM Program respondents reported their children needed approval from their MCO for care, tests, or

treatment. Of those who needed approval, the majority (65 percent for STAR and 58 percent for PCCM) reported that obtaining needed care was “not a problem.”

- Families of adolescents with a special health care need often received care from doctors who only treat children (58 percent in the STAR MCO Program and 52 percent in the PCCM Program). Parents indicated that although doctors and other health care providers rarely discussed issues relating to their child’s transition to adult care, they would have found this type of discussion helpful.

The Texas Health and Human Services Commission (HHSC) may wish to consider the following strategies when developing future policy regarding health insurance for children receiving Medicaid.

- **Strategies to increase performance related to *Getting Needed Care, Getting Care Quickly, Personal Doctor or Nurse, and Care Coordination* should be explored.** All of these fell below the 75 point criterion for both the STAR MCO and PCCM Programs. Strategies should be developed to address deficiencies in these areas including: (1) reviewing MCO provider panels to ensure adequate numbers of and access to primary and specialty care providers, (2) reviewing procedures that facilitate connections for children and families with needed services and resources, and (3) reviewing authorization procedures to ensure that care can be rendered quickly. In addition, the American Academy of Pediatrics (AAP) has training programs related to providing a medical home, which include components that discuss issues related to families’ positive experiences with their child’s personal doctor.
- **Monitor care of children with special health care needs in the program.** A higher percentage of children with special health care needs are enrolling in the program than one might expect based on state estimates (16 percent of children enrolled in the STAR MCO Program and 17 percent of children enrolled in the PCCM Program compared to 12 percent in the general Texas population). Based on this finding, HHSC might consider increasing emphasis on monitoring the quality of care for these children by using ongoing indicators specifically addressing CSHCN and/or focus studies. Families of adolescents with a special health care need are not getting the support they need from their doctors and other health care providers for their child’s upcoming transition from pediatric to adult care. Although many of these adolescents are receiving care from pediatricians, their doctors are not discussing important issues such as the child’s changing health care needs or obtaining insurance for their child as they become an adult. Most parents indicated that this type of discussion would be helpful to them.

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)

Likelihood of Usually or Always Getting Needed Care (MCO Reference = Community Health Choice)

need1	Coef.	Std. Err.	t	P> t	[95% Conf. Interval]	
cshcn	-1.645046	.1678652	-9.80	0.000	-1.974315	-1.315777
hispanic	-.078797	.1937523	-0.41	0.684	-.4588439	.30125
black	-.3361687	.2419339	-1.39	0.165	-.8107244	.1383869
other	-.7156453	.4337003	-1.65	0.099	-1.566353	.135062
hsgrad1	.0311824	.1661941	0.19	0.851	-.294809	.3571737
somecoll1	.1273193	.2147754	0.59	0.553	-.2939648	.5486034
collgrad1	-.0787654	.2216046	-0.36	0.722	-.513445	.3559142
ameridallas	-.0605131	.3000156	-0.20	0.840	-.6489967	.5279704
ameriharris	-.4070712	.3132467	-1.30	0.194	-1.021508	.2073653
ameritarrant	-.5679795	.2962818	-1.92	0.055	-1.149139	.0131801
ameritravis	-.3301134	.3022336	-1.09	0.275	-.9229476	.2627207
comfirst	-.418221	.29079	-1.44	0.151	-.9886085	.1521665
elpasso	-.3353735	.2886418	-1.16	0.245	-.9015471	.2308001
fcare	-.2370348	.2843235	-0.83	0.405	-.7947381	.3206685
park	-.6497234	.2992038	-2.17	0.030	-1.236615	-.0628323
supbexar	-.3578232	.2772934	-1.29	0.197	-.9017369	.1860904
supelpaso	-.2084051	.2915825	-0.71	0.475	-.7803469	.3635367
suptravis	-.300496	.2756812	-1.09	0.276	-.8412473	.2402554
txchildren	-.4659234	.3018082	-1.54	0.123	-1.057923	.1260762
_cons	.6611736	.2793169	2.37	0.018	.1132907	1.209057

Likelihood of Usually or Always Getting Care Quickly (MCO Reference = Amerigroup-Tarrant)

quick1	Coef.	Std. Err.	t	P> t	[95% Conf. Interval]	
cshcn	.1101411	.1220066	0.90	0.367	-.1290793	.3493615
hispanic	-.2449722	.1373259	-1.78	0.075	-.5142293	.024285
black	-.5255545	.1708419	-3.08	0.002	-.8605271	-.1905819
other	-.7902494	.2775885	-2.85	0.004	-1.334522	-.245977
hsgrad1	-.0855135	.1053368	-0.81	0.417	-.2920492	.1210222
somecoll1	.1004112	.1381277	0.73	0.467	-.1704181	.3712406
collgrad1	-.1416528	.1661429	-0.85	0.394	-.4674119	.1841063
ameridallas	-.1513777	.1928203	-0.79	0.432	-.5294437	.2266883
ameriharris	-.2875097	.1986186	-1.45	0.148	-.6769444	.1019251
ameritravis	-.3172226	.2009325	-1.58	0.114	-.7111944	.0767492
comfirst	-.6524921	.2024789	-3.22	0.001	-1.049496	-.2554884
chc	-.2467686	.1980043	-1.25	0.213	-.634999	.1414617
elpasso	-.4764874	.1975235	-2.41	0.016	-.8637751	-.0891998
fcare	-.0670534	.1904362	-0.35	0.725	-.4404449	.306338
park	-.3401307	.1996559	-1.70	0.089	-.7315995	.051338
supbexar	-.4150387	.1963974	-2.11	0.035	-.8001185	-.0299589
supelpaso	-.2176782	.1996565	-1.09	0.276	-.609148	.1737916
suptravis	-.1260363	.1949394	-0.65	0.518	-.5082573	.2561846
txchildren	-.2973551	.2038428	-1.46	0.145	-.6970331	.1023229
_cons	.098902	.1912896	0.52	0.605	-.2761627	.4739667

Likelihood of Usually or Always Having Positive Experience with Doctor's Communication
(MCO Reference = El Paso First)

doctor1	Coef.	Std. Err.	t	P> t	[95% Conf. Interval]	
cshcn	.0863124	.1451046	0.59	0.552	-.198203	.3708278
hispanic	-.0660485	.1639716	-0.40	0.687	-.3875575	.2554606
black	.4006757	.2175493	1.84	0.066	-.0258865	.8272378
other	-.8007414	.2831256	-2.83	0.005	-1.355883	-.2455999
hsgrad1	.0115847	.1214706	0.10	0.924	-.22659	.2497594
somecoll1	.3794423	.1636674	2.32	0.020	.0585298	.7003549
collgrad1	.3545332	.2081168	1.70	0.089	-.0535341	.7626006
ameridallas	-.3111833	.2485181	-1.25	0.211	-.7984678	.1761012
ameriharris	-.7330118	.2329303	-3.15	0.002	-1.189733	-.2762911
ameritarrant	-.4038707	.2501314	-1.61	0.106	-.8943186	.0865771
ameritravis	-.4701616	.2609265	-1.80	0.072	-.981776	.0414528
comfirst	-.6019027	.2427117	-2.48	0.013	-1.077802	-.126003
chc	-.4432992	.2470235	-1.79	0.073	-.9276532	.0410549
fcare	-.3081143	.2467715	-1.25	0.212	-.7919742	.1757456
park	-.5723588	.2419907	-2.37	0.018	-1.046845	-.0978728
supbexar	-.3314485	.2444588	-1.36	0.175	-.8107737	.1478767
supelpaso	-.102535	.2602323	-0.39	0.694	-.6127884	.4077183
suptravis	-.5964356	.2441686	-2.44	0.015	-1.075192	-.1176794
txchildren	-.5132064	.2444352	-2.10	0.036	-.9924853	-.0339275
_cons	1.551093	.2520315	6.15	0.000	1.056919	2.045266

Likelihood of Usually or Always Having Positive Experience with Doctor's Office Staff
(MCO Reference = El Paso First)

officel	Coef.	Std. Err.	t	P> t	[95% Conf. Interval]	
cshcn	.110457	.1414891	0.78	0.435	-.1669693	.3878833
hispanic	-.279949	.1649697	-1.70	0.090	-.6034151	.043517
black	.0952245	.2119905	0.45	0.653	-.3204383	.5108873
other	-.6317013	.2882565	-2.19	0.028	-1.196903	-.0664992
hsgrad1	.0649176	.1194625	0.54	0.587	-.1693199	.2991551
somecoll1	.1488251	.156151	0.95	0.341	-.1573497	.4549999
collgrad1	.207166	.1921009	1.08	0.281	-.169498	.58383
ameridallas	-.1289178	.2393305	-0.54	0.590	-.5981877	.3403521
ameriharris	-.5741873	.2230477	-2.57	0.010	-1.011531	-.1368439
ameritarrant	-.4436628	.2367973	-1.87	0.061	-.9079658	.0206401
ameritravis	-.3025931	.2453064	-1.23	0.217	-.7835804	.1783942
comfirst	-.5589979	.2288575	-2.44	0.015	-1.007733	-.1102631
chc	-.2711614	.2429906	-1.12	0.265	-.747608	.2052852
fcare	-.3456501	.2311196	-1.50	0.135	-.7988205	.1075203
park	-.6475236	.2278091	-2.84	0.005	-1.094203	-.2008444
supbexar	-.2800308	.2332906	-1.20	0.230	-.737458	.1773963
supelpaso	-.1583839	.23961	-0.66	0.509	-.6282018	.3114341
suptravis	-.7126355	.2291725	-3.11	0.002	-1.161988	-.2632828
txchildren	-.3963651	.2343795	-1.69	0.091	-.8559273	.0631972
_cons	1.601009	.2449748	6.54	0.000	1.120672	2.081346

Likelihood of Usually or Always Having Positive Experience with Health Plan Customer Service (MCO Reference = Superior-El Paso)

custserv1	Coef.	Std. Err.	t	P> t	[95% Conf. Interval]	
csn	-.3354579	.1563529	-2.15	0.032	-.6420924	-.0288233
hispanic	.3235633	.1774058	1.82	0.068	-.0243594	.671486
black	.5336755	.229399	2.33	0.020	.0837853	.9835658
other	-.1314395	.3335856	-0.39	0.694	-.7856573	.5227782
hsgrad1	.2350177	.1539561	1.53	0.127	-.0669162	.5369515
somecoll1	-.1945045	.1838767	-1.06	0.290	-.5551176	.1661087
collgrad1	-.5338947	.2113024	-2.53	0.012	-.9482943	-.1194951
ameridallas	-.6995703	.3310319	-2.11	0.035	-1.34878	-.0503609
ameriharris	-.610901	.3407065	-1.79	0.073	-1.279084	.0572819
ameritarrant	-.5098986	.3366585	-1.51	0.130	-1.170143	.1503456
ameritravis	-1.399274	.3174599	-4.41	0.000	-2.021866	-.7766813
comfirst	-1.10427	.3217983	-3.43	0.001	-1.735371	-.4731693
chc	-.6702626	.3386621	-1.98	0.048	-1.334436	-.0060892
elpaso	-.4738045	.3511572	-1.35	0.177	-1.162483	.214874
fcare	-.4476352	.3310599	-1.35	0.176	-1.096899	.2016291
park	-.967571	.3215893	-3.01	0.003	-1.598262	-.33688
supbexar	-.7817501	.3261633	-2.40	0.017	-1.421411	-.1420888
suptravis	-1.474421	.3204623	-4.60	0.000	-2.102902	-.84594
txchildren	-.5971883	.3440341	-1.74	0.083	-1.271897	.0775207
_cons	1.613623	.3347762	4.82	0.000	.9570704	2.270176

Likelihood of Usually or Always Having Positive Experience Obtaining Prescription Medication (MCO Reference = Superior-El Paso)

pharm1	Coef.	Std. Err.	t	P> t	[95% Conf. Interval]	
csn	-.9008731	.1900703	-4.74	0.000	-1.273618	-.5281277
hispanic	.1332562	.2330204	0.57	0.567	-.3237182	.5902305
black	.5321501	.3148914	1.69	0.091	-.085381	1.149681
other	-.4204916	.4246267	-0.99	0.322	-1.253224	.4122404
hsgrad1	.0955159	.2174595	0.44	0.661	-.3309423	.521974
somecoll1	-.2336036	.2588913	-0.90	0.367	-.7413132	.274106
collgrad1	.0012129	.3038509	0.00	0.997	-.5946666	.5970925
ameridallas	-.6668077	.4218154	-1.58	0.114	-1.494027	.1604111
ameriharris	-.3747435	.4665995	-0.80	0.422	-1.289788	.5403012
ameritarrant	-.646353	.434558	-1.49	0.137	-1.498561	.2058553
ameritravis	-.5539972	.4657191	-1.19	0.234	-1.467315	.3593209
comfirst	-.715012	.4217239	-1.70	0.090	-1.542051	.1120275
chc	-.3750345	.4531803	-0.83	0.408	-1.263763	.5136939
elpaso	-1.127084	.3975445	-2.84	0.005	-1.906705	-.3474629
fcare	-.4258187	.421197	-1.01	0.312	-1.251825	.4001875
park	-.8918998	.4227543	-2.11	0.035	-1.72096	-.0628397
supbexar	-.3120537	.4241168	-0.74	0.462	-1.143786	.5196785
suptravis	-.9523189	.4225152	-2.25	0.024	-1.78091	-.1237277
txchildren	-.3781612	.4498336	-0.84	0.401	-1.260326	.5040038
_cons	2.860642	.4327792	6.61	0.000	2.011922	3.709362

Likelihood of Usually or Always Having Positive Experience with Personal Doctor or Nurse
(MCO Reference = Superior-El Paso)

persondr1	Coef.	Std. Err.	t	P> t	[95% Conf. Interval]	
cshcn	.2570336	.1169661	2.20	0.028	.0277073	.4863599
hispanic	.3968189	.1322315	3.00	0.003	.137563	.6560749
black	.1087419	.1609683	0.68	0.499	-.2068561	.4243398
other	.0505941	.2570499	0.20	0.844	-.4533834	.5545716
hsgrad1	.0686171	.0971275	0.71	0.480	-.1218133	.2590474
somecoll1	.2264583	.1281056	1.77	0.077	-.0247083	.4776248
collgrad1	.1312943	.1564795	0.84	0.401	-.1755028	.4380913
ameridallas	-.3183655	.1865366	-1.71	0.088	-.6840932	.0473622
ameriharris	-.1855695	.180207	-1.03	0.303	-.5388872	.1677483
ameritarrant	-.4632183	.184009	-2.52	0.012	-.8239903	-.1024463
ameritravis	-.7035316	.1880921	-3.74	0.000	-1.072309	-.3347541
comfirst	-.3642863	.1807064	-2.02	0.044	-.7185832	-.0099894
chc	-.5624034	.1855086	-3.03	0.002	-.9261156	-.1986913
el Paso	-.1617644	.1751187	-0.92	0.356	-.5051058	.1815771
fcare	-.1205799	.1790255	-0.67	0.501	-.4715811	.2304213
park	-.4843811	.183485	-2.64	0.008	-.8441256	-.1246365
supbexar	-.1342944	.1775107	-0.76	0.449	-.4823257	.2137369
suptravis	-.5776631	.1817108	-3.18	0.001	-.9339292	-.2213971
txchildren	-.3768645	.1847855	-2.04	0.041	-.739159	-.01457
_cons	-.2884677	.1934593	-1.49	0.136	-.6677681	.0908327

Notes

- ¹ Halfon, N., M. Inkelas, R. Mistry, and L. M. Olson. 2004. "Satisfaction with Health Care for Young Children." *Pediatrics* 113 (6 suppl.): 1965-1972.
- ² Mangione-Smith, R., and E. A. McGlynn. 1998. "Assessing the Quality of Healthcare Provided to Children." *Health Services Research* 33 (4 Pt 2): 1059-1090.
- ³ Darby, C. 2002. "Patient/Parent Assessment of the Quality of Care." *Ambulatory Pediatrics* 2 (4 suppl.): 345-348.
- ⁴ Schempf AH, Minkowitz CS, Strobino DM, Guyer B. 2007. "Parental Satisfaction with Early Pediatric Care and Immunization of Young Children: The Mediating Role of Age-Appropriate Well-Child Care Utilization." *Archives of Pediatric Adolescent Medicine* 2007 Jan; 161(1): 50-6.
- ⁵ Primary Care Case Management (PCCM) was originally a health plan model within the STAR Program which enrollees could select for their health care coverage. On September 1, 2005, PCCM exited from within the STAR areas it covered, except for the Southeast Region Service Area, and expanded to a total 197 Texas counties. The PCCM Program enrollees surveyed were those who resided within the expansion counties.
- ⁶ 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 the STAR MCO survey, for example, 84.19 percent of respondents replied "yes" to this question. Due to our confidence interval, we can say that we are 95 percent certain that the "true" response lies between 85.94 percent and 82.44 percent.
- ⁷ American Association of Public Opinion Research. *Standards and Best Practices*. [Accessed on July 25, 2007]. Available at <http://www.aapor.org/standards.asp>.
- ⁸ Anarella, J., P. Roohan, E. Balistreri, and F. Gesten. 2004. "A Survey of Medicaid Recipients with Asthma - Perceptions of Self-Management, Access, and Care." *Chest* 125 (4): 1359-1367.
- ⁹ Dick, A. W., C. Brach, R. A. Allison, E. Shenkman, L. P. Shone, P. G. Szilagyi, J. D. Klein, and E. M. Lewit. 2004. "SCHIP's Impact in Three States: How Do the Most Vulnerable Children Fare?" *Health Affairs* 23 (5): 63-75.
- ¹⁰ Coughlin, T. A., S. K. Long, and S. Kendall. 2002. "Health Care Access, Use, and Satisfaction Among Disabled Medicaid Beneficiaries." *Health Care Financing Review* 24 (2): 115-136.
- ¹¹ Blumberg, S. J., L. Olson, M. R. Frankel, L. Osborn, K. P. Srinath, and P. Giambo. 2005. *Design and Operation of the National Survey of Children's Health, 2003*. National Center for Health Statistics. Vital and Health Statistics 1(43).
- ¹² Levy, P. S., and S. Lemeshow. 1999. *Sampling of Populations: Methods and Applications*. New York NY: John Wiley & Sons.
- ¹³ 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." [Accessed on July 25, 2007]. Available at https://www.cahps.ahrq.gov/CAHPS_UsageGuide.asp.

-
- ¹⁴ National Committee for Quality Assurance. 2006. *HEDIS® 2007: Specifications for Survey Measures*. Washington, D.C.
- ¹⁵ U.S. Agency for Healthcare Research and Quality. 2002. *Article 8: CAHPS Reporting Composites and Global Ratings, CAHPS Survey and Reporting Kit*.
- ¹⁶ 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.
- ¹⁷ Hargraves, J. L., R. D. Hays, and P. D. Cleary. 2003. "Psychometric Properties of the Consumer Assessment of Health Plans Study (CAHPS) 2.0 Adult Core Survey." *Health Services Research* 38 (6 Pt 1): 1509-1527.
- ¹⁸ Bethell, C. D., D. Read, R. E. K. Stein, S. J. Blumberg, N. Wells, and P. W. Newacheck. 2002. "Identifying Children With Special Health Care Needs: Development and Evaluation of a Short Screening Instrument." *Ambulatory Pediatrics* 2 (1): 38-48.
- ¹⁹ Maternal and Child Health Bureau. *Definition of Children with Special Health Care Needs*. [Accessed on July 25, 2007]. Available at <http://mchb.hrsa.gov/about/dscshn.htm>.
- ²⁰ Centers for Disease Control and Prevention, *SLAITS National Survey of Children with Special Health Care Needs II*, CATI Specifications, July 6, 2005. [Accessed on July 25, 2007]. Available at http://www.cdc.gov/nchs/data/slaits/cshcn2005_english.pdf.
- ²¹ Centers for Disease Control and Prevention, National Center for Health Statistics. *National Health Interview Survey*. [Accessed on July 25, 2007]. Available at <http://www.cdc.gov/nchs/nhis.htm>.
- ²² U.S. Census Bureau. 2002. *Current Population Survey: Design and Methodology*. [Accessed on July 25, 2007]. Available at <http://www.census.gov/prod/2002pubs/tp63rv.pdf>.
- ²³ Urban Institute. *National Survey of America's Families*. [Accessed on July 25, 2007]. Available at <http://www.urban.org/center/anf/nsaf.cfm> for information.
- ²⁴ Keeter, S. 1995. "Estimating Telephone Noncoverage Bias with a Telephone Survey." *Public Opinion Quarterly* 59 (2): 196-217.
- ²⁵ Weinick, R. M., and N. A. Krauss. 2000. "Racial/Ethnic Differences in Children's Access to Care." *American Journal of Public Health* 90 (11): 1771-1774.
- ²⁶ Healthcare Financial Management Association. 2004. "Percentage of Population with No Usual Source of Health Care by Race/Ethnicity and Age", Healthcare Financial Management. [Accessed on July 25, 2007]. Available at http://www.findarticles.com/p/articles/mi_m3257/is_8_58/ai_n6154179.
- ²⁷ Weech-Maldonado, R., L. S. Morales, K. Spritzer, M. Elliot, and R. D. Hays. 2001. "Racial and Ethnic Differences in Parents' Assessments of Pediatric Care in Medicaid Managed Care." *Health Services Research* 36 (3): 575-594.
- ²⁸ Weech-Maldonado, R., L. S. Morales, M. Elliot, K. Spritzer, G. Marshall, and R. D. Hays. 2003. "Race/Ethnicity, Language, and Patients' Assessments of Care in Medicaid Managed Care." *Health Services Research* 38 (3): 789-808.
- ²⁹ Borders, T. F., A. Brannon-Goedeke, A. Arif, and K. T. Xu. 2004. "Parents' Reports of Children's Medical Care Access: Are There Mexican-American versus Non-Hispanic White Disparities?" *Medical Care* 42 (9): 884-892.

-
- ³⁰ Blumberg, S. J. 2003. *Comparing States Using Survey Data on Health Care Services for Children with Special Health Care Needs (CSHCN)*. Centers for Disease Control and Prevention, National Center for Health Statistics. [Accessed on July 25, 2007]. Available at http://www.cdc.gov/nchs/data/slaits/Comparing_States_CSHCNA.pdf.
- ³¹ Stein, R. E., and E. J. Siler. 1999. "Operationalizing a Conceptually Based Noncategorical Definition: A First Look at US Children with Chronic Conditions." *Archives of Pediatric and Adolescent Medicine* 153 (1): 68-74.
- ³² Newacheck, P. W., B. Strickland, J. P. Shonkoff, J. M. Perrin, M. McPherson, M. McManus, C. Lauver, H. Fox, and P. Arango. 1998. "An Epidemiologic Profile of Children with Special Health Care Needs." *Pediatrics* 102 (1 Pt1): 117-123.
- ³³ Bethell, C. D., D. Read, J. Neff, S. J. Blumberg, R. E. K. Stein, V. Sharp, and R. Newacheck. 2002. "Comparison of the Children with Special Health Care Needs Screener to the Questionnaire for Identifying Children with Chronic Conditions – Revised." *Ambulatory Pediatrics* 2 (1): 49-57.
- ³⁴ Kuhlthau, K.A., A. C. Beal, T. G. Ferris, and J. M. Perrin. 2002. "Comparing a Diagnosis List with a Survey Method to Identify Children with Chronic Conditions in an Urban Health Center." *Ambulatory Pediatrics* 2 (1): 58-62.
- ³⁵ Newacheck, P. W., M. McManus, H. B. Fox, Y. Y. Hung, and N. Halfon. 2000. "Access to Health Care for Children with Special Health Care Needs." *Pediatrics* 105 (4 Pt 1): 760-766.
- ³⁶ Shatin D., R. Levin, H. T. Ireys, and V. Haller. 1998. "Health Care Utilization by Children with Chronic Illnesses: A Comparison of Medicaid and Employer-Insured Managed Care." *Pediatrics* 102 (4): e44.
- ³⁷ U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. 2004. *The National Survey of Children with Special Health Care Needs Chartbook 2001*. Rockville, Maryland: U.S. Department of Health and Human Services. [Accessed on July 25, 2007]. Available at <http://mchb.hrsa.gov/chscn/pages/intro.htm>.
- ³⁸ Simpson, G., B. Bloom, R. A. Cohen, and P. E. Parsons. 1997. "Access to Health Care. Part 1: Children." *Vital and Health Statistics, Series 10* (196): 1-46.
- ³⁹ Bartman, B.A., E. Moy, and L. J. D'Angelo. 1997. "Access to Ambulatory Care for Adolescents: The Role of a Usual Source of Care." *Journal of Health Care for the Poor and Underserved* 8 (2): 214-226.
- ⁴⁰ Lutz, M.E. 1990. "The Effects of Family Structure and Regular Places of Care on Preventive Health for Children." *Health Values* 14 (1): 38-45.
- ⁴¹ Grumbach, K., D. Keane, and A. Bindman. 1993. "Primary Care and Public Emergency Department Overcrowding." *American Journal of Public Health* 83 (3): 372-378.
- ⁴² Cetta, M. G., B. R. Asplin, W. W. Fields, and C. S. Yeh. 2000. "Emergency Medicine and the Debate Over the Uninsured: A Report from the Task Force on Health Care and the Uninsured." *Annals of Emergency Medicine* 36 (3): 243-246.
- ⁴³ Fan, V.S., M. Burman, M. B. McDonell, and S. D. Fihn. 2005. "Continuity of Care and Other Determinants of Patient Satisfaction with Primary Care." *Journal of General Internal Medicine* 20 (3): 226-233.
- ⁴⁴ Hunt, K. A., A. Gaba, and R. Lavizzo-Mourey. 2005. "Racial and Ethnic Disparities and Perceptions of Health Care: Does Health Plan Type Matter?" *Health Services Research* 40 (2): 551-576.

⁴⁵ The reference group is the group that serves as the comparison group. For example, using the CSHCN variable, the experiences of children with special needs are compared to those without. The children without special needs are the reference group.

⁴⁶ Szilagyi, P.G. 1998. "Managed Care for Children: Effect on Access to Care and Utilization of Health Services." *The Future of Children* 8 (2): 39-59.

⁴⁷ Reiss, J. G., R. W. Gibson, and L. R. Walker. 2005. "Health Care Transition: Youth, Family, and Provider Perspectives." *Pediatrics* 2005 (115): 112-120.

⁴⁸ Olsen, D. G., and N. L. Swigonski. 2004. "Transition to Adulthood: The Important Role of the Pediatrician." *Pediatrics* 2004 (113): e159-e162.

⁴⁹ Lotsteini, D. S., M. McPherson, B. Strickland, and P. W. Newacheck. 2005. "Transition Planning for Youth with Special Health Care Needs: Results from the National Survey of Children with Special Health Care Needs." *Pediatrics* 2005 (115): 1562-1568.

⁵⁰ Scal, P., and M. Ireland. 2005. "Addressing Transition to Adult Health Care for Adolescents with Special Health Care Needs." *Pediatrics* 2005 (115): 1607-1612.