Quality of Care in the Children's Health Insurance Program in Texas

Volume I: Narrative Section

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I.   EXECUTIVE SUMMARY

Introduction   Several aspects of health care quality for CHIP enrollees in Texas were assessed using enrollment files, claims and encounter databases, and telephone survey data. The enrollment and claims and encounter files contain information on over 600,000 children who have participated or are currently participating in the CHIP. In addition, telephone surveys were conducted with families whose children were (1) new enrollees in the program for less than three months, (2) established enrollees in the program for 12 months or longer, and (3) disenrollees who were no longer in CHIP. A total of 6,517 interviews were conducted. The majority, 5,415 of them, was conducted with established enrollees. The large sample size was needed to make valid comparisons of family satisfaction and enrollee health and sociodemographic characteristics between the health plans participating in CHIP and the sites in which they are operating.

The following aspects of the program were assessed:
- How Families Learn About CHIP in Texas,
- Demographic Characteristics of CHIP Participants,
- Health Status Characteristics of CHIP Participants,
- Families' Experiences with the Application Process,
- Children's Usual Source of Care,
- Families' Satisfaction with Care,
- Children's Health Care Use Patterns,
- Inpatient and Emergency Room Use: The Incidence of
- Well Child Visit and Immunization Compliance,
- Special Populations: Children with Asthma and Mental/Behavioral Health Conditions, and
- Program Disenrollment.

Outreach   Families learned about CHIP from a variety of sources. During the telephone interviews new enrollees named all of the difference sources of their information about CHIP including television (43%), family and friends (40%), health care providers (38%) and the schools (28%). Newspapers (23%), radio (22%), and social service agencies (18%) also were important.

Although the preceding information sources were important for all of the enrollees, some were identified more so than others depending on the respondent's race and ethnicity. For example, a higher percentage of Hispanics said they learned about CHIP from the television when compared to both white and black non-Hispanics (48% versus 39% and 41%, respectively). White non-Hispanics named health care providers and newspapers as information sources more often than black non-Hispanics or Hispanics. These findings point to the importance of continued use of a variety of strategies to identify eligible families and inform them about CHIP. Particularly in a state as diverse as Texas, multiple strategies are needed to target families of differing racial and ethnic backgrounds.

Demographic Characteristics

The majority of children enrolled in CHIP for 12 months or longer (established enrollees) were (1) residing in two parent families (70%), (2) were Hispanic (58%), and (3) about 11 years old on average. A high percentage of parents of established enrollees had less than a high school education (25%). Thirty-nine percent had a high school education and 36% of them had some college or more.

Some interesting differences in demographic characteristics were noted between children enrolled in the program for 12 months or longer and those that were newly enrolled (in CHIP for less than 3 months). The most striking differences were noted in the children's average ages, the household type (i.e., two parent versus single parent), and the respondent's education. Newly enrolled children were younger on average than those in the program for 12 months or more (8 years old versus 11 years old). A significantly higher percentage of newly enrolled children resided in single parent families when compared to established enrollees (37% versus 30% respectively).

Finally, newly enrolled children resided in families where a higher percentage of respondents (usually the children's mothers) had less than a high school education when compared to established enrollees (36% versus 25%, respectively). Results from the disenrollee survey suggest that some of these families transition to the Medicaid Program. However, others do not. In fact, upon disenrollment from CHIP the majority (63%) are uninsured. Perhaps as part of its outreach program, Texas may want to consider strategies targeted toward less well-educated mothers and single parent families to encourage them to keep their children enrolled.

Health Status   Children's health status was measured in two ways. First, the Child Health Questionnaire (CHQ) was used, which assesses children's physical and psychosocial health in 16 domains. Descriptively, in each of the categories, children in CHIP had higher or the same scores in each of the health domains when compared to scores obtained for a random sample of the childhood population in the United States, with one exception. Children in CHIP in Texas scored lower on the behavior assessment domain than children nationally. Overall, the children in CHIP were healthy.

Second, children's health was assessed using the Children with Special Health Care Needs (CSHCN) Screener. The CSHCN Screener is designed to assess whether the child has special health care needs by asking about (1) the use of compensatory mechanisms (i.e., medications), (2) elevated use of health care services, and (3) presence of functional limitations. Children can have just one of these three circumstances, two of them, or all three. This measure is similar to the screening tool used in CHIP in Texas to identify children with chronic conditions. In addition, it was scored using the same strategy as CHIP in Texas, that is children had to have all three circumstances before they were considered to have special health care needs. In CHIP, 3% of the enrollees were identified as having special health care needs based on all three CSHCN Screener criteria. These children had eight times the health care expenditures per month compared to children not identified with any special health care needs.

The health status information about the new enrollees was compared to that of established enrollees to determine whether there were any differences. A statistical model was developed to assess whether the length of time in CHIP was related to any changes in health status as measured by the CHQ scores, missed school days, and restricted activity days, after considering other important factors such as the presence of special health care needs and the child's sociodemographic characteristics.

The most important factor related to children's health status scores, missed school days, and restricted activity days was whether or not the children had special health care needs. A modest program effect was noted for children's psychosocial functioning, with improved scores noted among established enrollees relative to new enrollees.

The finding about improved psychosocial functioning is encouraging. The failure to detect significant change in other health dimensions measured by the CHQ (such as physical health and well-being) or in missed school days and restricted activity days is not surprising for several reasons. First, most children are healthy and one of the most valuable components of any health insurance program is the entrée it provides to preventive care and prompt treatment of acute conditions. Second, because children are generally healthy, the results of neglected health care may not emerge until adulthood. Without a longitudinal study of these children, the long-term benefits of the program on their health are hard to ascertain. Third, many sociodemographic factors influence children's school attendance – an outcome indicator that generates great interest. For example, survey respondents reported children missed school most frequently for conditions such as a cold and the flu. While access to health care for these conditions can be important to prevent complications, it is not likely to prevent these conditions from occurring. Therefore the child would still have missed school days for those events.

Finally, a study focused only on children with special health care needs may detect some changes in health status related to the health insurance program. Some descriptive information indicates that there are small reductions in the percentage of children with special needs who have missed school days and restricted activity days based on comparing new and established enrollee survey findings.

The Application Process

The overwhelming majority of families (98%) found the application and enrollment process "easy to understand" and "convenient". The vast majority of children began receiving coverage within two months of their parents submitting applications (86%).

Children's Usual Source of Care

The benefits of a usual source of care, or a place where the child receives most of his or her preventive and routine care needs, is well documented and includes early detection of health care problems and reduced costs of care. Prior to enrollment in CHIP, 85% of children had a usual source of care. Of those, 19% of children used the emergency room (ER) as their usual source of care. However, three months post-enrollment in CHIP 90% of families reported their children had a usual source of care and this percentage increased to 92% by 12 months post-enrollment.

The location of that usual source of care was in places where the children can develop long-term relationships with their providers and receive good primary care. For example, 62% of children received their health care in doctors' office post-enrollment compared to only 48% pre-enrollment. An additional 16% were seen in hospital clinics after enrolling in CHIP compared to none prior to enrollment.

However, about 10% of families reported using an urgent care center as their children's usual source of care post-enrollment compared to none pre-enrollment. Urgent care centers are typically known for providing short-term acute care and are not desirable as a usual source of care. Four of the health plans participating in CHIP, representing 8 different sites, had 10% or more of enrollees reporting that an urgent care center was their usual source of care.

Some of these sites are in very impoverished areas. Thus these findings may be indicative of a lack of providers in the areas. However, the adequacy of the provider networks for these plans, within the context of any community constraints they are facing should be examined. In addition, the process that health plans use to assist families in selecting primary care providers for their children also should be assessed.

While this concern should be addressed, the striking improvement in the percentage of children with a usual source of care is a significant finding about the quality of the program. The overwhelming majority of children in CHIP have a usual source of care and the location of that care is a doctor's office or hospital clinic for most of them.

Families' Satisfaction with Care

The Consumer Assessment of Health Plans Survey (CAHPS) was administered, via a telephone, to families whose children were in CHIP for 12 months or longer. Three hundred completed surveys were obtained for each health plan. In instances where health plans were serving large geographic regions, the coverage areas for those plans were subdivided and sampled individually. There were 5,415 completed surveys from 13 health plans or 18 sites.

Responses for each individual CAHPS item for each health plan are contained in Appendix B. In addition, the CAHPS items were grouped into the following five clusters and scores were developed for each health plan/site:

- Getting Needed Care,
- Getting Care Quickly,
- Doctor's Communication,
- Courtesy of Office Staff, and
- Health Plan Communication.

Responses to questions in each of the preceding areas required families to have experience in that area. For example, families were asked if they had taken their children to the doctor in the past 12 months. If the child had seen a doctor, then the families were asked the questions in the Getting Needed Care and Getting Care Quickly clusters. If the child had not seen the doctor, the interviewer skipped to the next section. Therefore the cluster responses represent the experiences of families using those particular services only.

Understanding who is not using a particular service is as important, if not more important, than learning about the satisfaction of those that do. Therefore, the responses to four different items, which serve as filters or screens for the previously described clusters, were analyzed individually for each health plan/site. These items addressed whether (1) the child had a personal doctor or nurse that knows him or her, (2) the family called the doctor's office for advice, (3) the family made an appointment for regular or routine care, and (4) the child had been to the doctor or clinic at least once.

Responses to the clusters and to the individual items are influenced by health plan differences, and the child's health and sociodemographic characteristics. Therefore, statistical models were developed to examine health plan differences in satisfaction and use of services, after considering or controlling for sociodemographic characteristics and whether the child had special health care needs.

Across the 5 clusters and 4 different individual items considered in the statistical analyses, some plans/sites performed consistently as well as or consistently lower than the highest performing plans (Table 10 of the narrative). The following health plans/sites performed *consistently well* by either having the highest score for a cluster or item or by being equally as good as the reference plan in at least five areas: EPO Clarendon Health Plan (Rural Counties), Seton Health Plan, Mercy Health Plans, Texas Children's Health Plan, Cook Children's Health Plan, EPO Clarendon Health Plan (Houston Area Counties), Driscoll Children's Health Plan, Texas University Health Plan (Amarillo), Community First Health Plans, UTMB Health Care System, FirstCare, and EPO Clarendon Health Plan (Border Counties).

The following health plans/sites consistently performed *less well* than the highest scoring plans/sites by having a lower score than the reference plan in at least five areas: El Paso 1st, Amerikids (Dallas), Amerikids (Houston), Texas University Health Plan (San Antonio), Parkland Community Health Plan, and Texas University Health Plan (El Paso). It is interesting to note that two of the plans in this group performed better than the reference plan/site in the areas of doctor communication and customer service. Five of these sites had a higher percentage of enrollees reporting the use of urgent care centers as their usual source of care (El Paso 1st, Seton Health Plan, Amerikids (Houston), Texas University Health Plan (San Antonio), and Texas University Health Plan (El Paso). Finally, Texas University Health Plan (El Paso) had the lowest percentage of children with a follow-up mental health visit within 30 days after an inpatient mental health-related stay (18% of the children). Texas Children's Health Plan, Amerikids (Dallas), Amerikids (Houston), Texas University Health Plan (San Antonio), and Parkland Community Health Plan also performed poorly on this measure with 50% or less of their children having follow-up visits after an inpatient mental health stay. These findings about the mental health follow-up visits are discussed in more detail in the Section XIII of the report.

In addition to health plan/site differences in satisfaction and use of health care services, several sociodemographic and health status characteristics were significantly related to satisfaction with and use of health care services. The following key findings were obtained:

- As expected, children with special health care needs, as measured by meeting one, two, or all three CSHCN Screener criteria were significantly more likely than their healthy counterparts to (1) have a personal doctor or nurse (in other words a usual source of care), (2) have sought help or advice from their doctors, (3) have had an appointment for routine care, and (4) have been to see the doctor at least once in the past 12 months.

- However, families of children with special needs as measured by the CSHCN Screener, while using the health care system more, were significantly less satisfied with some aspects of their health care than families of healthy children. Children meeting all three of the criteria on the CSHCN Screener had significantly lower scores in the area of Getting Needed Care and Doctor Communication than children without special needs.

- However, very importantly, children who were identified as having special needs based on two components of the CSHCN Screener were 23% more likely to report getting needed care quickly than those not identified with special needs. Similarly, those who were identified as having special needs based on all three components of the Screener were 19% more likely than those without special health care needs to report getting needed care quickly. Thus, the health care providers and health plans participating in CHIP in Texas are responsive to families who have children with special health care needs by providing timely care.

- Race and ethnicity were significantly related to health care experience with Hispanic families about one-half as likely as white, non-Hispanic families to (1) have a personal doctor or nurse (in other words a usual source of care), (2) have sought help or advice from their doctors, (3) have had an appointment for routine care, and (4) have been to see the doctor at least once in the past 12 months.

- Once Hispanic families sought care, they had lower satisfaction scores than white non-Hispanic families in the areas of getting care quickly, interacting with office staff, and health plan customer service.

- Black non-Hispanic families were less likely than white non-Hispanic families to call their doctors for advice and to take their children to the doctor. However, when they did use health care services for their children, they were much more satisfied with their care than white non-Hispanic families, in most areas.

Similar findings were obtained for the Florida KidCare Program. In the KidCare Program, reduced access to and satisfaction with care have been documented for Hispanic families relative to non-Hispanic families. Black families in the KidCare Program also have reduced access to care relative to white families, but report greater satisfaction. Finally some of the highest dissatisfaction scores are from families who have children with special health care needs. Perhaps these families require more complex care for their children that pose challenges to the health care system, contributing to dissatisfaction.

Children's Health care Use Patterns – The CDPS

The Chronic Disability Payment System (CDPS) was used to assess children's actual health care expenditures relative to their expected health care expenditures based on their case-mix or illness burden. The CDPS categorizes diagnoses assigned at the time of health care encounters into groups depending on their expected costs and clinical consequences. The use of such a system is essential, particularly when assessing health care use and expenditures in a state program contracting with multiple health plans. In this way, the health plans can be compared while taking into account the children's illness burden. Ensuring that children receive care that is consistent with their needs is critical and fundamental to the quality of any health care program.

As expected, the majority of children were seen for low cost pulmonary, ear, skin, infectious, and eye conditions. Overall the estimated health care expenditures for each plan were as expected after considering the case-mix of their enrollees. Two plans demonstrated health care expenditures significantly above what would be expected given their case-mix. FirstCare and Texas Children's Health Plan had expenditures that were 83% and 26% higher than expected. Only El Paso 1st had health care expenditures that were somewhat low relative to the expected (0.79% of the expected). Thus, overall in CHIP, the health care expenditures for the health plans/sites are as expected based on the children's illness burden. Further assessment of the highest and lowest expenditure plans should be conducted to determine if the expenditures are related to the cost of the services provided or the quantity or both.

Access to Care

Children's access to health care at each health plan/site was assessed using the Health Plan Employer Data and Information Set (HEDIS) indicator called *Children's Access to Primary Care Practitioners*. Overall, access to care was excellent with 90% of children 12 through 24 months old, 82% of children 25 months through 6 years old, and 89% of children 7 through 11 years old visiting their primary care providers at least once in a 12 month period. Compliance at the individual health plan/site level also was excellent with a couple of exceptions. For children ages 12 through 24 months, compliance was only 78% at Texas Children's Health Plan. For children ages 25 months through 6 years, compliance was low at Seton Health Plan, Texas Children's Health Plan, Texas University Health Plan (San Antonio), Parkland Community Health Plan, and Texas University Health Plan (El Paso). All of these sites had less than 80% compliance, that is 20% or more of their enrollees in the 25 months to 6 year age category did not have any contact with a primary care provider in 12 months. Only two health plans/sites had somewhat low compliance with access to care for children ages 7 through 11 years (Seton Health Plan and Texas University Health Plan (San Antonio)).

Incidence of Emergency Room Use and Inpatient Stays for Ambulatory Care Sensitive Conditions (ACSCs)

There was a total of 10,005 inpatient stays among the CHIP enrollees. Several findings were noteworthy based on enrollees' sociodemographic characteristics. First, children ages 1 through 5 years and 6 through 14 years had the highest percentage of inpatient stays due to an ACSC (approximately 14% for both groups). Families that were between 100% and 150% of the FPL had the highest percentage of inpatient stays (15%) compared to any other income group. Males were not significantly different than females in terms of the percentage of their inpatient stays that were due to ACSCs. Significant differences were noted among the racial and ethnic groups. Thirteen percent of inpatient stays for Hispanic children were due to ACSCs compared to 8% for white non-Hispanics.

The incidence of ER use for these conditions was lower than for inpatient stays. However, the same sociodemographic patterns were observed for ER use for ACSC as was seen for inpatient stays.

The results for CHIP in Texas compare favorably to a study conducted among Medicaid beneficiaries (adults under age 65 and children) in another state.[1] For example, among Medicaid recipients 25% of the inpatient stays were for ACSCs compared to a high of 14% among the CHIP enrollees in Texas. In this same study with the Medicaid population, there were 21.9 ER visits/100 enrollees among those receiving primary care at Federally Qualified Health Centers (FQHCs). FQHCs are not typical of the Medicaid providers in Texas. Among the CHIP enrollees in Texas, the highest ER visit rate for ACSCs was approximately 17.33/1,000 children for otitis media.

Childhood Immunization Status

Vaccine compliance within CHIP in Texas was calculated using claims data. The analysis is based on the 2001 United States Recommended Childhood Immunization Schedule, and the 2002 HEDIS childhood immunization status specifications. The 2001 US Recommended Childhood Immunization Schedule includes a recommendation for the Pneumococcal conjugate vaccine. The HEDIS specifications are written for children who were enrolled on their second birthday. In addition, the child had to be continuously enrolled for 12 months prior to their second birthday, or turn 2 years old during the 12 month reporting period. The US Recommended Childhood Immunization Schedule specifies age brackets for recommended doses through the age of 24 months. This analysis includes all children enrolled in CHIP with 12 months of continuous coverage or coverage since birth who are 2.10 years old or younger as of December 31, 2002.

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[1] Falik M, Needleman J, Wells BL, Korb J. Ambulatory care sensitive hospitalizations and emergency visits: Experiences of Medicaid patients using federally qualified health centers. *Medical Care.* 2001; 39(6):551-561.

CHIP in Texas compares favorably to the results reported by the NCQA for 120 health plans serving Medicaid enrollees. For example, in 2000, the participating Medicaid plans reported 66%% of children were in compliance with the Diptheria, Tetanus, Pertussis (DTP) vaccine compared to 81% in CHIP in Texas and 74% with the Polio vaccine compared to 82% in Texas. Compliance with Hepatitis B vaccines was higher in CHIP than in the NCQA Medicaid sample (92% versus 69%). H. Influenze vaccine was markedly lower than the national sample (46% versus 71%). Overall compliance with the vaccines was somewhat higher in the CHIP group compared to the national sample (55% versus 51%). The NCQA recommends the use of 24 months of data for these calculations. However for CHIP in Texas only 19 months and not 24 months of data were available for these analyses.

However, there are some individual health plan/site differences in performance that should be explored further. It is important to note that individual immunization calculations are relying on claims and encounter data only. The evaluators do not have access to the children's medical records. Health plans may exclude from the analysis children who (1) have evidence of the antigen for which they are being immunized, (2) have a documented history of the illness, or (3) have a seropositive test result. Without more detailed clinical information on the children, it is impossible to know if some children included in the analysis may have met one of the three criteria described above for exclusion.

Percent of Children with Mental Health Hospitalizations Who Had An Outpatient Visit Within 30 Days of Discharge

There were 2,713 hospitalizations for mental health conditions. Of the mental health hospitalizations, 56.7% showed either a mental health or a primary care outpatient visit within 30 days of discharge. In the NCQA State of Managed Care Quality Report, participating commercial plans reported that 71% of their enrollees with inpatient mental health stays had an outpatient follow-up within 30 days. It is important to note that in our calculations, we used more liberal criteria for outpatient visits when compared to the HEDIS standards.

There was plan variability noted in the percentage of children with some outpatient visit following an inpatient mental health stay. It is important to note that the national comparison groups are commercial health plans and not a similar low-income population. In Florida with a Title XXI population, the overall compliance is 65%. However, in Texas, some of these health plans operate in primarily rural areas with limited provider networks, resulting in limited access to care for program enrollees. Further analyses should be conducted examining the provider networks and community characteristics in which some of the poorest performing health plans/sites are operating.

Use of Appropriate Medications for Children With Asthma

A group of 830 children with persistent asthma (according to HEDIS specifications) were identified. The type of filled prescriptions these children had for their asthma was then assessed using pharmacy claims data. Assessing medication compliance for this group of children is essential because those with well-controlled asthma have better outcomes of care in terms of overall health status and reduced inpatient and ER use.

Only 43% of the children had a filled prescription for any of the recommended drugs, which is significantly lower than in a commercially insured group (about 60%). However, only 36% of Florida's Title XXI enrollees had a filled prescription in any of the recommended categories. It is important to note that physicians could be ordering these medications for the children but families are not filling the prescriptions.

Detailed telephone interviews with families about their children's asthma revealed that about one-third of families reported they did not understand what their children's doctors were telling them about asthma. In addition, one-quarter of families indicated that their children were not taking their asthma medications properly, although they were ordered. Further analyses will be provided about asthma care in the program.

Disenrollment   Families' disenrollment experiences in Texas are very positive overall. Both administrative and family interview data were used to conduct this comprehensive analysis. In terms of findings using the administrative data:

- About 20% of the children in SCHIP disenrolled for any reason during the 22 month period studied. About 19% of these later re-enrolled in the program. About 30% of families did not renew their children's coverage at the end of the 12 month continuous eligibility period. However, 26% of them did re-enroll within 3 months of disenrollment.
- Children with physical and mental health special health care needs are 20% and 30% less likely to disenroll for any reason when compared to healthy children. They are also less likely to not renew at the end of the continuous eligibility period than healthy children.

While it is important to continue to monitor disenrollment from CHIP, the results are favorable compared to those obtained in other states using administrative data. For example, a study using administrative data from Oregon and Kansas found that 50% to 60% of CHIP enrollees did not renew coverage after the continuous eligibility period. These findings compare to 30% of children in Texas.

More detailed information was obtained about families' reasons for disenrolling their children from the telephone surveys. Less than 2% of families reported any program dissatisfaction as a primary reason for disenrollment. Moreover, using family report (16%), few families reported they could not or did not renew their children's coverage at the end of the continuous eligibility period as a primary disenrollment reason. This finding is consistent with that obtained from a NASHP seven state study. NASHP notes that families may appear to "*fail* to renew" coverage based on administrative data when in fact they *chose* not to renew their children's coverage. For those families who do renew their children's coverage, they report that the experience a positive and easy one.

Recommendations   Overall, the quality of care in CHIP in Texas is excellent. The majority of respondents view the initial application and subsequent renewal process as easy and convenient. Most children have a usual source of health care with a physician or in a hospital clinic. There is a marked reduction in the percentage of children using the ER as a usual source of care. Family satisfaction is high with all aspects of health care. Access to care is very good for all age cohorts and children are receiving the amount of health care that would be expected based on their illness burden.

There are some individual differences in these performance measures between the health plans/sites. Some of these health plans/sites may face increased challenges in some of the rural areas of Texas and in the border counties in terms of establishing provider networks and ensuring good access to care. Despite these challenges, some of the lowest performing plans should be assessed further to determine if improvements can be made within the context in which they are operating.

Immunization compliance, follow-up care after an inpatient mental health stay, and compliance with asthma medications all require improvement. Some of the low findings may be the result of using only claims data without supplemental medical record information. Despite this, some health plans/sites performed well relative to a commercially insured population or relative to another CHIP population and some did not. Further review should be conducted with these health plans to determine potential strategies for improvement.

Many of the quality findings are strongly influenced by the child's health status and the family's sociodemographic characteristics. While not unique to Texas, there are some racial and ethnic disparities in access to and satisfaction with care. There are numerous challenges associated with addressing this issue. For example, improved satisfaction may be obtained if the race and ethnicity of the provider match that of the patient. However this is not always possible depending on provider availability.

Children's health status is extremely important. For example, children with special health care needs get needed care more quickly than children without special needs. Moreover, families are more likely to keep these children enrolled in the program than their healthier counterparts.

Outreach to families should incorporate educational messages that are targeted toward families of healthy children encouraging them to keep their children insured to obtain needed primary and preventive care. In addition, single parent families and the less well educated (less than a high school diploma) may benefit from special outreach efforts targeted at keeping their children enrolled.

II. INTRODUCTION

Background

In 1997, Title XXI of the Social Security Act established the State Children's Health Insurance Program (SCHIP) to provide coverage for uninsured children residing in families with incomes below 200 percent of the federal poverty level (FPL). States were given considerable latitude in the design of their SCHIP initiatives and options ranged from expanding Medicaid eligibility to developing free-standing programs. Texas used two major approaches to provide coverage for low-income children.

First, in July 1998, Texas expanded Medicaid coverage to children up to age 19 residing in families with incomes up to 100 percent of the FPL. This group included children, ages 15 through 18, who were not already eligible for Medicaid. While this Medicaid expansion was federally mandated, Texas accelerated the process to cover these adolescents more rapidly than they were required to do so. Second, Texas elected to offer a non-Medicaid coverage option for families with incomes up to 200 percent of the FPL.

Using three year averages from the United States (U.S.) Census Bureau for 1998, 1999, and 2000, 46 percent of the children in Texas resided in families with incomes at or below 200 percent of the FPL. It is estimated that an average of 35 percent of these children, or 973,000 of them, were uninsured during those three years.

The children's health insurance program (CHIP) enrollment began in April 2000 with coverage beginning in May 2000. Enrollment grew rapidly with over 500,000 enrollees as of March 2002. The Texas Health and Human Services Commission (THHSC) administers the program.

As part of the program administration the THHSC contracted with the Institute for Child Health Policy to conduct an evaluation of the quality of care that children receive while enrolled in CHIP. The evaluation was designed to assess several major aspects of care including:
- Family satisfaction with the application and enrollment process;
- Family satisfaction with the health care that the children receive;
- The presence of a usual source of care;
- Changes in children's functioning as measured by missed school days and restricted activity days;

- The percentage of children with special health care needs and the percentage of adolescents engaging in risk-taking behaviors;
- The type and amount of health care that children use;
- Children's compliance with American Academy of Pediatrics well child visit guidelines;
- Immunization compliance;
- Incidence of inpatient and emergency room (ER) use for ambulatory care sensitive conditions (ACSC); ACSCs are those conditions that are not expected to result in ER use or inpatient stays if proper outpatient care is provided. Otitis media is an example of an ACSC. More examples are provided in the report;
- Use of appropriate medications for children with asthma;
- Compliance with HEDIS access to care measures;
- The percentage of children that had either a mental health outpatient visit or a primary care outpatient visit within 30 days of discharge after an inpatient mental health stay; and
- Children's disenrollment patterns and families' reasons for disenrolling their children from the program.

These major areas of quality assessment and evaluation were selected based on several factors. First, the THHSC had several quality indicators that the Texas legislature required them to track and/or assess. These indicators include: (1) the percentage of adolescents engaging in risk-taking behavior (such as attempted suicide, drug and alcohol use, and others); (2) the number of immunizations administered; and (3) the number of hospital days related to injuries.

Second, previous studies examining problems in quality of care for uninsured children were reviewed. CHIP was intended to provide coverage and to improve quality of care for low-income, uninsured children. Therefore it is expected, at minimum, that enrollment in the program would result in improvement in the quality of the children's care to a level above that which they would have had if they were uninsured. Previous studies have shown that uninsured children lack a usual source of health care, have lower immunization rates, are more likely to be hospitalized for ACSCs, and have lower health care use rates when compared to their privately and publicly insured counterparts.[2]

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[2] Szilagyi P, Zwanziger J, Rodewald LE, et al., Evaluation of a State Health Insurance Program for Low-Income Children: Implications for State Children's Health Insurance Programs. *Pediatrics*. 2000; 105(2):363-371.

Therefore, indicators addressing access to care, health care use patterns and the incidence of ACSCs were included in the evaluation of CHIP in Texas. Comparisons to uninsured children using national data are included in this report. In addition comparisons are made to children enrolled in CHIP in other states and to commercially insured children. These comparisons provide valuable information about whether CHIP in Texas is improving health care for children in its program relative to both the uninsured nationally and to other publicly and commercially insured children.

Third, recommendations from national quality assurance organizations, such as the National Commission on Quality Assurance (NCQA), and from researchers working in the area of quality assessment were reviewed. Based on this review, additional indicators were incorporated into the CHIP evaluation, such as child health indicators from the Health Plan Employer Data and Information Set (HEDIS).[3]

This report is organized into the following sections:
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[3] National Commission on Quality Assurance. *HEDIS 2002: Narrative and Technical Specifications*. Washington, DC: 2001.

III. METHODS

Evaluation Methods   Because of the range of topics addressed, a variety of methods were used to conduct this evaluation. To address each of these comprehensively, this section is organized into the following subsections:
- Data Sources,
- Sampling Strategies, and
- Data Analysis Strategies.

Data Sources: Three primary data sources were used to conduct the evaluation. These were: (1) CHIP enrollment files, (2) claims and encounter data provided by each of the health plan participating in CHIP, and (3) telephone survey data collected from families whose children were either enrolled or currently disenrolled from CHIP.

The third party administrator provided the enrollment files, which contain basic demographic information on the enrollees including the amount of premium subsidy received, race and ethnicity, gender, age, and the months of program enrollment. The claims and encounter information is organized into inpatient, outpatient, and pharmacy files. The inpatient and outpatient files (which includes emergency room visits) contains information about the children's diagnoses assigned at the time of the health care encounter, the date(s) of service, the service rendered, and the place of service. The pharmacy files contain information about newly filled and refilled prescriptions. Enrollment and claims and encounter data from May 2000 through December 2001 were used in these analyses.

In addition, the following telephone surveys were conducted with families whose children were participants in CHIP: (1) a New Enrollee Survey conducted with families whose children were enrolled for less than 3 months; (2) an Established Enrollee Survey conducted with families whose children were enrolled for 12 months or longer; and (3) a Disenrollee Survey conducted with families whose children were disenrolled from the program.

Sampling Strategies   For analyses involving claims and encounter data, a complete census of all children enrolled in Title XXI and meeting the eligibility criteria for the analysis were included. For example, all children were included in an assessment of access to primary care providers and calculations of the incidence of inpatient and ER use for ACSC. When assessing medication compliance among children with severe asthma, a complete census of all children with severe asthma was included in the analyses. More detail about the population of children included in each of the analyses using claims and encounter data is provided in the results section of this report.

For both the New Enrollee and the Disenrollee Surveys, simple random samples of children meeting the eligibility criteria (i.e., new enrollees were those enrolled for less than three months) were included in the surveys. For the Established Enrollee Survey, a minimum of 300 completed surveys per health plan was obtained. In addition, a larger sample size was obtained from health plans serving large geographic regions so that there was a sufficient sample size from each of the regions they were serving. The sample size for each health plan (and their regions, where appropriate) was selected based on recommendations from the developers of the Consumer Assessment of Health Plans Survey (CAHPS).[4]

Table 1 contains a summary of the number of completed interviews, the percentage of those that could not be located, the percentage that refused to participate once located, and the confidence interval for the responses. To interpret the confidence intervals, refer to the New Enrollee Survey as an example. For that survey, the sample size provides a 95 percent confidence interval of ± 4.5. So, for example, if 94 percent of families said that they were satisfied with the CHIP enrollment process, there is 95 percent confidence that the true percentage of the population expressing satisfaction was 89.5 percent to 98.5 percent. This information is provided as a general estimate only. There are many different types of questions on each of the surveys with different response levels. This information is provided to give the reader overall information about the adequacy of the sample size and the high level of confidence in the results.

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[4] Agency for Health Care Research and Quality. Consumer Assessment of Health Plans 2.0 Survey and Reporting Kit. Rockville, Maryland: US Department of Health and Human Services, 1999.

Table 1.   Summary of Surveys Conducted

Survey	Number of Completed Interviews	Unable to Locate	Refused	Confidence Interval, *p*<.05
New Enrollee	602	28%	13%	± 4.5
Established Enrollee	5,415	19%	8%	At the plan level ± 3.6
Disenrollee	500	26%	10%	± 4.4

Data Analysis Strategies

Several different data analysis strategies were used to prepare this report. First, simple descriptive statistics are used. Next, a variety of multivariate techniques were used including Generalized Estimating Equations, logistic regression models, and discrete-time hazards models. Technical Appendix A summarizes these techniques in greater detail.

IV.   HOW FAMILIES LEARN ABOUT CHIP IN TEXAS

Overview

On the New Enrollee Survey, families were asked about the different ways that they learned about CHIP in Texas. Respondents could name more than one source of information; therefore the categories will not total 100%. Television and family and friends were the two main sources of information about CHIP for 43% and 40% of the respondents respectively. Thirty percent heard about the program from a health care provider and 28% indicated they heard about the program through their children's schools. However, a variety of other information sources also were important including newspapers (23%), radio (22%), and social service agencies (18%).

In addition, responses were analyzed according to the respondents' race and ethnicity (Figure 1). Television, family and friends, the workplace, and health care providers were important sources of information, regardless of the families' race or ethnicity. However, a higher percentage of Hispanics heard about CHIP from the television than White or Black non-Hispanics (48% versus 39% and 41%, respectively). About 40% of Hispanics and white non-Hispanics heard about the program from family and friends versus about 35% of black non-Hispanics.

Figure 1. How Families Learned About CHIP
by Race and Ethnicity
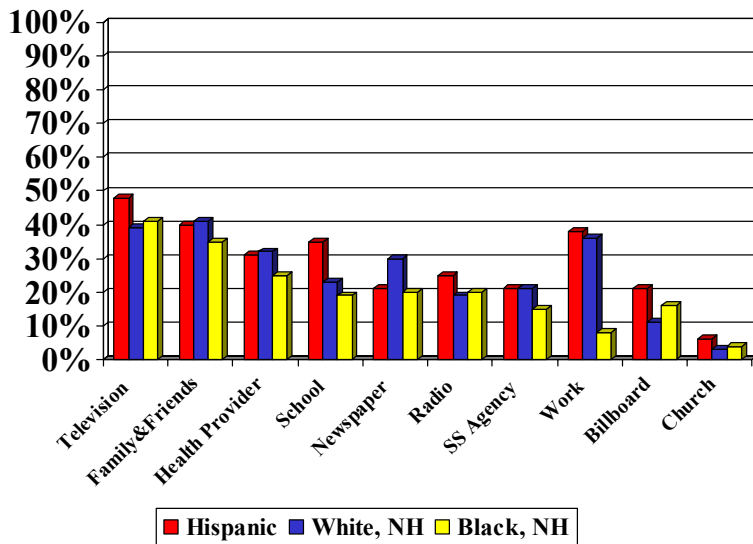
V. DEMOGRAPHIC CHARACTERISTICS OF CHIP PARTICIPANTS

Results

Table 2 displays the demographic characteristics of families who participated in the New Enrollee and Established Enrollee Surveys. Those who disenrolled from the program are discussed in Section XIV of this report.

About 50% or more of the children in both the new enrollee and the established enrollee groups were Hispanic. The next largest racial/ethnic group was White, non-Hispanic children, comprising about one-third of the population among the new and the established enrollees. Thirteen percent of both groups were Black, non-Hispanic.

Most children in the two groups resided in two-parent families. However, a significantly higher percentage of established enrollees lived in families where the respondent was married compared to new enrollees (68% versus 56%, respectively). As expected, a significantly higher percentage of new enrollees compared to established enrollees lived in families where the respondent was single (19% versus 11%, respectively). No other significant differences were noted in marital status between the two groups.

Respondent education also varied significantly between the two groups. For example, a significantly higher percentage of new enrollee respondents had less than a high school education compared to established enrollee respondents (36% versus 25%, respectively). Fifty-eight percent of new enrollee respondents were high school graduates or had some college education compared to 68% of established enrollees. The percentage with a Bachelor's Degree or higher did not vary significantly between the two groups (about 6%).

No significant differences were noted in income between the two groups with over 70% of children living in families with incomes at or below 150% of the FPL. Significant differences were noted in the children's ages, with a higher percentage of older children among the established enrollees. For example, 30% of the new enrollees were between 1 to 5 years old compared to only 15% of established enrollees. No significant differences in the child's gender were noted between the two groups, with slightly more males than females participating in CHIP.

In summary, families whose children are enrolled in CHIP for less than three months differ significantly on several sociodemographic characteristics when compared to those whose children are enrolled for 12 months or longer. Children who remain in the program tend to be predominantly Hispanic, reside in families where the respondents are married and are more likely to be better educated, and tend to be older children relative to those who are newly enrolled.

Table 2. **Demographic Characteristics of CHIP Families Participating in the Telephone Surveys**

Category	New Enrollee N=602	Established Enrollee N=5,415
Child Race and Ethnicity		
Hispanic	48%	58%
White, Non-Hispanic	37%	31%
Black, Non-Hispanic	13%	13%
Other	2%	3%
Don't Know	<1%	<1%
Respondent Marital Status		
Married	56%	68%
Common law	4%	2%
Divorced	13%	11%
Separated	4%	5%
Single	19%	11%
Widowed	4%	3%
Refused	<1%	<1%
Household Type		
Single parent	37%	30%
Two parent	63%	70%
Respondent Education		
Less than high school	36%	25%
High school	21%	39%
Some college	37%	29%
Bachelor's degree or higher	6%	7%
Household Income As A Percent of Federal Poverty Level (FPL)		
150% FPL and below	71%	74%
151% to 200% FPL	29%	26%
Mean Age of the Child	8.4 ± 4.8[5]	10.85 ± 4.56
Age Distribution		
<1 year	3%	<1%
1 to 5 years	30%	15%
6 to 14 years	54%	58%
15 to 18 years	13%	27%
Child Gender		
Male	54%	51%
Female	46%	49%

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[5] The mean is another term for the average number (i.e., age, income, and so on), and the standard deviation indicates how far the observations vary from the mean or the average. So the greater the observations are from the mean, the greater the standard deviation. For example, the average of children in CHIP overall is 8 years, but the observations vary about 5 years around that average.

VI.   HEALTH STATUS CHARACTERISTICS OF CHIP PARTICIPANTS

Overview   Families were asked an extensive series of questions about their children's health status on all three surveys. Health status information is important for two main reasons. First, this information will form a baseline to track changes in health status across time. Second, such information is crucial for program planning and financing. For example, in prior studies with a Title XXI population in Florida, children whose families reported they were in fair to poor health used eight times more health care services than children in good to excellent health. Understanding the percentage of children in poor health or with chronic conditions is important to ensure adequate provider networks and financing for health care services.

Children's health status and health care needs were assessed using the following:

- The Children with Special Health Care Needs (CSHCN) Screener - The CSHCN Screener is adapted from questions used on the National Health Interview Survey (NHIS) and the Questionnaire for Identifying Children with Chronic Conditions (QuICCC).[6] The instrument was designed to be a short, non-categorical approach to identifying children with chronic conditions. The CSHCN Screener has five questions and 15 items and addresses the child's need for medications or medical care as well as the presence of any functional impairment. The National Commission for Quality Assurance (NCQA) has adopted the CSHCN Screener as the recommended screening instrument for managed care plans to use in identifying children with chronic conditions.

- The Child Health Questionnaire (CHQ) - The CHQ is designed to comprehensively measure children's physical and psychosocial well-being. The 28-item parent version (CHQ-PF28) was used for this evaluation.[7]

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[6] Bethell C, Read D. Child and Adolescent Health Initiative. Living with Illness Screener and Supplemental Survey Module: Description and Summary of Development and Testing. Portland, Oregon: Foundation for Accountability; May, 1999.
[7] Landgraf JM, Abetz L, Ware JE. The CHQ User's Manual. First Edition. Boston MA: The Health Institute, New England Medical Center, 1996.

The following health concepts are measured:
- ➢ Physical functioning,
- ➢ Role/social limitations - physical,
- ➢ General health,
- ➢ Bodily pain/discomfort,
- ➢ Parental impact - time,
- ➢ Parental impact - emotional,
- ➢ Role/social limitations - emotional,
- ➢ Role/social limitations - behavior,
- ➢ Family activities,
- ➢ Family cohesion, and
- ➢ Changes in health.

The scale was tested on children of different ages living in families with varying socioeconomic backgrounds. Transformed scores for all scales of the CHQ range from 0 to 100, with a higher score indicating better health. The instrument has good reliability and validity.

- • Questions From the National Health Interview Survey (NHIS) – Questions about overall health status, missed school days, and restricted activity days were adopted from the NHIS and used in this evaluation. The NHIS is a national survey conducted to gather health information from families.

The descriptive findings about the children's health status are summarized in Tables 3A-C and in Figure 2 for new and established enrollees. Information about disenrollees' health status is presented in Section XIV of this report. As expected, most children were healthy, with 91% of new enrollee families and 92% of established enrollee families reporting their children were in good to excellent health.

In addition, parents were asked to answer questions on the CSHCN Screener to assess whether the children had special health care needs. This measure is similar to the screening tool used in CHIP to identify children with chronic conditions. The CSHCN Screener was scored using a stringent approach that required the parent to respond affirmatively to *all* five-question sequences before the child was identified as having a chronic condition. Using this scoring approach, 3% of the established enrollee pool was identified as having special health care needs. This means that based on parent report, the children were dependent on medications, had increased need for and/or use of health care services, and had limitations in their functioning. The same percentage of enrollees in Florida's CHIP also respond affirmatively to all five CSHCN Screener questions.

If the CSHCN Screener were scored as recommended by the developers, that is, the parent responds affirmatively to only one of the question sequences, then 20% of the established enrollees would have special health care needs.

Analyses were conducted to examine the relationship between the children's results on the CSHCN screener and their health care charges. Children who were identified as having a special health care need due to all three components of the screener (i.e., dependence on medications, increased need for and/or use of health care services, and limitations in functioning) had estimated total monthly health care expenditures of about $800. These expenditures were about eight times higher than expenditures for children who did not have any special health care needs based on the CSHCN Screener. However, these children represent a very small percentage of the overall enrollee pool.

Table 3B shows the descriptive results of the CHQ for the new and established enrollees in comparison to United States (US) averages obtained from random samples of children in the population. New and established enrollees had significantly better functioning in the following categories when compared to the US average: physical functioning, role-emotional behavior, role-physical functioning, bodily pain, mental health, self-esteem, parent impact-emotional, and parent impact-time.

Significantly higher self-esteem scores and psychosocial summary scores were noted when comparing new to established enrollees. Further analyses were conducted to determine if there were any significant differences between new and established enrollees on any of the health status items. Because health status outcomes are influenced by sociodemographic factors and whether the child has special health care needs, these variables also were included in the analyses.

Overwhelmingly the most important predictor of the children's health status outcomes (i.e., missed school days, restricted activity days, and the psychosocial and physical summary scores on the CHQ) was whether or not the children had special health care needs, after including sociodemographic characteristics and the length of the children's CHIP enrollment in the statistical models. For example, children with special health care needs (based on all three screening criteria on the CSHCN Screener) were 3.7 times more likely to have missed school days than healthy children. Children that met only one or two of the CSHCN Screener criteria were almost twice as likely as their healthy counterparts to miss school. No changes or reductions in missed school days were noted for new enrollees compared to established enrollees.

However, a modest but significant improvement was noted in the children's psychosocial functioning, as measured by the CHQ, between new and established enrollees. This finding was obtained even when considering other covariates in the statistical models such as the presence of special health care needs and the family's sociodemographic characteristics.

Detecting changes or improvement in children's health status that can be attributable to health insurance programs is difficult for several reasons. First, most children are healthy and the goal is to provide preventive care and prompt treatment for acute health care needs to maintain their good health. Second, outcomes such as missed school days are influenced by sociodemographic and health related factors. On the surveys, parents were asked why their children missed school. The most common reason given is that the children had mild illnesses such as colds and the flu. While health insurance will help parents obtain treatment for their children for these conditions if needed, it is not likely to prevent the conditions from occurring. Thus no impact on missed school days is expected. In addition, children missed school due to social reasons such as transportation problems, "oversleeping and missing the bus", and childcare issues where an older sibling was caring for a younger sibling. Health insurance will not reduce school absences in those cases.

The fact that a small but significant improvement was noted on the psychosocial scores on the CHQ is encouraging. In addition, further work is being conducted to examine health status changes in a cohort of children with asthma. It may be possible to detect improvement in health status as measured by the CHQ and improved school attendance in a group of children with special health care needs. For example, Table 3C shows some promising descriptive results that warrant further examination in a cohort of children with special health care needs.

Ten percent of newly enrolled children without any special health care needs missed school in the two weeks prior to the telephone survey compared to 13% of those enrolled 12 months or longer. Among these healthy children, 5% of both new and established enrollees had restricted activity days in the two weeks prior to the survey.

However, for children with special health care needs, improvements were noted in missed school days and restricted activity days for established enrollees in comparison to new enrollees. For example, 4% of those new enrollees with special health care needs missed school during the reference period compared to 2% of established enrollees. For this same group of children, 2% had restricted activity days as reported on the new enrollee survey compared to 1% on the established enrollee survey. While these findings are not dramatic, they are encouraging. Moreover, as previously discussed, the findings are expected, given the myriad of social factors that influence school attendance.

Table 3A.   General Health Status Measures

Category	New Enrollee N=602	Established Enrollee N=5,415
Perceived Health Status of Target Child		
Excellent	37%	37%
Very good	29%	28%
Good	25%	28%
Fair	8%	7%
Poor	1%	<1%
Child Requires More Supervision Than Others of His or Her Age		
Yes	10%	7%
No	89%	93%
Don't know	1%	0%
Did your child miss school at any time during the last two weeks?		
Yes	24%	21%
No	76%	79%
Mean number of days missed	2.5±2.2	2.0±1.8
Were any of the missed school days due to a chronic condition? (N=115)	N=115	N=1015
Yes	30%	33%
No	70%	67%
Was your child unable to engage in his or her usual activities during the last two weeks		
Yes	12%	8%
No	88%	92%
Was your child unable to engage in his or her usual activities due to a chronic condition?	N=70	N=448
Yes	43%	48%
No	57%	52%

Table 3B.   Health Status Measure As Measured by the Child Health Questionnaire

Category Child Health Questionnaire (CHQ) Scores	Mean Score Texas New Enrollee	Mean Score Texas Established Enrollees	Mean Score National
Single Item General Health	79.80 ± 21.67	79.06 ± 21.83	--
Single Item Global Behavior	76.93 ± 23.48	77.73 ± 22.74	--
Single Item Family Cohesion	76.67 ± 23.72	75.47 ± 22.34	--
Physical Functioning	95.08 ± 16.25	95.75 ± 14.35	90.85 ± 16.38
Role-Emotional/Behavior	95.64 ± 17.61	96.95 ± 14.39	90.40 ± 19.51
Role-Physical	96.19 ± 16.27	96.59 ± 15.36	91.50 ± 18.91
Bodily Pain	85.41 ± 22.62	84.29 ± 21.93	78.68 ± 20.74
Behavior	70.68 ± 22.12	69.89 ± 19.60	72.31 ± 17.14
Mental Health	80.73 ± 19.25	80.67 ± 16.72	77.26 ± 13.69
Self-Esteem	82.27 ± 16.79	85.77 ± 16.59	79.26 ± 17.83
General health	68.15 ± 20.38	66.71 ± 20.25	66.70 ± 19.20
Parent Impact-Emotional	78.57 ± 25.93	80.98 ± 24.50	73.98 ± 22.45
Parent Time Impact	90.58 ± 22.54	93.37 ± 17.92	83.88 ± 18.93
Family Activities	85.75 ± 23.74	85.05 ± 22.27	--
Physical Summary Score	53.07 ± 9.28	53.01 ± 8.46	53.37 ± 0.51
Psychosocial Summary Score	51.42 ± 10.93	52.73 ± 9.22	51.12 ± 0.51

Figure 2. Child Health Status as Measured by the Child Health Questionnaire (CHQ)
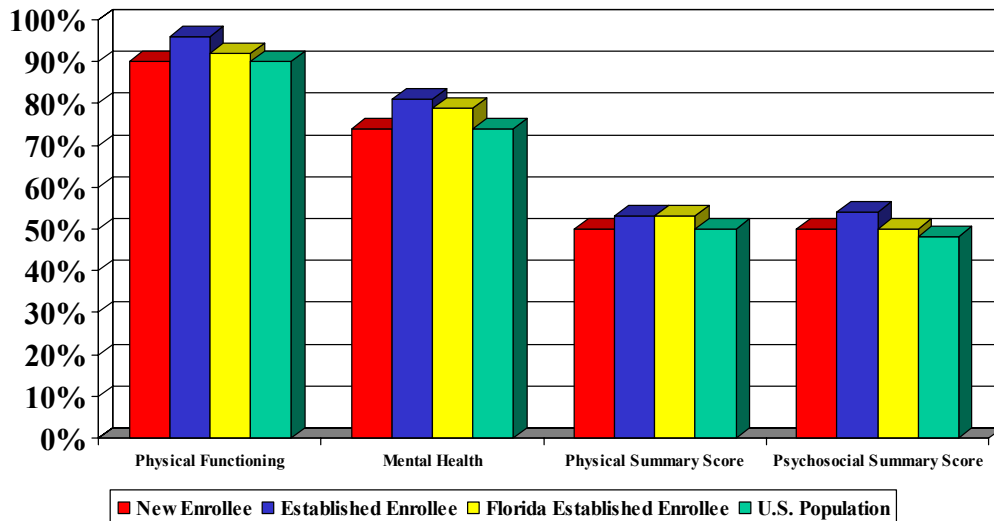
**Table 3C.   Missed School Days and Restricted Activity Days
for Children With Special Health Care Needs**

CSHCN Screener Score	New Enrollee Survey Results		Caregiver Survey Results	
	Missed School in the Last Two Weeks	**Unable to Engage in Activities in the Last Two Weeks**	**Missed School in the Last Two Weeks**	**Unable to Engage in Activities in the Last Two Weeks**
	Percent Yes	**Percent Yes**	**Percent Yes**	**Percent Yes**
Met None	10.3	4.6	13.1	4.7
Met One	4.0	2.2	2.4	1.2
Met Two	2.7	2.8	2.0	1.1
Met All Three	2.2	2.0	1.3	1.2

VII. FAMILIES' EXPERIENCES WITH THE APPLICATION PROCESS

Satisfaction with the Application and Enrollment Process

Table 4 contains a summary of families' satisfaction with the application and enrollment process. Sixty percent of families reported waiting one month or less from the time they applied to the time their children were covered, that is actually able to receive health care services. An additional 26% of families waited between one and two months from application to coverage. Eleven percent of families waited more than two months.

The family's responses are based on their *perceptions* of the time from application submittal to coverage. Therefore the times reported by the families are not the same as the processing times reported by the third party administrator (TPA). The TPA has reported longer times from application to coverage when compared to family report.

To provide a context, the wait times from application to coverage in Texas are compared to the Title XXI Program in Florida. These comparisons are contained in Table 5.[8]

Families were highly satisfied with the application and enrollment process. Seventy-eight percent felt they were kept well informed of the status of their children's application while waiting, whereas 22% did not. The vast majority of families reported that the application process was "easy to understand" (98%) and convenient (98%).

Seventy-four percent of families reported using a toll-free number for assistance at some time during the application process. Of those using the toll-free number, 87% reported that they reached someone easily. However, 13% or 57 families reported difficulty with the toll-free number. The 57 families reporting problems indicated that (1) they were "on hold" for too long, that is more than 15 minutes (36% or 20 families), (2) the line was busy (36% or 20 families), (3) they left a message and never received a return call (22% or 13 families), or (4) the person answering the telephone could not answer their questions (7% or 4 families).

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[8] Shenkman E, et al., The Florida KidCare Evaluation 1999-2000. Gainesville, Florida: Institute for Child Health Policy, December 2000.

It should be noted that the Program TPA manages the toll-free number and this number is set up so that the odds of receiving a busy signal are extremely low. Thus, for those families experiencing a busy signal during the call, the problem may have been an issue with their local telephone service as opposed to a problem with the toll-free number.

Of the 57 families with complaints, 91% of them were applying to the Program in July and August 2000. At this same time, the toll-free number call center experienced a staff reduction due to employee terminations and resignations. In addition, the call volume increased 75% over that experienced prior to July 2000. The combination of reduced staffing and heavy call volume resulted in significant performance problems. These issues were addressed through increased staffing and infrastructure improvements. The experience of the majority of the 57 families with complaints is consistent with the time period when the call center was experiencing problems, which were subsequently addressed.

Eighty-nine percent of families using the toll-free number found the person at that number to be helpful to very helpful, 7% found the person to be somewhat helpful, and only 3% said the person was not helpful at all. Thus the vast majority of families using the toll-free number were able to reach someone easily and to obtain the help they needed.

Table 4.   Experience With The Application Process[9]

Category	Percentage (N=602)
Respondent Report of Time Lapse From Application to Coverage	
Two weeks or less	14%
Three weeks	15%
1 month	31%
Over 1 month but less than 2 months	16%
Two months	10%
Over 2 months	11%
Don't know	3%

Table 4 continued.   Families' Experiences With The Application Process

[9] The family's responses are based on their *perceptions* of the time from application submittal to coverage. Therefore the times reported by the families are not the same as the processing times reported by the TPA. The TPA has reported longer times from application to coverage when compared to family report.

Category	Percentage (N=602)
Were you kept informed while waiting	
Yes	78%
No	22%
Was the application form easy to understand	
Strongly agree	57%
Agree	41%
Disagree	1%
Strongly disagree	0%
Don't know	<1%
Was the application process convenient?	
Strongly agree	54%
Agree	44%
Disagree	<1%
Strongly disagree	<1%
Don't know	<1%
Did you use a toll-free number for assistance?	
Yes	74%
No	26%
Could you reach someone at the number? (N=443)	
Yes	87%
No	13%
How helpful was the person at the toll-free number?	
Not helpful at all	3%
Somewhat helpful	7%
Helpful	21%
Very helpful	68%
Don't know	1%
For those who did not easily reach someone at the toll-free number, what problems were encountered? (N=57)	
On hold too long	N=20 (36% of families with a complaint)
Line busy	N=20 (36% of families with a complaint)
Left message and never received a return call	N=13 (22% of families with a complaint)
Person at number could not answer question	N= 4 (7% of families with a complaint)

Table 5.   Comparison of Wait Times From Application to Coverage

Category	Texas Percentage	Florida Percentage 2001
Respondent Report of Time Lapse From Application to Coverage		
Two weeks or less	14%	5%
Three weeks	15%	10%
1 month	31%	22%
Over 1 month but less than 2 months	16%	22%
Two months	10%	14%
Over 2 months	11%	28%
Don't know	3%	5%

Medical Expenditures While Awaiting Coverage

As previously reported, 86% of families wait two months or less from the time they submitted their CHIP applications to the time their children received coverage. Fourteen percent of families reported waiting two months or longer. While the majority of wait times are acceptable for application processing and coverage, it is important to assess the impact on families and their children during this time. Thus, families were asked a series of questions about medical expenses incurred while awaiting coverage and whether they did not seek needed care for their children during that time. Table 6 contains a summary of these findings.

About 34% of families reported taking their children to a doctor or a nurse for care while awaiting coverage. The reasons for the visits were all due to minor acute illness such as a cold or the flu, minor injuries such as sprains, and well child check-ups. Forty-four percent of these families reported paying $50 or more for the visit, which is a significant cost, given the low reported family incomes.

Nine percent of families reported taking their children to the emergency room for minor illnesses or injuries. Of these families, 44% reported paying $50 or more for the visit, 15% reported not paying anything at all, and 41% of families paid between $10 and $49 for the encounter. Nineteen percent of families reported not seeking medical care while awaiting coverage because of the amount of money they would have to pay.

Table 6.   Medical Expenditures While Awaiting Coverage

Category	Percentage (N=602)
Did your child see a doctor or nurse in the doctor's office for medical care	
Yes	34%
No	66%
How much did you pay at the time of the visit?	
Nothing	13%
Less than $10	11%
$11 to $15	5%
$16 to $20	4%
$21 to $30	6%
$31 to $50	16%
More than $50	44%
Was your child seen in the emergency room while awaiting coverage	
Yes	9%
No	91%
Did you not seek medical attention when you felt you should have because of the amount of money that you would have to pay?	
Yes	19%
No	79%
Don't know	1%
Refused	<1%

VIII. CHILDREN'S USUAL SOURCE OF CARE

Background   Assessing whether children have a usual source of health care is an important component of quality monitoring. A usual source of care implies that the child and his or her family have a personal relationship with their health care provider over time. The benefits associated with a usual source of care are well documented and include early detection of health care problems and reduced costs of care.[10] Uninsured children are less likely than insured children to have a usual source of care.

During the New Enrollee and Established Enrollee Surveys, families were asked if their children had a usual source of care and the type of place where their children received that care (i.e., emergency room, doctor's office, and so on). Figure 3 describes the percentage of children with a usual source of care pre-enrollment in CHIP, immediately post-enrollment, and at 12 months post-enrollment. Figure 4 contains information about the location of that usual source of care.

Results   Nationally, about 75% of uninsured children have a usual source of care.[11] Prior to enrollment in CHIP, 85% of the families reported that their children had a usual source of care. Of those, 19% reported that the emergency room was their children's usual source of care prior to enrollment in CHIP.

The emergency room is generally considered to be a poor location to serve as a usual source of care for children. The care is costly and the child and family cannot develop a relationship with one provider who gets to know them and their needs. Often, evaluators will categorize families whose children use the emergency room on a regular basis as *not* having a usual source of care. If all of the children who used the emergency room regularly were re-categorized, only 69% of children in Texas prior to their CHIP enrollment had a usual source of health care, which is significantly worse than the national average.

However, three months post-CHIP enrollment 90% of families reported their children had a usual source of care and that percentage had increased to 92% by 12 months post-enrollment. More importantly, the location of that usual source of care shifted dramatically. At 12 months post-enrollment, 1% of the children used the emergency room as their usual source of care compared to 19% pre-enrollment. Sixty-two percent of children received their usual health care in a doctor's office by 12 months post-enrollment compared to 48% pre-enrollment. An additional 16% have a hospital clinic as their usual source of care, compared to none pre-enrollment.

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[10] Starfield B. *Primary Care: Concept, Evaluation, and Policy*. New York: Oxford University Press; 1992.
[11] Shenkman E, Bono C. Uninsured Children and Their Access to Care. Gainesville, Florida: Institute for Child Health Policy; 2002.

One unusual finding is that 10% of families at 12 months post-enrollment reported using an urgent care center as their children's usual source of health care, compared to none of the families pre-enrollment. Urgent care centers are typically known for short-term, acute care needs and are not desirable as a usual source of care. Four of the health plans had more than 10% of its enrollees reporting that an urgent care center was their usual source of care. Two of these plans served more than one site, so these four plans represented eight different sites. These health plans/sites were: El Paso 1st, Amerikids (Dallas), EPO Clarendon Health Plan (Houston Area Counties), Texas University Health Plan (Amarillo), Amerikids (Houston), Texas University Health Plan (San Antonio), Texas University Health Plan (El Paso), and EPO Clarendon Health Plan (Border Counties). This finding should be explored further to determine if the provider networks in those sites are adequate and if not, if changes can be made. In addition, further work should be conducted to examine how these health plans assist families in choosing a usual source of care for their children. Perhaps the provider networks are adequate and families need assistance to select providers for their children.

In summary, CHIP in Texas has resulted in significant improvements in the percentage of children with a usual source of care. Moreover, that usual source of care is a doctor's office or a hospital clinic for the 78% of the children. These findings are not adjusted for the children's sociodemographic or health characteristics. Further detail assessing differences in the percentage of children with a usual source of care by health plan after controlling for or considering the children's health and sociodemographic characteristics is contained in Section IX of this report.

Figure 3. Percentage of Children With A Usual Source of Care
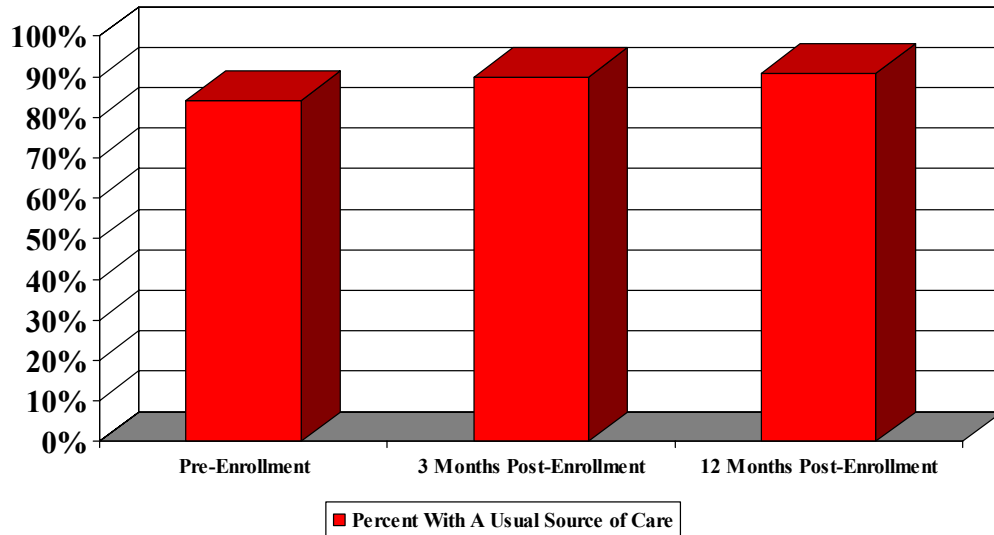
Figure 4. Type of Usual Source of Care

Legend: ■ Pre-Enrollment ■ 12 Months Post-Enrollment

(Chart y-axis: 0% to 100% in 10% increments. Categories: Emergency Room, Hospital Clinic, Doctor's Office, HMO Clinic, Community Health Center, Health Department, Urgent Care Center, School Clinic)
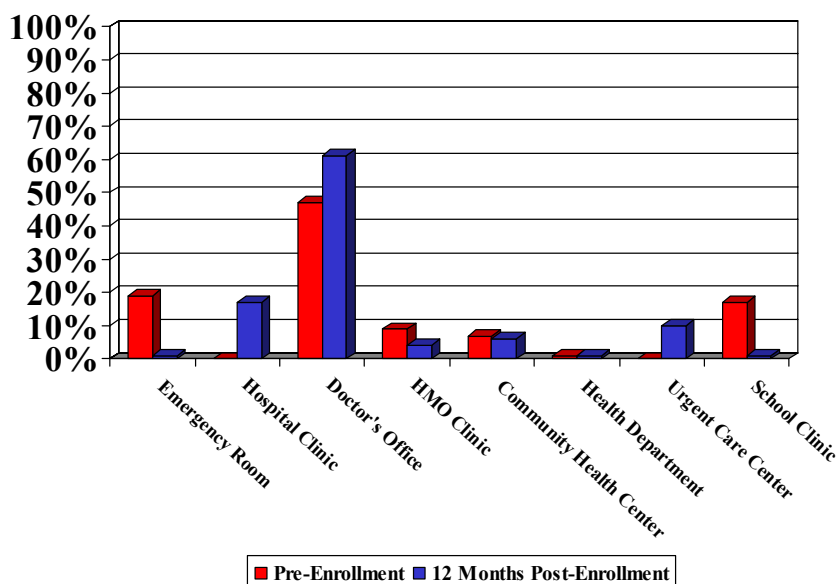
IX. FAMILIES' SATISFACTION WITH CARE

Background   A detailed telephone survey was used to assess family satisfaction with care. The survey contained questions about the health insurance status and general health of every member of the child's household. In addition, detailed questions were asked about the children's usual source of care and their health status. The largest section of the telephone survey contained the CAHPS. The CAHPS was chosen for use in this evaluation because it is currently used for other state CHIP evaluations and the National Commission on Quality Assurance recommends its use. The Medicaid version of the CAHPS was administered to families and contained the following sections:

- Children's Core Questions, Medicaid Managed Care Version
- Children's Supplemental Questions
    - o Chronic Conditions
    - o Prescription Medication
    - o Transportation

As previously described, 300 completed surveys were obtained for each health plan. In instances where health plans were serving large geographic regions, the coverage areas for those health plans were subdivided and sampled individually. There were 5,415 completed surveys that spanned 13 health plans and 18 sites. Of these 13 health plans, one plan served children in two different CSAs; one plan served children in three different CSAs; and one plan served very large rural areas and was subdivided into three regions. Thus, there were 18 sites included in the analysis.

Several steps were taken to analyze the data from the CAHPS. First item responses for CHIP in Texas overall and in comparison to Florida were summarized and are described in the following paragraphs. The results for each CAHPS items for each of the 18 health plans/sites are contained in Appendix B. The interested reader is referred to these appendices to review the responses for each item. Second, the CAHPS was scored using categories recommended by the developers. Third, specific items are discussed in-depth. The rest of this section will address a health plan/site comparison for the following five categories of items on the CAHPS:

- Getting Needed Care
- Getting Care Without Long Waits
- Doctor's Communication
- Courtesy of Office Staff
- Health Plan Communication

The CAHPS Child survey contains 18 specific questions about the family's experience with their CHIP doctor, the doctors' office staff, and the health plan customer service. The questions can be answered by choosing one of 3 choices (1-big problem, 2-small problem, 3-not a problem), or 4 choices (1-never, 2-sometimes, 3-usually, 4-always). The low end of the scale implies a negative experience, and the high end implies a positive experience. The developers recommend analyzing quality of experience by combining these 18 questions into the following 5 groups, or clusters:

(1) Getting Needed Care
    Getting a doctor for your child you are happy with
    Getting a referral to a specialist that your child needed
    Getting the care for you child that your or your doctor believed necessary
    Getting health care while waiting for approval from the health plan

(2) <u>Getting Care Without Long Waits</u>

How often did you get needed help or advice when calling during office hours

How often did you get appointment for routine care as soon as you wanted

How often did you get care for illness or injury as soon as you wanted

How often did you wait more than 15 minutes past appointment time

(3) <u>Doctor's Communication</u>

How often did the doctor listen carefully to you

How often did doctor explain things in a way you could understand

How often did doctor show respect for what you had to say

How often did doctor explain things in a way that your child could understand

How often did doctor spend enough time with your child

(4) <u>Courtesy of Office Staff</u>

Did office staff treat you with courtesy and respect

Was office staff as helpful as you thought they should be

(5) <u>Health Plan Customer Service</u>

Ease in finding or understanding information in written materials

Getting help when calling customer service

Ease in filling out paperwork associated with the health plan

The above survey questions were preceded by a question asking if the child had the experience that served as the basis for the subsequent questions. For example, the respondent would first be asked if they had called the doctor's office for help and advice in the past 12 months before asking them if they were happy with the help and advice they received. If the respondent indicated the child had not had that experience, the interviewer skipped forward to another section. The cluster score was thus defined as the average value of the answered questions within the cluster. A missing question, due to not having had the experience, was not counted as an observation in the mean. That is, the scores reflect the opinions of the members who had an experience to comment on, versus the entire surveyed pool. The resulting cluster score is a number between 1 to 3 (Get Needed Care, Customer Service), or 1 to 4 (Get Care Quickly, Doctor's Communication, Office Courtesy).

As previously noted, Texas was divided into 18 health plans/regions for comparison of member satisfaction with their CHIP experience. Three hundred CHIP members completed surveys for each of the health plans. However, not all of the children had the health care experiences addressed in the CAHPS. Therefore the numbers of respondents per cluster per plan are listed in Table 7.

Additional analyses were conducted for individual items that served as "filters" or screens for particular experiences. The following items were analyzed individually to detect differences between health plans in the responses:

(1) Do you have one person you think of as your child's personal doctor or nurse?

(2) In the last 12 months, did you call a doctor's office or clinic during regular office hours to get help or advice for your child?

(3) In the last 12 months, did you make any appointments for your child with a doctor or other health care provider for regular or routine health care?

(4) In the last 12 months, how many times did your child go to a doctor's office or clinic? collapsed to "In the last 12 months, did your child got to the doctor's office or clinic at least once?" for analytic purposes.

Table 7.   Sample Size of Health Plan Responses for CAHP Clusters Reported by Site

Health Plan	Get Needed Care	Get Care Quickly	Doctor's Communication	Office Staff Courtesy	Customer Service
El Paso 1st	266	262	249	247	189
EPO Clarendon (Rural Areas)	274	273	267	267	195
Seton Health Plan	276	274	264	264	203
Mercy Health Plans	283	283	276	275	167
Texas Children's Health Plan	286	284	275	273	221
Amerikids (Dallas)	280	282	273	273	217
Cook Children's Health Plan	281	285	276	276	220
EPO Clarendon (Houston Area)	275	278	272	272	206
Driscoll Children's Health Plan	280	276	270	269	173
Texas University (Amarillo)	274	268	264	264	176
Amerikids (Houston)	274	274	264	263	178
Texas University (San Antonio)	275	268	250	250	193
Parkland Community HP	275	271	259	259	185
Texas University (El Paso)	241	244	222	221	203
Community First Health Plans	278	279	271	271	199
UTMB Health Care System	282	279	272	272	211
FirstCare	285	286	278	278	197
EPO Clarendon (Border Areas)	268	273	260	261	149
Not included because family did not use that particular service	462	476	654	660	1933

The primary goal of the analyses was to evaluate parents' satisfaction with their children's health care while enrolled in CHIP. In addition, a substantial body of literature has demonstrated that children's health and sociodemographic characteristics also influence families' satisfaction with health care.[12,13] Understanding variations in assessments of health care based on race and ethnicity is critical when evaluating health plan performance particularly in a state like Texas where CHIP and the participating health plans have an extremely diverse enrollee group.

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[12] Fiscella K, Franks P, Gold M, Clancy CM. Inequality in quality: Addressing socioeconomic disparities in health care. *JAMA*. 2000; 283.

[13] Shenkman E, Pendergast J, Reiss J, Walther E, Bucciarelli R, Freedman S. The school enrollment-based health insurance program: Impact on health care use of low-income children. *American Journal of Public Health*. 1996; 86:1791-1793.

Therefore, in addition to analyzing differences in satisfaction based on health plan and site, the following sociodemographic characteristics were included in the analysis:

- Age,
- Gender,
- Race/ethnicity,
- Annual income,
- Months enrolled in CHIP, and
- Parent's education.

The following health status information also was included:

- Scores for the psychosocial summary and physical summary domains on the CHQ and
- Scores on the CSHCN Screener (4 levels – 0= no special need, 1=child has one of the screening criteria for a special need, 2=child has two of the screening criteria for a special need, 3=child has all three of the screening criteria for a special need).

Data Analysis

The SUDAAN (Survey Data Analysis) software was used. The survey sample design was single-stage, using simple random sampling from each of the 18 health plans/sites. Observations (parent interviews) within each strata (health plan/site) were weighted by the reciprocal of the sampling proportion, where the sampling proportion is simply the ratio of the number of completed surveys within the health plan to the number of enrollees in the health plan target population (i.e., those enrolled for 12 months or longer).

Descriptive Results: Texas and Florida Comparison

Tables 8A-J shows the CAHPS results for Texas in comparison to the Healthy Kids component of the Florida Kidcare Program. Overall, satisfaction in both programs was high, with most families indicating that they "usually" to "always" were satisfied with or received certain services. Tables 8A and B compare responses in Texas and Florida about children's usual source of care. As already noted, most children in CHIP in Texas have a usual source of care, as do the children in Florida. In both states, the primary reason families give for not having a usual source of care is that the "child does not need medical attention." However, a significantly higher percentage of families in Texas give this response compared to those in Florida (50% versus 43%, respectively). Families need to be encouraged to have a usual source of care for their children for primary and preventive care, in addition to acute or "sick" care needs.

In Texas, 94% of families report their children are seeing a family practitioner or a pediatrician as their usual source of care. Seventy-eight percent reported it was "no problem" to find a usual source of care. However, 15% found it a "small problem" and 8% found it a "big problem." Similar results were obtained in Florida.

The majority of families in Texas have a long-term relationship with their children's providers. One-third of them got a new usual source of care for their children after joining CHIP; whereas 66% of them kept the same provider. Seventy-nine percent of the children have been going to their usual source of care for 12 months or longer.

The majority of families indicate that the child's doctor talks to them about how health problems affect the child's day-to-day life (90%) and the family's day-to-day life (87%). However, only 69% of families report that the doctors "usually or always" talk to them about growth and behavioral issues; whereas 31% do not. Similar results were obtained in Florida. The provision of anticipatory guidance, that is information about the child's growth and development, is a critical component of any preventive care visit. This is an area where further exploration is required to determine if physicians are discussing the children's growth and development with families.

About 25% of children in Texas needed to see a specialist in the last year, according to parent report, compared to 40% in Florida (Table 8C). Of those in Texas, 90% reported it was "not a problem" to a "small problem" to get such care, compared to 88% in Florida.

A higher percentage of Florida enrollees reported they made appointments for routine care for their children compared to Texas enrollees (77% versus 67% respectively) (Table 8D). However, the wait times for such care was shorter in Texas than in Florida with 82% of those in Texas receiving an appointment within 3 days of calling compared to 63% in Florida.

About 33% of children in Texas compared to 43% in Florida needed immediate care for an illness or injury in the 12 months prior to the survey. Care was prompt in Texas with 89% of families reporting that their children "always" or "usually" received care as soon as they wanted. Seventy-eight percent of children were seen the same day and an additional 13% were seen within one day. Similar results were obtained in Florida.

Comparable results were obtained in Texas and Florida in the areas of: courtesy and respect, helpfulness, and listening to family concerns. Over 85% of families in Texas reported that the doctor and/or his or her office staff treated them with courtesy and respect, were helpful, and listened to them.

Providers in Texas also received positive ratings from families in speaking to them in a language they could understand (88%) and explaining things in a way they could understand (78%). Eighty-four percent of families in Texas reported that their providers "usually" to "always" spent enough time with their children compared to 91% in Florida.

In addition, to overall access to care and satisfaction items, questions were asked about services for families who had children with special health care needs (Table 8G). Very few children needed services such as special medical equipment (4%); speech, physical, or occupational therapies (4%); home health care (<1%); respite care (<1%); or treatment for emotional, developmental, or behavioral difficulties (7%). However, when these services were needed, less than 10% of families reported it was a "big problem" to obtain the care or service. Comparable results were obtained in Florida.

Table 8A. Usual Source of Care

Category	Texas Overall (N=5,408)	Florida Overall (N=344)
Had a usual source of care		
Yes	90.9	93.3
No	9.1	6.7
Reasons for no usual source of care		
Child did not need medical attention at that time	50.3	43.48
Did not have a child prior to enrollment in program	7.16	4.35
Had to see whichever doctor would agree to see child for free	14.72	4.35
Had to go to whichever doctor's office was open	18.61	17.39
Not able to afford copay		8.70
Other	4.42	23.81
Type of usual source of care		
Hospital ER	1.04	1.28
Clinic at a hospital	10.12	0
Particular doctor's office outside a hospital	56.63	79.55
Particular doctor's office inside a hospital	4.38	1.60
An HMO-run clinic	4.29	3.51
A community health center	6.04	3.51
A school clinic	0.37	0
The local health department	0.58	2.56
Walk-in clinic or urgent care center	9.50	2.88
Another type of place	7.05	5.11

Table 8B. CAHPS – Your Child's Personal Doctor or Nurse

Questions	Texas Overall (N = 5,408)		Florida Overall (N=344)	
	#	%	#	%
When your child joined this program, did he/she get a new personal doctor or nurse?				
Yes	1806	33.49	174	51.03
No	3587	66.51	167	48.97
How much of a problem, if any, was it to get a personal doctor or nurse for your child you are happy with?				
A big problem	137	7.62	12	6.94
A small problem	260	14.46	29	16.76
Not a problem	1401	77.92	132	76.30

Table 8B continued. CAHPS – Your Child's Personal Doctor or Nurse

Questions	Texas Overall (=5,408)		Florida Overall (N=344)	
	#	%	#	%
Is this person a <u>general</u> doctor, a <u>pediatrician</u>, a <u>specialist doctor, a physician assistant,</u> or a <u>nurse</u>?				
General Doctor (Family practice or general pediatrician)	4250	93.94	283	95.61
Specialist doctor	123	2.72	7	2.36
Physician assistant	96	2.12	1	0.34
Nurse	55	1.22	5	1.69
How many months or years has your child been going to his or her personal doctor or nurse?				
Less than 6 months	324	7.20	23	7.74
6 up to 12 months	623	13.84	43	14.48
12 up to 24 months	1161	25.79	59	19.87
2 up to 5 years	1279	28.42	115	38.72
5 years or more	1114	24.75	57	19.19
Does your child have a physical, emotional, or mental condition that seriously <u>interferes with your child's ability to do the things</u> most children that age can do?				
Yes	300	6.60	21	7.07
No	4246	93.40	276	92.93
Does your child's personal doctor or nurse <u>understand how any health problems your child has affect his or her day-to-day life?</u>				
Yes	263	90.38	20	95.24
No	28	9.62	1	4.76
Does your child's personal doctor or nurse understand <u>how any health problems your child has affect you and the family's day-to-day life?</u>				
Yes	251	86.85	20	95.24
No	38	13.15	1	4.76
In the last 12 months, when your child went to his or her personal doctor or nurse's office or clinic, how often did the doctor or nurse talk with the about how our child is feeling, growing, or behaving?				
Never	687	15.33	36	12.16
Sometimes	746	16.65	42	14.19
Usually	595	13.28	55	18.58
Always	2453	54.74	163	55.07
	Mean	**SD**	**Mean**	**SD**
How would you rate <u>your child's personal doctor or nurse?</u> (0 Worst to 10 Best)	8.97	1.54	8.67	1.54

Table 8C. CAHPS – Getting Health Care From a Specialist

Questions	Texas		Florida	
	#	%	#	%
In the last 12 months, did you or a doctor think your child needed to see a specialist?				
Yes	1365	25.24	136	39.65
No	4044	74.76	207	60.35
In the last 12 months, how much of a problem, if any, was it to get a referral to a specialist that your child needed to see?				
A big problem	128	9.51	16	11.85
A small problem	234	17.38	14	10.37
Not a problem	984	73.11	105	77.78
In the last 12 months, did your child see a specialist?				
Yes	1297	23.99	122	35.67
No	4110	76.01	220	64.33
How would you rate your child's specialist?				
(0 Worst to 10 Best)				
Mean/Standard Deviation	8.87	1.84	8.55	2.06
In the last 12 months, was the specialist your child saw most often the same doctor as your child's personal doctor?				
Yes	249	19.30	14	11.48
No	1041	80.70	108	88.52

Table 8D. CAHPS – Your Child's Health Care in the Last 12 Months

Questions	Texas		Florida	
	#	%	#	%
In the last 12 months, did you call a doctor's office or clinic <u>during regular office hours</u> to get help or advice <u>for your child?</u>				
Yes	2195	40.63	177	51.91
No	3208	59.37	164	48.09
In the last 12 months, when you called during regular office hours, how often did you <u>get</u> the help or advice you needed <u>for your child?</u>				
Never	51	2.33	3	1.69
Sometimes	213	9.73	17	9.60
Usually	350	15.99	36	20.34
Always	1575	71.95	121	68.36
In the last 12 months, did you make any appointments for your child with a doctor or other health care provider for <u>regular or routine</u> health care?				
Yes	3642	67.43	262	76.61
No	1759	32.57	80	23.39
In the last 12 months, how often did your child get an appointment for <u>regular or routine</u> health care as soon as you wanted?				
Never	70	1.93	4	1.53
Sometimes	451	12.44	26	9.92
Usually	700	19.32	56	21.37
Always	2403	66.31	176	67.18
In the last 12 months, how many days did your child usually have to wait between making an appointment for <u>regular or routine care</u>, and actually seeing a provider?				
Same day	1456	40.61	59	22.87
1 day	782	21.81	42	16.28
2-3 days	671	18.72	63	24.42
4-7 days	352	9.82	43	16.67
8-14 days	156	4.35	33	12.79
15-30 days	100	2.79	9	3.49
31 days or longer	68	1.90	9	3.49
In the last 12 months, did your child have an <u>illness or injury</u> that needed care right away from a doctor's office, clinic, or emergency room?				
Yes	1790	33.11	149	43.44
No	3616	66.89	194	56.56

Table 8D continued. CAHPS – Your Child's Health Care in the Last 12 Months

Questions	Texas		Florida	
	#	%	#	%
In the last 12 months, when your child needed care right away for an <u>illness or injury</u>, how often did your child get care as soon as you wanted?				
Never	50	2.81	5	3.36
Sometimes	140	7.86	10	6.71
Usually	216	12.12	17	11.41
Always	1376	77.22	117	78.52
In the last 12 months, how <u>long</u> did your child usually have to wait between trying to get care and actually seeing a provider for an <u>illness or injury</u>?				
Same day	1358	76.77	107	73.29
1 day	223	12.61	17	11.64
2 days	90	5.09	8	5.48
3 days	30	1.70	3	2.05
4-7 days	41	2.32	9	6.16
8-14 days	6	0.34	1	0.68
15 days or longer	21	1.19	1	0.68
In the last 12 months, how many times did your child go to an <u>emergency room</u>? (mean in # column, S.D. in % column)	0.42	0.97	0.37	0.74
In the last 12 months, how many times did your child go to a <u>doctor's office or clinic</u>?				
None	652	12.28	26	7.72
1	722	13.60	57	16.91
2	942	17.74	81	24.04
3	827	15.57	55	16.32
4	639	12.03	33	9.79
5 to 9	1023	19.27	58	17.21
10 or more	505	9.51	27	8.01
In the last 12 months, how much of a problem, if any, was it to get care for your child that you or a doctor believed necessary?				
A big problem	94	1.98	8	2.52
A small problem	470	9.90	30	9.43
Not a problem	4184	88.12	280	88.05

Table 8D continued. CAHPS – Your Child's Health Care in the Last 12 Months

Questions	Texas		Florida	
	#	%	#	%
In the last 12 months, how much of a problem, if any, were delays in your child's health care while you waited approval from your child's health plan?				
A big problem	104	2.19	11	3.46
A small problem	342	7.21	24	7.55
Not a problem	4299	90.60	283	88.99
In the last 12 months, how often did your child wait in the doctor's office or clinic more than 15 minutes past the appointment time to see the person your child went to see?				
Never	1172	24.79	103	32.39
Sometimes	1874	39.64	111	34.91
Usually	599	12.67	42	13.21
Always	1082	22.89	62	19.50
In the last 12 months, how often office staff at your child's doctor's office or clinic treat you and your child with courtesy and respect?				
Never	104	2.19	4	1.26
Sometimes	268	5.65	11	3.47
Usually	495	10.43	31	9.78
Always	3880	81.74	271	85.49
In the last 12 months, how often office staff at your child's doctor's office or clinic as helpful as you thought they should be?				
Never	103	2.17	7	2.22
Sometimes	462	9.73	26	8.23
Usually	751	15.81	43	13.61
Always	3433	72.29	240	75.95
In the last 12 months, how often did your child's doctor or health care providers listen carefully to you?				
Never	55	1.16	5	1.57
Sometimes	303	6.37	16	5.03
Usually	612	12.87	52	16.35
Always	3785	79.60	245	77.04

Table 8D continued. CAHPS – Your Child's Health Care in the Last 12 Months

Questions	Texas		Florida	
	#	%	#	%
In the last 12 months, how often did you have a hard time <u>speaking with or understanding</u> your child's doctors or other health care providers because you spoke different languages?				
Never	4179	87.83	275	86.75
Sometimes	379	7.97	32	10.09
Usually	67	1.41	5	1.58
Always	133	2.80	5	1.58
In the last 12 months, how often did <u>your child</u> have a hard time <u>speaking with or understanding</u> your child's doctors or other health care providers because you spoke different languages?				
Never	4246	89.75	277	87.11
Sometimes	342	7.23	33	10.38
Usually	52	1.10	3	0.94
Always	91	1.92	5	1.57
In the last 12 months, how often did your child's doctor or health care providers <u>explain things</u> in a <u>way you could understand</u>?				
Never	279	5.87	8	2.52
Sometimes	283	5.95	11	3.46
Usually	484	10.17	38	11.95
Always	3711	78.01	261	82.08
In the last 12 months, have any of your child's doctors or other health care providers talked with you about the <u>skills you need</u> to take care of your child?				
Yes	2616	55.51	139	44.41
No	2097	44.49	174	55.59
In the last 12 months, have any of your child's doctors or other health care providers given you <u>reassurance and support</u> about the care you are providing for your child?				
Yes	3653	77.67	223	71.25
No	1050	22.33	90	28.75

Table 8D continued. CAHPS – Your Child's Health Care in the Last 12 Months

Questions	Texas		Florida	
	#	%	#	%
In the last 12 months, have any of your child's doctors or other health care providers had <u>respect for what you had to say</u>?				
Never	139	2.93	4	1.27
Sometimes	301	6.34	13	4.13
Usually	590	12.43	52	16.51
Always	3718	78.31	246	78.10
Is your child old enough to talk with doctors about his or her health care?				
Yes	3658	76.98	295	92.77
No	1094	23.02	23	7.23
In the last 12 months how often did doctors or other health care providers <u>explain things</u> in a way <u>your child</u> could understand?				
Never	87	2.39	5	1.71
Sometimes	334	9.17	19	6.51
Usually	569	15.63	55	18.84
Always	2651	72.81	213	72.95
In the last 12 months how often did doctors or other health care providers <u>spend enough time with your child</u>?				
Never	160	3.37	5	1.58
Sometimes	630	13.27	25	7.91
Usually	934	19.68	69	21.84
Always	3022	63.67	217	68.67
In the last 12 months were <u>any</u> decisions made about your child's health care?				
Yes	2104	45.03	157	51.14
No	2568	54.97	150	48.86
In the last 12 months, how often were you <u>involved as much as your wanted</u> in these decisions about your child's health care?				
Never	15	0.71	2	1.28
Sometimes	79	3.75	5	3.21
Usually	133	6.32	11	7.05
Always	1877	89.21	138	88.46
In the last 12 months, how much of a problem, if any, was it to get your child's doctor or other health care provider to <u>agree with you</u> on the best way to manage your child's health conditions or problems?				
A big problem	27	1.28	2	1.27
A small problem	171	8.13	12	7.64
Not a problem	1905	90.58	143	91.08

Table 8D continued. CAHPS – Your Child's Health Care in the Last 12 Months

Questions	Texas		Florida	
	#	%	#	%
Is your child enrolled in any kind of school?				
Yes	4155	87.25	309	97.48
No	607	12.75	8	2.52
Does your child have health care needs that require any <u>special help</u> from teachers, nurses, or staff at your child's school?				
Yes	526	12.70	40	13.03
No	3615	87.30	267	86.97
In the last 12 months, have any of your child's doctors or other health providers helped <u>let the school know</u> about these needs?				
Yes	307	59.73	19	47.50
No	207	40.27	21	52.50
How would you rate your child's health care?				
(0 Worst to 10 Best)	**Mean**	**SD**	**Mean**	**SD**
Mean/Standard Deviation	9.09	1.34	8.75	1.37

Table 8E. CAHPS – Interpreter Services

Questions	Texas		Florida	
	#	%	#	%
In the last 12 months, did you need an interpreter to speak with <u>your child's</u> doctors or other health providers?				
Yes	228	4.21	1	0.29
No	5186	95.79	343	99.71
In the last 12 months, when <u>you</u> needed an interpreter to help you speak with <u>your child's</u> doctors or other health providers, how often did you get one?				
Never	8	3.52	0	0
Sometimes	59	25.99	1	100.00
Usually	18	7.93	0	0
Always	142	62.56	0	0
In the last 12 months, did <u>your child need</u> an interpreter to help him or her speak with doctors or other health providers?				
Yes	95	1.76	3	0.87
No	5315	98.24	341	99.13

Table 8E continued. CAHPS – Interpreter Services

Questions	Texas		Florida	
	#	%		#
In the last 12 months, when <u>your child</u> needed an interpreter to help him or her speak with doctors or other health providers, how often did he or she get one?				
Never	6	6.32	1	33.33
Sometimes	14	14.74	2	66.67
Usually	7	7.37	0	0
Always	68	71.58	0	0
What language do you <u>mainly</u> speak at home?				
English	3895	71.96	312	90.70
Spanish	1315	24.29	13	2.78
Vietnamese	8	0.15		
Haitian-Creole			3	0.87
Other	195	3.60	16	4.65
What language does your child <u>mainly</u> speak at home?				
English	4272	78.94	329	95.64
Spanish	965	17.83	8	2.33
Vietnamese	6	0.11		
Haitian-Creole			0	0
Other	169	3.12	7	2.03

Table 8F. CAHPS Dental Services

Questions	Texas		Florida	
	#	%	#	%
In the last 12 months, did your child get care from a dentist's office or dental clinic?				
Yes	3431	63.58	229	66.76
No	1965	36.42	114	33.24
In the last 12 months, how many times did <u>your child</u> go to a dentist's office or dental clinic?				
None	18	0.53	3	1.32
1	1469	42.97	69	30.26
2	1130	33.05	87	38.16
3	399	11.67	28	12.28
4	170	4.97	16	7.02
5-9	167	4.88	9	3.95
10 or more	66	1.93	16	7.02
How would you rate your child's dental care?				
(0 Worst to 10 Best)				
Mean/Standard Deviation	8.71	1.97	8.02	2.19

Table 8G. CAHPS Special Needs and Services

Questions	Texas		Florida	
	#	%	#	%
In the last 12 months, did your child have any health problems that required you to get or replace <u>any special medical equipment</u> or devices such as a walker, wheelchair, nebulizer, feeding tubes, or oxygen equipment?				
Yes	227	4.19	9	2.62
No	5186	95.81	335	97.38
In the last 12 months, how much of a problem, if any, was it to get the <u>special medical equipment</u> your child needed through your child's health plan?				
A big problem	16	7.17	0	0
A small problem	26	11.66	0	0
Not a problem	181	81.17	9	100.00
In the last 12 months, did your child have any health problems that needed <u>special therapy</u>, such as physical, occupational, or speech therapy?				
Yes	222	4.10	17	4.94
No	5188	95.90	327	95.06
In the last 12 months, how much of a problem, if any, was it to get the <u>therapy</u> your child needed through your child's health plan?				
A big problem	17	8.42	0	0
A small problem	17	8.42	1	8.33
Not a problem	168	83.17	11	91.67
In the last 12 months, has your child needed home health care services?				
Yes	6	0.11	0	0
No	5408	99.89	343	100.00
In the last 12 months, how much of a problem, if any, was it to get these <u>home health services</u> for your child through your child's health plan?				
A big problem	1	16.67	0	0
A small problem	1	16.67	0	0
Not a problem	4	66.67	0	0
In the past 12 months, did you need respite services for your child?				
Yes	42	0.78	0	0
No	5364	99.22	343	100.00

Table 8G continued. CAHPS Special Needs and Services

Questions	Texas		Florida	
	#	%	#	%
In the last 12 months, how much of a problem, if any, was it to get these <u>respite services</u> through your child's health plan?				
A big problem	7	21.21	0	0
A small problem	5	15.15	0	0
Not a problem	21	63.64	0	0
How would you rate your health plan <u>now</u> regarding equipment and services?				
(0 Worst to 10 Best)				
Mean/Standard Deviation	9.26	1.36	8.96	1.49
Does your child have any kind of emotional, developmental, or behavior difficulty now for which he or she has received <u>treatment or counseling?</u>				
Yes	367	6.79	49	14.29
No	5038	93.21	294	85.71
In the last 12 months, did your child have any <u>treatment or counseling</u> for an emotional, development, or behavior difficulty?				
Yes	369	6.83	47	13.70
No	5036	93.17	296	86.30
In the past 12 months, how much of a problem, if any, was it to get this <u>treatment or counseling</u> through your child's health plan?				
A big problem	32	9.09	8	18.60
A small problem	44	12.50	1	2.33
Not a problem	276	78.41	34	79.07
How would you rate your child's treatment or counseling <u>now</u>? (0 Worst to 10 Best)				
Mean/Standard Deviation	8.34	2.28	7.91	2.53

Table 8H. CAHPS – Your Child's Health Plan

Questions	Texas		Florida	
	#	%	#	%
In the last 12 months, did you look for any <u>information in written materials</u> from your child's health plan?				
Yes	1920	35.58	142	41.28
No	3476	64.42	202	58.72
In the last 12 months, how much of a problem, if any, was it to find or understand information in the written materials?				
A big problem	55	2.87	14	9.86
A small problem	300	15.63	22	15.49
Not a problem	1564	81.50	106	74.65
In the last 12 months, did you call the health plan's <u>customer service</u> to get information or help for your child?				
Yes	2145	39.77	182	53.22
No	3249	60.23	160	46.78
In the last 12 months, how much of a problem, if any, was it get the help you needed when you called your child's health plan's customer service?				
A big problem	159	7.43	36	19.89
A small problem	348	16.25	45	24.86
Not a problem	1634	76.32	100	55.25
In the last 12 months, did you have any experiences with paperwork for your child's health plan?				
Yes	1609	29.84	105	30.70
No	3783	70.16	237	69.30
In the last 12 months, how much of a problem, if any, did you have with paperwork for your child's health plan?				
A big problem	127	7.90	19	18.10
A small problem	338	21.02	28	26.67
Not a problem	1143	71.08	58	55.24
How would you rate your child's health plan <u>now</u>?				
(0 Worst to 10 Best)				
Mean/Standard Deviation	9.26	1.28	8.73	1.56

Table 8I. CAHPS – Prescription Medicine

Questions	Texas		Florida	
	#	%	#	%
In the last 12 months, did your child get any new prescription medicine or refill a prescription?				
Yes	3325	61.63	211	61.70
No	2070	38.37	131	38.30
In the last 12 months, did you pick up any of your child's prescription medicine?				
Yes	3235	97.35	208	98.58
No	88	2.65	3	1.42
How much of a problem, if any, was it to get your child's prescription medicine from your health plan?				
A big problem	90	2.78	4	1.92
A small problem	331	10.24	19	9.13
Not a problem	2812	86.98	185	88.94
How often did your child get the prescription medicine needed through his or her health plan?				
Never	80	2.48	6	2.88
Sometimes	306	9.48	19	9.13
Usually	287	8.89	10	4.81
Always	2554	79.14	173	83.17

Table 8J. CAHPS – Transportation

Questions	Texas		Florida	
	#	%	#	%
In the last 12 months, did you call your child's health plan to get help with transportation for your child?				
Yes	37	0.68	0	0
No	5374	99.32	344	100.00
When you called to get help with transportation from your child's health plan, how often did you get it?				
Never	8	22.22	0	0
Sometimes	3	8.33	0	0
Usually	1	2.78	0	0
Always	24	66.67	0	0
How often did the help with transportation for your child meet your needs?				
Never	3	11.11	0	0
Sometimes	3	11.11	0	0
Usually	0	0.00	0	0
Always	21	77.78	0	0

Cluster Scores   Table 9 lists the weighted mean scores for each of the five clusters by health plan/site. Both the lowest and highest scores are shaded for each cluster. Getting Needed Care and Customer Service had possible ranges of 1 to 3 (big problem, small problem, no problem). Getting Care Quickly, Doctor Communication, and Office Staff Courtesy had possible ranges of 1 to 4 (never, sometimes, usually, always). In all cases, the spread between the mean scores is relatively small, and the low scores are still very favorable. Getting Care Quickly showed the lowest scores of 2.89 -3.36. But, this corresponds to an opinion that members <u>usually</u> received care quickly. In general, it appears that health plans are providing care in a consistent manner across Texas, and that members are having positive experiences in CHIP.

Although the mean or the average scores are positive overall, the standard deviations (not shown) are broad for some of the clusters, indicating variability in the responses. The preceding statement can be illustrated by examining some of the individual item responses, which are of some concern for some of the health plans/sites. For example, referring to Appendix B, the reader will note that 17% of respondents in Amerikids (Dallas) indicated it was "a problem" to get a usual source of care that they were "happy with." This percentage compares to a high of 11% of respondents at the other health plans/sites, with as few as 0% to 4% of respondents in some health plans/sites indicating a "problem" in this area. This particular item was part of the Getting Needed Care Cluster.

A similar issue was noted for the responses about obtaining specialty care. Over 20% of respondents at Amerikids (Dallas) and Parkland Community Health Plan reported a "big problem" obtaining this care compared 3% to 15% at the other health plans/sites. Therefore, further analyses were conducted to examine how much of these differences were attributable to the health plans and how much of these differences were related to the children's health and sociodemographic characteristics.

Honing in on health plan/site differences, Amerikids (Dallas) had the lowest mean score for three out of the five clusters (getting needed care, office staff helpfulness, and customer service), and Parkland Community Health Plan had the lowest mean scores for the remaining two (getting care quickly and doctor's communication). EPO Clarendon Health Plan (Rural Counties), Mercy Health Plans, and FirstCare had the highest mean scores. Therefore, two out of the 18 plans dominated the lower scores, and three out of the 18 plans dominated the higher scores. These findings are before adjusting for enrollees' sociodemographic and health status characteristics.

Consistently, there were statistically significant differences in the scores between the health plans, although all of them generally performed well. In addition, some of the sociodemographc and health status characteristics were significantly related to differences in parental satisfaction. These results are described in detail for each of the clusters and the four screening questions in the following paragraphs.

Table 9. **Order of Health Plans/Sites By Care Quality Cluster by Lowest to Highest Score – No Adjustments for Children's Health and Sociodemographic Characteristics**

Health Plan	Getting Needed Care (Scale 1-3)	Getting Care Quickly (Scale 1-4)	Doctor's Communication (Scale 1-4)	Office Staff (Scale 1-4)	Customer Service (Scale 1-3)
El Paso 1st	2.83	2.96	3.51	3.60	2.68
EPO Clar. Rural	2.88	3.36	3.64	3.74	2.72
Seton	2.82	3.26	3.63	3.70	2.73
Mercy	2.90	3.11	3.61	3.65	2.88
TCHP	2.84	3.11	3.60	3.65	2.77
Ameri. (Dallas)	2.73	3.05	3.51	3.51	2.59
Cook Child.	2.88	3.23	3.66	3.71	2.77
EPO Clar. Houst.	2.86	3.26	3.61	3.68	2.80
Driscoll	2.89	3.20	3.58	3.70	2.73
TUHP (Amarillo)	2.89	3.30	3.67	3.71	2.75
Ameri. (Houst.)	2.78	3.14	3.50	3.58	2.74
TUHP (San Ant.)	2.80	3.04	3.51	3.55	2.71
Parkland	2.76	2.89	3.49	3.55	2.67
TUHP (El Paso)	2.79	3.03	3.60	3.67	2.73
Community First	2.80	3.06	3.56	3.60	2.74
UTMB	2.87	3.22	3.62	3.70	2.81
FirstCare	2.90	3.30	3.71	3.71	2.81
EPO Clar. Border	2.89	3.18	3.69	3.72	2.81

Health Plan Differences

Further statistical analyses were conducted to examine how the health plans/sites, sociodemographic characteristics, and health status measures were related to the odds of a high cluster score. For each cluster, the health plan/site with the highest weighted score was used as the reference and all other health plans/sites were compared to that reference. The odds of each health plan/site having a favorable score in comparison to the reference health plan/site were calculated, after considering variations due to the children's health and sociodemomgraphic characteristics. Because health and sociodemographic characteristics are known to influence satisfaction with care, it is important to consider these factors when comparing health plan/site satisfaction scores. These statistical results (odds ratios and significance levels) are contained in Appendix A. Table 10 contains the relative rankings of the health plans/sites for each of the clusters and the four screening questions, after considering the enrollees' health and sociodemographic characteristics.

Getting Needed Care

Mercy Health Plans had the highest score for this cluster and is the reference health plan. Nine of the health plans/sites had significantly lower scores in the Getting Needed Care cluster, after considering the children's sociodemographic and health characteristics. These health plan/sites were: El Paso 1st, Seton Health Plan, Texas Children's Health Plan, Amerikids (Dallas), Amerikids (Houston), Texas University Health Plan (San Antonio), Parkland Community Health Plan, Texas University Health Plan (El Paso), and Community First Health Plans. For example, children in Parkland Community Health Plan were 0.49 times as likely to report negative scores in the Getting Needed Care cluster as children in Mercy Health Plans. The rest of the plans did not differ significantly from Mercy Health Plans.

The following health and sociodemographic factors were significantly related to scores for **Getting Needed Care:**

- Scores decreased 2.3% with each year increase in age.
- Black non-Hispanics were 1.47 times *more* likely to be satisfied than whites.
- Those in the "other" racial/ethnic category were less than half as likely to be satisfied as whites.
- Children with scores in the 4th quartile (the highest scores) on the CHQ physical summary domain had the highest scores in Getting Needed Care; whereas those with the poorest physical functioning had the lowest scores. For example, families with children in the 0 to 25th percentile of physical functioning (lowest scores) were only 0.58 times as satisfied as those in the 75th percentile of functioning.
- Children with scores in the 3rd and 4th quartile (high scores) on the psychosocial summary domain of the CHQ had the *greatest* satisfaction for Getting Needed Care compared to those with lower psychosocial functioning scores. Children with psychosocial summary scores at the 50th percentile and below were 0.49 to 0.59 times as satisfied as those with scores above the 50th percentile.

- Those that met all three of the CSHCN Screener measures were half as likely to have a favorable opinion of getting needed care as those who met none of the Screener criteria for having a special need.

Getting Care Quickly

EPO Clarendon (Rural Counties) had the highest score for this cluster and is the reference health plan. Twelve of the 17 (non-reference) health plans had significantly lower scores than EPO Clarendon (Rural Counties), after considering health and sociodemographic characteristics in the models. These plans/sites were: El Paso 1st, Mercy Health Plans, Texas Children's Health Plan, Amerikids (Dallas), Cook Children's Health Plan, Driscoll Children's Health Plan, Amerikids (Houston), Texas University Health Plan (San Antonio), Parkland Community Health Plan, Texas University Health Plan (Ell Paso), Community First Health Plans, and EPO Clarendon Health Plan (Border Counties). For example, children in Cook Children's Health Plan were almost one-half (.48 times) as likely as children in EPO Clarendon (Rural Counties) to obtain care quickly.

In addition, the following <u>health and sociodemographic factors</u> were significantly related to scores for **Getting Care Quickly**:

- Black non-Hispanics were more likely to be satisfied with the wait for care than white non-Hispanics.
- Hispanics and those in the "other" racial/ethnic group were approximately half as likely to be satisfied when compared to white non-Hispanic families (odds ratios of 0.645 and 0.414 respectively).
- Members with physical summary scores in the lower three quartiles (the poorest functioning) were about 80% as likely as those with the highest functioning to report that they got needed care quickly.
- In contrast, children who were identified as having special needs based on <u>two components</u> of the CSHCN Screener were 23% *more* likely to report getting needed care quickly than those not identified with special needs.
- Similarly, those who were identified as having special needs based on <u>all three components</u> of the Screener were 19% *more* likely than those without special health care needs to report getting needed care quickly.

Doctor's Communication   FirstCare is the reference health plan. Eleven of the 17 (non-reference) health plans had significantly higher scores from the reference, once sociodemographic and health variables were included in the model. Those plans/sites with higher scores were: El Paso 1st, Mercy Health Plans, Texas Children's Health Plan, Amerikids (Dallas), EPO Clarendon Health Plan (Houston Area Counties), Driscoll Children's Health Plan, Amerikids (Houston), Texas University Health Plan (San Antonio), Parkland Community Health Plan, Texas University Health Plan (El Paso), and Community First Health Plans.

In addition, the following health and sociodemographic factors were significantly related to scores for **Doctor's Communication**:

- Hispanic responses were not significantly different than the responses by white non-Hispanics.
- Black non-Hispanics were about 0.8 times *less* likely to be satisfied with their doctor's communication than white non-Hispanics.
- Those in the "other" race and ethnicity categories were 2.6 times *more* likely to be satisfied with their doctor's communication than white non-Hispanics.
- The lower the child's physical and psychosocial functioning as measured by the CHQ, the *greater* the satisfaction with the doctor's communication. For example, families with children below the 50th percentile in physical functioning were 31% to 37% more satisfied with their doctors' communication than families with healthier children.
- Those that met one or more of the CSHCN Screener measures were about 0.7 times *less* likely than those who met none of the measures to be satisfied with their doctor's communication.

Doctor Office Staff   EPO Clarendon Health Plan (Rural Counties) is the reference health plan. Only 6 of the 17 (non-reference) health plans were significantly different from the reference. Health plans/sites El Paso 1st, Amerikids (Dallas), Amerikids (Houston), Texas University Health Plan (San Antonio), Parkland Community Health Plan, and Community First Health Plans had lower scores than the reference plan.

In addition, the following health and sociodemographic factors were significantly related to scores for **Doctor Office Staff**:

- The race/ethnicity pattern shows Hispanics and those in the "other" racial/ethnic group approximately half as likely to report favorably about office staff helpfulness than white non-Hispanics (odds ratios of 0.572 and 0.366 respectively).
- Black non-Hispanics were 1.3 times *more* likely to be satisfied than white non-Hispanics.
- Both CHQ summary scores show an increase in favorable response with increasing physical and psychosocial summary scores.

Customer Service   Mercy Health Plans is the reference health plan. Thirteen of the 17 (non-reference) health plans had significantly higher scores than the reference plan. El Paso 1st, EPO Clarendon Health Plan (Rural Counties), Seton Health Plan, Texas Children's Health Plan, Amerikids (Dallas), Cook's Children Health Plan, Driscoll Children's Health Plan, Texas University Health Plan (Amarillo), Amerikids (Houston), Texas University Health Plan (San Antonio), Parkland Community Health Plan, Texas University Health Plan (El Paso), and Community First Health Plans had higher scores than Mercy Health Plans after considering the children's health and sociodemographic characteristics.

In addition, the following health and sociodemographic factors were significantly related to scores for **Customer Service**:

- Both Hispanics and black non-Hispanics were less likely to be satisfied than whites (odds ratios of 0.779 and 0.595 respectively).
- Those with CHQ summary scores in the lower quartiles (indicating poorer functioning) were more likely to be satisfied with the customer service than those with better scores.

Specific Items Analyzed

As previously described, the clusters reflect responses only for those families who used health care services, interacted with their doctor and their doctor's staff, and/or called customer service. Families who did not seek health care for their children were not included in these calculations. Therefore, four questions from the CAHPS that address the extent to which families interacted with the health care system with their children were selected for further analyses. Understanding the characteristics of enrollees who do not use health care services can be very critical for improving access to care and the overall quality of any program. The results of these four items by health plan/site are contained in Appendix B, along with the other CAHPS items, but are also summarized in Table 11 of this report for the reader's convenience.

A Personal Doctor or Nurse

FirstCare had the highest percentage of respondents reporting that their child had a personal doctor or nurse without considering other factors and therefore is the reference health plan for this analysis. Only two health plans/sites (Driscoll Children's Health Plan and Mercy Health Plans), were not significantly different than the reference. All other health plans/sites had significantly lower odds of a child having a personal doctor or nurse compared to the reference plan, after considering the children's sociodemographic and health characteristics. For example, a child in Texas University Health Plan (Amarillo) had odds that were just 0.29 times those of a child in FirstCare of having a personal doctor or nurse. Overall, the odds of having a personal doctor for the health plans/sites differing from the reference health plan/site were 0.248 to 0.521 times lower than that of the reference.

In addition, the following health and sociodemographic factors were significantly related to the percentage of children with **A Personal Doctor or Nurse**:

- Younger children were more likely to have a personal doctor, decreasing 5.6% with each year increase in age.
- Hispanics and those in the "other" race/ethnicity group were half as likely as white non-Hispanics to have a personal doctor (odds ratios of 0.554 and 0.355 respectively).
- There was no difference between black and white non-Hispanics.
- Neither CHQ summary score had a significant effect on this question and Children meeting one or more criteria on the CSHCN Screener were twice as likely to have a personal doctor than those meeting none of the Screener criteria.

Call During Office Hours for Help or Advice

Cook Children's Health Plan is the reference health plan. However, the proportion of affirmative responses is similar for most of the health plans/sites. Only 6 plans differed from the reference, corresponding to about half the likelihood of a yes response (odds ratios of 0.475 to 0.568). These health plans/sites were Amerikids (Dallas), Amerikids (Houston), Texas University Health Plan (San Antonio), Parkland Community Health Plan, Texas University Health Plan (El Paso), and EPO Clarendon Health Plan (Border Counties).

In addition, the following health and sociodemographic factors were significantly related to the percentage of families who **Call During Office Hours for Help or Advice**:

- Parents of younger children were more likely to call for advice, decreasing 5.1% with each year increase in age.
- Hispanics were half as likely to call for help as white non-Hispanics.
- There was no difference between whites and other races and ethnicities.
- Black non-Hispanics were also *less* likely to call than whites (odds ratio of 0.680).
- Parents with a high school diploma or less were half as likely to call than parents with a college degree or higher, but there was no difference between the parents with some vocational training or college education and those with a 4-year degree or more,
- Parents of children with low scores in physical and psychosocial functioning were approximately 1.5 times *more* likely to call for advice.
- Parents of children meeting all three measures of the CSHCN Screener were 5.74 times more likely to call for help than those meeting none. Those meeting two measures were 2.56 times more likely to call, and those meeting one measure were 1.95 times more likely to call.

Make Appointments for Routine Care

Cook Children's Health Plan is the reference plan for this analysis. Eleven other health plans/sites differed significantly from Cook Children's Health Plan with respondents in the other plans about half as likely as those in the reference plan to make routine appointments for health care (odds ratios of 0.471 to 0.650). These health plans/sites were El Paso 1st, EPO Clarendon Health Plan (Rural Counties), Amerikids (Dallas), EPO Clarendon Health Plan (Houston Area Counties), Driscoll Children's Health Plan, Texas University Health Plan (Amarillo), Amerikids (Houston), Texas University Health Plan (San Antonio) , Parkland Community Health Plan, Texas University Health Plan (El Paso), and FirstCare

In addition, the following <u>health and sociodemographic factors</u> were significantly related to the percentage of families who **Make Appointments for Routine Care**:

- Younger children were more likely to have appointments for routine care, decreasing 4.1% with each year increase in age.
- Only Hispanics showed a difference to white non-Hispanics, making appointments only 34% as often.
- Parents with a high school education were less likely to make appointments than parents with a college degree (odds ratio of 0.644). But, again, there was no difference between those with some college or vocational training to those with a 4-year degree or more.
- Neither of the CHQ summary scores was significantly related to the probability of a yes response.
- Those meeting all three of the CSHCN Screener measures were 4.36 times more likely to make appointments than those that met none, and meeting one or two measures of the Screener resulted in making appointments twice as often as those children who did not meet any of the CSHCN Screening criteria for the presence of special health care needs.

Go to the Doctor At Least Once

FirstCare is the reference health plan. Similar to the outcome on calling for advice, the proportion of children going to the doctor at least once was similar for most of the health plans. Five plans differed from the reference, corresponding to less than half the likelihood of a yes response (odds ratios of 0.267 to 0.499). These plans/sites were El Paso 1st, Seton Health Plan, Texas University Health Plan (San Antonio), Parkland Community Health Plan, and Texas University Health Plan (El Paso).

In addition, the following <u>health and sociodemographic factors</u> were significantly related to the percentage of children who **Go to the Doctor at Least Once:**

- Parents of younger children were more likely to go to the doctor, decreasing 7.7% with each year increase in age.
- Hispanics and black non-Hispanics are less likely to go to the doctor than white non-Hispanics (odds ratios of 0.687 and 0.624 respectively).
- There was no difference between the other races and ethnicities relative to whites.

- Consistent with the trend in the previous outcomes, parents with a high school education were less likely to take their children to the doctor than more educated parents (odds ratio of 0.598).
- The CHQ scores were not related to the odds of going to the doctor at least once.
- Those that met all three criteria for the presence of a special health care need using the CSHCN Screener were 4.63 times more likely to go to the doctor than those that met none of the criteria. Those meeting two of the criteria were 4.27 times more likely to go, and those meeting one of the criteria were 2.15 times more likely to go to the doctor.

Summary

The weighted scores on the CAHPS, unadjusted for the children's health and sociodemographic characteristics, overall indicate that families are satisfied with the care that they receive in several critical areas: (1) access to or getting needed care, (2) getting care quickly, (3) communication with the doctor, (4) interactions with the office staff, and (5) interactions with the health plan customer service representatives. Families generally report that they usually to always can get needed care and report that most interactions with their health care providers are "not a problem" to a "small problem."

Statistical analyses revealed significant differences in the health plan/site scores after considering children's health and sociodemographic characteristics. In addition to the health plan effects on family satisfaction and use of health care services, characteristics such as the child's age, family race and ethnicity, respondent education, the child's physical and psychosocial functioning, and the presence of special health care needs as measured by the CSHCN Screener were also significantly related to satisfaction with care.

Across the 5 clusters and 4 different individual items considered in the statistical analyses, some plans/sites performed consistently as well as or consistently lower than the highest performing plans (Table 10). The following health plans/sites performed *consistently well* by either having the highest score for a cluster or item or by being equally as good as the reference plan in at least five areas: EPO Clarendon Health Plan (Rural Counties), Seton Health Plan, Mercy Health Plans, Texas Children's Health Plan, Cook Children's Health Plan, EPO Clarendon Health Plan (Houston Area Counties), Driscoll Children's Health Plan, Texas University Health Plan (Amarillo), Community First Health Plans, UTMB Health Care System, FirstCare, and EPO Clarendon Health Plan (Border Counties).

The following health plans/sites consistently performed *less well* than the highest scoring plans/sites by having a lower score than the reference plan in at least five areas: El Paso 1st, Amerikids (Dallas), Amerikids (Houston), Texas University Health Plan (San Antonio), Parkland Community Health Plan, and Texas University Health Plan (El Paso). It is interesting to note that two of the plans in this group performed better than the reference plan/site in the areas of doctor communication and customer service. Five of these sites had a higher percentage of enrollees reporting the use of urgent care centers as their usual source of care (El Paso 1st, Amerikids (Dallas), Amerikids (Houston), Texas University Health Plan (San Antonio), and Texas University Health Plan (El Paso)). Finally, Texas University Health Plan (El Paso) had the lowest percentage of children with a follow-up mental health visit within 30 days after an inpatient mental health-related stay (18% of the children). Texas Children's Health Plan, Amerikids (Dallas), Amerikids (Houston), Texas University Health Plan (San Antonio), and Parkland Community Health Plan also performed poorly on this measure with 50% or less of their children having follow-up visits after an inpatient mental health stay. These findings about the mental health follow-up visits are discussed in more detail in the Section XIII of this report.

While the differences in scores on the clusters between the health plans were small, albeit statistically significant, the findings about access to care (i.e., having a usual source of care, scheduling routine care visits, and seeing the doctor) were strikingly different. In addition, some plans seemed to have a consistent pattern of poorer performance across multiple clusters and access questions. Perhaps these plans are located in counties with poor health care infrastructures that limit their ability to provide good access to care. This possibility should be examined further. In addition, further assessments should be made of their provider networks to ensure appropriate capacity within whatever community constraints they face.

In addition to health plan/site differences in satisfaction and use of health care services, several sociodemographic and health status characteristics were significantly related to satisfaction with and use of health care services. The following key findings were obtained:

- As expected, children with special health care needs, as measured by meeting one, two, or all three CSHCN Screener criteria were significantly more likely than their healthy counterparts to (1) have a personal doctor or nurse (in other words a usual source of care), (2) have sought help or advice from their doctors, (3) have had an appointment for routine care, and (4) have been to see the doctor at least once in the past 12 months.

- However, families of children with special needs as measured by the CSHCN Screener, while using the health care system more, were significantly less satisfied with some aspects of their health care than families of healthy children. Children meeting all three of the criteria on the CSHCN Screener had significantly lower scores in the area of Getting Needed Care and Doctor Communication than children without special needs.

- However, very importantly, children who were identified as having special needs based on two components of the CSHCN Screener were 23% more likely to report getting needed care quickly than those not identified with special needs. Similarly, those who were identified as having special needs based on all three components of the Screener were 19% more likely than those without special health care needs to report getting needed care quickly. Thus, the health care providers and health plans participating in CHIP in Texas are responsive to families who have children with special health care needs by providing timely care.

- Finally families whose children had lower physical and psychosocial health as measured by the CHQ reported greater dissatisfaction with all of the CAHPS clusters than children with high health scores. While this finding may seem to be contradictory when viewed in context with the findings about children with special health care needs, this is not necessarily the case.

  Families who have children with special health care needs often rate the children's health status positively. In fact, many children with special health care needs have high physical and psychosocial functioning. However, if a parent perceives the child to have poorer functioning, regardless of the presence of special health care needs, he or she is less satisfied with that child's care.

- Race and ethnicity were significantly related to health care use with Hispanic families about one-half as likely as white, non-Hispanic families to *not* (1) have a personal doctor or nurse (in other words a usual source of care), (2) have sought help or advice from their doctors, (3) have had an appointment for routine care, and (4) have been to see the doctor at least once in the past 12 months.

- Once Hispanic families sought care, they had lower satisfaction scores than white, non-Hispanic families in the areas of getting care quickly, interacting with office staff, and health plan customer service.

- Black, non-Hispanic families were less likely than white, non-Hispanic families to call their doctors for advice and to take their children to the doctor. However, when they did use health care services for their children, they were much more satisfied with their care than white, non-Hispanic families, in most areas.

Similar findings were obtained for the Florida KidCare Program. In the KidCare Program, reduced access to and satisfaction with care have been documented for Hispanic families relative to non-Hispanic families. Black families in the KidCare Program also have reduced access to care relative to white families, but report greater satisfaction. Finally some of the highest dissatisfaction scores are from families who have children with special health care needs. Perhaps these families require more complex care for their children that pose challenges to the health care system, contributing to dissatisfaction.

Few national studies have specifically examined satisfaction with health care among children with special health care needs. However, the importance of positive experiences with the health care system for children with special health care needs cannot be underestimated. One study has demonstrated reductions in emergency room use for children with special needs who receive more culturally competent care and who have good continuity of care with their primary care provider.[14]

However, several studies have examined variations in family satisfaction with their children's care based on socioeconomic status and race and ethnicity.[15,16] Some of the Texas findings are consistent with those studies while others are not.

One national study found that Hispanic, English-speaking families did not differ from white, non-Hispanic families in their satisfaction with care. However, Hispanic, Spanish-speaking families had more negative reports than white, non-Hispanic families in the areas of Getting Care Quickly, Provider Communication, Office Courtesy, and Customer Service. In Texas, lower score were obtained for Hispanic families relative to non-Hispanic families regardless of the language spoken, although satisfaction was somewhat lower among the Spanish-speaking group. Also in Texas, Hispanic families showed no significant difference when compared to white non-Hispanic families in their satisfaction with their communication with their children's doctors, unlike the national sample.

Unlike national studies, black, non-Hispanics in Texas had more favorable reports in the areas of Getting Needed Care, Getting Care Quickly, and Office Staff Courtesy when compared to white non-Hispanic families. Like national findings, black non-Hispanic families rated communication with their doctors and customer service more poorly than white non-Hispanic families.

The factors contributing to the differences in the national trends versus trends seen in Texas among black non-Hispanic and Hispanic families is not clear. None-the-less, it is important to remember that overall satisfaction scores were high, albeit lower among certain subgroups.

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[14] Shenkman E, Vargas D, Sloyer P, Nackashi J, Starfield B. Providing a Medical Home for Children with Special Health Care Needs: Implications for Health Care Use and Charges. 2002. Under Consideration: *HSR*.

[15] Carlson MJ, Lustein J, Fiorentino N, et al. Socioeconomic status and dissatisfaction among HMO enrollees. *Medical Care*. 2000; 38:508-516.

[16] Weech-Maldonado, R Morales LS, Spitzer K, et al. Racial and ethnic differences in parents' assessments of pediatric care in Medicaid managed care. *HSR*. 2001;36:575-594.

Perhaps the findings about reduced access to care for Hispanic and black non-Hispanic families (i.e., usual source of care, seeking routine health care) relative to white non-Hispanic families are more concerning. While not unique to Texas, these racial and ethnic disparities in access to care are more striking than the variations in satisfaction scores and require further examination. Perhaps special outreach programs need to be devised to encourage minority families to have a usual source of care and to take their children for preventive care visits.

Table 10. **Rankings of the Health Plans/Sites Across Dimensions: High or Low Scores Relative to the Reference Health Plan/Site After Considering the Health and Sociodemographic Characteristics of the Plans' Enrollees**

Health Plan	Getting Needed Care	Getting Care Quickly	Doctor's Communication	Office Staff	Customer Service	Do You Have One Person You Consider Your Child's Personal Doctor?	Did You Call During Regular Office Hours for Help or Advice?	Did You Make Any Appointments for Regular or Routine Health Care?	Did Your Child Go To the Doctor's Office At Least Once?
El Paso 1st	L	L	H	H	H	L	NS	L	L
EPO Clar. (Rural)	NS	REF	NS	REF	H	L	NS	L	NS
Seton	L	NS	NS	NS	H	L	NS	NS	L
Mercy	REF	L	H	REF	REF	NS	NS	NS	NS
TCHP	L	L	H	NS	H	L	NS	NS	NS
Ameri. (Dallas)	L	L	L	L	H	L	L	L	NS
Cook Child.	NS	NS	NS	NS	H	REF	REF	REF	NS
EPO Clar. (Houst.)	NS	NS	H	NS	NS	L	NS	L	NS
Driscoll	NS	L	H	NS	H	NS	NS	L	NS
TUHP (Amarillo)	NS	NS	NS	NS	H	L	NS	L	NS
Ameri. (Houston)	L	L	H	L	H	L	L	L	NS
TUHP (San Anton.)	L	L	H	L	H	L	L	L	L
Parkland	L	L	H	L	H	L	L	L	L
TUHP (El Paso)	L	L	H	NS	H	L	L	L	L
Community First	L	L	H	L	H	L	NS	NS	L
UTMB Health Care	NS	NS	NS	NS	L	L	NS	NS	NS
FirstCare	NS	NS	REF	NS	NS	REF	NS	L	REF
EPO Clar.(Border)	NS	L	NS	NS	NS	L	L	NS	NS

L=Lower than the reference plan/site
H=Higher than the reference plan/site
NS=Not significantly different than the reference plan/site
REF=The reference plan for that category, i.e., the plan/site with the highest weighted score for that category

Table 11.   Percentage Responding Yes by Plan/Site for Selected Individual Items

Health Plan	Do You Have One Person You Consider Your Child's Personal Doctor?	Did You Call During Regular Office Hours for Help or Advice?	Did You Make Any Appointments for Regular or Routine Health Care?	Did Your Child Go To the Doctor's Office At Least Once?
El Paso 1st	82.3%	34.5%	63.6%	83.1%
EPO Clar. (Rural)	90.9%	46.0%	68.7%	88.8%
Seton	84.3%	49.5%	74.6%	87.5%
Mercy	90.0%	37.8%	67.1%	90.9%
TCHP	85.7%	43.7%	71.8%	90.8%
Ameri. (Dallas)	82.8%	37.8%	66.6%	90.3%
Cook Child.	87.6%	53.8%	79.1%	91.2%
EPO Clar. (Houst.)	84.6%	53.3%	70.3%	90.4%
Driscoll	89.0%	43.3%	65.0%	86.4%
TUHP (Amarillo)	82.3%	40.8%	63.6%	87.6%
Ameri. (Houston)	84.8%	32.9%	60.7%	87.6%
TUHP (San Anton.)	75.8%	34.1%	65.2%	82.5%
Parkland	81.4%	33.6%	64.7%	86.2%
TUHP (El Paso)	73.9%	26.9%	58.3%	73.8%
Community First	87.2%	46.7%	70.2%	90.3%
UTMB Health Care	88.9%	42.9%	70.9%	90.5%
FirstCare	93.7%	48.8%	69.5%	91.8%
EPO Clar.(Border)	81.3%	24.8%	63.7%	86.4%

X.   CHILDREN'S HEALTH CARE USE PATTERNS

Overview

Examining children's health care use patterns is an important component of any quality assurance initiative. At a very basic level, it is expected that the majority of children's care will be provided in an outpatient setting with little inpatient and emergency room use.

However, more specifically, an essential component of health care quality is the extent to which health care services are used in a manner consistent with the expected pattern of use for the population of enrolled children.[17] Assessing health care use as an indicator of quality of care is particularly important when contracting with managed care organizations (MCOs) because of the *perception* that financial and utilization review arrangements with providers may restrict the enrollees' access to needed health care.[18] For example, MCOs often require a physician to seek prior authorization before rendering certain types of services in an effort to reduce health care use and control costs. Concern has been raised that some of the reduction in use and costs *may be* excessive and possibly detrimental to the enrollee.[19]

In many instances, when contracting with more than one MCO to deliver services, it may be necessary and desirable to compare health care use across multiple MCOs.[20] Such comparisons can be difficult to make unless the health care needs of children within each MCO are taken into consideration. Various risk adjustment methods have been developed that allow for meaningful comparisons of health care use from one setting to the next by controlling for differences in patient severity or case-mix.[21]

The Chronic Disability Payment System

The Chronic Disability Payment System (CDPS) was used to make comparisons between the health plans participating in CHIP on children's health care charges.[22] The CDPS is designed to assess the illness burden or case-mix of enrollees in a health care program. The system groups International Classification of Diseases 9th Revision-Clinical Modification (ICD-9 CM) codes into categories according to the expected costs and clinical

[17] Durch JS, ed. *Protecting and Improving Quality of Care for Children Under Health Care Reform: Workshop Highlights.* Washington, DC: National Research Council, Institute of Medicine; 1994
[18] Newacheck PW, Stein REK, Walker DK, Gortmaker SL, Kuhlthau K, Perrin JM. Monitoring and evaluating managed care for children with chronic illnesses and disabilities. *Pediatrics.* 1996;98:952-958
[19] Hughes DC, Newacheck PW, Stoddard JJ, Halfon N. Medicaid managed care: can it work for children? *Pediatrics.* 1995;95:591-594
[20] Shenkman E. Pendergast J, Wegener DH, Hartzel T, Naff R, Freedman S, Bucciarell R. Children's Health Care Use in the Healthy Kids Program. *Pediatrics.* 1997; 100:947-953.
[21] Fowler EJ. *Health Risk Adjustment for Pediatric Populations: Implications for Children's Hospitals. Economics and Care Delivery Report.* Alexandria, VA: National Association of Children's Hospitals and Related Institutions; 1995
[22] Kronick, R. The Chronic Disability Payment System. 2001

implications associated with the condition. The system is organized by body system into high, medium, and low cost categories. The ICD-9 CM codes are grouped hierarchically. That is, a person with multiple related conditions will be placed into the highest cost category indicated by those conditions but will not be placed in multiple categories. However, a person with two distinct conditions such as asthma and severe depression would be categorized in two separate categories. The system was developed using data from millions of Medicaid enrollees and supplemental security income (SSI) recipients including both adults and children.

As recommended by the developers, analyses were restricted to children with 12 months of continuous eligibility to obtain the most stable estimates possible. The system first classified physician reported diagnostic information into risk subcategories for each child having 12 months of continuous eligibility. These results are reported for CHIP overall and by health plan in Appendix C. The top five diagnostic groupings based on the percentage of children overall assigned to those categories is reported in Figure 5.

As expected, the highest percentage of children was seen for mild conditions such as pulmonary conditions, classified as low expenditure conditions by the CDPS. Other top categories were low expenditure, eye, ear, skin, and infectious conditions. These findings did not vary significantly by health plan/site.

To further refine the analysis, the risk category indicator was multiplied by the associated national regression coefficient generated by the CDPS developers using 2.3 million TANF and TANF-related Medicaid children from five states, for health-based predicted expenditures. We then used this information to extrapolate back to dollars using CHIP estimated expenditures (based on the Texas Medicaid fee schedule). The CHIP estimated expenditures were compared to the national health-based predicted expenditures.

A ratio was then developed for each health plan. A ratio at or around 1 indicates that the estimated expenditures were as expected based on the children's case-mix. Ratios over 1 (generally 1.20 and higher) indicate possible overuse of health care services or a more expensive mix of health care services than is expected based on the case-mix. Ratios under 1 (generally 0.80 and less) indicate some possible underuse of health care services, again based on the case-mix of the children enrolled in that plan.

It is important to note that the Institute for Child Health Policy estimates the actual expenditures for children in CHIP using the Texas Medicaid fee schedule and a national fee schedule that provides information about physician reimbursement at the 50th percentile for various procedure codes. Inpatient charges are assigned using an average of $3,000 per each day of a stay. Fees are assigned to each service the child received, typically expressed as either revenue codes, Current Procedure Terminology Codes (CPT), other procedure codes (HCPCs), and inpatient lengths of stay. Less the 1% of the codes cannot be assigned a fee either because the code appears to be inaccurately recorded or because the code appears to be legitimate but a corresponding fee cannot be located in any of the available fee databases.

The advantage of assigning standard fees to each plan is that variations in findings between the plans cannot be attributed to variations in negotiated reimbursement rates with their providers. Rather, variations in health care charges between the plans are due to providing a different combination of services to their enrollee pool either in quantity or cost or both. To the extent that health plans are reimbursing their providers at approximately a Medicaid rate, then these findings in this report reflect the plans' experiences.

The disadvantage to the fee assignment approach is that the exact health plan experience cannot be determined. To date, the health plans/sites have not provided the amount paid in the claims data given to the Institute for Child Health Policy. A more thorough and accurate picture of program expenditures relative to the children's illness burden could be obtained if the CDPS was used with (1) the fee assignment approach to allow for valid comparisons and (2) with each plan's actual reimbursements to assess their unique experiences relative to the other plans.

Tables 12a and 12b contain the results of the CDPS analysis. Overall, each of the plans had health care expenditures that were expected based on the case-mix of their enrollees. Three health plans had borderline results. Seton Health Plan and Driscoll Children's Health plan have health care expenditures that are 23% and 19% higher than expected, respectively. Amerikids (Houston) has health care expenditures that are about 20% lower than expected. Three other plans require further exploration. Texas Children's Health Plan and FirstCare have health care expenditures that are 26% and 83% higher than expected, respectively. El Paso 1st has expenditures that are 0.79 the expected after considering the case-mix of their enrollees. El Paso 1st and Amerikids (Houston) also had consistently lower performance in parental report of health care use and satisfaction with care when compared to other health plans/sites.

Figure 5. Top 5 Diagnoses –
Chronic Disability Payment System (CDPS)
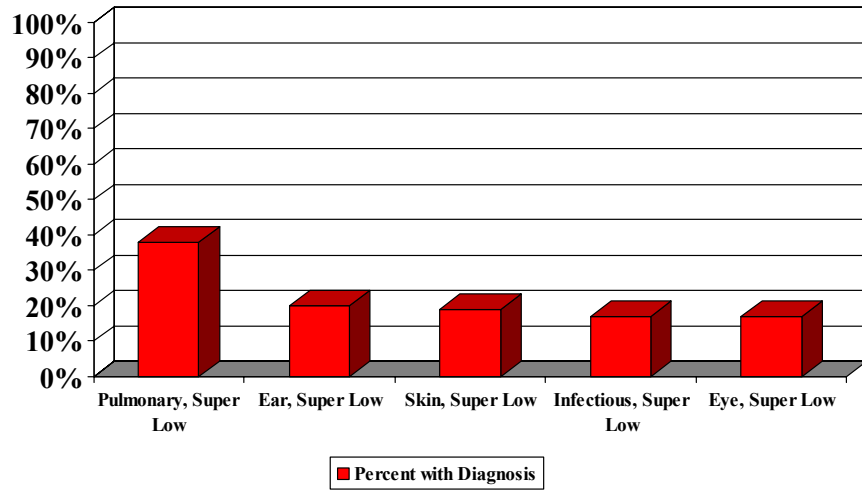
Table 12a.   CDPS Results: Comparison of the CHIP Health Plans/Sites, Plans Ranked High to Low Based on Predicted Charges

Health Plan/Site	Estimated Health Care Charges	Predicted Health Care Charges Based on Case-Mix	Ratio	Rank*
EPO Clar. (Border)	79.80	92.60	0.86	1
UTMB	95.36	92.30	1.03	2
Comm. First	81.64	88.59	0.92	3
Driscoll	107.67	88.25	1.23	4
Mercy	86.71	87.39	0.99	5
FirstCare	159.52	87.16	1.83	6
Cook Child.	93.14	85.34	1.09	7
TUHP (Amarillo)	92.60	82.07	1.13	8
Parkland	90.32	81.78	1.10	9
Seton	96.39	81.19	1.19	10
TUHP (San Anton)	70.07	79.15	0.89	11
TUHP (El Paso)	70.31	78.89	0.89	12
Ameri. (Dallas)	70.99	76.93	0.92	13
Ameri (Houston)	61.23	75.86	0.81	14
El Paso 1st	59.00	74.84	0.79	15
TCHP	94.34	74.63	1.26	16

*The plan ranked #1 has the highest predicted expenditures based on the case-mix of their enrollees.

Table 12b.   CDPS Results: Comparison of the CHIP Health Plans/Sites: Plans Ranked High to Low Based on Their Ratio of Actual to Expected Charges

Health Plan/Site	Estimated Health Care Charges	Predicted Health Care Charges Based on Case-Mix	Ratio	Rank*
FirstCareQ	159.52	87.16	1.83	1
TCHP	94.34	74.63	1.26	2
Driscoll	107.67	88.25	1.23	3
Seton	96.39	81.19	1.19	4
TUHP (Amarillo)	92.60	82.07	1.13	5
Parkland	90.32	81.78	1.10	6
Cook Child.	93.14	85.34	1.09	7
UTMB	95.36	92.30	1.03	8
Mercy	86.71	87.39	0.99	9
Comm. First	81.64	88.59	0.92	10
Ameri. (Dallas)	70.99	76.93	0.92	11
TUHP (San Anton)	70.07	79.15	0.89	12
TUHP (El Paso)	70.31	78.89	0.89	13
EPO Clar. (Border)	79.80	92.60	0.86	14
Ameri. (Houston)	61.23	75.86	0.81	15
El Paso 1st	59.00	74.84	0.79	16

*The plan ranked 1 has the highest ratio of actual to predicted health care expenditures

Access to Care   In addition to examining children's actual versus expected health care use for each plan, children's access to care within CHIP overall and for each individual health plan was assessed. The Health Plan Employer Data and Information Set (HEDIS) indicator called *Children's Access to Primary Care Practitioners* was used.[23] This indicator requires that health plans report the percentage of children age 12 months through 24 months, and 25 months through 6 years who were continuously enrolled and who had a visit with a primary care practitioner at least once during the year.

There is also an indicator for older children ages 7 to 11, which requires them to have had at least one visit with the primary care practitioner during the measurement year or the year preceding the measurement year. Because there is only 22 months of data, children ages 7 to 11 were included, but it was not possible to check their access to care prior to the measurement year for all of them. Table 13 contains the results of the HEDIS access to care measure for CHIP overall and by health plan. These results are not adjusted for the case-mix of the enrollees in the health plans.

Overall, access to care in the program is good with 90% of children ages 12-24 months having at least one primary care visit within the last 12 months. This percentage declined somewhat for children ages 25 months through 6 years with 82% of them having a primary care visit. Finally, 89% of 7 to 11 year olds saw their primary care providers in the last year. Nationally, only 65% of uninsured children see a health care provider within a 12 month period.

While the findings overall were excellent for CHIP, there were individual plan differences. For example, 98% of children ages 12 through 24 months in FirstCare saw a provider in the last year compared to a low of 78% of the children in that age cohort in Texas Children's Health Plan. Texas Children's Health Plan also had the lowest percentage of 25 month through 6 year olds seeing a primary care provider in the last year (64%).

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[23] National Commission on Quality Assurance. *HEDIS 2002: Narrative and Technical Specifications*. Washington, DC: 2001.

Table 13. **Children's Access to Care: Percent of Children with a Primary Care Visit**

Age Group	Children 12 through 24 months	Children 25 months through 6 years	Children 7 through 11 years
Overall	**89.9% (N=3,249)**	**82.3% (N=47,684)**	**88.6% (N=9,250)**
El Paso 1st	87.7% (n=154)	78.3% (n=2,562)	87.3% (n=488)
Seton	88.5% (n=191)	77.1% (n=2,165)	78.9% (n=418)
Mercy	92.9% (n=85)	87.3% (n=1,200)	91.3% (n=414)
TCHP	77.7% (n=600)	64.1% (n=6,675)	91.8% (n=944)
Ameri. (Dallas)	92.1% (n=127)	81.5% (n=2,023)	81.8% (n=411)
Cook Child.	95.7% (n=277)	87.3% (n=3,450)	91.8% (n=585)
EPO Clar. (Houst.)*	93.9% (n=685)	88.2% (12,721)	89.2% (n=2,452)
Driscoll	94.9% (n=137)	92.0% (n=2,240)	93.4% (n=637)
TUHP (Amarillo)	90.6% (n=32)	88.9% (n=712)	87.6% (n=185)
Ameri. (Houst.)	93.8% (n=146)	88.1% (n=2,315)	86.9% (n=357)
TUHP (San Antonio)	91.5% (n=47)	71.9% (n=835)	76.9% (n=199)
Parkland	86.5% (n=200)	71.8% (n=2,544)	79.6% (n=401)
TUHP (El Paso)	92.3% (n=26)	78.7% (n=328)	86.9% (n=46)
Comm. First	93.3% (n=178)	87.4% (n=2,743)	90.6% (n=587)
UTMB	94.8% (n=324)	87.8% (n=4,537)	90.6% (n=937)
FirstCare	97.5% (n=40)	91.6% (n=634)	91.5% (n=189)

*Multiple Site Plan that represents Sites B, H,and R for the CAHPS.

Health Care Use Across Time

The children's health care use pattern by month of enrollment was examined for children identified as having special health care needs and for those without such conditions. The purpose of this analysis was to examine whether children's use of health care resources diminishes the longer that they are in the program. Presumably, unmet health care needs can be addressed early in the enrollment period with decreased health care use once these needs are met.

For this analysis, children with special health care needs were identified using the claims and encounter files, which contain ICD-9-CM codes recorded at the time of a health care encounter. These ICD-9-CM codes were matched to a list of codes that may indicate the presence of a chronic condition. The list is broad and includes high prevalence and low severity conditions like asthma and attention deficit disorder and low prevalence and high severity conditions like cystic fibrosis, malignancies, and others. A panel of physicians at the University of Florida developed the list and staff at the National Association of Children's Hospitals and Related Institutions (NACHRI) reviewed it further. Children with chronic conditions were identified to determine if their health care use trends differed from those of healthy children.

Approximately 200,000 children who were continuously enrolled in CHIP for 12 months or longer were included in this analysis. The children's use rates were plotted for each of 12 months beginning with the first month of enrollment for each child. The plots were generated for those with and without special health care needs. In addition, the plots were generated for the following age cohorts:

- Less than 1 year,
- 1 through 3 years,
- 4 through 6 years,
- 7 through 10 years,
- 11 through 13 years, and
- 14 through 19 years.

The purpose of the age cohort breakdown was to examine whether trends differed for the differing age groups. Health care use trends will vary by age. For example, as infants grow older, there are fewer preventive care visits required, which would lead to decreased health care use in and of itself. In addition, sometimes children's conditions improve as they grow older. Asthma is a good example of this.

The trend analysis in this report is descriptive only but the age cohort breakdown provides some indication of whether the children's changes in health care use are related to them growing older or to having unmet health care needs met that lead to a reduction in use across time. Figures 6 and 7 contain the results of this analysis.

As expected, for both the children with special needs (Figure 6) and the healthy cohort (Figure 7), health care use rates declined dramatically the longer the children were in the program for those less than one year of age. However, all of the age cohorts showed a statistically significant downward trend in the amount of health care they used each month that they were enrolled. For example, 14 to 19 year old children with special needs had a per member per month (PMPM) use rate of about 1.5 health care encounters per month during the first month of enrollment, which declined to about 1 health care encounter per month by the 12th month of enrollment. The health care use patterns of children who were over the age of 7 and healthy were consistently low but showed slightly declining trends across the 12 months of enrollment.

While descriptive only, these findings point to the importance of keeping children enrolled in the program as long as they have no other insurance options. Their use tends to decline across time, even for older children (although more subtly). This may be an indication that unmet health care needs are being addressed, contributing to reduced health care consumption.

**Figure 6.   Use Per Member Per Month in CHIP By Age Cohort
            for Special Needs Children**
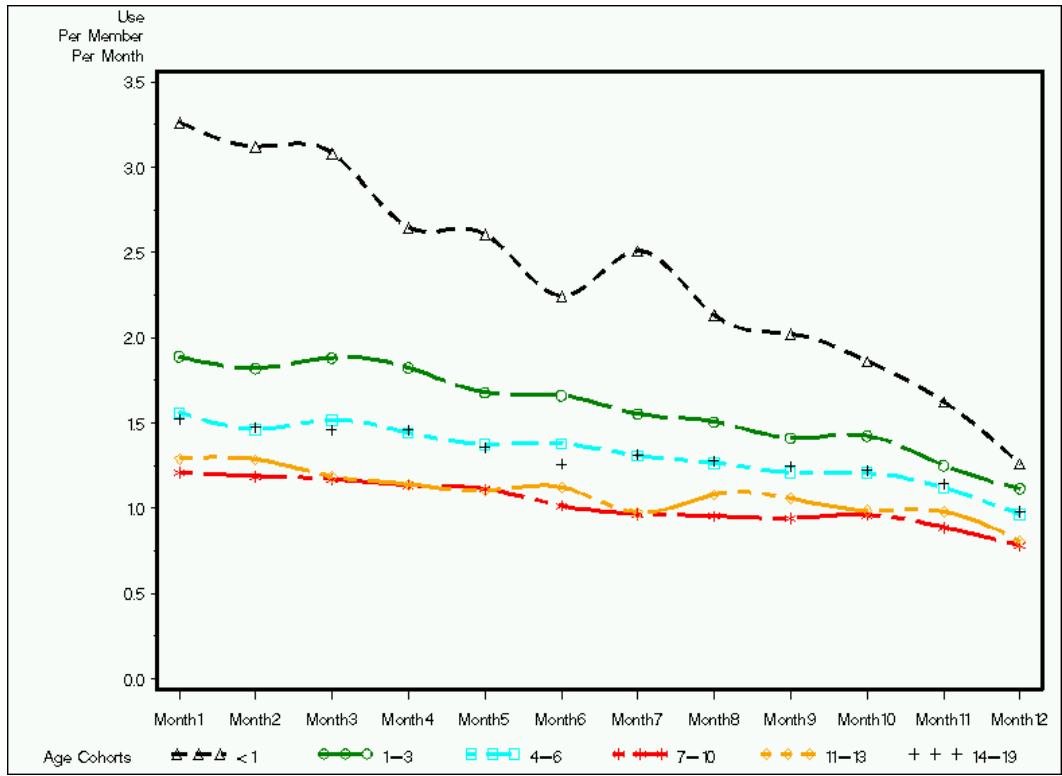
**Figure 7.   Use Per Member Per Month in CHIP By Age Cohort
for Children Without Special Needs**
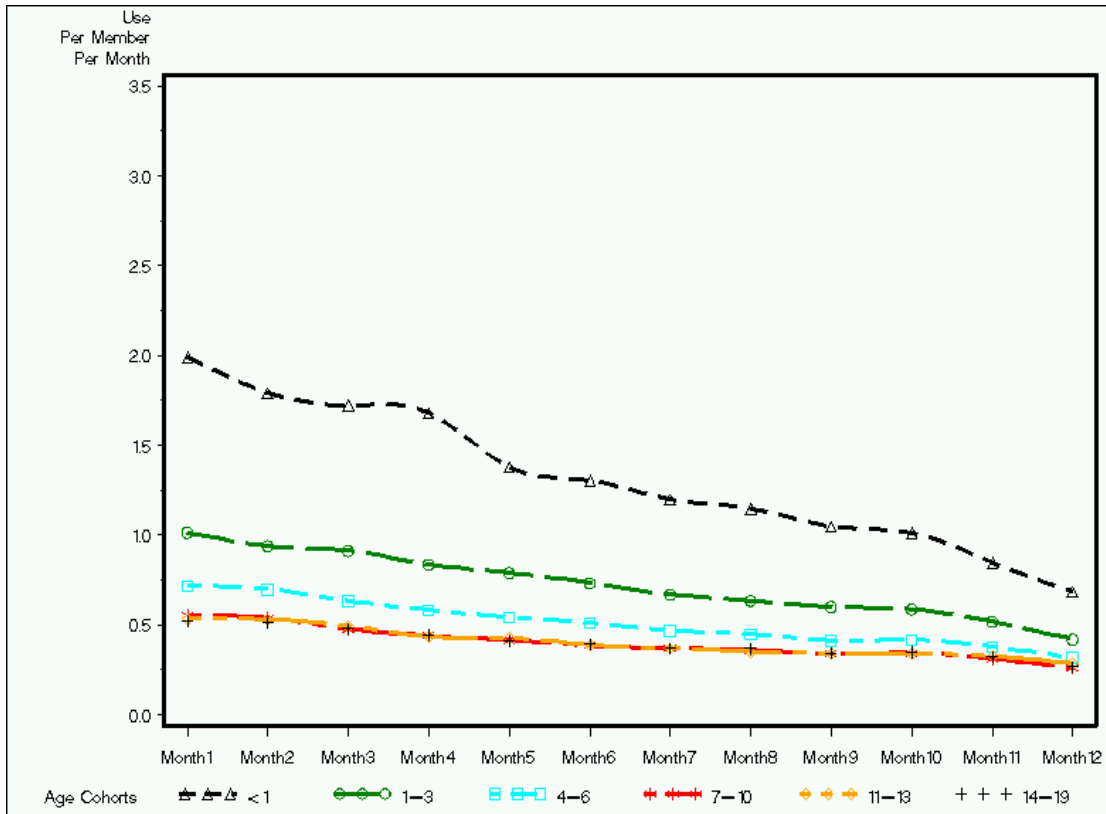
XI. INPATIENT AND EMERGENCY ROOM USE: THE INCIDENCE OF AMBULATORY CARE SENSITIVE CONDITIONS

Overview

Some hospitalizations and emergency room (ER) visits are called ambulatory condition sensitive (ACS) admissions or visits because there is consensus that the condition usually can be managed successfully in the outpatient setting.[24] The Institute for Medicine (IOM) has specifically recommended that ACS inpatient discharge rates be used as an indicator of access to primary care services among populations.[25] The following conditions were included in this phase of the study:

1. Immunization preventable conditions such as pertussis, rheumatic fever, tetanus, polio, and hemophilus meningitis,
2. Chronic conditions such as asthma, diabetes with ketoacidosis or hyperosmolar coma, diabetes with specified manifestations, diabetes without specified complications, grand mal seizures, and hypoglycemia,
3. Acute conditions such as cellulites, dehydration, gastroenteritis, pneumonia, and kidney/urinary tract infections, ear, nose, and throat infections, ruptured appendix, and untyped conditions such as failure to thrive, congenital syphilis, and nutritional deficiency.

A total of 23 conditions were contained on the list of ACSCs. This list was compiled based on published reports in the medical literature about conditions that should be considered ACSCs. Thirteen have been used for the quarterly Texas CHIP SB 445 ACSC hospitalization counts, and 12 were added to expand the list for this report. Both inpatient encounters and emergency room encounters were evaluated for ACSC diagnoses. The percentage of hospital stays or emergency room visits are tabulated, by diagnosis by age band, copay level, gender and race/ethnicity (Table 14). In addition, the incidence of inpatient stays and ER visits expressed as rates per 1,000 by age cohort is contained in Table 15. Because so few children had any inpatient or ER visits for ACSCs, the results are reported overall and not by health plan/site. With such small numbers it is hard to detect any significant patterns across health plans/sites, with the exception of two conditions.

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[24] Porell FW. A comparison of ambulatory care-sensitive hospital discharge rates for Medicaid HMO enrollees and nonenrollees. *Medical Care Research and Review*. 2001;58(4):404-424.
[25] Institute of Medicine. *Access To Health Care In America*. Washington DC: National Academy Press. 1993.

There was a total of 10,005 inpatient stays among the CHIP enrollees. Several findings were noteworthy based on enrollees' sociodemographic characteristics. First, children ages 1 through 5 years and 6 through 14 years had the highest percentage of inpatient stays due to an ACSC (approximately 14% for both groups). Families that were between 100% and 150% of the FPL had the highest percentage of inpatient stays (15%) compared to any other income group. Males were not significantly different than females in terms of the percentage of their inpatient stays that were due to ACSCs. Significant differences were noted among the racial and ethnic groups. Thirteen percent of inpatient stays for Hispanic children were due to ACSCs compared to 8% of white non-Hispanics.

The incidence of ER use for these conditions was lower than for inpatient stays. However, the same sociodemographic patterns were observed for ER use for ACSC as was seen for inpatient stays.

The results for CHIP in Texas compare favorably to a study conducted among Medicaid beneficiaries (adults under age 65 and children).[26] For example, among Medicaid recipients 25% of the inpatient stays were for ACSCs compared to a high of 14% among the CHIP enrollees in Texas. In this same study with the Medicaid population, there were 21.9 ER visits/100 enrollees among those receiving primary care at Federally Qualified Health Centers. Among the CHIP enrollees in Texas, the highest ER visit rate for ACSCs was approximately 17.33/1,000 children for otitis media.

The highest incidence of ER use for ACSCs was for otitis media and upper respiratory infections. Therefore, these two conditions were assessed further to determine if there was any variability in ER use by health plan/site. Two plans stand out as having significantly lower rates than the others for ER use for otitis media overall. These are Amerikids (Dallas), Parkland Community Health Plan, and UTMB Health Care System (3.83/1,000 children, 3.55/1,000 children and 2.96 per 1,000 children, respectively). One plan stands out as having a significantly higher overall rate of ER use for otitis media relative to the others. That is Amerikids (Houston) with a rate of 14.37/1,000 children.

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[26] Falik M, Needleman J, Wells BL, Korb J. Ambulatory care sensitive hospitalizations and emergency visits: Experiences of Medicaid patients using federally qualified health centers. *Medical Care.* 2001; 39(6):551-561.

Amerikids (Dallas), Parkland Community Health Plan, and UTMB Health Care System also had the lowest rates of ER use for upper respiratory infections (2.66/1,000 children, 2.76/1,000 children, and 3.87/1,000 children, respectively). In addition, Texas University Health Plan (El Paso) had a low rate of 3.21/1,000 children. The health plan/site with the highest rate was Cook Children's Health Plan (9.29/1,000 children). The rest of the health plans/sites did not demonstrate any marked differences from each other.

Table 14. Primary Diagnosis of Ambulatory Care Sensitive Condition					
Hospitalizations and ER Visits With Ambulatory Care Sensitive Condition Diagnoses					
	Mean Length of Hospital Stay	Total Number of Hospital Stays N=10,005	Percent of Total Hospital Stays That Were ACSC Related	Total Number of Emergency Room Visits N=147,664	Percent of Total ER Visits That Were ACSC Related
By Age Band					
Less Than 1 Year	5.58	43	0.43%	235	0.16%
1 - 5 Years	2.85	1386	13.85%	9429	6.39%
6 - 14 Years	3.11	1426	14.25%	8052	5.45%
15 - 18 Years	3.36	401	4.01%	2016	1.37%
By Copay Level					
No copay	3.12	812	8.12%	5259	3.56%
100% - 150% FPL	3.00	1471	14.70%	9294	6.29%
151% - 185% FPL	3.09	748	7.48%	4038	2.73%
186% - 200% FPL	3.15	225	2.25%	1148	0.78%
By Gender					
Female	2.85	1502	15.01%	9586	6.49%
Male	3.23	1740	17.39%	10089	6.83%
Unknown	4.96	14	0.14%	64	0.04%
By Race/Ethnicity					
White, non-Hispanic	2.75	768	7.68%	4842	3.28%
Black, non-Hispanic	3.07	254	2.54%	1877	1.27%
Hispanic	3.24	1332	13.31%	7725	5.23%
American Indian or Alaskan	2.00	1	0.01%	13	0.01%
Asian, Pacific Islander	2.46	57	0.57%	244	0.17%
Other	3.13	844	8.44%	5038	3.41%

Table 15. Ambulatory Care Sensitive Conditions Rates/1,000 Children				
By Age Band	**Number of Emergency Room Visits**	**Rate per 1000 Children Enrolled in Age Band**	**Number of Hospitalizations**	**Rate per 1000 Children Enrolled in Age Band**
Asthma				
Less than 1 year	3	0.54	6	1.08
1 - 5 years	524	3.77	297	2.13
6 - 14 years	833	2.77	377	1.26
15 - 18 years	156	1.77	59	0.67
Diabetes				
Less than 1 year	0	0.00	0	0.00
1 - 5 years	11	0.80	14	0.10
6 - 14 years	41	0.14	63	0.21
15 - 18 years	30	0.34	59	0.67
Epilepsy				
Less than 1 year	0	0.00	1	0.18
1 - 5 years	7	0.05	32	0.23
6 - 14 years	17	0.06	35	0.12
15 - 18 years	13	0.15	15	0.17
Dehydration				
Less than 1 year	4	0.72	10	1.79
1 - 5 years	224	1.61	387	2.78
6 - 14 years	194	0.65	202	0.67
15 - 18 years	51	0.58	52	0.59
Gastroenteritis				
Less than 1 year	17	3.05	1	0.18
1 - 5 years	790	5.68	111	0.80
6 - 14 years	703	2.34	109	0.36
15 - 18 years	184	2.08	21	0.24
Pneumonia				
Less than 1 year	0	0.00	6	1.08
1 - 5 years	47	0.34	101	0.73
6 - 14 years	23	0.08	70	0.23
15 - 18 years	2	0.02	6	0.07
Urinary Tract Infection				
Less than 1 year	6	1.08	7	1.25
1 - 5 years	211	1.52	46	0.33
6 - 14 years	393	1.31	38	0.13
15 - 18 years	198	2.24	13	0.15
Cellulitis				
Less than 1 year	2	0.36	1	0.18
1 - 5 years	184	1.32	96	0.69
6 - 14 years	337	1.12	130	0.43
15 - 18 years	129	1.46	52	0.59

Table 15 cont'd. Ambulatory Care Sensitive Conditions Rates/1,000 Children				
	Number of Emergency Room Visits	Rate per 1000 Children Enrolled in Age Band	Number of Hospitalizations	Rate per 1000 Children Enrolled in Age Band
Immunizable Conditions				
Less than 1 year	0	0.00	0	0.00
1 - 5 years	21	0.15	1	0.01
6 - 14 years	20	0.07	7	0.02
15 - 18 years	4	0.05	1	0.01
Pyelonephritis				
Less than 1 year	0	0.00	0	0.00
1 - 5 years	11	0.08	35	0.25
6 - 14 years	27	0.09	43	0.14
15 - 18 years	42	0.48	33	0.37
Ruptured Appendix				
Less than 1 year	0	0.00	0	0.00
1 - 5 years	2	0.01	21	0.15
6 - 14 years	20	0.07	109	0.36
15 - 18 years	1	0.01	20	0.23
Congestive Heart Failure				
Less than 1 year	0	0.00	1	0.18
1 - 5 years	2	0.01	4	0.03
6 - 14 years	1	0.00	0	0.00
15 - 18 years	0	0.00	0	0.00
Hypokalemia				
Less than 1 year	0	0.00	0	0.00
1 - 5 years	1	0.01	3	0.02
6 - 14 years	5	0.02	2	0.01
15 - 18 years	3	0.03	1	0.01
Acute Otitis Media				
Less than 1 year	59	10.57	0	0.00
1 - 5 years	2411	17.33	74	0.53
6 - 14 years	1310	4.36	22	0.07
15 - 18 years	145	1.64	3	0.03
Mastoiditis				
Less than 1 year	0	0.00	0	0.00
1 - 5 years	1	0.01	2	0.01
6 - 14 years	3	0.01	7	0.02
15 - 18 years	0	0.00	3	0.03
Upper Respiratory Infection				
Less than 1 year	56	10.03	0	0.00
1 - 5 years	1424	10.24	41	0.29
6 - 14 years	923	3.07	54	0.18
15 - 18 years	165	1.87	12	0.14

Table 15 cont'd. Ambulatory Care Sensitive Conditions Rates/1,000 Children				
	Number of Emergency Room Visits	Rate per 1000 Children Enrolled in Age Band	Number of Hospitalizations	Rate per 1000 Children Enrolled in Age Band
Acute Bronchitis				
Less than 1 year	5	0.90	1	0.18
1 - 5 years	373	2.68	55	0.40
6 - 14 years	440	1.46	36	0.12
15 - 18 years	138	1.56	7	0.08
Pelvic Inflammatory Disease				
Less than 1 year	0	0.00	0	0.00
1 - 5 years	0	0.00	0	0.00
6 - 14 years	3	0.01	1	0.00
15 - 18 years	29	0.33	15	0.17
Jaundice - Infant Re-admission				
Less than 1 year	2	0.36	4	0.72
1 - 5 years	0	0.00	0	0.00
6 - 14 years	0	0.00	0	0.00
15 - 18 years	0	0.00	0	0.00
Volume Depletion - Infant Re-admission				
Less than 1 year	0	0.00	0	0.00
1 - 5 years	0	0.00	1	0.01
6 - 14 years	0	0.00	0	0.00
15 - 18 years	0	0.00	0	0.00
Nausea and Vomiting				
Less than 1 year	7	1.25	2	0.36
1 - 5 years	562	4.04	40	0.29
6 - 14 years	471	1.57	38	0.13
15 - 18 years	164	1.86	9	0.10
Viral Meningitis				
Less than 1 year	0	0.00	2	0.36
1 - 5 years	10	0.07	22	0.16
6 - 14 years	29	0.10	79	0.26
15 - 18 years	5	0.06	14	0.16
Viral Syndrome				
Less than 1 year	0	0.00	0	0.00
1 - 5 years	0	0.00	0	0.00
6 - 14 years	0	0.00	0	0.00
15 - 18 years	0	0.00	0	0.00

XII. WELL CHILD VISITS AND IMMUNIZATION COMPLIANCE

Compliance with Well Child Visits in the First 15 Months of Life

This measure is for the percentage of enrolled members who turn 15 months old, and were continuously enrolled since 31 days of age. The measure addresses the percentage of members with zero to six well child visits during this age span. Because so few children met the criteria for inclusion in this measure, the percentage of those with at least one visit is all that is reported. Only 231 CHIP members met the criteria for this measure. All 231 had at least one well-child visit. As the program matures, it is expected that more children will be included in this quality indicator. While this is an important indicator of the quality of health care in a program, the findings must be viewed with caution given the small sample.

Childhood Immunization Status

The purpose of this analysis is to provide an estimate of vaccine compliance within the CHIP in Texas. The analysis is based on the 2001 United States Recommended Childhood Immunization Schedule, and the 2002 HEDIS childhood immunization status specifications. The 2001 US Recommended Childhood Immunization Schedule includes a recommendation for the pneumococcal conjugate vaccine. The HEDIS specifications are written for children who were enrolled on their second birthday. In addition, the child had to be continuously enrolled for 12 months prior to their second birthday, or turn 2 years old during the 12 month reporting period.   The US Recommended Childhood Immunization Schedule specifies age brackets for recommended doses through the age of 24 months. This analysis includes all children enrolled in CHIP with 12 months of continuous coverage or coverage since birth who are 2.10 years old or younger as of December 31, 2002.

The following steps were taken to compile the data for analysis:

1. All children enrolled in CHIP through September 2002 were pooled for creating the sample.
2. Within this pool, children 2.10 years old or younger with a minimum of 12 months of continuous coverage or coverage since birth created the sample.
3. Current Procedural Terminology (CPT) codes and ICD-9-CM codes specified in the HEDIS documentation were matched to claims and encounter data for each vaccine.
4. Children identified as having a contraindication for a specific vaccine were excluded from the data set according to HEDIS specifications.
5. The vaccine counts were then matched to the immunization schedules according to appropriate age requirements.

Table 16 shows the percentage of children from the total pool of 4755 children 2.10 years or younger with continuous coverage who are in compliance with the recommended immunization schedule. A combined rate, which requires children to be in compliance for DTP, Polio, H. Influenzae, Hepatitis B and the Measles, Mumps and Rubella (MMR) series, is included. *However, this combined score requires two years of data and only 19 months of data were available for inclusion in these analyses.*

CHIP in Texas compares favorably to the results reported by the NCQA for 120 health plans serving Medicaid enrollees. For example, in 2000, the participating Medicaid plans reported 66%% of children were in compliance with the Diptheria, Tetanus, Pertussis (DTP) vaccine compared to 81% in CHIP in Texas and 74% with the Polio vaccine compared to 82% in Texas. Compliance with Hepatitis B vaccines was higher in CHIP than in the NCQA Medicaid sample (92% versus 69%). H. Influenze vaccine was markedly lower than the national sample (46% versus 71%). Overall compliance with the vaccines was somewhat higher in the CHIP group compared to the national sample (55% versus 51%). However for CHIP in Texas only 19 months and not 24 months of data were available for these analyses.

Table 16.   Percentage of Children Enrolled in CHIP In Compliance With 24 Month Immunization Schedule

Vaccine	Percentage of Children in Compliance in Texas	Percentage of Children in Compliance Nationally, 2000 – NCQA: Medicaid Results
Diptheria, Tetanus, Pertussis (DTP)	80.8%	65.6%
Polio	81.6%	74.0%
H. Influenzae	46.1%	71%
Pneumococcal Conjugate	35.8%	Not reported
Measles, Mumps, Rubella	73.4%	78.6%
Hepatitis B	92.4%	69.2%
Varicella	61.6%	55.3%
HEDIS Compliance	54.8%	51.3%

An important point must be noted in evaluating the findings about immunization compliance. The individual calculations are relying on claims and encounter data only. The evaluators do not have access to the children's medical records. Health plans may exclude from the analysis children who (1) have evidence of the antigen for which they are being immunized, (2) have a documented history of the illness, or (3) have a seropositive test result. Without more detailed clinical information on the children, it is impossible to know if some children included in the analysis may have met one of the three criteria described above for exclusion. `

Table 17 shows the individual plan performance on the immunizations measures. There was variability between the health plans/sites in their immunization compliance. Overall all of the plans/sites did well with the DTP and Polio vaccines. Only two health plans/sites – Mercy Health Plans and Texas University Health Plan (San Antonio) - were notable for their low compliance with the DTP vaccine (57.5% and 62.5%, respectively) and the Polio vaccine (58.3% and 62.5% respectively).

As noted above, there are reasons why immunizations may not be administered. It is not known to what extent compliance with H. Influenzae and MMR vaccines might improve if more detailed clinical information about the children were available. However, overall the compliance with the H. Influenzae and MMR vaccines, as calculated from the claims data is not adequate.

Compliance with the Hepatitis B vaccine is excellent across all of the health plans/sites. Compliance with the Varicella vaccine does vary across the health plans/sites, but this is an instance where children may not need the vaccine if they had a history of the illnesss, for example.

Finally, some plans have reasonably favorable overall HEDIS compliance when compared to the sample of Medicaid enrollees nationally and to the overall average for the CHIP in Texas enrollees. These health plans/sites are Cook Children's Health Plan, Texas University Health Plan (Amarillo), and Community First Health Plans with 64%, 62%, and 69% compliance, respectively. As a reminder to the reader, only 18 months of data were available for these analyses. These analyses will be repeated when a full 24 months of data are available, approximately in May 2002.

Table 17. **Percentage of Children Enrolled in CHIP In Compliance With 24 Month Immunization Schedule**

Health Plan/Site	DTP	Polio	H. Influenzae	MMR	Hepatitis B	Varicella	HEDIS Compliance
Overall	**80.8**	**81.6**	**46.1**	**73.4**	**92.34**	**61.6**	**54.8**
El Paso 1st	80.45	81.82	48.18	58.18	92.73	60.91	40.91
Seton	82.25	82.25	33.70	59.78	92.75	57.61	50.80
Mercy	57.50	58.33	8.33	49.17	87.50	49.17	25.75
TCHP	82.42	83.33	39.16	59.59	91.32	59.02	43.68
Amer.-Dal	80.50	83.50	48.00	74.50	92.00	61.00	52.50
Cook Chil.	87.00	86.75	59.50	73.25	95.75	69.00	63.50
EPO Clar*	75.99	76.79	27.58	47.82	90.67	46.73	23.71
Driscoll	84.47	84.47	50.00	68.45	92.72	68.45	45.63
TUHP-Am	84.74	86.33	56.72	67.88	94.76	64.69	61.94
Amer.-Hou	81.66	81.22	38.43	61.57	93.01	58.95	48.31
TUHP-San	62.50	62.50	29.17	56.25	89.58	56.25	42.92
Parkland	82.33	82.33	40.00	55.33	91.67	51.67	34.67
TUHP-El	72.06	77.94	39.71	70.59	88.24	64.71	30.88
Comm.Fir.	88.64	89.77	63.64	73.48	95.08	69.32	69.47
UTMB	70.00	66.67	30.00	60.00	100.00	60.00	26.67
FirstCare	81.69	80.28	38.03	69.01	92.96	67.61	35.21

*Multiple Site Plan that represents Sites B, H, and R for the CAHPS.

XIII. SPECIAL POPULATIONS: MENTAL HEALTH DIAGNOSES AND ASTHMA

Percent of Children with Mental Health Hospitalizations Who Had An Outpatient Visit Within 30 Days of Discharge

The population used for this measure was a census of all members with inpatient claims containing mental health ICD-9-CM codes. There were 2,713 hospitalizations for mental health conditions. Of the mental health hospitalizations, 56.7% showed either a mental health or a primary care outpatient visit within 30 days of discharge. In the NCQA State of Managed Care Quality Report, participating commercial plans reported that 71% of their enrollees with inpatient mental health stays had an outpatient follow-up within 30 days. It is important to note that in our calculations, we used more liberal criteria for outpatient visits when compared to the HEDIS standards.

There was a great deal of plan variability noted in the percentage of children with some outpatient visit following an inpatient mental health stay (Table 18). For example at Mercy Health Plans, 91% of the children had an outpatient visit following a mental health inpatient stay compared with only 18% at Texas University Health Plan (El Paso). If one were to use the NCQA commercial plan visit percentage of 71% as a benchmark, only three of the health plans met or exceeded the benchmark: Mercy Health Plans, Community First Health Plans, and EPO Clarendon Health Plan (Border Counties). Three other plans had somewhat positive findings: El Paso 1st (64%), Seton Health Plan (67%), and Driscoll Children's Health Plan (65%).

It is important to note that the national comparison groups are commercial health plans and not a similar low-income population. In Florida with a Title XXI population, the overall compliance is 65%. However, in Texas, some of these health plans operate in primarily rural areas with limited provider networks, resulting in limited access to care for program enrollees. Further analyses should be conducted examining the provider networks and community characteristics in which some of the poorest performing health plans/sites are operating.

Table 18. Percent of Mental Health Hospitalizations with an Outpatient Mental Health or Primary Care Visit within 30 days of Discharge			
	Mental Health Outpatient Visit	**Primary Care Outpatient Visit**	**Overall**
Overall	46.48%	13.71%	56.71%
Within Age Band			
Less than 1 year	0.00%	0.00%	0.00%
1 - 5 years	52.13%	19.15%	68.09%
6 - 14 years	44.97%	14.63%	55.82%
15 - 18 years	47.78%	12.23%	57.31%
Within Health Plan			
El Paso 1st	35.71%	57.14%	64.29%
Seton	58.33%	11.90%	66.67%
Mercy	81.82%	9.09%	90.91%
TCHP	31.48%	5.57%	36.40%
Ameri. (Dallas)	18.18%	27.27%	45.45%
Cook Child.	11.32%	41.51%	52.83%
EPO Clar. (Houst.)*	57.25%	18.76%	71.57%
Driscoll	58.03%	12.38%	64.80%
TUHP (Amarillo)	38.46%	23.08%	58.97%
Ameri. (Houst.)	6.25%	43.75%	50.00%
TUHP (San Antonio)	35.56%	16.67%	50.00%
Parkland	29.80%	13.18%	39.83%
TUHP (El Paso)	5.13%	12.82%	17.95%
Comm. First	83.80%	3.52%	87.32%
UTMB	47.94%	14.41%	58.82%
FirstCare	0.00%	50.00%	50.00%

*Multiple Site Plan that represents Sites B,H, and R for the CAHPS.

Use of Appropriate Medications for Children With Asthma

Asthma is the most common chronic condition in childhood affecting 4% to 7% of children in the United States, with estimated costs of $3.6 billion annually.[27] Asthma prevalence in the United States is reported to be higher among Blacks and Hispanics, when compared to Whites or non-Hispanics. Some, but not all of these differences in prevalence are due to variations in income, place of residence, and parental education. Cultural and linguistic barriers to health care may also play an important role.[28] These facts have particular salience in Texas with its high Hispanic population.

There are five classes of drugs that are recommended for those with persistent asthma.[29] These are:
1. Inhaled Corticosteroids (preferred therapy),
2. Cromolyn Sodium and Nedromil (alternative therapy for mild persistent asthma),
3. Leukotriene Modifiers (alternative therapy for mild persistent asthma),
4. Methylxanthines (alternative but not preferred for mild persistent asthma), and
5. Long-acting inhaled beta-2 agonists (add on therapy for persistent asthma).

Children with well-controlled asthma may experience better outcomes of care in terms of overall health status and functioning and reduced inpatient and ER use. Children ages 5 through 17 were identified as having persistent asthma using the HEDIS specifications:
1. At least four asthma medication dispensing events or
2. At least one ER visit with asthma as the principal diagnosis or
3. At least one hospitalization with asthma as the principal diagnosis or
4. At least four outpatient visits with asthma as one of the diagnoses and at least two asthma medication dispensing events.

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[27] Weiss KB, Gergen PJ, Hodgson TA. An economic evaluation of asthma in the United States. *New England Journal of Medicine*. 1992;326:862-866.
[28] Litonjua AA, Carey VJ, Weiss ST, Gold-DR. Race, socioeconomic factors, and area of residence are associated with asthma prevalence. *Pediatr-Pulmonol*. 1999; 28: 394-401.
[29] Categories used by HEDIS and consistent with the National Heart, Lung, and Blood Institute's National Asthma Education and Prevention Program Guidelines for the Diagnosis and Management of Asthma.

There were only 830 children who met the preceding criteria for inclusion in the analysis. Therefore results are only reported for the overall group and not by individual health plan/sites. Of the 830 children, only 43% had a filled prescription for any of the recommended drugs. Table 19 shows the percentage of children who had drugs filled in each of the drug classes. These percentages are below those reported by the health plans contributing to the NCQA State of Managed Care Quality Report. For example, in 2000, 59.5% of those 10 to 17 years of age and 61.4% of those 5 to 9 years of age with persistent asthma had one of the drug classes ordered for their asthma. However, in Florida's CHIP, only 36% of children had a filled prescription for any of the recommended drugs.

It is important to note that a physician could have ordered the drug for the child and the family did not fill the prescription. If the prescription was not filled, there would be no record in the claims files.

There also are health care consequences for children who do not have filled prescriptions in the pharmacy claims. Table 20 is a summary of the health care use patterns for the 830 children with persistent asthma who did and did not have filled prescriptions of the type recommended by the National Heart Blood and Lung Institute.

Children who did not have filled prescriptions but used outpatient health care services had 13 health care encounters annually, compared to 10 for those who had at least one of their medications filled. The percentage of children with inpatient admissions was the same for both the medication and the no medication groups (about 21%). However, the use rates among those who were hospitalized and did not have a filled asthma prescription was about two inpatient stays annually compared to one for those who had a filled prescription.

A high percentage of all of these children had an emergency room visit: 82% of those with a filled prescription and 93% of those with no filled prescriptions. For children using the ER, the use rates were about the same between the two groups.

Table 19. Children with Persistent Asthma (n=830)		
HEDIS Measure = Number of patients with at least one prescription divided by 830 (total population)		
Medication Class	Number of Persistent Asthma Patients with At Least One Prescription in Class*	HEDIS Measure
None filled	473	56.9%
Inhaled Corticosteroids	356	42.9%
Leukotriene Modifiers	317	38.19%
Mast Cell Stabilizers	43	5.18%
Methylxanthines	5	0.6%

Table 20. Utilization Patterns of Children With Persistent Asthma by Medication Status									
Category	Outpatient			Inpatient			Emergency Room		
	% Using	Annual Use Rate Among Users	Annual Use Rate Overall	% Using	Annual Use Rate Among Users	Annual Use Rate Overall	% Using	Annual Use Rate Among Users	Annual Use Rate Overall
Had One or More Filled Prescriptions N=357	97%	10	9	22%	1	0.3	82%	2	2
Had None of the Filled Prescriptions N=473	99%	13	10	21%	2	0.3	93%	2	2

In addition to the pharmacy claims data analyses, an additional 600 surveys were conducted with three health plans/sites in CHIP in Texas that had the highest number of children with asthma.[30] Children did not have to have severe asthma to be included in this study. Rather, they only needed two occurrences in the claims data of the ICD-9-CM code that indicates an asthma diagnosis. Currently data are available for 200 enrollees. An additional report will be provided that will include data for all 600 children and health plan/site comparisons for the participating health plans/sites. Selected results for the 200 surveys are reported in this section in Tables 21 and 22. The American Academy of Pediatrics Asthma Module was used to assess the children's health care related to their asthma.

Despite two diagnoses of asthma in the claims data, 5% of families stated their children did not have asthma. Their responses are not included in the results. Eighty-one percent of these families reported that a pediatrician or a pulmonologist was their children's usual source of care. The remaining families took their children to family practitioners. Thirteen percent of the children not seeing a pulmonologist as a usual source of care, did see one on some regular basis throughout the year.

Ninety-four percent of families reported that the doctor did discuss their children's asthma with them. However 34% of the families were worried that they did not understand what the doctor was telling them.

Forty-five percent of the children used a peak flow meter and 60% of the children were taking medications daily for their asthma. Only 6% of the children did not take medications at all. Seventy-four percent of families reported that their children most or all of the time took their medications properly. However, the remaining 26% reported that their children took their medication properly "some of the time" to "none of the time."

Ninety-five percent of families were satisfied to very satisfied with their children's asthma care. However 5% were not.

These preliminary findings may shed some light on the results using the pharmacy claims data. If about one-third of families do not understand what their doctors are telling them about their children's asthma, this may affect their compliance with filling needed prescriptions. In addition, about one-quarter of families indicate that their children do not take their medications properly. These findings point to the need for more family education about asthma.

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[30] Shenkman E, Vogel B. The Quality of Care for Children with Special Health Care Needs in Managed Care. Funded by the Agency for Health Care Research and Quality, the American Association of Health Plans Foundation, and Health Resources and Services Administration, Grant #U01 HS09949-02.

Future analyses with these data will incorporate information from all 600 children linked to pharmacy and claims records. The analyses will focus on (1) understanding differences between the three health plans on the asthma care delivered; (2) examining the relationship between families' reports of medication compliance and understanding of the disease and filled prescription medications; and (3) examining the relationship between families' reports of medication compliance and understanding of the disease and the children's health care use patterns (predominantly ER use and inpatient stays).

Health Plan Use Summary

Table 23 contains a summary of the major health care use indicators. Immunizations were not included because only 19 months of data and not 24 months were used. Three health plans are notable in terms of having two of six areas where health care use or access to care was lower than expected. Those plans were: El Paso 1st, Seton Health Plan, Texas Children's Health Plan, Texas University Health Plan (San Antonio), and Parkland Community Health Plan. The reader will recall that El Paso 1st, Texas University Health Plan (San Antonio), and Parkland Community Health Plan, also fell into the group that performed consistently less well than the other health plans/sites on the CAHPS clusters and individual items.

Table 21.   AAP Asthma Survey Results (N=200)

Item	Percentage
Is the person responsible for most of your health care a..	
Pediatrician	70%
Family practitioner	20%
Pediatric pulmonologist	10%
Adult pulmonologist	1%
How often does your child see this doctor for his or her asthma?	
1-2 times per year	32%
3-4 times per year	31%
5 or more times per year	37%
How satisfied with your doctor's overall treatment of your child's asthma?	
Very satisfied	62%
Satisfied	33%
Dissatisfied	1%
Very dissatisfied	4%
Not sure	0%
For those children who do not see a pediatric pulmonologist for most of their health care…does your child see a pediatric pulmonologist	
Yes	13%
No	87%
How often does your child see this doctor for his or her asthma?	
1-2 times per year	35%
3-4 times per year	41%
5 or more times per year	6%
Has someone from your doctor's office spent time discussing your child's asthma with you?	
Yes	94%
No	6%
Are you concerned that you do not understand the information that the doctor gives you about your child's asthma?	
Strongly agree	17%
Agree	17%
Not sure	6%
Disagree	28%
Strongly disagree	31%

Table 21 continued.   **AAP Asthma Survey Results (N=200)**

Item	Mean
During the past 4 weeks, how many times has your child had a wheezing, whistling sound when breathing out?	10.5
During the past 4 weeks, how many times has your child had an asthma attack, or trouble breathing, or needed extra medical care?	1.7
	Percentage
Does your child use a peak flow meter?	
Yes every day	10%
Yes sometimes	35%
No	53%
I don't know what a peak flow meter is	1%
Does your child use medications for his or her asthma?	
Yes every day	60%
Yes a few times a week	4%
Yes but only with symptoms	31%
No	6%
During the past 4 weeks how many times did your child take his or her asthma medications as he or she should?	
All of the time	61%
Most of the time	14%
Some of the time	8%
A little of the time	5%
None of the time	13%

Table 22.   **AAP Asthma Survey: Asthma Symptoms (N=200)**

Symptoms	All of the Time	Most of the Time	Some of the Time	Little of the Time	None of the Time
Shortness of breath	5%	11%	18%	28%	38%
Tightness in the chest	3%	9%	20%	25%	44%
Wheezing without a cold	5%	10%	20%	23%	42%
Cough	6%	17%	31%	20%	26%
A cold that won't go away	3%	9%	16%	15%	57%
Wheezing with a cold	4%	10%	18%	11%	57%
Difficulty sleeping	4%	9%	33%	13%	41%

Table 23.   Rankings of the Health Plans/Sites For Selected Health Care Use Measures

Health Plan	CDPS Actual Versus Expected	Access 12-24 Months Old	Access 25 Months to 6 Years	Access 7 to 11 Years	Outpatient Mental Health Visit	ER Use for Otitis Media	ER Use for URI
El Paso 1st	L	Std	L	Std	L	NS	NS
Seton	Exp	Std	L	L	L	NS	NS
Mercy	Exp	Std	Std	Std	Std	L	L
TCHP	H	L	L	Std	L	NS	NS
Amer.-Dal	Exp	Std	Std	Std	L	L	L
Cook Chil.	Exp	Std	Std	Std	L	NS	NS
EPO Clar*	Exp	Std	Std	Std	Std	NS	NS
Driscoll	H	Std	Std	Std	L	NS	NS
TUHP-Am	Exp	Std	Std	Std	L	NS	NS
Amer.-Hou	Exp	Std	Std	Std	L	H	NS
TUHP-San	Exp	Std	L	L	L	NS	NS
Parkland	Exp	Std	L	L	L	NS	NS
TUHP-El	Exp	Std	L	Std	L	Ns	L
Comm.Fir.	Exp	Std	Std	Std	Std	NS	L
UTMB	Exp	Std	Std	Std	L	L	L
FirstCare	H	Std	Std	Std	L	NS	NS

L=Lower than expected health care use based on case-mix
H=Higher than expected health care use based on case-mix
Std=Provide acceptable standard of care
NS=Not significantly different from average ER use for the condition
L=Lower than the average ER use for the condition
H=Higher than the average ER use for the condition

*Multiple Site Plan that represents Sites B, H, and R for the CAHPS

XIV. DISENROLLMENT: EXECUTIVE SUMMARY

Background   The following section is the Executive Summary from the Disenrollment Report that was released in May 2002. The interested reader is encouraged to go to the Texas Health and Human Services Commission website at www.hhsc.state.tx.us to obtain a copy or to the Institute for Child Health Policy website at www.ichp.edu.

When Congress passed legislation establishing the State Children's Health Insurance Program (SCHIP), its primary focus was to decrease the number of uninsured children. After states decided on the design of their SCHIP initiatives (i.e., Medicaid expansions, free-standing programs, or other models), attention shifted to outreach efforts. States including Texas worked diligently to develop and implement outreach strategies to encourage families to enroll their children in the newly designed programs. Due to these efforts more than 3.3 million children were enrolled in SCHIP nationally in 2000. By the spring of 2002, Texas had enrolled more than 500,000 children.

SCHIP was intended to improve children's access to health care by providing affordable insurance coverage to low-income families. However, access to care and the quality of the children's health care may be hampered if they are covered for only short periods of time. Unfortunately, very little information is available about the factors influencing disenrollment and re-enrollment patterns in subsidized children's health insurance programs.

In addition to understanding factors associated with disenrollment in general, more information is needed about why families do not renew their children's enrollment at the end of a continuous eligibility period. Texas offers families a period of continuous eligibility for children enrolled in CHIP. This means that once the child is determined to be eligible for the program, he or she can remain enrolled for 12 months.

At the end of the continuous eligibility period, families must provide documentation to demonstrate that their children are still eligible for the program. Other states have found that as many as 50% to 60% of families do not renew their children's coverage at the end of the continuous eligibility period.

As part of its quality monitoring and evaluation initiative, Texas Health and Human Services Commission (THHSC) wanted to examine a variety of issues concerning children's disenrollment from the children's health insurance program (CHIP) in Texas. THHSC was particularly interested in factors contributing to families not renewing their children's CHIP enrollment at the end of the 12 month continuous eligibility periods. Both health and sociodemographic factors are known to influence children's disenrollment from public insurance programs. Therefore, these factors were included in the analyses conducted for this report.

Three data sources were used for these analyses. First, enrollment files spanning 22 months were used. These files contain sociodemographic information about the children such as age, gender, income, race, and ethnicity. These files also contain information about the number of months the children were enrolled in CHIP. Second, claims and encounter data were used to characterize the health of the children using diagnostic information found in these files. Third, telephone surveys were conducted with a random sample of 500 families whose children had disenrolled from CHIP in Texas to obtain more in-depth information from families about their satisfaction with CHIP, their reasons for disenrollment, and whether they chose other insurance for their children upon disenrollment.

Results Using Administrative Data

Using enrollment files provided by the third party administrator for CHIP in Texas, the following results were obtained:

- Disenrollment and re-enrollment were examined for all children ever enrolled during the time period studied (N=646,326). During the 22 month period included in this analysis, 20% of the children disenrolled from the program (the number of disenrollees/the total number of enrollees). This percentage represented 128,796 children.

- Of those who disenrolled, 19%, or 24,471 children, later re-enrolled.

In addition to examining disenrollment in general, disenrollment due to non-renewal after the continuous eligibility period was also studied. The following findings were obtained:

- There were 241,196 children during the 22 month period who were enrolled for at least 12 continuous months. Of those, 31% or 75,516 children were not enrolled in the 13th month.

- Of those children who disenrolled in the 13th month, 26% of them (N=19,634) re-enrolled within 1 to 3 months of their disenrollment (that is between months 14 through 16).

Several child health and sociodemographic variables were significantly related to the odds of a children disenrolling from CHIP *for any reason*. The following results were obtained:

- Children categorized as having a physical special health care need were 20% less likely to disenroll from the program than their healthy counterparts. Children with mental health conditions were 30% less likely to disenroll than children without such conditions.

- Older children were overall about 14% to 19% less likely to disenroll than children five years of age and younger.

- Families below 186% of the federal poverty level (FPL) were as much as 30% less likely to disenroll than families above 186% FPL.

- Black Non-Hispanic families were 16% more likely to disenroll from the program (even after considering other factors such as income and child health status).

Several child health and sociodemographic variables were significantly related to the odds that a parent would *not renew* the child's coverage at the end of the 12 month continuous eligibility period. The following results were obtained:

- Families with children with physical special health care needs were 15% less likely to not renew coverage than their healthy counterparts. Those with children with mental health conditions were 22% less likely to not renew coverage when compared to families with healthy children.

- Families below 186% FPL were 2% to 28% less likely to not renew coverage (depending on their exact income) than families above 186% FPL.

- Families who have children over age 5 are less likely to not renew coverage than those with those age 5 and below (about 18% less likely overall).

Thus based on information contained in enrollment files and claims data, families appear to make decisions about keeping their children enrolled (including renewing coverage) based on their income and their children's health. Poorer families may have fewer insurance options.

Families who have children that require health care may also place a higher value on the coverage than those with healthy children. The finding about age is somewhat surprising. It is uncertain why families with older children are more likely to keep their children enrolled than those with younger children.

While families may be making understandable and rational decisions about whether to keep their children enrolled in CHIP, the finding about the children's health status warrants further attention. Texas is experiencing retention of sicker enrollees, as seen in at least one other state. If in fact, children with physical and mental special health care needs continue to have greater odds of remaining enrolled than healthy children, there could be implications for the financing and organization of the program over the long term. Perhaps as part of its outreach efforts, Texas could consider including educational information about the importance of insuring all children, including those that are healthy, so they have good access to primary and preventive care.

Results Using Telephone Survey Data

Using telephone survey data to obtain more in-depth information about families' disenrollment experiences, the following key findings were obtained:

1. The most frequent *primary* reason for disenrolling given by 19% of families was that the child switched to Medicaid.
2. The next most common primary reason was that the child was no longer eligible due to an increase in income (18%).
3. The third most common primary reason given was that the family did not or could not complete the renewal process (16%).

The reader will note that the percentage of families reporting they did not complete the renewal process is significantly less than the percentage noted based on the analyses using the enrollment files (16% versus 31%). There are several possibilities for this result. One possibility is that the survey responses are not representative of the overall disenrollee pool. However, this reason is unlikely given the excellent response rates that were obtained for this survey.

A second possibility is that families reported the disenrollment reasons more accurately on the telephone survey, under structured interview conditions, than were reported in the administrative data. In fact, a recent report from the National Academy of State Health Policy (NASHP) found that disenrollee survey findings often contradict state administrative records. One of the most striking areas of difference between administrative and survey data are findings about the percentage of families who do not complete the renewal process at the end of a continuous eligibility period.[31] The NASHP reports that families state they did not renew their children's coverage in CHIP because they obtained private insurance or they did not think their children were eligible any longer. NASHP further notes that families may appear to "*fail* to renew" coverage based on administrative data when in fact they *chose* not to renew their children's coverage.

During the telephone interviews almost none of the parents of disenrollees reported dissatisfaction with the program as the primary reason for leaving. For example, only 2% of families indicated dissatisfaction with their children's providers, less than 1% was dissatisfied with the premium, and 1% was dissatisfied with their co-payments.

Whether parents' reports about the percentage that do not renew (16%) or administrative data (31%) are used, the Texas results compare favorably to other states. For example, when compared to national figures calculated from administrative data, as many as 50% to 60% of enrollees do not renew coverage at the end of the continuous eligibility period.

More than 80% of families who did experience the renewal process thought it was "about as easy as it could be." However, 50% of them thought too much documentation was requested. The primary reason families gave for not completing the renewal process was that they "forgot" or "did not get around to doing it" (24%). The second most common reason given was that they were planning on getting other coverage for their children and did not want to renew (18%).

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[31] Pernice C, Riley T. NASHP News: New Study Finds that States are Overestimating the Number of Children who 'Lapse Out' of SCHIP Coverage. Portland, Maine: National Academy of State Health Policy, 2002.

Only 37% of families chose another type of coverage after disenrolling. Of those, 54% went to the Medicaid Program and 38% chose coverage from a current or past employer. Of those who obtained other coverage, 77% kept the same primary care provider for their children.

Thus many positive findings were obtained from this analysis. Families are very satisfied with all aspects of the program and do not report dissatisfaction with the premiums, the co-payments, or the providers. Disenrollment overall and at the renewal period is low in comparison to other states. Finally, families appear to be making decisions about their children's insurance coverage based, in part, on the children's health. While this is rational and understandable, families need education about the importance of health insurance and preventive care for all children, not just those with special needs.

XV. SUMMARY AND RECOMMENDATIONS

Summary   Several aspects of health care quality for CHIP enrollees in Texas were assessed using enrollment files, claims and encounter databases, and telephone survey data. The enrollment and claims and encounter files contain information on over 600,000 children who have participated or are currently participating in the CHIP. In addition, telephone surveys were conducted with families whose children were (1) new enrollees in the program for less than three months, (2) established enrollees in the program for 12 months or longer, and (3) disenrollees who were no longer in CHIP. A total of 6,517 interviews were conducted. The majority, 5,415 of them, was conducted with established enrollees. The large sample size was needed to make valid comparisons of family satisfaction and enrollee health and sociodemographic characteristics between the health plans participating in CHIP and the sites in which they are operating.

The following aspects of the program were assessed:
- How Families Learn About CHIP in Texas,
- Demographic Characteristics of CHIP Participants,
- Health Status Characteristics of CHIP Participants,
- Families' Experiences with the Application Process,
- Children's Usual Source of Care,
- Families' Satisfaction with Care,
- Children's Health Care Use Patterns,

- Inpatient and Emergency Room Use: The Incidence of
- Well Child Visit and Immunization Compliance,
- Special Populations: Children with Asthma and Mental/Behavioral Health Conditions, and
- Program Disenrollment.

Outreach

Families learned about CHIP from a variety of sources. During the telephone interviews new enrollees named all of the difference sources of their information about CHIP including television (43%), family and friends (40%), health care providers (38%) and the schools (28%). Newspapers (23%), radio (22%), and social service agencies (18%) also were important.

Although the preceding information sources were important for all of the enrollees, some were identified more so than others depending on the respondent's race and ethnicity. For example, a higher percentage of Hispanics said they learned about CHIP from the television when compared to both white and black non-Hispanics (48% versus 39% and 41%, respectively). White non-Hispanics named health care providers and newspapers as information sources more often than black non-Hispanics or Hispanics. These findings point to the importance of continued use of a variety of strategies to identify eligible families and inform them about CHIP. Particularly in a state as diverse as Texas, multiple strategies are needed to target families of differing racial and ethnic backgrounds.

Demographic Characteristics

The majority of children enrolled in CHIP for 12 months or longer (established enrollees) were (1) residing in two parent families (70%), (2) were Hispanic (58%), and (3) about 11 years old on average. A high percentage of parents of established enrollees had less than a high school education (25%). Thirty-nine percent had a high school education and 36% of them had some college or more.

Some interesting differences in demographic characteristics were noted between children enrolled in the program for 12 months or longer and those that were newly enrolled (in CHIP for less than 3 months). The most striking differences were noted in the children's average ages, the household type (i.e., two parent versus single parent), and the respondent's education. Newly enrolled children were younger on average than those in the program for 12 months or more (8 years old versus 11 years old). A significantly higher percentage of newly enrolled children resided in single parent families when compared to established enrollees (37% versus 30% respectively).

Finally, newly enrolled children resided in families where a higher percentage of respondents (usually the children's mothers) had less than a high school education when compared to established enrollees (36% versus 25%, respectively). Results from the disenrollee survey suggest that some of these families transition to the Medicaid Program. However, others do not. In fact, upon disenrollment from CHIP the majority (63%) are uninsured. Perhaps as part of its outreach program, Texas may want to consider strategies targeted toward less well-educated mothers and single parent families to encourage them to keep their children enrolled.

Health Status

Children's health status was measured in two ways. First, the Child Health Questionnaire (CHQ) was used, which assesses children's physical and psychosocial health in 16 domains. In each of the categories, children in CHIP had higher or the same scores in each of the health domains when compared to national averages, with one exception. Children in CHIP in Texas scored lower on the behavior assessment domain than children nationally. Overall, the children in CHIP were healthy.

Second, children's health was assessed using the Children with Special Health Care Needs (CSHCN) Screener. The CSHCN Screener is designed to assess whether the child has special health care needs by asking about (1) the use of compensatory mechanisms (i.e., medications), (2) elevated use of health care services, and (3) presence of functional limitations. Children can have just one of these three circumstances, two of them, or all three. In CHIP, 3% of the enrollees were identified as having special health care needs based on all three CSHCN Screener criteria. These children had eight times the health care expenditures per month compared to children not identified with any special health care needs.

The health status information about the new enrollees was compared to that of established enrollees to determine whether there were any differences. A statistical model was developed to assess whether the length of time in CHIP was related to any changes in health status as measured by the CHQ scores, missed school days, and restricted activity days, after considering other important factors such as the presence of special health care needs and the child's sociodemographic characteristics.

The most important factor related to children's health status scores, missed school days, and restricted activity days was whether or not the children had special health care needs. A modest program effect was noted for children's psychosocial functioning, with improved scores noted among established enrollees relative to new enrollees.

The finding about improved psychosocial functioning is encouraging. The failure to detect significant change in other health dimensions measured by the CHQ (such as physical health and well-being) or in missed school days and restricted activity days is not surprising for several reasons. First, most children are healthy and one of the most valuable components of any health insurance program is the entrée it provides to preventive care and prompt treatment of acute conditions. Second, because children are generally healthy, the results of neglected health care may not emerge until adulthood. Without a longitudinal study of these children, the long-term benefits of the program on their health are hard to ascertain. Third, many sociodemographic factors influence children's school attendance – an outcome indicator that generates great interest. For example, survey respondents reported children missed school most frequently for conditions such as a cold and the flu. While access to health care for these conditions can be important to prevent complications, it is not likely to prevent these conditions from occurring. Therefore the child would still have missed school days for those events.

Finally, a study focused only on children with special health care needs may detect some changes in health status related to the health insurance program. Some descriptive information indicates that there are small reductions in the percentage of children with special needs who have missed school days and restricted activity days based on comparing new and established enrollee survey findings.

The Application Process

The overwhelming majority of families (98%) found the application and enrollment process "easy to understand" and "convenient". The vast majority of children began receiving coverage with two months of their parents submitting applications (86%).

Children's Usual Source of Care

The benefits of a usual source of care, or a place where the child receives most of his or her preventive and routine care needs, is well documented and includes early detection of health care problems and reduced costs of care. Prior to enrollment in CHIP only 69% of children had a usual source of care. This figure excludes the 19% of children whose usual source of care was the emergency room (ER). In comparison, about 75% of uninsured children nationally have a usual source of care. However, three months post-enrollment in CHIP 90% of families reported their children had a usual source of care and this percentage increased to 92% by 12 months post-enrollment.

The location of that usual source of care was in places where the children can develop long-term relationships with their providers and receive good primary care. For example, 62% of children received their health care in doctors' office post-enrollment compared to only 48% pre-enrollment. An additional 16% were seen in hospital clinics after enrolling in CHIP compared to none prior to enrollment.

However, about 10% of families reported using an urgent care center as their children's usual source of care post-enrollment compared to none pre-enrollment. Urgent care centers are typically known for providing short-term acute care and are not desirable as a usual source of care. Four of the health plans participating in CHIP, representing 8 different sites, had 10% or more of enrollees reporting that an urgent care center was their usual source of care.

Some of these sites are in very impoverished areas. Thus these findings may be indicative of a lack of providers in the areas. However, the adequacy of the provider networks for these plans, within the context of any community constraints they are facing should be examined. In addition, the process that health plans use to assist families in selecting primary care providers for their children also should be assessed.

While this concern should be addressed, the striking improvement in the percentage of children with a usual source of care is a significant finding about the quality of the program. The overwhelming majority of children in CHIP have a usual source of care and the location of that care is a doctor's office or hospital clinic for most of them.

Families' Satisfaction with Care
The Consumer Assessment of Health Plans Survey (CAHPS) was administered, via a telephone, to families whose children were in CHIP for 12 months or longer. Three hundred completed surveys were obtained for each health plan. In instances where health plans were serving large geographic regions, the coverage areas for those plans were subdivided and sampled individually. There were 5,415 completed surveys from 13 health plans or 18 sites.

Responses for each individual CAHPS item for each health plan are contained in Appendix B. In addition, the CAHPS items were grouped into the following five clusters and scores were developed for each health plan/site:

- Getting Needed Care,
- Getting Care Quickly,
- Doctor's Communication,
- Courtesy of Office Staff, and
- Health Plan Communication.

Responses to questions in each of the preceding areas required families to have experience in that area. For example, families were asked if they had taken their children to the doctor in the past 12 months. If the child had seen a doctor, then the families were asked the questions in the Getting Needed Care and Getting Care Quickly clusters. If the child had not seen the doctor, the interviewer skipped to the next section. Therefore the cluster responses represent the experiences of families using those particular services only.

Understanding who is not using a particular service is as important, if not more important, than learning about the satisfaction of those that do. Therefore, the responses to four different items, which serve as filters or screens for the previously described clusters, were analyzed individually for each health plan/site. These items addressed whether (1) the child had a personal doctor or nurse that knows him or her, (2) the family called the doctor's office for advice, (3) the family made an appointment for regular or routine care, and (4) the child had been to the doctor or clinic at least once.

Responses to the clusters and to the individual items are influenced by health plan differences, and the child's health and sociodemographic characteristics. Therefore, statistical models were developed to examine health plan differences in satisfaction and use of services, after considering or controlling for sociodemographic characteristics and whether the child had special health care needs.

Across the 5 clusters and 4 different individual items considered in the statistical analyses, some plans/sites performed consistently as well as or consistently lower than the highest performing plans (Table 10 of the narrative). The following health plans/sites performed *consistently well* by either having the highest score for a cluster or item or by being equally as good as the reference plan in at least five areas: EPO Clarendon Health Plan (Rural Counties), Seton Health Plan, Mercy Health Plans, Texas Children's Health Plan, Cook Children's Health Plan, EPO Clarendon Health Plan (Houston Area Counties), Driscoll Children's Health Plan, Texas University Health Plan (Amarillo), Community First Health Plans, UTMB Health Care System, FirstCare, and EPO Clarendon Health Plan (Border Counties).

The following health plans/sites consistently performed *less well* than the highest scoring plans/sites by having a lower score than the reference plan in at least five areas: El Paso 1st, Amerikids (Dallas), Amerikids (Houston), Texas University Health Plan (San Antonio), Parkland Community Health Plan, and Texas University Health Plan (El Paso). It is interesting to note that two of the plans in this group performed better than the reference plan/site in the areas of doctor communication and customer service. Five of these sites had a higher percentage of enrollees reporting the use of urgent care centers as their usual source of care (El Paso 1st, Seton Health Plan, Amerikids (Houston), Texas University Health Plan (San Antonio), and Texas University Health Plan (El Paso)). Finally, Texas University Health Plan (El Paso) had the lowest percentage of children with a follow-up mental health visit within 30 days after an inpatient mental health-related stay (18% of the children). Amerikids (Dallas), Amerikids (Houston), and Texas University Health Plan (San Antonio) also performed poorly on this measure with 50% or less of their children having follow-up visits after an inpatient mental health stay. These findings about the mental health follow-up visits are discussed in more detail in the Section XIII of the report.

In addition to health plan/site differences in satisfaction and use of health care services, several sociodemographic and health status characteristics were significantly related to satisfaction with and use of health care services. The following key findings were obtained:

- As expected, children with special health care needs, as measured by meeting one, two, or all three CSHCN Screener criteria were significantly more likely than their healthy counterparts to (1) have a personal doctor or nurse (in other words a usual source of care), (2) have sought help or advice from their doctors, (3) have had an appointment for routine care, and (4) have been to see the doctor at least once in the past 12 months.

- However, families of children with special needs as measured by the CSHCN Screener, while using the health care system more, were significantly less satisfied with some aspects of their health care than families of healthy children. Children meeting all three of the criteria on the CSHCN Screener had significantly lower scores in the area of Getting Needed Care and Doctor Communication than children without special needs.

- However, very importantly, children who were identified as having special needs based on two components of the CSHCN Screener were 23% more likely to report getting needed care quickly than those not identified with special needs. Similarly, those who were identified as having special needs based on all three components of the Screener were 19% more likely than those without special health care needs to report getting needed care quickly. Thus, the health care providers and health plans participating in CHIP in Texas are responsive to families who have children with special health care needs by providing timely care.

- Race and ethnicity were significantly related to health care experiences with Hispanic families about one-half as likely as white, non-Hispanic families to (1) have a personal doctor or nurse (in other words a usual source of care), (2) have sought help or advice from their doctors, (3) have had an appointment for routine care, and (4) have been to see the doctor at least once in the past 12 months.

- Once Hispanic families sought care, they had lower satisfaction scores than white, non-Hispanic families in the areas of getting care quickly, interacting with office staff, and health plan customer service.

- Black non-Hispanic families were less likely than white, non-Hispanic families to call their doctors for advice and to take their children to the doctor. However, when they did use health care services for their children, they were much more satisfied with their care than white non-Hispanic families, in most areas.

Similar findings were obtained for the Florida KidCare Program. In the KidCare Program, reduced access to and satisfaction with care have been documented for Hispanic families relative to non-Hispanic families. Black families in the KidCare Program also have reduced access to care relative to white families, but report greater satisfaction. Finally some of the highest dissatisfaction scores are from families who have children with special health care needs. Perhaps these families require more complex care for their children that pose challenges to the health care system, contributing to dissatisfaction.

Children's Health care Use Patterns – The CDPS

The Chronic Disability Payment System (CDPS) was used to assess children's actual health care expenditures relative to their expected health care expenditures based on their case-mix or illness burden. The CDPS categorizes diagnoses assigned at the time of health care encounters into groups depending on their expected costs and clinical consequences. The use of such a system is essential, particularly when assessing health care use and expenditures in a state program contracting with multiple health plans. In this way, the health plans can be compared while taking into account the children's illness burden. Ensuring that children receive care that is consistent with their needs is critical and fundamental to the quality of any health care program.

As expected, the majority of children were seen for low cost pulmonary, ear, skin, infectious, and eye conditions. Overall the estimated health care expenditures for each plan were as expected after considering the case-mix of their enrollees. Two plans demonstrated health care expenditures significantly above what would be expected given their case-mix. FirstCare and Texas Children's Health Plan had expenditures that were 83% and 26% higher than expected. Only El Paso 1st had health care expenditures that were somewhat low relative to the expected (0.79% of the expected). Thus, overall in CHIP, the health care expenditures for the health plans/sites are as expected based on the children's illness burden. Further assessment of the highest and lowest expenditure plans should be conducted to determine if the expenditures are related to the cost of the services provided or the quantity or both.

Access to Care

Children's access to health care at each health plan/site was assessed using the Health Plan Employer Data and Information Set (HEDIS) indicator called *Children's Access to Primary Care Practitioners*. Overall, access to care was excellent with 90% of children 12 through 24 months old, 82% of children 25 months through 6 years old, and 89% of children 7 through 11 years old visiting their primary care providers at least once in a 12 month period. Compliance at the individual health plan/site level also was excellent with a couple of exceptions. For children ages 12 through 24 months, compliance was only 78% at Texas Children's Health Plan. For children ages 25 months through 6 years, compliance was low at Seton Health Plan, Texas Children's Health Plan, Texas University Health Plan (San Antonio), Parkland Community Health Plan, and Texas University Health Plan (El Paso). All of these sites had less than 80% compliance, that is 20% or more of their enrollees in the 25 months to 6 year age category did not have any contact with a primary care provider in 12 months. Only two health plans/sites had somewhat low compliance with access to care for children ages 7 through 11 years (Seton Health Plan and Texas University Health Plan (San Antonio)).

Incidence of Emergency Room Use and Inpatient Stays for Ambulatory Care Sensitive Conditions

There was a total of 10,005 inpatient stays among the CHIP enrollees. Several findings were noteworthy based on enrollees' sociodemographic characteristics. First, children ages 1 through 5 years and 6 through 14 years had the highest percentage of inpatient stays due to an ACSC (approximately 14% for both groups). Families that were between 100% and 150% of the FPL had the highest percentage of inpatient stays (15%) compared to any other income group. Males were not significantly different than females in terms of the percentage of their inpatient stays that were due to ACSCs. Significant differences were noted among the racial and ethnic groups. Thirteen percent of inpatient stays for Hispanic children were due to ACSCs compared to 8% for white non-Hispanics.

The incidence of ER use for these conditions was lower than for inpatient stays. However, the same sociodemographic patterns were observed for ER use for ACSC as was seen for inpatient stays.

The results for CHIP in Texas compare favorably to a study conducted among Medicaid beneficiaries (adults under age 65 and children).[32] For example, among Medicaid recipients 25% of the inpatient stays were for ACSCs compared to a high of 14% among the CHIP enrollees in Texas. In this same study with the Medicaid population, there were 21.9 ER visits/100 enrollees among those receiving primary care at Federally Qualified Health Centers. Among the CHIP enrollees in Texas, the highest ER visit rate for ACSCs was approximately 17.33/1,000 children for otitis media.

Childhood Immunization Status

Vaccine compliance within CHIP in Texas was calculated using claims data. The analysis is based on the 2001 United States Recommended Childhood Immunization Schedule, and the 2002 HEDIS childhood immunization status specifications. The 2001 US Recommended Childhood Immunization Schedule includes a recommendation for the Pneumococcal conjugate vaccine. The HEDIS specifications are written for children who were enrolled on their second birthday. In addition, the child had to be continuously enrolled for 12 months prior to their second birthday, or turn 2 years old during the 12 month reporting period. The US Recommended Childhood Immunization Schedule specifies age brackets for recommended doses through the age of 24 months. This analysis includes all children enrolled in CHIP with 12 months of continuous coverage or coverage since birth who are 2.10 years old or younger as of December 31, 2002.

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[32] Falik M, Needleman J, Wells BL, Korb J. Ambulatory care sensitive hospitalizations and emergency visits: Experiences of Medicaid patients using federally qualified health centers. *Medical Care.* 2001; 39(6):551-561.

CHIP in Texas compares favorably to the results reported by the NCQA for 273 commercial health plans representing 63 million covered lives. For example, in 2000, the participating plans reported 80% of children were in compliance with the Diptheria, Tetanus, Pertussis (DTP) vaccine compared to 81% in CHIP in Texas and 84% with the Polio vaccine compared to 82% in Texas. Compliance with Hepatitis B vaccines was higher in CHIP than in the NCQA sample (92% versus 78%). H. Influenzae vaccine was markedly lower than the national sample (46% versus 83%). Overall compliance with the vaccines was lower in the CHIP group compared to the national sample (55% versus 67%). However, the national sample was comprised of commercial health plans were one might expect better compliance than in a subsidized insurance program. In addition, only 19 months and not 24 months of data were available for these analyses.

However, there are some individual health plan/site differences in performance that should be explored further. It is important to note that individual immunization calculations are relying on claims and encounter data only. The evaluators do not have access to the children's medical records. Health plans may exclude from the analysis children who (1) have evidence of the antigen for which they are being immunized, (2) have a documented history of the illness, or (3) have a seropositive test result. Without more detailed clinical information on the children, it is impossible to know if some children included in the analysis may have met one of the three criteria described above for exclusion.

Percent of Children with Mental Health Hospitalizations Who Had An Outpatient Visit Within 30 Days of Discharge

There were 2,713 hospitalizations for mental health conditions. Of the mental health hospitalizations, 56.7% showed either a mental health or a primary care outpatient visit within 30 days of discharge. In the NCQA State of Managed Care Quality Report, participating commercial plans reported that 71% of their enrollees with inpatient mental health stays had an outpatient follow-up within 30 days. It is important to note that in our calculations, we used more liberal criteria for outpatient visits when compared to the HEDIS standards.

There was plan variability noted in the percentage of children with some outpatient visit following an inpatient mental health stay. It is important to note that the national comparison groups are commercial health plans and not a similar low-income population. In Florida with a Title XXI population, the overall compliance is 65%. However, in Texas, some of these health plans operate in primarily rural areas with limited provider networks, resulting in limited access to care for program enrollees. Further analyses should be conducted examining the provider networks and community characteristics in which some of the poorest performing health plans/sites are operating.

Use of Appropriate Medications for Children With Asthma

A group of 830 children with severe asthma (according to HEDIS specifications) were identified. The type of filled prescriptions these children had for their asthma was then assessed using pharmacy claims data. Assessing medication compliance for this group of children is essential because those with well-controlled asthma have better outcomes of care in terms of overall health status and reduced inpatient and ER use.

Only 43% of the children had a filled prescription for any of the recommended drugs, which is significantly lower than in a commercially insured group (about 60%). However, only 36% of Florida's Title XXI enrollees had a filled prescription in any of the recommended categories. It is important to note that physicians could be ordering these medications for the children but families are not filling the prescriptions.

Detailed telephone interviews with families about their children's asthma revealed that about one-third of families reported they did not understand what their children's doctors were telling them about asthma. In addition, one-quarter of families indicated that their children were not taking their asthma medications properly, although they were ordered. Further analyses will be provided about asthma care in the program.

Disenrollment   Families' disenrollment experiences in Texas are very positive overall. Both administrative and family interview data were used to conduct this comprehensive analysis. In terms of findings using the administrative data:

- About 20% of the children in SCHIP disenrolled for any reason during the 22 month period studied. About 19% of these later re-enroll in the program. About 30% of families did not renew their children's coverage at the end of the 12 month continuous eligibility period. However, 26% of them did re-enroll within 3 months of disenrollment.
- Children with physical and mental health special health care needs are 20% and 30% less likely to disenroll for any reason when compared to healthy children. They are also less likely to not renew at the end of the continuous eligibility period than healthy children.

While it is important to continue to monitor disenrollment from CHIP, the results are favorable compared to those obtained in other states using administrative data. For example, a study using administrative data from Oregon and Kansas found that 50% to 60% of CHIP enrollees did not renew coverage after the continuous eligibility period. These findings compare to 30% of children in Texas.

More detailed information was obtained about families' reasons for disenrolling their children from the telephone surveys. Less than 2% of families reported any program dissatisfaction as a primary reason for disenrollment. Moreover, using family report (16%), few families reported they could not or did not renew their children's coverage at the end of the continuous eligibility period as a primary disenrollment reason. This finding is consistent with that obtained from a NASHP seven state study. NASHP notes that families may appear to "*fail* to renew" coverage based on administrative data when in fact they *chose* not to renew their children's coverage. For those families who do renew their children's coverage, they report that the experience a positive and easy one.

Recommendations   Overall, the quality of care in CHIP in Texas is excellent. The majority of respondents view the initial application and subsequent renewal process as easy and convenient. Most children have a usual source of health care with a physician or in a hospital clinic. There is a marked reduction in the percentage of children using the ER as a usual source of care. Family satisfaction is high with all aspects of health care. Access to care is very good for all age cohorts and children are receiving the amount of health care that would be expected based on their illness burden.

There are some individual differences in these performance measures between the health plans/sites. Some of these health plans/sites may face increased challenges in some of the rural areas of Texas and in the border counties in terms of establishing provider networks and ensuring good access to care. Despite these challenges, some of the lowest performing plans should be assessed further to determine if improvements can be made within the context in which they are operating.

Immunization compliance, follow-up care after an inpatient mental health stay, and compliance with asthma medications all require improvement. Some of the low findings may be the result of using only claims data without supplemental medical record information. Despite this, some health plans/sites performed well relative to a commercially insured population or relative to another CHIP population and some did not. Further review should be conducted with these health plans to determine potential strategies for improvement.

Many of the quality findings are strongly influenced by the child's health status and the family's sociodemographic characteristics. While not unique to Texas, there are some racial and ethnic disparities in access to and satisfaction with care. There are numerous challenges associated with addressing this issue. For example, improved satisfaction may be obtained if the race and ethnicity of the provider match that of the patient. However this is not always possible depending on provider availability.

Children's health status is extremely important. For example, children with special health care needs get needed care more quickly than children without special needs. Moreover, families are more likely to keep these children enrolled in the program than their healthier counterparts.

Outreach to families should incorporate educational messages that are targeted toward families of healthy children, encouraging them to keep their children insured to obtain needed primary and preventive care. In addition, single parent families and the less well educated (less than a high school diploma) may benefit from special outreach efforts targeted at keeping their children enrolled.

Quality of Care in the
Children's Health Insurance Program in Texas

Volume II: Appendices

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Please refer to this key for determining health plans/sites in Appendices A, B, and C

Health Plans/Sites	
El Paso 1st	A
EPO Clarendon Health Plan – Rural Counties	B
Seton Health Plan	C
Mercy Health Plans	D
Texas Children's Health Plan	E
Amerikids CSA 2	F
Cook Children's Health Plan	G
EPO Clarendon Health Plan – Houston Area Counties	H
Driscoll Children's Health Plan	I
Texas University Health Plan CSA 1	J
Amerikids CSA 6	K
Texas University Health Plan CSA 7	L
Parkland Community Health Plan	M
Texas University Health Plan CSA 11	N
Community First Health Plans	O
UTMB Health Care System	P
FirstCare	Q
EPO Clarendon Health Plan – Border Counties	R

Analyses For the Consumer Assessment of Health Plans (CAHPS)

Conducted by Jana Col, MA

The following specification of the variables was used in the model development.

Age	discrete: 0 – 19
Gender	dichotomous: 1=Male, 0=Female
Race/Ethnicity	nominal: A=Hispanic,
	B=Black NonHispanic,
	C=Other,
	D=White NonHispanic
Income	continuous
Months Enrolled	discrete: 10 – 22
Parents Education	ordinal: 1=grade school – 13=graduate degree
CHQ Psychosocial Summary	continuous
CHQ Physical Summary	continuous
SHCN Screener	ordinal:0=met three measures, high special need
	1=met two measures
	2=met one measure
	3=met none of the measures, no special need

Three models were developed for each cluster:

Cluster score= $\beta_0 + \beta_1$health plan

Cluster score= $\beta_0 + \beta_1$health plan+
$\quad\quad\quad \beta_2$age+$\beta_3$sex+$\beta_4$race+$\beta_5$income+$\beta_6$months+$\beta_7$education

Cluster score= $\beta_0 + \beta_1$health plan+
$\quad\quad\quad \beta_2$age+$\beta_3$sex+$\beta_4$race+$\beta_5$income+$\beta_6$months+$\beta_7$education
$\quad\quad\quad \beta_8$CHQpss+β_9CHQphs+β_{10}SHCNscore

Each sequential block was tested for significant decrease in residual error using an F test under the following hypothesis:

Ho: $\quad \beta_1=0, \quad$ F=R(β_1 | β_0)/1 /MSE$_1$
Ho: $\quad$ [β_2
$\quad\quad\quad \beta_3$
$\quad\quad\quad \beta_4 \quad\quad$ F=R(β_2 β_3 β_4 β_5 β_6 β_7 | β_0 β_1)/6 /MSE$_2$
$\quad\quad\quad \beta_5$
$\quad\quad\quad \beta_6$
$\quad\quad\quad \beta_7$]=0
Ho: $\quad$ [β_8

$$\beta_9 \qquad F=R(\beta_8\ \beta_9\ \beta_{10} \mid \beta_0\ \beta_1\ \beta_2\ \beta_3\ \beta_4\ \beta_5\ \beta_6\ \beta_7)/3\ /MSE_3$$
$$\beta_{10}]=0$$

Where, MSEn represents the Mean Square Error of the full model, and the R notation represents the sum of squares of the explanatory block. The results of sequential adjustment are provided in Table 1.2. Health plan mean scores were tested for significant differences (multiple comparison tests) using Tukey's HSD t-tests, after adjustment by both blocks. And further evaluated through cumulative or binary logit models to determine the odds of a higher score relative to the health plan with the highest adjusted mean score, controlling for the socioeconomic and health status characteristics.

Table 1.   Significance Matrix for Health Plan/Sites and Factors Within Adjustor Blocks Sequential Sum of Squares (Reduction in Residual Sum of Squares)

	Get Needed Care Parameter Estimate (Significance Level)	Get Care Quickly Parameter Estimate (Significance Level)	Doctor Communication Parameter Estimate (Significance Level)	Office Courtesy Parameter Estimate (Significance Level)	Customer Service Parameter Estimate (Significance Level)
	Satterthwaite Adjusted Chi Square p-value				
Health Plan/Site	<0.0001	<0.0001	<0.0001	0.0014	<0.0001
Sociodemographic Block					
Age	0.0158	0.3619	0.1294	0.1872	0.1283
Gender	0.6950	0.0771	0.1297	0.2523	0.1401
Race/Ethnicity	<0.0001	<0.0001	<0.0001	<0.0001	0.0313
Annual Income	0.1287	0.3808	0.5732	0.6561	0.6411
Parents' Education	0.2155	0.2777	0.0071	0.2652	0.0008
Months Enrolled	0.7730	0.3934	0.1025	0.6259	0.1091
Health Status Block					
CHQ Psychosocial Summary Score	<0.0001	<0.0001	<0.0001	<0.0001	<0.001
CHQ Physical Summary Score	<0.0001	0.0042	0.0002	0.0112	0.0028
CSHCN Screener	0.0145	0.0362	0.0096	0.8289	0.1842
Simultaneous Test of Main Effects of Adjustment Blocks					
Test Main Effects of Socioeconomic Characteristics	<0.0001	<0.0001	<0.0001	<0.0001	0.0009
Test Main Effects of Health Status Factors	<0.0001	<0.0001	<0.0001	<0.0001	<0.0001

Influence of the Explanatory Measures on Cluster Scores

SUDAAN was used for the data analysis and derives parameter coefficients using the method of weighted (pseudo) maximum likelihood, and variance estimates using implicit Taylor linearization (Generalized Estimating Equations, GEE).

Table 2. The Odds of Having a Favorable Score By Cluster, Adjusted for Health Plan/Site and Sociodemographic and Health Characteristics

Model Parameters	Getting Needed Care Odds Ratio (Probability of a Higher Score)	p-Value	Getting Care Quickly Odds Ratio (Probability of a Higher Score)	p-Value	Doctor Communication Odds Ratio (Probability of a Higher Score)	p-Value	Doctor Office Staff Odds Ratio (Probability of a Higher Score)	p-Value	Customer Service Odds Ratio (Probability of a Higher Score)	p-Value
Intercept	9.813	0.0000	11.675	0.0000	0.604	0.0000	41.7	0.0000	0.153	0.0000
Health Plan/Site	Health Plan Reference: HP/Site D		Health Plan Reference: HP/Site B		Health Plan Reference: HP/Site Q		Health Plan Reference: HP/Site B		Health Plan Reference: HP/Site D	
HP/Site A	0.777	0.0151	0.299	0.0000	2.009	0.0001	0.555	0.0089	2.628	0.0000
HP/Site B	0.851	0.3612	1.000	.	1.134	0.1084	1	.	2.229	0.0008
HP/Site C	0.588	0.0031	0.639	0.0960	1.253	0.0860	0.76	0.4589	1.991	0.0011
HP/Site D	1.000	.	0.386	0.0001	1.362	0.0293	0.512	0.1221	1	.
HP/Site E	0.659	0.0209	0.398	0.0000	1.250	0.0155	0.572	0.0876	1.739	0.0046
HP/Site F	0.353	0.0000	0.344	0.0000	1.651	0.0000	0.368	0.0000	4.187	0.0000
HP/Site G	0.848	0.4855	0.483	0.0140	1.287	0.2868	0.904	0.5770	1.778	0.0105
HP/Site H	0.786	0.1822	0.747	0.0846	1.334	0.0304	0.792	0.2062	1.626	0.0550
HP/Site I	1.079	0.7493	0.509	0.0051	1.729	0.0027	0.721	0.4287	2.15	0.0011
HP/Site J	1.330	0.7651	0.687	0.2824	1.100	0.3486	0.961	0.6116	2.002	0.0034
HP/Site K	0.500	0.0001	0.491	0.0008	1.891	0.0000	0.475	0.0052	2.119	0.0017
HP/Site L	0.587	0.0006	0.372	0.0000	1.765	0.0001	0.392	0.0018	2.347	0.0001
HP/Site M	0.491	0.0000	0.272	0.0000	1.740	0.0000	0.429	0.0009	3.152	0.0000
HP/Site N	0.535	0.0004	0.300	0.0000	1.587	0.0203	0.652	0.2522	1.774	0.0010
HP/Site O	0.543	0.0006	0.349	0.0000	1.495	0.0023	0.542	0.0086	1.774	0.0019
HP/Site P	0.713	0.1949	0.523	0.0142	1.206	0.0660	0.713	0.3926	1.415	0.1069
HP/Site Q	1.221	0.8747	0.723	0.3536	1.000	.	0.952	0.6071	1.406	0.0794
HP/Site R	0.995	0.6485	0.482	0.0054	1.055	0.6175	0.871	0.7258	1.075	0.1227

Table 2 continued.   The Odds of Having a Favorable Score By Cluster, Adjusted for Health Plan/Site and Sociodemographic and Health Characteristics

Model Parameters (continued)	Getting Needed Care Odds Ratio (Probability of a Higher Score)	p-Value	Getting Care Quickly Odds Ratio (Probability of a Higher Score)	p-Value	Doctor Communication Odds Ratio (Probability of a Higher Score)	p-Value	Doctor Office Staff Odds Ratio (Probability of a Higher Score)	p-Value	Customer Service Odds Ratio (Probability of a Higher Score)	p-Value
Sociodemographic Characteristics										
Age	0.977	0.0156	0.992	0.3617	0.982	0.1291	1.013	0.1870	1.02	0.1281
Months Enrolled		0.7730		0.3932		0.1023		0.6258		0.1089
Income		0.1284		0.3806		0.5731		0.6560		0.6410
Race Ref: White, Non-Hispanic										
Hispanic	0.862	0.5578	0.645	0.0001	1.135	0.0949	0.572	0.0037	0.779	0.0202
Black, NonHispanic	1.468	0.0001	1.126	0.0463	0.769	0.0296	1.306	0.0387	0.595	0.0146
Other	0.420	0.0041	0.414	0.0056	2.618	0.0001	0.366	0.0012	0.758	0.9382
Gender Ref: Female										
Male	0.918	0.6949	1.046	0.0768	0.889	0.1294	1.08	0.2520	0.944	0.1399
Parents' Education Ref: College Degree of Higher										
High School or Less	1.348	0.0936	1.306	0.1217	0.774	0.2306	0.861	0.7877	0.504	0.0004
Some Vocational or College	1.338	0.1739	1.200	0.1688	0.693	0.0094	1.091	0.4771	0.617	0.0142

Table 2 continued. The Odds of Having a Favorable Score By Cluster, Adjusted for Health Plan/Site and Sociodemographic and Health Characteristics

Model Parameters (continued)	Getting Needed Care Odds Ratio (Probability of a Higher Score)	p-Value	Getting Care Quickly Odds Ratio (Probability of a Higher Score)	p-Value	Doctor Communication Odds Ratio (Probability of a Higher Score)	p-Value	Doctor Office Staff Odds Ratio (Probability of a Higher Score)	p-Value	Customer Service Odds Ratio (Probability of a Higher Score)	p-Value
Health Status Characteristics										
CHQ Psychosocial Summary Ref: >75th Percentile*										
0-25th Percentile	0.490	0.0000	0.430	0.0000	2.785	0.0000	0.425	0.0000	2.662	0.0000
26-50th Percentile	0.592	0.0000	0.579	0.0000	2.106	0.0000	0.517	0.0000	1.969	0.0005
51-75th Percentile	1.010	0.2597	0.682	0.0060	1.354	0.0369	0.9	0.0379	1.364	0.1762
CHQ Physical Summary Ref: >75th Percentile*										
0-25th Percentile	0.579	0.0000	0.833	0.0015	1.373	0.0000	0.636	0.0082	1.672	0.0001
26-50th Percentile	0.683	0.0010	0.859	0.0020	1.313	0.0013	0.591	0.0022	1.261	0.1028
51-75th Percentile	0.776	0.0060	0.821	0.0292	1.187	0.0153	0.764	0.0709	1.228	0.1242
CSHCN Screener Ref: Met None										
Met All Three	0.522	0.0098	1.185	0.0717	0.708	0.0273	0.998	0.7867	0.622	0.2260
MetTwo	0.919	0.2093	1.226	0.0136	0.982	0.8139	1.478	0.3335	1.205	0.2480
Met One	0.725	0.0821	1.110	0.2277	0.768	0.0061	0.859	0.9585	1.19	0.2030

* 75th percentile are children with the highest functioning

Table 3.   Specific Item Analysis, Adjusted for Health Plan/Site and Sociodemographic and Health Characteristics

Model Parameters	Do You Have One Person You Consider Your Child's Personal Doctor?		Did You Call During Regular Office Hours for Help or Advice?		Did You Make Any Appointments for Regular or Routine Health Care?		Did Your Child Go To the Doctor's Office At Least Once?	
	Odds Ratio (Probability Yes)	p-Value	Odds Ratio (Probability Yes)	p-Value	Odds Ratio (Probability Yes)	p-Value	Odds Ratio (Probability Yes)	p-Value
Intercept	47.475	0.0000	11.675	0.0000	7.695	0.0000	43.3	0.0000
Health Plan/Site	Health Plan Reference: HP/Site Q		Health Plan Reference: HP/Site G		Health Plan Reference: HP/Site G		Health Plan Reference: HP/Site Q	
HP/Site A	0.402	0.0017	0.757	0.1376	0.624	0.0187	0.499	0.0136
HP/Site B	0.508	0.0346	0.745	0.1014	0.564	0.0043	0.593	0.0872
HP/Site C	0.318	0.0001	0.926	0.6617	0.787	0.2372	0.511	0.0213
HP/Site D	0.755	0.3701	0.864	0.4354	0.733	0.1267	0.903	0.7408
HP/Site E	0.388	0.0016	0.779	0.1646	0.713	0.0941	0.752	0.3625
HP/Site F	0.287	0.0000	0.544	0.0007	0.549	0.0024	0.737	0.3218
HP/Site G	0.380	0.0014	1.000	.	1.000	.	0.712	0.2804
HP/Site H	0.260	0.0000	1.006	0.9749	0.587	0.0074	0.691	0.2385
HP/Site I	0.597	0.0930	0.934	0.7102	0.590	0.0079	0.795	0.4450
HP/Site J	0.298	0.0000	0.761	0.1307	0.530	0.0013	0.648	0.1448
HP/Site K	0.403	0.0023	0.568	0.0024	0.471	0.0001	0.588	0.0716
HP/Site L	0.249	0.0000	0.653	0.0241	0.650	0.0319	0.428	0.0024
HP/Site M	0.282	0.0000	0.475	0.0001	0.509	0.0006	0.479	0.0128
HP/Site N	0.248	0.0000	0.517	0.0007	0.519	0.0009	0.267	0.0000
HP/Site O	0.521	0.0321	1.011	0.9507	0.710	0.0896	0.798	0.4591
HP/Site P	0.491	0.0219	0.751	0.1068	0.704	0.0823	0.760	0.3787
HP/Site Q	1.000	.	0.989	0.9532	0.671	0.0465	1.000	.
HP/Site R	0.394	0.0012	0.473	0.0002	0.706	0.0830	0.697	0.2221

Table 3 continued.   Specific Item Analysis, Adjusted for Health Plan/Site and Sociodemographic and Health Characteristics

Model Parameters (continued)	Do You Have One Person You Consider Your Child's Personal Doctor?		Did You Call During Regular Office Hours for Help or Advice?		Did You Make Any Appointments for Regular or Routine Health Care?		Did Your Child Go To the Doctor's Office At Least Once?	
	Odds Ratio (Probability of a Higher Score)	p-Value	Odds Ratio (Probability of a Higher Score)	p-Value	Odds Ratio (Probability of a Higher Score)	p-Value	Odds Ratio (Probability of a Higher Score)	p-Value
Sociodemographic Characteristics								
Age	0.944	0.0000	0.949	0.0000	0.959	0.0000	0.923	0.0000
Race Ref: White, Non-Hispanic								
Hispanic	0.554	0.0000	0.492	0.0000	0.660	0.0000	0.687	0.0074
Black, NonHispanic	1.049	0.8102	0.680	0.0037	0.865	0.2900	0.624	0.0175
Other	0.355	0.0001	0.903	0.6569	0.633	0.0524	0.538	0.0634
Gender Ref: Female								
Male	0.851	0.0881	0.873	0.0561	0.995	0.9420	0.899	0.3094
Parents' Education Ref: College Degree of Higher								
High School or Less	0.928	0.6806	0.594	0.0001	0.644	0.0024	0.598	0.0140
Some Vocational or College	1.233	0.2919	0.849	0.2542	0.858	0.3226	0.884	0.5902

Table 3 continued. Specific Item Analysis, Adjusted for Health Plan/Site and Sociodemographic and Health Characteristics

Model Parameters (continued)	Do You Have One Person You Consider Your Child's Personal Doctor?		Did You Call During Regular Office Hours for Help or Advice?		Did You Make Any Appointments for Regular or Routine Health Care?		Did Your Child Go To the Doctor's Office At Least Once?	
	Odds Ratio (Probability of a Higher Score)	p-Value	Odds Ratio (Probability of a Higher Score)	p-Value	Odds Ratio (Probability of a Higher Score)	p-Value	Odds Ratio (Probability of a Higher Score)	p-Value
Health Status Characteristics								
CHQ Psychosocial Summary Ref: >75th Percentile								
0-25th Percentile	0.784	0.0834	1.529	0.0001	1.256	0.0355	1.179	0.3056
26-50th Percentile	0.945	0.6770	1.343	0.0038	1.114	0.2938	1.066	0.6735
51-75th Percentile	0.961	0.7678	1.098	0.3630	1.012	0.9078	0.803	0.1280
CHQ Physical Summary Ref: >75th Percentile								
0-25th Percentile	0.827	0.1740	1.609	0.0000	0.962	0.7232	1.414	0.0288
26-50th Percentile	0.815	0.1333	1.180	0.1144	1.026	0.8055	1.208	0.1961
51-75th Percentile	0.935	0.6291	1.131	0.2297	0.885	0.2369	1.064	0.6636
CSHCN Screener Ref: Met None								
Met All Three	1.982	0.0559	5.738	0.0000	4.362	0.0000	4.627	0.0461
MetTwo	1.930	0.0032	2.564	0.0000	1.969	0.0001	4.266	0.0002
Met One	1.957	0.0002	1.953	0.0000	1.843	0.0000	2.149	0.0016

DISCRETE-TIME HAZARD MODEL FOR REENROLLMENT AND DISENROLLMENT: TEXAS DATA

Technical Report
By Delfino Vargas-Chanes

The Analytic Model

Discrete-time hazards model are used to analyze the time to disenrollment for any reason, and reenrollment after a disenrollment spell. Discrete-time hazard models were used. A logit model was used to examine the odds of not renewing coverage after 12 months of continuous eligibility. The discrete-time approach incorporates the complementary log-log function into the logit model and uses a regular logistic model. Estimates and standard errors using this approach are equivalent to proportional hazard models with discrete ties option.

The model

The person-level discrete-time hazard model utilizes a regular logistic regression model where time is included as dummy variable with no intercept is a follows (Reardon, Brennan, & Buka, 2001):

$$\eta_{it} = \ln\left(\frac{p_{it}}{1-p_{it}}\right) = \sum_{t=1}^{p-1}\alpha_t(MONTH_{it}), \tag{1}$$

where p_{it} denotes the probability of disenrollment (reenrollment) for a subject i at month t. If we add the child characteristics (age, gender, poverty level, race, and children with special care needs) then the model is as follows

$$\eta_{it} = \sum_{t=1}^{p-1}\alpha_t(MONTH_{it}) + \sum_{j=1}^{q}\beta_j x_j, \tag{2}$$

where x_j denotes the covariates needed in the model. In order to assess whether the health plan has an effect on the covariates the following model was proposed

$$\eta_{ijt} = \sum_{t=1}^{p-1}\alpha_t(MONTH_{it}) + \sum_{j=1}^{q}\beta_j x_j + \sum_{l=1}^{r}\lambda_l PLAN_l \tag{3}$$

where *PLAN$_l$* denotes the effect of health plan into the model. The *MONTH* effect has *p*-1 terms to avoid linear dependence, thus if we have 15 month of data there will be 14 parameter for the variable month. The estimates α and β indicate the effects of months and the covariates on the risk to disenroll (reenroll) from the health plans. In addition, by comparing the estimates from model (2) and (3) we can assess the relevance of health plans into the conditional discrete-time model. The contribution of health plan into the model is tested by taking the difference of log-likelihood functions form each model. If logΛ$_2$ and logΛ$_3$ denotes the log-likelihood for models (2) and (3), respectively then $\mathcal{K}$=2(logΛ$_2$ - logΛ$_3$) assess the contribution of health plans into model (3). We compare $\mathcal{K}$ versus a χ^2 statistic with *p*-1 degrees of freedom at α=0.05 level of confidence to determine the statistical significance of health plans into the model.

Appendix B - CAHPS Results by Health Plan/Site
April 2002
Texas CHIP

Table 1. Demographics

Questions	HP/Site A	HP/Site B	HP/Site C	HP/Site D	HP/Site E	HP/Site F	HP/Site G	HP/Site H	HP/Site I	HP/Site J	HP/Site K	HP/Site L	HP/Site M	HP/Site N	HP/Site O	HP/Site P	HP/Site Q	HP/Site R
Age Groups																		
0-1	0.67	1.33	1.66	0.00	1.32	0.33	1.66	0.67	0.66	0.67	0.67	0.33	0.67	1.66	0.00	1.67	1.66	0.00
2-5	15.33	16.00	19.27	18.54	26.49	20.20	19.87	18.67	16.94	15.33	24.67	12.58	24.33	10.96	19.00	19.67	19.87	13.33
6-10	32.33	34.33	34.88	35.43	35.43	38.74	33.11	34.00	29.24	34.00	38.67	33.44	34.67	31.89	33.00	31.33	31.79	30.67
11-14	24.67	26.67	25.91	25.83	25.17	28.15	26.49	26.67	25.91	29.00	21.67	28.15	24.67	29.57	24.67	28.67	26.16	29.67
15-19	27.00	21.67	18.27	20.20	11.59	12.58	18.87	20.00	27.24	21.00	14.33	25.50	15.67	25.91	23.33	18.67	20.53	26.33
Gender																		
Male	51.00	53.67	50.50	48.68	52.32	50.00	49.67	54.00	51.83	52.00	56.33	47.35	53.00	46.18	53.67	46.67	51.99	48.67
Female	49.00	46.33	49.50	51.32	47.68	50.00	50.33	46.00	48.17	48.00	43.67	52.65	47.00	53.82	46.33	53.33	48.01	51.33
Race and Ethnicity																		
Hispanic	87.63	25.34	42.71	97.35	48.33	42.67	30.85	14.43	71.14	52.51	60.07	77.67	42.81	92.31	64.98	34.23	55.48	94.97
White, Non-Hispanic	9.36	68.58	44.07	2.32	28.00	36.33	56.95	65.10	24.50	37.79	20.13	15.67	26.37	6.02	27.27	44.30	41.20	4.70
Black, Non-Hispanic	1.67	5.07	8.81	0.00	16.67	17.33	7.12	19.13	3.36	7.36	16.11	5.67	24.32	1.67	5.05	18.12	2.66	0.00
Other, Non-Hispanic	1.34	1.01	4.41	0.33	7.00	3.67	5.08	1.34	1.01	2.34	3.69	1.00	6.51	0.00	2.69	3.36	0.66	0.34
Education																		
< High School	17.00	8.66	17.00	25.50	21.33	28.15	22.75	17.73	19.60	23.16	34.00	21.93	27.27	32.89	19.06	25.00	22.26	28.19
HS grad or GED	40.33	40.00	44.33	29.47	39.67	39.07	35.12	43.48	41.86	41.27	38.00	46.18	41.41	36.22	42.47	42.00	38.87	35.23
Technical/Vocational	3.66	7.00	4.33	2.98	3.67	2.98	5.68	4.35	2.32	3.69	3.67	3.32	2.36	3.66	3.01	3.67	2.66	6.37
Some College	21.33	22.67	16.67	18.87	17.67	15.56	20.40	18.06	22.26	20.81	13.00	19.60	17.51	15.28	21.74	17.00	18.60	17.11
College degree or higher	17.67	14.34	17.67	23.18	17.66	14.24	16.06	16.39	13.96	11.07	11.34	8.97	11.45	11.97	13.71	12.33	17.60	13.09

Table 2. CAHPS – Your Child's Personal Doctor or Nurse

Questions	HP/Site A	HP/Site B	HP/Site C	HP/Site D	HP/Site E	HP/Site F	HP/Site G	HP/Site H	HP/Site I	HP/Site J	HP/Site K	HP/Site L	HP/Site M	HP/Site N	HP/Site O	HP/Site P	HP/Site Q	HP/Site R
When your child joined this program, did he/she get a new personal doctor or nurse?																		
Yes	25.08	27.42	39.46	28.81	34.44	38.87	38.67	23.91	32.23	33.22	30.77	49.83	41.61	31.89	38.93	35.23	30.46	22.00
No	74.92	72.58	60.54	71.19	65.56	61.13	61.33	76.09	67.77	66.78	69.23	50.17	58.39	68.11	61.07	64.77	69.54	78.00
How much of a problem, if any, was it to get a personal doctor or nurse for your child you are happy with?																		
A big problem	9.46	8.54	10.26	3.45	3.92	17.09	2.59	9.86	8.25	7.07	7.61	10.74	10.66	5.26	10.43	2.86	3.26	0.00
A small problem	16.22	21.95	15.38	10.34	15.69	20.51	18.97	11.27	8.25	8.08	15.22	10.07	16.39	13.68	20.00	20.95	9.78	1.52
Not a problem	74.32	69.51	74.36	86.21	80.39	62.39	78.45	78.87	83.51	84.85	77.17	79.19	72.95	81.05	69.57	76.19	86.96	98.48
Do you have one person you think of as your child's personal doctor or nurse?																		
Yes	82.27	90.97	84.28	90.00	85.67	82.78	87.63	84.56	89.04	82.27	84.80	75.75	81.42	73.91	87.21	88.89	93.69	81.27
No	17.73	9.03	15.72	10.00	14.33	17.22	12.37	15.44	10.96	17.73	15.20	24.25	18.58	26.09	12.79	11.11	6.31	18.73
Is this person a general doctor, a pediatrician, a specialist doctor, a physician assistant, or a nurse?																		
General Doctor (Family practice or general pediatrician)	95.51	87.50	94.80	96.30	97.25	92.74	92.66	93.20	91.76	86.31	98.38	97.32	94.96	95.87	94.19	94.27	95.67	93.00
Specialist doctor	3.27	2.57	2.80	3.33	2.35	1.21	4.63	2.80	2.62	4.56	1.62	1.34	3.36	3.21	1.16	3.05	1.44	3.70
Physician assistant	0.82	6.99	1.60	0.37	0.39	2.02	1.16	2.80	4.87	4.98	0.00	0.45	0.84	0.46	3.88	1.91	1.44	2.47
Nurse	0.41	2.94	0.80	0.00	0.00	4.03	1.54	1.20	0.75	4.15	0.00	0.89	0.84	0.46	0.78	0.76	1.44	0.82
How many months or years has your child been going to his or her personal doctor or nurse?																		
Less than 6 months	6.97	3.72	5.22	7.58	5.51	10.48	6.98	6.83	3.77	5.79	8.40	15.25	7.53	7.94	8.66	8.56	5.36	6.61
6 up to 12 months	11.07	14.87	11.65	7.95	12.60	15.32	12.79	9.64	10.94	16.12	17.20	16.59	17.15	20.09	16.14	14.79	11.43	14.88
12 up to 24 months	23.36	20.07	32.53	20.83	35.43	35.48	32.56	21.29	21.13	22.73	19.60	26.46	33.47	25.23	25.20	28.02	24.29	17.36
2 up to 5 years	25.41	29.74	34.94	25.38	25.98	21.77	26.74	27.71	28.68	32.64	32.00	22.87	25.94	26.64	28.35	30.35	35.36	29.34
5 years or more	33.20	31.60	15.66	38.26	20.47	16.94	20.93	34.54	35.47	22.73	22.80	18.83	15.90	20.09	21.65	18.29	23.57	31.82

Table 2 continued. CAHPS - Your Child's Personal Doctor or Nurse

Questions	HP/Site A	HP/Site B	HP/Site C	HP/Site D	HP/Site E	HP/Site F	HP/Site G	HP/Site H	HP/Site I	HP/Site J	HP/Site K	HP/Site L	HP/Site M	HP/Site N	HP/Site O	HP/Site P	HP/Site Q	HP/Site R
Does your child have a physical, emotional, or mental condition that seriously <u>interferes with your child's ability to do the things</u> most children that age can do?																		
Yes	2.85	7.09	7.23	5.93	5.47	9.24	8.78	10.40	5.26	2.45	6.37	7.52	7.08	4.07	8.11	7.58	8.19	4.53
No	97.15	92.91	92.77	94.07	94.53	90.76	91.22	89.60	94.74	97.55	93.63	92.48	92.92	95.93	91.89	92.42	91.81	95.47
Does your child's personal doctor or nurse <u>understand how any health problems your child has affect his or her day-to-day life?</u>																		
Yes	100.00	88.89	81.25	100.00	92.86	76.19	95.65	88.46	92.86	80.00	93.33	94.12	76.47	88.89	95.00	95.00	95.65	90.91
No	0.00	11.11	18.75	0.00	7.14	23.81	4.35	11.54	7.14	20.00	6.67	5.88	23.53	11.11	5.00	5.00	4.35	9.09
Does your child's personal doctor or nurse understand <u>how any health problems your child has affect you and the family's day-to-day life?</u>																		
Yes	100.00	83.33	77.78	93.75	92.31	73.91	86.96	76.00	100.00	100.00	81.25	94.12	78.57	88.89	85.00	89.47	95.65	100.00
No	0.00	16.67	22.22	6.25	7.69	26.09	13.04	24.00	0.00	0.00	18.75	5.88	21.43	11.11	15.00	10.53	4.35	0.00
In the last 12 months, when your child went to his or her personal doctor or nurse's office or clinic, how often did the doctor or nurse talk with the about how our child is feeling, growing, or behaving?																		
Never	16.81	12.69	13.06	15.79	13.10	17.00	13.08	10.89	15.00	11.52	17.60	16.36	16.74	20.83	19.14	15.27	13.26	19.33
Sometimes	21.01	8.21	19.18	22.93	13.49	19.84	15.77	14.92	17.69	13.58	15.20	21.82	14.16	19.44	14.84	19.47	10.75	19.33
Usually	13.45	17.54	14.69	10.53	13.89	13.77	17.69	10.89	13.08	14.40	9.20	12.27	13.73	10.65	12.50	9.92	16.49	13.45
Always	48.74	61.57	53.06	50.75	59.52	49.39	53.46	63.31	54.23	60.49	58.00	49.55	55.36	49.07	53.52	55.34	59.50	47.90
How would you rate <u>your child's personal doctor or nurse?</u> (0 Worst to 10 Best)																		
Mean/Standard Deviation	8.91 ±1.46	9.11 ±1.41	8.74 ±1.81	9.20 ±1.42	8.96 ±1.73	8.62 ±1.77	8.96 ±1.44	9.18 ±1.31	9.05 ±1.43	9.08 ±1.34	9.08 ±1.28	8.60 ±2.00	8.82 ±1.69	8.95 ±1.50	8.80 ±1.72	8.97 ±1.53	9.28 ±1.24	9.05 ±1.37

Table 3. CAHPS – Getting Health Care From a Specialist

Questions	HP/Site A	HP/Site B	HP/Site C	HP/Site D	HP/Site E	HP/Site F	HP/Site G	HP/Site H	HP/Site I	HP/Site J	HP/Site K	HP/Site L	HP/Site M	HP/Site N	HP/Site O	HP/Site P	HP/Site Q	HP/Site R
In the last 12 months, did you or a doctor think your child needed to see a specialist?																		
Yes	19.73	26.67	25.58	27.57	30.46	24.50	29.14	24.33	25.33	21.00	24.00	25.50	26.76	23.33	25.42	26.33	27.15	21.33
No	80.27	73.33	74.42	72.43	69.54	75.50	70.86	75.67	74.67	79.00	76.00	74.50	73.24	76.67	74.58	73.67	72.85	78.67
In the last 12 months, how much of a problem, if any, was it to get a referral to a specialist that your child needed to see?																		
A big problem	10.17	6.25	11.84	6.02	4.55	22.54	5.81	4.23	2.63	9.52	15.28	12.16	20.25	12.86	14.47	6.49	2.47	6.25
A small problem	23.73	15.00	17.11	15.66	15.91	18.31	11.63	19.72	17.11	9.52	23.61	18.92	20.25	24.29	23.68	12.99	16.05	10.94
Not a problem	66.10	78.75	71.05	78.31	79.55	59.15	82.56	76.06	80.26	80.95	61.11	68.92	59.49	62.86	61.84	80.52	81.48	82.81
In the last 12 months, did your child see a specialist?																		
Yes	20.47	26.76	22.59	27.24	29.14	20.53	28.15	24.33	22.67	22.67	21.00	19.67	24.33	23.92	23.33	26.09	29.14	19.67
No	79.53	73.24	77.41	72.76	70.86	79.47	71.85	75.67	77.33	77.33	79.00	80.33	75.67	76.08	76.67	73.91	70.86	80.33
How would you rate your child's specialist?																		
(0 Worst to 10 Best)																		
Mean/Standard Deviation	8.90 ±1.30	8.64 ±1.96	8.94 ±1.72	8.72 ±2.26	8.94 ±1.96	8.48 ±1.94	9.14 ±1.15	8.89 ±1.86	9.22 ±1.44	9.06 ±1.53	8.58 ±2.80	9.07 ±1.46	8.82 ±2.11	8.87 ±1.90	8.71 ±2.10	8.66 ±1.89	8.95 ±1.45	9.00 ±1.61
In the last 12 months, was the specialist your child saw most often the same doctor as your child's personal doctor?																		
Yes	23.33	17.50	17.65	18.29	22.73	25.81	21.18	15.07	14.71	19.70	27.42	16.95	16.44	32.39	17.39	11.54	11.49	22.03
No	76.67	82.50	82.35	81.71	77.27	74.19	78.82	84.93	85.29	80.30	72.58	83.05	83.56	67.61	82.61	88.46	88.51	77.97

Table 4. CAHPS – Your Child's Health Care in the Last 12 Months

Questions	HP/Site A	HP/Site B	HP/Site C	HP/Site D	HP/Site E	HP/Site F	HP/Site G	HP/Site H	HP/Site I	HP/Site J	HP/Site K	HP/Site L	HP/Site M	HP/Site N	HP/Site O	HP/Site P	HP/Site Q	HP/Site R
In the last 12 months, did you call a doctor's office or clinic during regular office hours to get help or advice for your child?																		
Yes	34.45	46.00	49.50	37.75	43.71	37.75	53.82	53.33	43.33	40.80	32.89	34.11	33.56	26.91	46.67	42.95	48.84	24.75
No	65.55	54.00	50.50	62.25	56.29	62.25	46.18	46.67	56.67	59.20	67.11	65.89	66.44	73.09	53.33	57.05	51.16	75.25
In the last 12 months, when you called during regular office hours, how often did you get the help or advice you needed for your child?																		
Never	1.94	0.00	4.05	0.88	3.05	0.88	1.85	2.50	1.55	1.64	2.04	3.88	6.00	3.75	2.86	2.36	0.68	4.05
Sometimes	11.65	4.35	11.49	7.89	12.21	20.35	6.17	3.13	6.20	5.74	15.31	6.80	19.00	16.25	12.14	8.66	6.80	10.81
Usually	16.50	17.39	14.19	9.65	17.56	18.58	20.37	17.50	16.28	10.66	17.35	22.33	14.00	16.25	22.14	14.96	10.88	6.76
Always	69.90	78.26	70.27	81.58	67.18	60.18	71.60	76.88	75.97	81.97	65.31	66.99	61.00	63.75	62.86	74.02	81.63	78.38
In the last 12 months, did you make any appointments for your child with a doctor or other health care provider for regular or routine health care?																		
Yes	63.55	68.67	74.58	67.11	71.76	66.56	79.14	70.33	65.00	63.64	60.74	65.23	64.67	58.33	70.23	70.90	69.54	63.67
No	36.45	31.33	25.42	32.89	28.24	33.44	20.86	29.67	35.00	36.36	39.26	34.77	35.33	41.67	29.77	29.10	30.46	36.33
In the last 12 months, how often did your child get an appointment for regular or routine health care as soon as you wanted?																		
Never	4.26	0.49	2.73	0.99	0.93	3.02	1.68	0.95	1.04	1.59	1.12	3.55	4.15	2.29	1.91	1.42	0.95	2.11
Sometimes	15.43	4.90	9.09	19.80	14.81	10.05	12.61	8.06	6.25	6.88	13.41	16.24	22.28	18.86	11.48	12.26	6.67	16.84
Usually	22.34	16.18	20.91	17.33	16.67	23.12	25.21	19.43	20.83	20.11	16.20	23.35	16.06	24.00	22.01	11.79	14.76	17.37
Always	57.98	78.43	67.27	61.88	67.59	63.82	60.50	71.56	71.88	71.43	69.27	56.85	57.51	54.86	64.59	74.53	77.62	63.68

Table 4 continued. CAHPS – Your Child's Health Care in the Last 12 Months

Questions	HP/Site A	HP/Site B	HP/Site C	HP/Site D	HP/Site E	HP/Site F	HP/Site G	HP/Site H	HP/Site I	HP/Site J	HP/Site K	HP/Site L	HP/Site M	HP/Site N	HP/Site O	HP/Site P	HP/Site Q	HP/Site R
In the last 12 months, how many days did your child usually have to wait between making an appointment for <u>regular or routine care</u>, and actually seeing a provider?																		
Same day	33.87	49.25	33.18	44.22	39.25	42.64	27.54	43.00	51.03	47.83	44.94	30.26	38.74	16.18	36.23	41.43	52.15	60.43
1 day	20.97	22.39	23.04	25.13	20.56	21.32	24.58	20.77	24.74	22.28	23.03	19.49	19.37	20.81	19.81	22.38	22.49	18.72
2-3 days	17.74	15.42	19.35	16.58	22.90	19.80	22.88	17.39	13.40	15.22	16.85	24.10	16.23	26.59	24.15	21.90	13.88	11.23
4-7 days	9.14	7.96	13.82	11.56	9.35	9.64	11.86	10.63	5.67	7.61	7.30	12.31	8.38	16.76	13.04	8.57	8.13	4.28
8-14 days	6.45	2.99	5.99	1.51	4.67	2.03	3.81	3.38	3.61	3.80	3.93	9.74	6.81	9.25	2.90	3.81	2.39	2.14
15-30 days	8.06	1.49	1.84	1.01	1.87	3.55	4.66	2.42	1.55	2.72	1.12	1.03	6.81	6.36	2.90	0.95	0.48	2.14
31 days or longer	3.76	0.50	2.76	0.00	1.40	1.02	4.66	2.42	0.00	0.54	2.81	3.08	3.66	4.05	0.97	0.95	0.48	1.07
In the last 12 months, did your child have an <u>illness or injury</u> that needed care right away from a doctor's office, clinic, or emergency room?																		
Yes	31.33	40.13	37.21	25.83	32.12	35.10	35.12	39.67	37.21	33.44	23.33	32.12	30.77	23.26	33.00	38.33	39.80	28.33
No	68.67	59.87	62.79	74.17	67.88	64.90	64.88	60.33	62.79	66.56	76.67	67.88	69.23	76.74	67.00	61.67	60.20	71.67
In the last 12 months, when your child needed care right away for an <u>illness or injury</u>, how often did your child get care as soon as you wanted?																		
Never	2.13	0.00	4.46	5.13	2.06	4.72	1.94	0.00	0.89	1.00	2.86	7.22	3.30	2.86	4.12	3.51	2.52	3.53
Sometimes	11.70	4.20	8.93	8.97	12.37	9.43	8.74	6.78	0.89	4.00	7.14	13.40	12.09	8.57	9.28	4.39	5.04	9.41
Usually	11.70	10.92	15.18	8.97	16.49	11.32	10.68	7.63	9.82	15.00	11.43	11.34	13.19	18.57	15.46	11.40	12.61	8.24
Always	74.47	84.87	71.43	76.92	69.07	74.53	78.64	85.59	88.39	80.00	78.57	68.04	71.43	70.00	71.13	80.70	79.83	78.82

Appendix B - CAHPS Results by Health Plan/Site
April 2002
Texas CHIP

Table 4 continued. CAHPS – Your Child's Health Care in the Last 12 Months

Questions	HP/Site A	HP/Site B	HP/Site C	HP/Site D	HP/Site E	HP/Site F	HP/Site G	HP/Site H	HP/Site I	HP/Site J	HP/Site K	HP/Site L	HP/Site M	HP/Site N	HP/Site O	HP/Site P	HP/Site Q	HP/Site R
In the last 12 months, how <u>long</u> did your child usually have to wait between trying to get care and actually seeing a provider for an <u>illness or injury</u>?																		
Same day	73.12	84.75	73.39	81.58	70.10	73.33	71.43	84.62	83.04	82.00	84.29	70.53	71.26	68.12	67.68	75.44	78.81	85.88
1 day	17.20	9.32	11.93	11.84	17.53	15.24	15.24	8.55	11.61	11.00	11.43	11.58	10.34	13.04	18.18	13.16	12.71	7.06
2 days	5.38	3.39	5.50	2.63	7.22	5.71	7.62	5.98	3.57	4.00	0.00	9.47	5.75	5.80	8.08	6.14	2.54	1.18
3 days	2.15	0.00	5.50	1.32	0.00	0.95	3.81	0.00	0.89	0.00	1.43	1.05	4.60	5.80	2.02	1.75	0.85	0.00
4-7 days	1.08	0.85	1.83	2.63	5.15	2.86	0.95	0.00	0.00	2.00	2.86	4.21	3.45	1.45	1.01	3.51	4.24	4.71
8-14 days	1.08	0.85	0.00	0.00	0.00	0.00	0.00	0.00	0.89	1.00	0.00	0.00	0.00	0.00	1.01	0.00	0.85	0.00
15 days or longer	0.00	0.85	1.83	0.00	0.00	1.90	0.95	0.85	0.00	0.00	0.00	3.16	4.60	5.80	2.02	0.00	0.00	1.18
In the last 12 months, how many times did your child go to an <u>emergency room</u>? Mean/Standard Deviation	0.26 ±0.54	0.48 ±0.94	0.44 ±0.82	0.45 ±1.03	0.38 ±0.76	0.60 ±1.12	0.45 ±0.98	0.53 ±0.91	0.46 ±0.84	0.56 ±2.06	0.34 ±0.73	0.29 ±0.62	0.50 ±1.24	0.28 ±0.61	0.42 ±0.89	0.41 ±0.77	0.47 ±0.87	0.26 ±0.64
In the last 12 months, how many times did your child go to a <u>doctor's office or clinic</u>?																		
None	16.95	11.19	12.46	9.06	9.22	9.67	8.78	9.59	10.47	12.37	12.37	17.51	13.76	26.25	9.73	9.52	8.25	13.59
1	18.31	8.81	20.20	15.10	12.63	11.00	14.53	13.70	11.15	16.15	13.06	17.85	14.09	14.62	13.76	10.88	10.31	8.36
2	20.00	16.27	13.47	17.79	17.06	20.33	20.61	17.81	18.58	16.15	18.21	17.85	16.44	17.61	21.14	19.39	14.43	16.03
3	14.58	20.34	14.81	15.77	16.04	15.33	16.89	18.84	15.88	13.75	13.75	14.81	20.13	15.28	13.76	13.27	14.78	12.20
4	11.86	10.85	10.44	10.07	12.97	14.00	12.16	13.01	10.81	13.75	14.78	10.10	9.73	10.30	11.41	13.27	11.68	15.68
5 to 9	12.88	22.03	20.54	20.81	22.53	20.67	16.89	16.78	20.27	18.21	17.87	16.84	17.45	12.29	21.81	22.45	24.40	22.30
10 or more	5.42	10.51	8.08	11.41	9.56	9.00	10.14	10.27	12.84	9.62	9.97	5.05	8.39	3.65	8.39	11.22	16.15	11.85
In the last 12 months, how much of a problem, if any, was it to get care for your child that you or a doctor believed necessary?																		
A big problem	2.00	1.50	2.27	1.46	1.47	3.30	2.18	1.48	0.74	1.15	1.15	2.02	4.25	4.95	2.60	0.74	1.81	1.15
A small problem	9.60	6.39	10.98	10.58	15.02	13.55	8.00	7.38	6.67	5.73	13.74	12.50	10.04	12.16	9.29	8.82	6.14	12.26
Not a problem	88.40	92.11	86.74	87.96	83.52	83.15	89.82	91.14	92.59	93.13	85.11	85.48	85.71	82.88	88.10	90.44	92.06	86.59

Table 4 continued. CAHPS – Your Child's Health Care in the Last 12 Months

Questions	HP/Site A	HP/Site B	HP/Site C	HP/Site D	HP/Site E	HP/Site F	HP/Site G	HP/Site H	HP/Site I	HP/Site J	HP/Site K	HP/Site L	HP/Site M	HP/Site N	HP/Site O	HP/Site P	HP/Site Q	HP/Site R
In the last 12 months, how much of a problem, if any, were delays in your child's health care while you waited approval from your child's health plan?																		
A big problem	3.60	0.75	1.91	0.73	0.00	3.66	1.82	0.74	1.12	1.14	3.04	3.21	5.79	3.62	5.56	1.11	1.08	1.15
A small problem	6.80	3.38	8.40	4.74	7.72	11.36	5.82	5.58	5.58	3.80	10.27	8.43	10.42	10.41	9.26	6.64	4.68	7.28
Not a problem	89.60	95.86	89.69	94.53	92.28	84.98	92.36	93.68	93.31	95.06	86.69	88.35	83.78	85.97	85.19	92.25	94.24	91.57
In the last 12 months, how often did your child wait in the doctor's office or clinic more than 15 minutes past the appointment time to see the person your child went to see?																		
Never	16.60	32.45	34.22	21.61	23.64	23.42	26.91	28.68	18.96	32.06	30.53	19.03	22.09	19.46	18.73	26.59	25.63	24.03
Sometimes	30.36	44.91	37.64	34.43	38.55	34.20	40.73	43.01	41.64	39.69	36.26	42.51	39.92	37.10	38.20	41.95	47.29	44.19
Usually	18.22	9.81	10.65	15.38	13.09	17.84	12.00	11.76	17.47	11.07	8.02	11.74	10.85	11.76	14.61	12.36	10.11	11.24
Always	34.82	12.83	17.49	28.57	24.73	24.54	20.36	16.54	21.93	17.18	25.19	26.72	27.13	31.67	28.46	19.10	16.97	20.54
In the last 12 months, how often office staff at your child's doctor's office or clinic treat you and your child with courtesy and respect?																		
Never	2.83	0.00	1.52	3.27	2.21	2.57	2.18	1.11	0.37	1.52	5.34	2.40	5.06	3.62	1.85	1.10	1.08	1.92
Sometimes	5.67	3.00	4.17	6.55	5.88	9.93	3.27	3.33	7.43	3.41	7.25	9.60	8.56	3.62	6.64	4.78	4.32	4.21
Usually	14.57	8.61	10.61	10.18	9.93	12.87	10.55	8.89	10.04	7.95	7.63	10.00	10.89	13.12	14.76	8.82	9.71	9.20
Always	76.92	88.39	83.71	80.00	81.99	74.63	84.00	86.67	82.16	87.12	79.77	78.00	75.49	79.64	76.75	85.29	84.89	84.67
In the last 12 months, how often office staff at your child's doctor's office or clinic as helpful as you thought they should be?																		
Never	2.43	1.12	1.14	2.91	1.83	2.57	1.82	1.47	0.37	2.27	3.80	4.03	3.86	1.81	2.58	1.84	1.44	1.92
Sometimes	11.34	5.24	10.61	9.82	11.36	14.34	6.18	6.99	8.21	6.06	12.55	13.31	13.51	9.05	12.55	7.35	6.14	11.11
Usually	19.03	15.73	12.88	13.45	13.92	18.75	16.36	16.54	17.54	14.39	12.17	15.73	15.06	17.19	17.71	14.71	19.86	13.79
Always	67.21	77.90	75.38	73.82	72.89	64.34	75.64	75.00	73.88	77.27	71.48	66.94	67.57	71.95	67.16	76.10	72.56	73.18

Table 4 continued. CAHPS – Your Child's Health Care in the Last 12 Months

Questions	HP/Site A	HP/Site B	HP/Site C	HP/Site D	HP/Site E	HP/Site F	HP/Site G	HP/Site H	HP/Site I	HP/Site J	HP/Site K	HP/Site L	HP/Site M	HP/Site N	HP/Site O	HP/Site P	HP/Site Q	HP/Site R
In the last 12 months, how often did your child's doctor or health care providers listen carefully to you?																		
Never	1.61	1.50	0.38	1.82	0.73	1.10	0.36	1.84	0.00	0.38	1.52	1.20	1.93	1.81	2.21	1.10	0.72	0.77
Sometimes	8.87	4.49	6.44	5.82	8.39	8.79	3.26	3.68	4.83	4.96	11.36	11.60	9.27	2.26	6.27	5.88	5.04	3.46
Usually	13.31	11.99	14.77	10.91	8.76	16.12	15.58	12.87	13.75	12.98	12.12	10.80	12.74	16.74	16.24	11.40	10.07	11.15
Always	76.21	82.02	78.41	81.45	82.12	73.99	80.80	81.62	81.41	81.68	75.00	76.40	76.06	79.19	75.28	81.62	84.17	84.62
In the last 12 months, how often did you have a hard time speaking with or understanding your child's doctors or other health care providers because you spoke different languages?																		
Never	91.13	89.14	89.39	90.91	85.09	83.09	88.77	94.10	85.93	89.39	79.92	89.96	79.92	85.59	92.62	86.03	89.93	89.66
Sometimes	5.65	5.99	7.58	50.9	9.45	11.40	7.25	3.69	10.37	6.44	12.50	6.02	13.90	8.56	5.09	9.93	7.55	6.13
Usually	1.21	0.37	2.27	0.73	1.82	1.84	1.09	0.37	1.48	1.14	1.89	1.61	1.93	2.70	1.11	1.84	1.08	1.15
Always	2.02	4.49	0.76	3.27	3.64	3.68	2.90	1.85	2.22	3.03	5.68	2.41	4.25	3.15	0.37	2.21	1.44	3.07
In the last 12 months, how often did your child have a hard time speaking with or understanding your child's doctors or other health care providers because you spoke different languages?																		
Never	93.55	89.81	92.75	93.04	89.01	83.76	91.27	95.57	86.57	90.80	84.73	93.60	83.20	87.78	91.45	85.93	89.49	93.08
Sometimes	4.44	6.42	4.20	4.76	8.42	10.70	5.82	2.95	8.58	7.28	10.69	4.00	12.50	9.05	7.06	10.74	7.61	5.00
Usually	0.40	1.13	1.53	0.37	1.10	1.85	0.73	0.74	1.87	0.77	1.53	0.40	1.95	1.81	1.49	0.74	0.72	0.77
Always	1.61	2.64	1.53	1.83	1.47	3.69	2.18	0.74	2.99	1.15	3.05	2.00	2.34	1.36	0.00	2.59	2.17	1.15
In the last 12 months, how often did your child's doctor or health care providers explain things in a way you could understand?																		
Never	8.03	4.12	4.92	9.49	6.55	4.41	5.07	4.41	5.93	4.18	9.47	6.00	7.72	8.60	3.69	3.68	3.24	6.92
Sometimes	7.63	4.49	6.82	7.30	8.00	8.46	5.43	2.57	4.81	3.04	8.71	8.00	7.34	4.52	6.64	4.04	5.04	4.23
Usually	7.63	9.74	9.47	6.93	9.09	9.56	9.78	10.29	15.19	12.17	8.71	11.60	9.27	12.22	11.81	11.76	8.63	9.62
Always	76.71	81.65	78.79	76.28	76.36	77.57	79.71	82.72	74.07	80.61	73.11	74.40	75.68	74.66	77.86	80.51	83.09	79.23

Table 4 continued. CAHPS – Your Child's Health Care in the Last 12 Months

Questions	HP/Site A	HP/Site B	HP/Site C	HP/Site D	HP/Site E	HP/Site F	HP/Site G	HP/Site H	HP/Site I	HP/Site J	HP/Site K	HP/Site L	HP/Site M	HP/Site N	HP/Site O	HP/Site P	HP/Site Q	HP/Site R
In the last 12 months, have any of your child's doctors or other health care providers talked with you about the <u>skills you need </u>to take care of your child?																		
Yes	53.44	55.30	57.47	66.06	55.51	53.16	50.91	52.06	58.43	54.41	54.02	56.22	51.76	57.99	51.69	53.53	59.64	57.47
No	46.56	44.70	42.53	33.94	44.49	46.84	49.09	47.94	41.57	45.59	45.98	43.78	48.24	42.01	48.31	46.47	40.36	42.53
In the last 12 months, have any of your child's doctors or other health care providers given you <u>reassurance and support</u> about the care you are providing for your child?																		
Yes	72.54	82.33	76.36	81.62	75.55	71.27	81.32	77.70	78.73	80.69	72.87	76.11	72.87	78.64	77.61	74.44	84.36	82.31
No	27.46	17.67	23.64	18.38	24.45	28.73	18.68	22.30	21.27	19.31	27.13	23.89	27.13	21.36	22.39	25.56	15.64	17.69
In the last 12 months, have any of your child's doctors or other health care providers had <u>respect for what you had to say?</u>																		
Never	5.24	1.87	0.77	4.00	4.36	4.06	2.54	2.57	2.96	1.14	5.68	4.02	4.65	3.64	2.99	1.10	0.72	0.77
Sometimes	6.45	4.49	5.75	6.91	6.18	10.33	3.62	4.04	5.56	5.30	7.95	7.23	10.47	6.36	7.84	6.62	4.32	5.00
Usually	10.48	16.10	16.09	4.73	11.27	15.87	11.96	15.07	16.30	11.74	10.23	14.06	12.40	11.82	15.30	11.76	8.99	9.62
Always	77.82	77.53	77.39	84.36	78.18	69.74	81.88	78.31	75.19	81.82	76.14	74.70	72.48	78.18	73.88	80.51	85.97	84.62
Is your child old enough to talk with doctors about his or her health care?																		
Yes	73.90	82.40	76.14	72.36	63.50	74.63	76.36	81.25	87.78	82.58	61.74	86.35	67.05	79.73	81.18	78.81	80.94	79.54
No	26.10	17.60	23.86	27.64	36.50	25.37	23.64	18.75	12.22	17.42	38.26	13.65	32.95	20.27	18.82	21.19	19.06	20.46

Table 4 continued. CAHPS – Your Child's Health Care in the Last 12 Months

Questions	HP/Site A	HP/Site B	HP/Site C	HP/Site D	HP/Site E	HP/Site F	HP/Site G	HP/Site H	HP/Site I	HP/Site J	HP/Site K	HP/Site L	HP/Site M	HP/Site N	HP/Site O	HP/Site P	HP/Site Q	HP/Site R
In the last 12 months how often did doctors or other health care providers explain things in a way your child could understand?																		
Never	4.42	0.91	2.00	0.50	4.02	3.00	2.87	0.91	1.27	0.92	1.85	2.79	5.85	3.41	4.57	2.84	2.22	0.00
Sometimes	9.94	7.73	9.00	7.04	11.49	9.50	9.57	8.64	8.47	6.42	14.81	12.56	9.36	8.52	9.59	9.48	6.22	8.78
Usually	11.60	18.64	14.00	11.56	13.22	19.50	12.92	14.55	20.76	15.60	13.58	16.28	18.71	14.20	15.98	18.48	14.22	15.61
Always	74.03	72.73	75.00	80.90	71.26	68.00	74.64	75.91	69.49	77.06	69.75	68.37	66.08	73.86	69.86	69.19	77.33	75.61
In the last 12 months how often did doctors or other health care providers spend enough time with your child?																		
Never	6.07	1.12	2.27	4.74	4.40	5.51	1.09	2.21	3.72	1.52	4.18	4.40	5.47	4.07	2.21	4.04	1.44	2.71
Sometimes	14.98	7.49	12.12	15.69	9.89	15.44	10.51	11.03	13.75	5.70	21.29	18.00	18.36	14.48	16.61	11.03	9.71	13.95
Usually	23.48	21.35	19.32	15.33	19.778	19.85	21.01	22.79	26.39	20.91	15.97	15.60	16.41	19.91	20.66	19.49	19.06	16.67
Always	55.47	70.04	66.29	64.23	65.93	59.19	67.39	63.97	56.13	71.86	58.56	62.00	59.77	61.54	60.52	65.44	69.78	66.67
In the last 12 months were any decisions made about your child's health care?																		
Yes	40.16	54.79	44.57	38.46	42.34	38.43	46.49	53.23	52.65	43.85	38.85	47.18	40.47	42.33	41.22	50.00	53.85	40.86
No	59.84	45.21	55.43	61.54	57.66	61.57	53.51	46.77	47.35	56.15	61.15	52.82	59.53	57.67	58.78	50.00	46.15	59.14
In the last 12 months, how often were you involved as much as your wanted in these decisions about your child's health care?																		
Never	1.02	0.70	0.00	0.00	1.72	0.97	1.59	0.71	0.72	0.88	0.99	0.85	1.92	0.00	0.00	0.00	0.68	0.00
Sometimes	3.06	0.70	2.61	4.76	6.03	4.85	1.59	2.86	2.16	2.63	7.92	1.71	6.73	6.59	3.70	4.55	2.72	5.71
Usually	5.10	5.59	9.57	5.71	5.17	9.71	5.56	5.00	7.91	6.14	6.93	8.55	7.69	9.89	2.78	5.30	5.44	2.86
Always	90.82	93.01	87.83	89.52	87.07	84.47	91.27	91.43	89.21	90.35	84.16	88.89	83.65	83.52	93.52	90.15	91.16	91.43

Table 4 continued. CAHPS – Your Child's Health Care in the Last 12 Months

Questions	HP/Site A	HP/Site B	HP/Site C	HP/Site D	HP/Site E	HP/Site F	HP/Site G	HP/Site H	HP/Site I	HP/Site J	HP/Site K	HP/Site L	HP/Site M	HP/Site N	HP/Site O	HP/Site P	HP/Site Q	HP/Site R
In the last 12 months, how much of a problem, if any, was it to get your child's doctor or other health care provider to <u>agree with you</u> on the best way to manage your child's health conditions or problems?																		
A big problem	2.04	0.70	0.87	1.90	0.00	0.97	0.79	0.00	0.72	1.75	3.96	0.85	3.85	0.00	2.78	1.52	1.36	0.00
A small problem	11.22	7.69	9.57	6.67	13.79	11.65	9.52	7.86	3.60	4.39	12.87	11.11	13.46	5.56	9.26	7.58	1.36	2.86
Not a problem	86.73	91.61	89.57	91.43	86.21	87.38	89.68	92.14	95.68	93.86	83.17	88.03	82.69	94.44	87.96	90.91	97.28	97.14
Is your child enrolled in any kind of school?																		
Yes	89.20	85.02	85.23	90.18	84.31	86.08	85.87	85.29	89.63	88.26	82.20	90.80	82.24	89.64	87.82	87.87	89.21	92.34
No	10.80	14.98	14.77	9.82	15.69	13.92	14.13	14.71	10.37	11.74	17.80	9.20	17.76	10.36	12.18	12.13	10.79	7.66
Does your child have health care needs that require any <u>special help</u> from teachers, nurses, or staff at your child's school?																		
Yes	8.52	15.86	17.04	8.87	11.74	14.53	14.41	15.15	10.42	12.93	7.87	17.70	17.54	8.04	15.55	10.04	17.41	4.98
No	91.48	84.14	82.96	91.13	88.26	85.47	85.59	84.85	89.58	87.07	92.13	82.30	82.46	91.96	84.45	89.96	82.59	95.02
In the last 12 months, have any of your child's doctors or other health providers helped <u>let the school know</u> about these needs?																		
Yes	88.89	52.78	52.78	66.67	66.67	60.61	57.58	57.58	64.00	60.00	58.82	62.50	44.44	56.25	70.27	62.50	51.22	63.64
No	11.11	47.22	47.22	33.33	33.33	39.39	42.42	42.42	36.00	40.00	41.18	37.50	55.56	43.75	29.73	37.50	48.78	36.36
How would you rate your child's health care?																		
(0 Worst to 10 Best)																		
Mean/Standard Deviation	9.08 ±1.27	9.17 ±1.29	8.97 ±1.32	9.38 ±1.18	9.06 ±1.50	8.85 ±1.42	9.07 ±1.41	9.13 ±1.24	9.25 ±1.10	9.18 ±1.22	9.10 ±1.37	8.81 ±1.74	8.95 ±1.55	9.08 ±1.27	8.81 ±1.56	9.18 ±1.16	9.27 ±1.14	9.37 ±0.94

Table 5. CAHPS – Interpreter Services

Questions	HP/Site A	HP/Site B	HP/Site C	HP/Site D	HP/Site E	HP/Site F	HP/Site G	HP/Site H	HP/Site I	HP/Site J	HP/Site K	HP/Site L	HP/Site M	HP/Site N	HP/Site O	HP/Site P	HP/Site Q	HP/Site R
In the last 12 months, did you need an interpreter to speak with your child's doctors or other health providers?																		
Yes	4.33	1.33	2.33	4.30	6.29	7.95	5.63	2.33	2.00	3.33	9.00	1.32	7.67	6.31	2.00	4.00	1.99	3.67
No	95.67	98.67	97.67	95.70	93.71	92.05	94.37	97.67	98.00	96.67	91.00	98.68	92.33	93.69	98.00	96.00	98.01	96.33
In the last 12 months, when you needed an interpreter to help you speak with your child's doctors or other health providers, how often did you get one?																		
Never	0.00	0.00	0.00	0.00	5.26	4.17	12.50	0.00	0.00	0.00	3.70	0.00	0.00	5.26	0.00	0.00	0.00	18.18
Sometimes	30.77	25.00	14.29	23.08	26.32	16.67	18.75	28.57	16.67	30.00	37.04	0.00	34.78	31.58	33.33	33.33	16.67	9.09
Usually	7.69	0.00	14.29	0.00	5.26	12.50	6.25	0.00	16.67	10.00	14.81	25.00	8.70	0.00	16.67	0.00	16.67	0.00
Always	61.54	75.00	71.43	76.92	63.16	66.67	62.50	71.43	66.67	60.00	44.44	75.00	56.52	63.16	50.00	66.67	66.67	72.73
In the last 12 months, did your child need an interpreter to help him or her speak with doctors or other health providers?																		
Yes	2.34	1.67	1.33	0.66	3.31	3.64	1.99	1.33	1.00	2.34	3.33	0.00	3.67	1.00	0.00	3.33	0.00	0.67
No	97.66	98.33	98.67	99.34	96.69	96.36	98.01	98.67	99.00	97.66	96.67	100.00	96.33	99.00	100.00	96.67	100.00	99.33
In the last 12 months, when your child needed an interpreter to help him or her speak with doctors or other health providers, how often did he or she get one?																		
Never	14.29	0.00	25.00	0.00	0.00	0.00	16.67	0.00	0.00	0.00	10.00	0.00	0.00	0.00	0.00	10.00	0.00	50.00
Sometimes	14.29	20.00	0.00	0.00	10.00	9.09	16.67	0.00	0.00	14.29	30.00	0.00	36.36	0.00	0.00	10.00	0.00	0.00
Usually	0.00	0.00	0.00	0.00	10.00	0.00	0.00	25.00	0.00	14.29	30.00	0.00	0.00	0.00	0.00	10.00	0.00	0.00
Always	71.43	80.00	75.00	100.00	80.00	90.91	66.67	75.00	100.00	71.43	30.00	0.00	63.64	100.00	0.00	70.00	0.00	50.00

Table 5 continued. CAHPS – Interpreter Services

Questions	HP/Site A	HP/Site B	HP/Site C	HP/Site D	HP/Site E	HP/Site F	HP/Site G	HP/Site H	HP/Site I	HP/Site J	HP/Site K	HP/Site L	HP/Site M	HP/Site N	HP/Site O	HP/Site P	HP/Site Q	HP/Site R
What language do you <u>mainly</u> speak at home?																		
English	54.00	96.33	82.39	36.42	61.92	72.19	78.48	90.67	94.02	86.67	52.51	78.81	67.33	42.19	86.96	74.33	90.07	50.00
Spanish	42.67	3.00	13.62	58.28	29.80	24.83	15.89	8.00	5.98	10.33	42.14	15.89	26.33	55.15	10.37	21.67	8.28	45.00
Vietnamese	0.00	0.00	0.00	0.00	0.66	0.00	0.00	0.00	0.00	0.00	0.33	0.00	0.67	0.00	0.00	1.00	0.00	0.00
Other	3.33	0.67	3.99	5.30	7.62	2.98	5.63	1.33	0.00	3.00	5.02	5.30	5.67	2.66	2.68	3.00	1.66	5.00
What language does your child <u>mainly</u> speak at home?																		
English	64.67	96.67	86.67	51.99	69.21	77.81	83.11	92.33	96.33	93.00	59.33	87.09	75.00	53.82	92.33	81.67	94.68	65.33
Spanish	32.67	2.00	10.33	44.04	22.52	18.87	12.58	6.00	2.67	5.00	36.00	10.26	21.00	40.53	5.67	15.00	3.99	31.67
Vietnamese	0.00	0.00	0.00	0.00	0.66	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.33	0.00	0.00	1.00	0.00	0.00
Other	2.67	1.33	3.00	3.97	7.62	3.31	4.30	1.67	1.00	2.00	4.67	2.65	3.67	5.65	2.00	2.33	1.33	3.00

Table 6. CAHPS Dental Services

Questions	HP/Site A	HP/Site B	HP/Site C	HP/Site D	HP/Site E	HP/Site F	HP/Site G	HP/Site H	HP/Site I	HP/Site J	HP/Site K	HP/Site L	HP/Site M	HP/Site N	HP/Site O	HP/Site P	HP/Site Q	HP/Site R
In the last 12 months, did your child get care from a dentist's office or dental clinic?																		
Yes	63.55	63.88	61.54	61.26	71.76	63.79	61.92	62.33	63.00	58.33	62.54	69.77	63.55	56.48	71.91	62.08	59.20	67.68
No	36.45	36.12	38.46	38.74	28.24	36.21	38.08	37.67	37.00	41.67	37.46	30.23	36.45	43.52	28.09	37.92	40.80	32.32
In the last 12 months, how many times did your child go to a dentist's office or dental clinic?																		
None	2.12	0.52	0.00	0.54	0.46	0.52	1.08	1.07	0.00	0.57	0.53	0.48	0.53	0.59	0.00	0.00	0.57	0.00
1	47.09	36.13	55.49	46.20	41.20	41.36	40.86	42.25	45.50	35.43	39.57	36.84	39.68	36.69	45.58	48.37	43.75	51.00
2	29.0	37.17	28.02	28.26	38.89	30.37	29.57	30.48	36.51	38.86	37.43	41.63	34.39	36.69	28.37	30.98	28.41	29.00
3	7.94	17.28	8.79	12.50	10.65	15.18	16.67	15.51	8.47	11.43	10.70	11.00	8.99	11.83	10.23	8.15	11.93	13.00
4	5.29	3.14	3.85	5.98	3.24	4.19	3.76	3.74	4.76	5.71	6.95	4.78	3.17	5.33	9.77	7.61	5.68	2.50
5-9	5.82	4.19	2.75	5.43	4.17	7.33	6.99	4.81	3.17	5.71	3.74	4.31	8.47	4.73	4.19	3.26	6.82	2.50
10 or more	2.65	1.57	1.10	1.09	1.39	1.05	1.08	2.14	1.59	2.29	1.07	0.96	4.76	4.14	1.86	1.63	2.84	2.00
How would you rate your child's dental care?																		
(0 Worst to 10 Best)																		
Mean/Standard Deviation	8.38 ±2.28	8.98 ±1.53	8.62 ±1.98	9.10 ±1.51	8.75 ±1.90	8.58 ±2.16	8.48 ±2.27	8.39 ±2.42	8.94 ±1.69	8.97 ±1.68	8.74 ±2.04	8.86 ±1.87	8.34 ±2.50	8.62 ±1.91	8.74 ±1.77	8.76 ±1.81	8.62 ±1.88	8.84 ±1.85

Table 7. CAHPS - Special Needs and Services

Questions	HP/Site A	HP/Site B	HP/Site C	HP/Site D	HP/Site E	HP/Site F	HP/Site G	HP/Site H	HP/Site I	HP/Site J	HP/Site K	HP/Site L	HP/Site M	HP/Site N	HP/Site O	HP/Site P	HP/Site Q	HP/Site R
In the last 12 months, did your child have any health problems that required you to get or replace <u>any special medical equipment</u> or devices such as a walker, wheelchair, nebulizer, feeding tubes, or oxygen equipment?																		
Yes	4.67	4.68	4.65	4.97	5.96	2.32	3.64	3.33	5.67	4.33	4.33	3.31	4.00	2.66	3.67	5.67	4.64	3.00
No	95.33	95.32	95.35	95.03	94.04	97.68	96.36	96.67	94.33	95.67	95.67	96.69	96.00	97.34	96.33	94.33	95.36	97.00
In the last 12 months, how much of a problem, if any, was it to get the <u>special medical equipment</u> your child needed through your child's health plan?																		
A big problem	7.69	7.14	0.00	6.67	5.56	14.29	0.00	11.11	0.00	0.00	15.38	20.00	25.00	0.00	10.00	5.88	0.00	11.11
A small problem	15.38	0.00	30.77	13.33	5.56	0.00	0.00	22.22	5.88	7.69	23.08	30.00	0.00	12.50	20.00	17.65	7.14	0.00
Not a problem	76.92	92.86	69.23	80.00	88.89	85.71	100.00	66.67	94.12	92.31	61.54	50.00	75.00	87.50	70.00	76.47	92.86	88.89
In the last 12 months, did your child have any health problems that needed <u>special therapy</u>, such as physical, occupational, or speech therapy?																		
Yes	2.33	4.38	5.98	4.30	4.64	2.66	4.30	5.33	5.98	3.00	2.00	2.99	5.67	1.99	6.67	3.67	5.30	2.67
No	97.67	95.62	94.02	95.70	95.36	97.34	95.70	94.67	94.02	97.00	98.00	97.01	94.33	98.01	93.33	96.33	94.70	97.33
In the last 12 months, how much of a problem, if any, was it to get the <u>therapy</u> your child needed through your child's health plan?																		
A big problem	28.57	16.67	11.76	0.00	7.69	25.00	8.33	8.33	5.88	0.00	0.00	0.00	7.14	0.00	11.76	0.00	16.67	0.00
A small problem	42.86	16.67	11.76	7.69	7.69	12.50	8.33	16.67	5.88	0.00	0.00	0.00	14.29	0.00	0.00	9.09	0.00	0.00
Not a problem	28.57	66.67	76.47	92.31	84.62	62.50	83.33	75.00	88.24	100.00	100.00	100.00	78.57	100.00	88.24	90.91	83.33	100.00
In the last 12 months, has your child needed home health care services?																		
Yes	0.00	0.00	0.00	0.33	0.00	0.00	0.33	0.00	0.33	0.00	0.00	0.00	0.33	0.00	0.33	0.00	0.33	0.00
No	100.00	100.00	100.00	99.67	100.00	100.00	99.67	100.00	99.67	100.00	100.00	100.00	99.67	100.00	99.67	100.00	99.67	100.00

Table 7 continued. CAHPS - Special Needs and Services

Questions	HP/Site A	HP/Site B	HP/Site C	HP/Site D	HP/Site E	HP/Site F	HP/Site G	HP/Site H	HP/Site I	HP/Site J	HP/Site K	HP/Site L	HP/Site M	HP/Site N	HP/Site O	HP/Site P	HP/Site Q	HP/Site R
In the last 12 months, how much of a problem, if any, was it to get these <u>home health services</u> for your child through your child's health plan?																		
A big problem	0.00	0.00	0.00	100.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
A small problem	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100.00	0.00	0.00	0.00	0.00	0.00
Not a problem	0.00	0.00	0.00	0.00	0.00	0.00	100.00	0.00	100.00	0.00	0.00	0.00	0.00	0.00	100.00	0.00	100.00	0.00
In the past 12 months, did you need respite services for your child?																		
Yes	0.00	0.00	1.66	1.33	1.33	0.66	0.66	1.00	1.00	0.33	0.67	0.99	1.33	1.00	1.00	0.00	0.33	0.67
No	100.00	100.00	98.34	98.67	98.67	99.34	99.34	99.00	99.00	99.67	99.33	99.01	98.67	99.00	99.00	100.00	99.67	99.33
In the last 12 months, how much of a problem, if any, was it to get these <u>respite services</u> through your child's health plan?																		
A big problem	0.00	0.00	50.00	25.00	0.00	0.00	100.00	0.00	0.00	0.00	0.00	0.00	25.00	0.00	0.00	0.00	100.00	0.00
A small problem	0.00	0.00	25.00	0.00	25.00	0.00	0.00	0.00	0.00	0.00	0.00	33.33	0.00	50.00	0.00	0.00	0.00	50.00
Not a problem	0.00	0.00	25.00	75.00	75.00	100.00	0.00	100.00	100.00	0.00	100.00	66.67	75.00	50.00	100.00	0.00	0.00	50.00
How would you rate your health plan <u>now</u> regarding equipment and services?																		
(0 Worst to 10 Best)																		
Mean/Standard Deviation	9.18 ±1.36	9.29 ±1.38	9.11 1.48	9.55 ±1.02	9.25 ±1.53	8.95 ±1.72	9.26 ±1.31	9.26 ±1.41	9.39 ±1.16	9.33 ±1.39	9.40 ±1.16	9.07 ±1.48	9.16 ±1.40	9.28 ±1.31	9.06 ±1.47	9.41 ±1.23	9.27 ±1.36	9.46 ±1.10
Does your child have any kind of emotional, developmental, or behavior difficulty now for which he or she has received <u>treatment or counseling</u>?																		
Yes	2.33	8.70	7.33	4.30	6.98	7.62	12.91	8.70	8.31	4.00	5.35	7.95	4.35	2.99	10.00	10.67	7.02	2.68
No	97.67	91.30	92.67	95.70	93.02	92.38	87.09	91.30	91.69	96.00	94.65	92.05	95.65	97.01	90.00	89.33	92.98	97.32

Table 7 continued. CAHPS - Special Needs and Services

Questions	HP/Site A	HP/Site B	HP/Site C	HP/Site D	HP/Site E	HP/Site F	HP/Site G	HP/Site H	HP/Site I	HP/Site J	HP/Site K	HP/Site L	HP/Site M	HP/Site N	HP/Site O	HP/Site P	HP/Site Q	HP/Site R
In the last 12 months, did your child have any <u>treatment or counseling</u> for an emotional, development, or behavior difficulty?																		
Yes	2.33	9.06	7.97	3.99	6.31	8.28	12.25	9.03	7.67	4.68	5.02	5.63	4.68	3.65	10.33	11.67	7.31	3.00
No	97.67	90.94	92.03	96.01	93.69	91.72	87.75	90.97	92.33	95.32	94.98	94.37	95.32	96.35	89.67	88.33	92.69	97.00
In the past 12 months, how much of a problem, if any, was it to get this <u>treatment or counseling</u> through your child's health plan?																		
A big problem	14.29	3.70	9.52	0.00	0.00	13.04	11.43	8.00	17.39	7.14	20.00	5.88	35.71	10.00	3.45	5.71	5.26	0.00
A small problem	0.00	11.11	9.52	27.27	22.22	30.43	17.14	8.00	8.70	0.00	13.33	5.88	7.14	10.00	20.69	2.86	10.53	11.11
Not a problem	85.71	85.19	80.95	72.73	77.78	56.52	71.43	84.00	73.91	92.86	66.67	88.24	57.14	80.00	75.86	91.43	84.21	88.89
How would you rate your child's treatment or counseling <u>now</u>?																		
(0 Worst to 10 Best)																		
Mean/Standard Deviation	8.14 ±1.95	8.42 ±2.30	7.59 ±2.44	8.67 ±1.50	8.72 ±2.24	9.04 ±1.58	8.22 ±1.99	8.65 ±1.79	7.82 ±2.57	9.21 ±1.42	8.14 ±2.35	8.47 ±2.53	8.46 ±2.03	8.36 ±3.01	8.04 ±2.70	8.11 ±2.62	8.62 ±2.33	7.56 ±3.28

Table 8. CAHPS – Your Child's Health Plan

Questions	HP/Site A	HP/Site B	HP/Site C	HP/Site D	HP/Site E	HP/Site F	HP/Site G	HP/Site H	HP/Site I	HP/Site J	HP/Site K	HP/Site L	HP/Site M	HP/Site N	HP/Site O	HP/Site P	HP/Site Q	HP/Site R
In the last 12 months, did you look for any <u>information in written materials</u> from your child's health plan?																		
Yes	38.33	38.72	35.12	32.12	40.20	37.75	38.74	42.91	33.22	29.10	32.78	37.09	31.21	39.20	34.45	37.92	35.00	26.67
No	61.67	61.28	64.88	67.88	59.80	62.25	61.26	57.09	66.78	70.90	67.22	62.91	68.79	60.80	65.55	62.08	65.00	73.33
In the last 12 months, how much of a problem, if any, was it to find or understand information in the written materials?																		
A big problem	2.61	5.22	4.76	0.00	1.65	2.63	2.59	3.15	2.00	1.15	4.08	0.89	4.30	4.24	6.80	1.77	0.95	2.50
A small problem	17.39	17.39	18.10	14.43	19.83	24.56	19.83	12.60	15.00	18.39	11.22	17.86	19.35	12.71	5.83	8.85	15.24	11.25
Not a problem	80.00	77.39	77.14	85.57	78.51	72.81	77.59	84.25	83.00	80.46	84.69	81.25	76.34	83.05	87.38	89.38	83.81	86.25
In the last 12 months, did you call the health plan's <u>customer service</u> to get information or help for your child?																		
Yes	39.46	40.94	45.18	26.67	42.05	52.33	44.04	43.58	31.44	35.12	40.13	38.87	43.14	42.52	44.67	42.14	38.67	24.75
No	60.54	59.06	54.82	73.33	57.95	47.67	55.96	56.42	68.56	64.88	59.87	61.13	56.86	57.48	55.33	57.86	61.33	75.25
In the last 12 months, how much of a problem, if any, was it get the help you needed when you called your child's health plan's customer service?																		
A big problem	11.86	9.02	10.29	1.25	5.56	9.62	6.02	4.69	8.51	4.76	7.50	9.40	10.08	8.59	7.52	5.56	4.31	5.41
A small problem	22.88	16.39	14.71	6.25	16.67	21.79	17.29	15.63	18.09	15.24	15.83	15.38	20.16	10.16	16.54	14.29	14.66	16.22
Not a problem	65.25	74.59	75.00	92.50	77.78	68.59	76.69	79.69	73.40	80.00	76.67	75.21	69.77	81.25	75.94	80.16	81.03	78.38
In the last 12 months, did you have any experiences with paperwork for your child's health plan?																		
Yes	30.54	34.78	29.90	22.00	28.48	33.55	40.00	27.36	20.81	29.10	26.33	32.33	30.67	26.91	33.89	37.46	33.67	19.33
No	69.46	65.22	70.10	78.00	71.52	66.45	60.00	72.64	79.19	70.90	73.67	67.67	69.33	73.09	66.11	62.54	66.33	80.67

Table 8 continued. CAHPS – Your Child's Health Plan

Questions	HP/Site A	HP/Site B	HP/Site C	HP/Site D	HP/Site E	HP/Site F	HP/Site G	HP/Site H	HP/Site I	HP/Site J	HP/Site K	HP/Site L	HP/Site M	HP/Site N	HP/Site O	HP/Site P	HP/Site Q	HP/Site R
In the last 12 months, how much of a problem, if any, did you have with paperwork for your child's health plan?																		
A big problem	6.59	12.50	8.89	1.52	5.81	12.87	6.67	4.94	9.68	8.05	7.59	9.28	6.52	15.00	8.91	5.36	5.94	3.45
A small problem	24.18	17.31	18.89	18.18	15.12	36.63	17.50	24.69	17.74	19.54	20.25	23.71	25.00	22.50	23.76	15.18	18.81	17.24
Not a problem	69.23	70.19	72.22	80.30	79.07	50.50	75.83	70.37	72.58	72.41	72.15	67.01	68.48	62.50	67.33	79.46	75.25	79.31
How would you rate your child's health plan now?																		
(0 Worst to 10 Best)																		
Mean/Standard Deviation	9.21 ±1.38	9.14 ±1.45	9.06 ±1.40	9.64 ±0.87	9.33 ±1.21	8.98 ±1.53	9.35 ±1.08	9.23 ±1.39	9.34 ±1.10	9.34 ±1.16	9.48 ±0.91	9.05 ±1.38	9.08 ±1.56	9.23 ±1.32	8.95 ±1.70	9.41 ±0.98	9.38 ±1.06	9.56 ±0.88

Table 9. CAHPS – Prescription Medicine

Questions	HP/Site A	HP/Site B	HP/Site C	HP/Site D	HP/Site E	HP/Site F	HP/Site G	HP/Site H	HP/Site I	HP/Site J	HP/Site K	HP/Site L	HP/Site M	HP/Site N	HP/Site O	HP/Site P	HP/Site Q	HP/Site R
In the last 12 months, did your child get any new prescription medicine or refill a prescription?																		
Yes	47.99	71.81	60.80	56.00	61.67	65.45	70.76	67.45	66.00	62.96	58.05	51.16	57.33	45.85	66.33	68.90	69.87	61.00
No	52.01	28.19	39.20	44.00	38.33	34.55	29.24	32.55	34.00	37.04	41.95	48.84	42.67	54.15	33.67	31.10	30.13	39.00
In the last 12 months, did you pick up any of your child's prescription medicine?																		
Yes	97.90	97.20	95.63	95.21	98.92	96.45	97.18	98.01	97.98	96.79	95.38	98.05	97.67	97.10	98.99	98.54	98.10	96.72
No	2.10	2.80	4.37	4.79	1.08	3.55	2.82	1.99	2.02	3.21	4.62	1.95	2.33	2.90	1.01	1.46	1.90	3.28

Table 9 continued. CAHPS – Prescription Medicine

Questions	HP/Site A	HP/Site B	HP/Site C	HP/Site D	HP/Site E	HP/Site F	HP/Site G	HP/Site H	HP/Site I	HP/Site J	HP/Site K	HP/Site L	HP/Site M	HP/Site N	HP/Site O	HP/Site P	HP/Site Q	HP/Site R
In the last 12 months, how much of a problem, if any, was it to get your child's prescription medicine from your health plan?																		
A big problem	2.86	2.40	2.87	1.89	4.37	1.05	0.48	0.00	3.09	1.11	2.42	2.65	3.57	6.72	6.09	1.49	6.76	1.13
A small problem	7.14	10.58	16.67	3.14	15.85	11.05	3.86	6.60	9.79	7.22	7.88	7.95	12.50	12.69	19.29	5.94	18.84	5.65
Not a problem	90.00	87.02	80.46	94.97	79.78	87.89	95.65	93.40	87.11	91.67	89.70	89.40	83.93	80.60	74.62	92.57	74.40	93.22
In the last 12 months, how often did your child get the prescription medicine he or she needed through his or her health plan?																		
Never	2.16	1.93	1.71	3.14	2.75	2.66	1.93	0.51	2.06	3.31	3.64	1.32	5.99	4.51	2.03	2.48	2.43	1.13
Sometimes	12.23	3.38	11.43	10.06	10.99	7.45	7.25	4.57	10.31	8.29	10.30	9.27	13.77	13.53	15.23	4.46	13.11	8.47
Usually	8.63	5.80	13.71	6.29	8.79	7.98	5.80	6.09	9.28	5.52	7.27	5.96	9.58	11.28	11.68	6.93	18.45	10.73
Always	76.98	88.89	73.14	80.50	77.47	81.91	85.02	88.83	78.35	82.87	78.79	83.44	70.66	70.68	71.07	86.14	66.02	79.66

Table 10. CAHPS – Transportation

Questions	HP/Site A	HP/Site B	HP/Site C	HP/Site D	HP/Site E	HP/Site F	HP/Site G	HP/Site H	HP/Site I	HP/Site J	HP/Site K	HP/Site L	HP/Site M	HP/Site N	HP/Site O	HP/Site P	HP/Site Q	HP/Site R
In the last 12 months, did you call your child's health plan to get help with transportation for your child?																		
Yes	0.67	0.67	0.00	0.33	0.66	0.99	0.00	1.00	1.33	0.67	2.67	0.33	0.33	0.33	0.00	1.34	0.99	0.00
No	99.33	99.33	100.00	99.67	99.34	99.01	100.00	99.00	98.67	99.33	97.33	99.67	99.67	99.67	100.00	98.66	99.01	100.00
In the last 12 months, when you called to get help with transportation from your child's health plan, how often did you get it?																		
Never	0.00	0.00	0.00	0.00	0.00	66.67	0.00	0.00	25.00	50.00	12.50	0.00	100.00	100.00	0.00	0.00	33.33	0.00
Sometimes	0.00	0.00	0.00	100.00	50.00	0.00	0.00	33.33	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Usually	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	12.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Always	100.00	100.00	0.00	0.00	50.00	33.33	0.00	66.67	75.00	50.00	75.00	100.00	0.00	0.00	0.00	100.00	66.67	0.00
In the last 12 months, how often did the help with transportation for your child meet your needs?																		
Never	0.00	50.00	0.00	0.00	0.00	0.00	0.00	0.00	33.33	0.00	14.29	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Sometimes	0.00	0.00	0.00	100.00	100.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	33.33	0.00	0.00
Usually	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Always	100.00	50.00	0.00	0.00	0.00	100.00	0.00	100.00	66.67	100.00	85.71	100.00	0.00	0.00	0.00	66.67	100.00	0.00

Table 11. CSHCN Screener

Questions	HP/Site A	HP/Site B	HP/Site C	HP/Site D	HP/Site E	HP/Site F	HP/Site G	HP/Site H	HP/Site I	HP/Site J	HP/Site K	HP/Site L	HP/Site M	HP/Site N	HP/Site O	HP/Site P	HP/Site Q	HP/Site R
DID NOT MEET CSHCN	88.33	74.00	77.74	88.08	81.46	76.82	73.18	75.67	80.40	79.33	82.67	80.13	79.00	83.72	78.67	77.33	78.48	88.33
MET 1 COMPONENT	5.67	15.00	11.63	5.96	8.94	10.26	13.58	15.00	10.30	11.33	8.33	9.93	10.67	10.30	10.00	13.33	7.95	6.67
MET 2 COMPONENTS	4.67	8.67	7.97	3.97	6.29	8.94	7.62	6.00	4.98	5.00	7.33	6.62	8.00	4.65	8.67	8.00	9.60	3.00
MET 3 COMPONENTS	1.33	2.33	2.66	1.99	3.31	3.97	5.63	3.33	4.32	4.33	1.67	3.31	2.33	1.33	2.67	1.33	3.97	2.00

Appendix C - Chronic Disability Payment System (CDPS)
Analysis by Health Plans/Sites

Health Plans / Diagnostic Category	Total Count	Total Freq	HP/Site A Count	HP/Site A Freq	HP/Site C Count	HP/Site C Freq	HP/Site D Count	HP/Site D Freq	HP/Site E Count	HP/Site E Freq	HP/Site F Count	HP/Site F Freq	HP/Site G Count	HP/Site G Freq	HP/Site H* Count	HP/Site H* Freq	HP/Site I Count	HP/Site I Freq
Age, under 1	5484	1.41%	212	1.07%	288	1.73%	114	1.25%	998	2.18%	286	1.66%	498	1.86%	1254	1.09%	183	1.02%
Age, 1 to 4	60740	15.63%	2412	12.12%	2879	17.30%	1303	14.31%	8860	19.29%	2751	16.00%	4746	17.75%	16388	14.24%	2556	14.25%
Age, 5 to 14, Female	119989	30.87%	6207	31.20%	5033	30.25%	2868	31.51%	14324	31.22%	5476	31.86%	8271	30.93%	35541	30.89%	5422	30.23%
Age, 5 to 14, Male	125736	32.35%	6477	32.56%	5407	32.50%	2881	31.65%	14910	32.50%	5755	33.48%	8682	32.47%	37103	32.25%	5740	32.01%
Age, 15 to 24, Female	37634	9.68%	2165	10.88%	1511	9.08%	952	10.46%	3334	7.27%	1441	8.38%	2243	8.39%	12027	10.45%	1973	11.00%
Age, 15 to 24, Male	39144	10.07%	2420	12.17%	1519	9.13%	985	10.82%	3465	7.55%	1481	8.62%	2299	8.60%	12743	11.08%	2059	11.48%
Cardiovascular, very high	59	0.02%	0	0.00%	0	0.00%	2	0.02%	10	0.02%	6	0.03%	6	0.02%	20	0.02%	0	0.00%
Cardiovascular, medium	22	0.01%	1	0.01%	1	0.01%	1	0.01%	1	0.00%	0	0.00%	0	0.00%	10	0.01%	0	0.00%
Cardiovascular, low	4178	1.07%	196	0.99%	127	0.76%	200	2.20%	299	0.65%	125	0.73%	228	0.85%	1620	1.41%	266	1.48%
Cardiovascular, extra low	772	0.20%	30	0.15%	27	0.16%	21	0.23%	22	0.05%	32	0.19%	44	0.16%	272	0.24%	33	0.18%
Cardiovascular, super low	1395	0.36%	23	0.12%	30	0.18%	44	0.48%	49	0.11%	22	0.13%	95	0.36%	641	0.56%	55	0.31%
Cardiovascular, not well defined	9057	2.33%	435	2.19%	304	1.83%	450	4.94%	368	0.80%	381	2.22%	544	2.03%	3421	2.97%	442	2.46%
Psychiatric, high	98	0.03%	3	0.02%	1	0.01%	1	0.01%	10	0.02%	0	0.00%	5	0.02%	40	0.03%	4	0.02%
Psychiatric, medium	893	0.23%	18	0.09%	21	0.13%	16	0.18%	76	0.17%	24	0.14%	68	0.25%	366	0.32%	50	0.28%
Psychiatric, low	15550	4.00%	511	2.57%	712	4.28%	233	2.56%	1389	3.03%	362	2.11%	1031	3.86%	5474	4.76%	1060	5.91%
Psychiatric, super low	228	0.06%	6	0.03%	2	0.01%	17	0.19%	7	0.02%	4	0.02%	7	0.03%	119	0.10%	11	0.06%
Psychiatric, not well defined	4607	1.19%	214	1.08%	185	1.11%	148	1.63%	359	0.78%	112	0.65%	398	1.49%	1758	1.53%	239	1.33%
Skeletal, medium	35	0.01%	1	0.01%	1	0.01%	1	0.01%	1	0.00%	1	0.01%	3	0.01%	13	0.01%	4	0.02%
Skeletal, low	2063	0.53%	80	0.40%	75	0.45%	86	0.94%	162	0.35%	66	0.38%	126	0.47%	719	0.62%	108	0.60%
Skeletal, very low	7342	1.89%	313	1.57%	234	1.41%	268	2.94%	379	0.83%	193	1.12%	568	2.12%	2773	2.41%	493	2.75%
Skeletal, extra low	1447	0.37%	74	0.37%	44	0.26%	53	0.58%	60	0.13%	90	0.52%	102	0.38%	523	0.45%	65	0.36%
Skeletal, super low	30418	7.83%	1285	6.46%	1269	7.63%	765	8.40%	1193	2.60%	1043	6.07%	2428	9.08%	11211	9.74%	2146	11.97%
Skeletal, not well defined	11503	2.96%	494	2.48%	498	2.99%	291	3.20%	544	1.19%	335	1.95%	623	2.33%	4460	3.88%	578	3.22%
Central Nervous System, high	37	0.01%	1	0.01%	2	0.01%	3	0.03%	8	0.02%	1	0.01%	2	0.01%	10	0.01%	1	0.01%
Central Nervous System, medium	340	0.09%	11	0.06%	17	0.10%	3	0.03%	31	0.07%	20	0.12%	22	0.08%	121	0.11%	16	0.09%
Central Nervous System, low	10330	2.66%	446	2.24%	377	2.27%	319	3.50%	625	1.36%	349	2.03%	774	2.89%	3800	3.30%	429	2.39%
Central Nervous System, super low	5517	1.42%	266	1.34%	185	1.11%	186	2.04%	221	0.48%	197	1.15%	383	1.43%	2117	1.84%	252	1.41%
Central Nervous System, not well defined	11808	3.04%	595	2.99%	399	2.40%	432	4.75%	516	1.12%	390	2.27%	703	2.63%	4290	3.73%	513	2.86%
Pulmonary, very high	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Pulmonary, high	640	0.16%	7	0.04%	19	0.11%	13	0.14%	32	0.07%	16	0.09%	34	0.13%	308	0.27%	13	0.07%
Pulmonary, medium	1112	0.29%	32	0.16%	78	0.47%	18	0.20%	86	0.19%	69	0.40%	97	0.36%	331	0.29%	22	0.12%
Pulmonary, low	32089	8.25%	1185	5.96%	1161	6.98%	837	9.19%	2230	4.86%	1360	7.91%	2493	9.32%	10476	9.11%	1708	9.52%
Pulmonary, super low	149599	38.48%	6778	34.07%	5456	32.79%	4397	48.30%	9382	20.45%	6482	37.71%	10049	37.58%	51334	44.62%	8130	45.34%
Pulmonary, not well defined	2886	0.74%	82	0.41%	108	0.65%	110	1.21%	296	0.65%	111	0.65%	168	0.63%	874	0.76%	144	0.80%
Gastrointestinal, high	89	0.02%	0	0.00%	3	0.02%	4	0.04%	5	0.01%	3	0.02%	7	0.03%	34	0.03%	3	0.02%

*Multiple Site Plan representing B, H, and R.

Appendix C – Chronic Disability Payment System (CDPS)
Analysis by Health Plans/Sites

Health Plans — Diagnostic Category	Total Count	Total Freq	HP/Site A Count	A Freq	HP/Site C Count	C Freq	HP/Site D Count	D Freq	HP/Site E Count	E Freq	HP/Site F Count	F Freq	HP/Site G Count	G Freq	HP/Site H* Count	H* Freq	HP/Site I Count	I Freq
Gastrointestinal, medium	743	0.19%	23	0.12%	30	0.18%	22	0.24%	31	0.07%	34	0.20%	47	0.18%	354	0.31%	12	0.07%
Gastrointestinal, low	11699	3.01%	369	1.85%	373	2.24%	553	6.07%	1025	2.23%	353	2.05%	1104	4.13%	3965	3.45%	498	2.78%
Gastrointestinal, super low	4216	1.08%	143	0.72%	133	0.80%	148	1.63%	204	0.44%	134	0.78%	284	1.06%	1589	1.38%	293	1.63%
Gastrointestinal, not well defined	50912	13.10%	2230	11.21%	1693	10.18%	1905	20.93%	2440	5.32%	1992	11.59%	2462	9.21%	19252	16.73%	2912	16.24%
Diabetes, type 1 high	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Diabetes, type 1 medium	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Diabetes, type 2 medium	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Diabetes, type 2 low	1523	0.39%	54	0.27%	39	0.23%	60	0.66%	76	0.17%	73	0.42%	72	0.27%	579	0.50%	77	0.43%
Skin, high	17	0.00%	1	0.00%	2	0.01%	0	0.00%	1	0.00%	1	0.01%	2	0.01%	8	0.01%	0	0.00%
Skin, low	64	0.02%	2	0.01%	3	0.01%	2	0.02%	7	0.02%	4	0.02%	4	0.01%	21	0.02%	5	0.03%
Skin, very low	9229	2.37%	218	1.10%	365	2.19%	303	3.33%	503	1.10%	401	2.33%	645	2.41%	3115	2.71%	553	3.08%
Skin, super low	75085	19.32%	2627	13.21%	2741	16.48%	2519	27.67%	3578	7.80%	3244	18.87%	5562	20.80%	26873	23.36%	4057	22.62%
Skin, not well defined	1397	0.36%	42	0.21%	52	0.31%	79	0.87%	67	0.15%	29	0.17%	72	0.27%	608	0.53%	49	0.27%
Renal, very high	50	0.01%	0	0.00%	1	0.01%	2	0.02%	5	0.01%	1	0.01%	4	0.01%	20	0.02%	1	0.01%
Renal, medium	132	0.03%	1	0.01%	5	0.03%	7	0.08%	8	0.02%	5	0.03%	12	0.04%	44	0.04%	6	0.03%
Renal, low	5556	1.43%	181	0.91%	196	1.18%	112	1.23%	307	0.67%	222	1.29%	484	1.81%	2125	1.85%	210	1.17%
Renal, super low	14099	3.63%	401	2.02%	394	2.37%	399	4.38%	674	1.47%	784	4.56%	921	3.44%	5237	4.55%	742	4.14%
Renal, not well defined	1495	0.38%	32	0.16%	83	0.50%	41	0.45%	99	0.22%	39	0.23%	104	0.39%	522	0.45%	146	0.81%
Substance abuse, low	329	0.08%	13	0.07%	10	0.06%	25	0.27%	26	0.06%	14	0.08%	14	0.05%	128	0.11%	9	0.05%
Substance abuse, very low	152	0.04%	4	0.02%	3	0.02%	7	0.08%	4	0.01%	10	0.05%	10	0.04%	65	0.06%	9	0.05%
Substance abuse, not well defined	379	0.10%	16	0.08%	5	0.03%	8	0.09%	13	0.03%	10	0.06%	24	0.09%	176	0.15%	13	0.07%
Cancer, high	256	0.07%	8	0.04%	8	0.05%	4	0.04%	27	0.06%	4	0.02%	26	0.10%	95	0.08%	12	0.07%
Cancer, medium	272	0.07%	5	0.03%	11	0.07%	5	0.05%	16	0.03%	11	0.06%	11	0.04%	114	0.10%	8	0.04%
Cancer, low	137	0.04%	9	0.05%	9	0.05%	1	0.01%	7	0.02%	5	0.03%	12	0.04%	47	0.04%	3	0.02%
Cancer, benign	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Cancer, not well defined	613	0.16%	17	0.09%	39	0.23%	25	0.27%	41	0.09%	24	0.14%	42	0.16%	188	0.16%	23	0.13%
Developmental Disability, high	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Developmental Disability, medium	26	0.01%	1	0.01%	1	0.01%	1	0.01%	8	0.02%	6	0.03%	7	0.03%	11	0.01%	1	0.01%
Developmental Disability, low	341	0.09%	17	0.09%	7	0.04%	8	0.09%	37	0.08%	37	0.22%	37	0.14%	100	0.09%	11	0.06%
Genital, extra low	2035	0.52%	83	0.42%	89	0.53%	40	0.44%	107	0.23%	89	0.52%	176	0.66%	696	0.60%	102	0.57%
Genital, super low	11085	2.85%	519	2.61%	413	2.48%	355	3.90%	473	1.03%	424	2.47%	739	2.76%	4056	3.53%	518	2.89%
Metabolic, high	554	0.14%	13	0.07%	12	0.07%	16	0.18%	37	0.08%	37	0.22%	47	0.18%	256	0.22%	18	0.10%
Metabolic, medium	324	0.08%	9	0.05%	10	0.06%	14	0.15%	27	0.06%	19	0.11%	36	0.13%	118	0.10%	9	0.05%
Metabolic, very low	1327	0.34%	65	0.33%	62	0.37%	23	0.25%	108	0.24%	86	0.50%	86	0.32%	425	0.37%	44	0.25%
Metabolic, super low	6981	1.80%	225	1.13%	90	0.54%	275	3.02%	246	0.54%	258	1.50%	365	1.37%	3195	2.78%	271	1.51%
Metabolic, not well defined	7791	2.00%	249	1.25%	192	1.15%	374	4.11%	453	0.99%	329	1.91%	586	2.19%	2637	2.29%	411	2.29%
Ectopic pregnancy	19	0.00%	0	0.00%	1	0.01%	0	0.00%	1	0.00%	1	0.01%	1	0.00%	7	0.01%	0	0.00%
Miscarriage/abortion	163	0.04%	4	0.02%	9	0.05%	4	0.04%	8	0.02%	11	0.06%	11	0.04%	51	0.04%	13	0.07%
High cost completed	84	0.02%	1	0.01%	1	0.01%	0	0.00%	0	0.00%	7	0.04%	7	0.03%	22	0.02%	1	0.01%
Moderate cost completed	194	0.05%	8	0.04%	4	0.02%	5	0.05%	21	0.05%	10	0.05%	10	0.04%	69	0.06%	4	0.02%

*Multiple Site Plan representing B, H, and R

Appendix C - Chronic Disability Payment System (CDPS)
Analysis by Health Plans/Sites

Health Plans Diagnostic Category	Total Count	Freq	HP/Site A Count	Freq	HP/Site C Count	Freq	HP/Site D Count	Freq	HP/Site E Count	Freq	HP/Site F Count	Freq	HP/Site G Count	Freq	HP/Site H* Count	Freq	HP/Site I Count	Freq
Normal delivery	129	0.03%	8	0.04%	9	0.05%	5	0.05%	7	0.02%	12	0.07%	10	0.04%	28	0.02%	9	0.05%
Higher cost w/o completion	140	0.04%	2	0.01%	4	0.02%	2	0.02%	5	0.01%	5	0.03%	10	0.04%	60	0.05%	6	0.03%
Lower cost w/o completion	813	0.21%	22	0.11%	35	0.21%	20	0.22%	17	0.04%	34	0.20%	61	0.23%	285	0.25%	40	0.22%
Pregnancy, complete	589	0.15%	21	0.11%	24	0.14%	14	0.15%	45	0.10%	31	0.18%	39	0.15%	177	0.15%	27	0.15%
Pregnancy, incomplete	953	0.25%	24	0.12%	39	0.23%	22	0.24%	22	0.05%	39	0.23%	71	0.27%	345	0.30%	46	0.26%
Extremely low birthweight	14	0.00%	0	0.00%	0	0.00%	0	0.00%	3	0.01%	1	0.01%	1	0.00%	3	0.00%	5	0.03%
Very low birthweight	11	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	3	0.02%	0	0.00%	3	0.00%	0	0.00%
Serious perinatal problem	373	0.10%	12	0.06%	14	0.08%	15	0.16%	48	0.10%	13	0.08%	26	0.10%	100	0.09%	12	0.07%
Other perinatal problems	594	0.15%	13	0.07%	24	0.14%	33	0.36%	36	0.08%	15	0.09%	36	0.13%	231	0.20%	23	0.13%
Normal, single birth	156	0.04%	7	0.04%	4	0.02%	0	0.00%	28	0.06%	8	0.05%	11	0.04%	57	0.05%	1	0.01%
Eye, low	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Eye, very low	943	0.24%	64	0.32%	30	0.18%	26	0.29%	52	0.11%	19	0.11%	92	0.34%	350	0.30%	38	0.21%
Eye, super low	67048	17.25%	4496	22.60%	2691	16.17%	2716	29.84%	1598	3.48%	1021	5.94%	1833	6.86%	27815	24.18%	4208	23.47%
Eye, not well defined	535	0.14%	15	0.08%	36	0.22%	5	0.05%	29	0.06%	21	0.12%	42	0.16%	192	0.17%	23	0.13%
Ear, super low	77696	19.99%	2401	12.07%	3128	18.80%	2326	25.55%	5041	10.99%	3254	18.93%	5982	22.37%	27709	24.08%	3581	19.97%
Ear, not well defined	1683	0.43%	72	0.36%	55	0.33%	36	0.40%	113	0.25%	39	0.23%	113	0.42%	678	0.59%	98	0.55%
Cerebrovascular, low	258	0.07%	10	0.05%	10	0.06%	7	0.08%	34	0.07%	3	0.02%	21	0.08%	107	0.09%	8	0.04%
Cerebrovascular, super low	20	0.01%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	2	0.01%	8	0.03%	5	0.00%	0	0.00%
Cerebrovascular, not well defined	918	0.24%	25	0.13%	47	0.28%	41	0.45%	31	0.07%	36	0.21%	85	0.32%	293	0.25%	46	0.26%
AIDS, high	54	0.01%	4	0.02%	2	0.01%	0	0.00%	7	0.02%	2	0.01%	4	0.01%	16	0.01%	3	0.02%
Infectious, high	33	0.01%	2	0.01%	0	0.00%	1	0.01%	4	0.01%	1	0.01%	3	0.01%	11	0.01%	1	0.01%
HIV, medium	11	0.00%	2	0.01%	0	0.00%	0	0.00%	1	0.00%	0	0.00%	1	0.00%	1	0.00%	0	0.00%
Infectious, medium	365	0.09%	10	0.05%	11	0.07%	5	0.05%	23	0.05%	16	0.09%	16	0.06%	178	0.15%	12	0.07%
Infectious, low	2877	0.74%	43	0.22%	88	0.53%	115	1.26%	123	0.27%	118	0.69%	142	0.53%	1171	1.02%	134	0.75%
Infectious, super low	67334	17.32%	2050	10.31%	2773	16.67%	1851	20.33%	4638	10.11%	2497	14.53%	5354	20.02%	23898	20.77%	3172	17.69%
Hematological, extra high	54	0.01%	1	0.01%	2	0.01%	1	0.01%	4	0.01%	1	0.01%	2	0.01%	18	0.02%	1	0.01%
Hematological, very high	400	0.10%	21	0.11%	10	0.06%	4	0.04%	49	0.11%	10	0.06%	27	0.10%	147	0.13%	3	0.02%
Hematological, medium	413	0.11%	9	0.05%	10	0.06%	10	0.11%	48	0.10%	32	0.19%	26	0.10%	109	0.09%	8	0.04%
Hematological, low	1249	0.32%	26	0.13%	11	0.07%	29	0.32%	66	0.14%	69	0.40%	44	0.16%	678	0.59%	36	0.20%
Hematological, super low	9943	2.56%	195	0.98%	165	0.99%	705	7.74%	479	1.04%	453	2.64%	480	1.80%	3655	3.18%	296	1.65%
Hematological, not well defined	10	0.00%	0	0.00%	1	0.01%	1	0.01%	0	0.00%	1	0.01%	2	0.01%	4	0.00%	0	0.00%

*Multiple Site Plan representing B, H, and R

Appendix C – Chronic Disability Payment System (CDPS)
Analysis by Health Plans/Sites

Health Plans Diagnostic Category	Total Count	Total Freq	HP/Site J Count	HP/Site J Freq	HP/Site K Count	HP/Site K Freq	HP/Site L Count	HP/Site L Freq	HP/Site M Count	HP/Site M Freq	HP/Site N Count	HP/Site N Freq	HP/Site O Count	HP/Site O Freq	HP/Site P Count	HP/Site P Freq	HP/Site Q Count	HP/Site Q Freq
Age, under1	5484	1.41%	59	0.87%	263	1.44%	86	0.92%	377	1.95%	37	1.14%	236	1.10%	526	1.43%	67	1.29%
Age, 1 to 4	60740	15.63%	892	13.22%	3062	16.75%	1111	11.84%	3711	19.17%	347	10.65%	3301	15.41%	5602	15.28%	829	15.99%
Age, 5 to 14, Female	119989	30.87%	2133	31.61%	5635	30.83%	2921	31.12%	5944	30.70%	1003	30.78%	6453	30.13%	11182	30.50%	1576	30.39%
Age, 5 to 14, Male	125736	32.35%	2202	32.64%	5909	32.33%	2879	30.68%	6231	32.18%	1019	31.27%	7076	33.04%	11827	32.26%	1638	31.59%
Age, 15 to 24, Female	37634	9.68%	754	11.18%	1680	9.19%	1227	13.07%	1604	8.28%	431	13.22%	2089	9.75%	3690	10.07%	513	9.89%
Age, 15 to 24, Male	39144	10.07%	707	10.48%	1730	9.46%	1161	12.37%	1496	7.73%	422	12.95%	2264	10.57%	3830	10.45%	563	10.86%
Cardiovascular, very high	59	0.02%	0	0.00%	2	0.01%	0	0.00%	0	0.03%	0	0.00%	3	0.01%	2	0.01%	3	0.06%
Cardiovascular, medium	22	0.01%	0	0.00%	3	0.02%	1	0.01%	1	0.01%	0	0.00%	0	0.00%	2	0.01%	1	0.02%
Cardiovascular, low	4178	1.07%	72	1.07%	151	0.83%	51	0.54%	171	0.88%	29	0.89%	166	0.78%	393	1.07%	84	1.62%
Cardiovascular, extra low	772	0.20%	12	0.18%	39	0.21%	15	0.16%	47	0.24%	7	0.21%	52	0.24%	109	0.30%	10	0.19%
Cardiovascular, super low	1395	0.36%	7	0.10%	97	0.53%	13	0.14%	48	0.25%	7	0.21%	74	0.35%	168	0.46%	22	0.42%
Cardiovascular, not well defined	9057	2.33%	136	2.02%	358	1.96%	113	1.20%	421	2.17%	51	1.56%	488	2.28%	981	2.68%	164	3.16%
Psychiatric, high	98	0.03%	1	0.01%	0	0.00%	0	0.00%	5	0.03%	1	0.03%	9	0.04%	18	0.05%	0	0.00%
Psychiatric, medium	893	0.23%	8	0.12%	20	0.11%	13	0.14%	27	0.14%	2	0.06%	54	0.25%	127	0.35%	3	0.06%
Psychiatric, low	15550	4.00%	243	3.60%	313	1.71%	288	3.07%	435	2.25%	90	2.76%	1165	5.44%	2062	5.63%	182	3.51%
Psychiatric, super low	228	0.06%	3	0.04%	17	0.09%	2	0.02%	3	0.02%	0	0.00%	3	0.01%	18	0.05%	9	0.17%
Psychiatric, not well defined	4607	1.19%	67	0.99%	143	0.78%	56	0.60%	197	1.02%	27	0.83%	189	0.88%	453	1.24%	62	1.20%
Skeletal, medium	35	0.01%	0	0.00%	1	0.01%	2	0.02%	2	0.01%	1	0.03%	1	0.00%	1	0.00%	2	0.04%
Skeletal, low	2063	0.53%	38	0.56%	75	0.41%	41	0.44%	111	0.57%	15	0.46%	114	0.53%	209	0.57%	38	0.73%
Skeletal, very low	7342	1.89%	120	1.78%	199	1.09%	150	1.60%	287	1.48%	67	2.06%	441	2.06%	697	1.90%	160	3.09%
Skeletal, extra low	1447	0.37%	26	0.39%	43	0.24%	27	0.29%	59	0.30%	14	0.43%	76	0.35%	159	0.43%	32	0.62%
Skeletal, super low	30418	7.83%	662	9.81%	872	4.77%	575	6.13%	1211	6.25%	201	6.17%	1828	8.53%	3055	8.33%	674	13.00%
Skeletal, not well defined	11503	2.96%	201	2.98%	441	2.41%	236	2.51%	394	2.03%	70	2.15%	737	3.44%	1410	3.85%	191	3.68%
Central Nervous System, high	37	0.01%	0	0.00%	0	0.00%	0	0.00%	4	0.02%	0	0.00%	1	0.00%	3	0.01%	1	0.02%
Central Nervous System, medium	340	0.09%	1	0.01%	5	0.03%	6	0.06%	21	0.11%	2	0.06%	30	0.14%	30	0.08%	4	0.08%
Central Nervous System, low	10330	2.66%	169	2.50%	313	1.71%	179	1.91%	515	2.66%	70	2.15%	678	3.17%	1117	3.05%	170	3.28%
Central Nervous System, super low	5517	1.42%	75	1.11%	257	1.41%	80	0.85%	207	1.07%	43	1.32%	214	1.00%	712	1.94%	122	2.35%
Central Nervous System, not well defined	11808	3.04%	125	1.85%	582	3.18%	150	1.60%	546	2.82%	59	1.81%	764	3.57%	1565	4.27%	179	3.45%
Pulmonary, very high	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Pulmonary, high	640	0.16%	19	0.28%	11	0.06%	16	0.17%	20	0.10%	7	0.21%	60	0.28%	50	0.14%	15	0.29%
Pulmonary, medium	1112	0.29%	13	0.19%	59	0.32%	6	0.06%	86	0.44%	7	0.21%	60	0.28%	125	0.34%	23	0.44%
Pulmonary, low	32089	8.25%	531	7.87%	1423	7.78%	649	6.92%	1874	9.68%	179	5.49%	2109	9.85%	3341	9.11%	533	10.28%
Pulmonary, super low	149599	38.48%	2443	36.21%	8221	44.98%	2310	24.61%	6539	33.77%	949	29.12%	8573	40.03%	16008	43.67%	2548	49.13%
Pulmonary, not well defined	2886	0.74%	87	1.29%	95	0.52%	71	0.76%	116	0.60%	23	0.71%	183	0.85%	356	0.97%	62	1.20%
Gastrointestinal, high	89	0.02%	1	0.01%	6	0.03%	1	0.01%	8	0.04%	1	0.03%	9	0.04%	4	0.01%	0	0.00%

Appendix C – Chronic Disability Payment System (CDPS) Analysis by Health Plans/Sites

Health Plans	Total		HP/Site J		HP/Site K		HP/Site L		HP/Site M		HP/Site N		HP/Site O		HP/Site P		HP/Site Q	
Diagnostic Category	Count	Freq	Count	Freq	Count	Freq	Count	Freq	Count	Freq	Count	Freq	Count	Freq	Count	Freq	Count	Freq
Gastrointestinal, medium	743	0.19%	9	0.13%	29	0.16%	11	0.12%	37	0.19%	3	0.09%	32	0.15%	62	0.17%	7	0.13%
Gastrointestinal, low	11699	3.01%	176	2.61%	451	2.47%	203	2.16%	539	2.78%	45	1.38%	570	2.66%	1282	3.50%	193	3.72%
Gastrointestinal, super low	4216	1.08%	43	0.64%	230	1.26%	63	0.67%	174	0.90%	19	0.58%	246	1.15%	427	1.16%	86	1.66%
Gastrointestinal, not well defined	50912	13.10%	665	9.86%	3007	16.45%	729	7.77%	2254	11.64%	287	8.81%	2679	12.51%	5604	15.29%	801	15.45%
Diabetes, type 1 high	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Diabetes, type 1 medium	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Diabetes, type 2 medium	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Diabetes, type 2 low	1523	0.39%	25	0.37%	68	0.37%	41	0.44%	77	0.40%	12	0.37%	98	0.46%	159	0.43%	13	0.25%
Skin, high	17	0.00%	0	0.00%	0	0.00%	0	0.00%	1	0.01%	1	0.03%	1	0.00%	1	0.00%	0	0.00%
Skin, low	64	0.02%	2	0.03%	3	0.02%	1	0.01%	3	0.02%	5	0.15%	5	0.02%	7	0.02%	1	0.02%
Skin, very low	9229	2.37%	125	1.85%	462	2.53%	130	1.39%	391	2.02%	37	1.14%	588	2.75%	1249	3.41%	144	2.78%
Skin, super low	75085	19.32%	1140	16.90%	3425	18.74%	1218	12.98%	3837	19.82%	430	13.19%	4182	19.52%	8413	22.95%	1239	23.89%
Skin, not well defined	1397	0.36%	19	0.28%	67	0.37%	23	0.25%	54	0.28%	11	0.34%	77	0.36%	127	0.35%	21	0.40%
Renal, very high	50	0.01%	0	0.00%	0	0.00%	0	0.00%	2	0.01%	2	0.06%	4	0.02%	8	0.02%	0	0.00%
Renal, medium	132	0.03%	1	0.01%	5	0.03%	1	0.01%	14	0.07%	0	0.00%	8	0.04%	16	0.04%	3	0.06%
Renal, low	5556	1.43%	95	1.41%	181	0.99%	75	0.80%	288	1.49%	38	1.17%	299	1.40%	655	1.79%	88	1.70%
Renal, super low	14099	3.63%	196	2.90%	740	4.05%	236	2.51%	676	3.49%	80	2.45%	907	4.23%	1502	4.10%	210	4.05%
Renal, not well defined	1495	0.38%	22	0.33%	53	0.29%	21	0.22%	68	0.35%	4	0.12%	57	0.27%	177	0.48%	27	0.52%
Substance abuse, low	329	0.08%	3	0.04%	11	0.06%	2	0.02%	9	0.05%	0	0.00%	12	0.06%	52	0.14%	1	0.02%
Substance abuse, very low	152	0.04%	5	0.07%	3	0.02%	1	0.01%	5	0.03%	2	0.06%	8	0.04%	16	0.04%	1	0.02%
Substance abuse, not well defined	379	0.10%	3	0.04%	15	0.08%	2	0.02%	6	0.03%	5	0.15%	15	0.07%	62	0.17%	6	0.12%
Cancer, high	256	0.07%	2	0.03%	10	0.05%	4	0.04%	15	0.08%	2	0.06%	16	0.07%	22	0.06%	3	0.06%
Cancer, medium	272	0.07%	4	0.06%	10	0.05%	2	0.02%	13	0.07%	2	0.06%	12	0.06%	41	0.11%	5	0.10%
Cancer, low	137	0.04%	1	0.01%	4	0.02%	2	0.02%	6	0.03%	2	0.06%	12	0.06%	12	0.03%	5	0.10%
Cancer, benign	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Cancer, not well defined	613	0.16%	14	0.21%	20	0.11%	3	0.03%	43	0.22%	5	0.15%	50	0.23%	71	0.19%	8	0.15%
Developmental Disability, medium	26	0.01%	0	0.00%	1	0.01%	0	0.00%	0	0.00%	0	0.00%	3	0.01%	6	0.02%	1	0.02%
Developmental Disability, low	341	0.09%	4	0.06%	14	0.08%	8	0.09%	29	0.15%	4	0.12%	13	0.06%	43	0.12%	3	0.06%
Genital, extra low	2035	0.52%	35	0.52%	83	0.45%	26	0.28%	109	0.56%	8	0.25%	129	0.60%	233	0.64%	30	0.58%
Genital, super low	11085	2.85%	175	2.59%	506	2.77%	203	2.16%	488	2.52%	75	2.30%	689	3.22%	1315	3.59%	137	2.64%
Metabolic, high	554	0.14%	9	0.13%	22	0.12%	9	0.10%	19	0.10%	1	0.03%	29	0.14%	50	0.14%	10	0.19%
Metabolic, medium	324	0.08%	6	0.09%	13	0.07%	5	0.05%	20	0.10%	4	0.12%	13	0.06%	39	0.11%	6	0.12%
Metabolic, very low	1327	0.34%	12	0.18%	71	0.39%	16	0.17%	107	0.55%	5	0.15%	95	0.44%	135	0.37%	23	0.44%
Metabolic, super low	6981	1.80%	52	0.77%	430	2.35%	82	0.87%	268	1.38%	53	1.63%	266	1.24%	833	2.27%	72	1.39%
Metabolic, not well defined	7791	2.00%	83	1.23%	363	1.99%	144	1.53%	446	2.30%	35	1.07%	424	1.98%	939	2.56%	126	2.43%
Ectopic pregnancy	19	0.00%	0	0.00%	0	0.00%	1	0.01%	1	0.01%	1	0.03%	3	0.01%	1	0.00%	1	0.02%
Miscarriage/abortion	163	0.04%	8	0.12%	9	0.05%	4	0.04%	7	0.04%	0	0.00%	11	0.05%	18	0.05%	2	0.04%
High cost completed	84	0.02%	0	0.00%	8	0.04%	3	0.03%	9	0.05%	1	0.03%	1	0.00%	15	0.04%	2	0.04%
Moderate cost completed	194	0.05%	2	0.03%	15	0.08%	3	0.03%	7	0.04%	1	0.03%	12	0.06%	22	0.06%	2	0.04%

Appendix C - Chronic Disability Payment System (CDPS)
Analysis by Health Plans/Sites

Health Plans	Total		HP/Site J		HP/Site K		HP/Site L		HP/Site M		HP/Site N		HP/Site O		HP/Site P		HP/Site Q	
Diagnostic Category	Count	Freq	Count	Freq	Count	Freq	Count	Freq	Count	Freq	Count	Freq	Count	Freq	Count	Freq	Count	Freq
Normal delivery	129	0.03%	0	0.00%	8	0.04%	2	0.02%	5	0.03%	1	0.03%	10	0.05%	14	0.04%	1	0.02%
Higher cost w/o completion	140	0.04%	3	0.03%	6	0.03%	2	0.02%	6	0.03%	2	0.06%	8	0.04%	19	0.05%	0	0.00%
Lower cost w/o completion	813	0.21%	23	0.34%	36	0.20%	19	0.20%	43	0.22%	6	0.18%	41	0.19%	117	0.32%	14	0.27%
Pregnancy, complete	589	0.15%	10	0.15%	40	0.22%	13	0.14%	29	0.15%	4	0.12%	37	0.17%	70	0.19%	8	0.15%
Pregnancy, incomplete	953	0.25%	26	0.39%	42	0.23%	21	0.22%	49	0.25%	8	0.25%	49	0.23%	136	0.37%	14	0.27%
Extremely low birthweight	14	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	1	0.00%	0	0.00%
Very low birthweight	11	0.00%	0	0.00%	0	0.00%	2	0.01%	2	0.01%	0	0.00%	1	0.00%	2	0.01%	0	0.00%
Serious perinatal problem	373	0.10%	7	0.10%	15	0.08%	4	0.04%	12	0.06%	0	0.00%	28	0.13%	54	0.15%	13	0.25%
Other perinatal problems	594	0.15%	8	0.12%	49	0.27%	1	0.01%	19	0.10%	2	0.06%	29	0.14%	68	0.19%	7	0.13%
Normal, single birth	156	0.04%	1	0.01%	4	0.02%	2	0.02%	8	0.04%	1	0.03%	3	0.01%	18	0.05%	3	0.06%
Eye, low	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Eye, very low	943	0.24%	20	0.30%	27	0.15%	21	0.22%	47	0.24%	8	0.25%	51	0.24%	83	0.23%	15	0.29%
Eye, super low	67048	17.25%	1616	23.95%	1078	5.90%	2168	23.10%	3005	15.52%	609	18.69%	1745	8.15%	9891	26.98%	558	10.76%
Eye, not well defined	535	0.14%	9	0.13%	28	0.15%	5	0.05%	34	0.18%	5	0.15%	34	0.16%	42	0.11%	15	0.29%
Ear, super low	77696	19.99%	1121	16.61%	3801	20.79%	1097	11.69%	3723	19.23%	275	8.44%	4557	21.28%	8418	22.96%	1282	24.72%
Ear, not well defined	1683	0.43%	15	0.22%	59	0.32%	32	0.34%	62	0.32%	8	0.25%	120	0.56%	166	0.45%	17	0.33%
Cerebrovascular, low	258	0.07%	3	0.04%	6	0.03%	2	0.02%	9	0.05%	1	0.03%	12	0.06%	22	0.06%	3	0.06%
Cerebrovascular, super low	20	0.01%	0	0.00%	1	0.01%	0	0.00%	1	0.01%	0	0.00%	1	0.00%	2	0.01%	0	0.00%
Cerebrovascular, not well defined	918	0.24%	12	0.18%	39	0.21%	21	0.22%	53	0.27%	7	0.21%	63	0.29%	109	0.30%	10	0.19%
AIDS, high	54	0.01%	0	0.00%	6	0.03%	3	0.03%	3	0.02%	0	0.00%	0	0.00%	4	0.01%	0	0.00%
Infectious, high	33	0.01%	0	0.00%	1	0.01%	1	0.01%	1	0.01%	0	0.00%	3	0.01%	4	0.01%	0	0.00%
HIV, medium	11	0.00%	0	0.00%	1	0.01%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	5	0.01%	0	0.00%
Infectious, medium	365	0.09%	4	0.06%	13	0.07%	3	0.03%	18	0.09%	1	0.03%	8	0.04%	40	0.11%	7	0.13%
Infectious, low	2877	0.74%	30	0.44%	195	1.07%	29	0.31%	124	0.64%	5	0.15%	140	0.65%	386	1.05%	34	0.66%
Infectious, super low	67334	17.32%	1047	15.52%	3021	16.53%	993	10.58%	3373	17.42%	243	7.46%	3671	17.14%	7642	20.85%	1111	21.42%
Hematological, extra high	54	0.01%	2	0.03%	3	0.02%	1	0.01%	9	0.05%	0	0.00%	1	0.00%	7	0.02%	1	0.02%
Hematological, very high	400	0.10%	5	0.07%	14	0.08%	2	0.02%	23	0.12%	5	0.15%	10	0.05%	64	0.17%	6	0.12%
Hematological, medium	413	0.11%	5	0.07%	16	0.09%	7	0.07%	31	0.16%	6	0.18%	17	0.08%	70	0.19%	9	0.17%
Hematological, low	1249	0.32%	10	0.15%	42	0.23%	7	0.07%	54	0.28%	6	0.18%	49	0.23%	108	0.29%	14	0.27%
Hematological, super low	9943	2.56%	65	0.96%	1045	5.72%	125	1.33%	445	2.30%	43	1.32%	474	2.21%	1249	3.41%	69	1.33%
Hematological, not well defined	10	0.00%	0	0.00%	0	0.00%	0	0.00%	1	0.01%	0	0.00%	0	0.00%	0	0.00%	0	0.00%