Tab P

Health Plan Exit in Miami-Dade County

Health Plan Market Exits in the Healthy Kids Program: Enrollee Health Status, Health Care Use, Expenditures and Family Satisfaction

A Report to the Healthy Kids Corporation

Prepared By

Betsy Shenkman, PhD
Institute for Child Health Policy
University of Florida

November 2004

Introduction

In 2003, eleven Florida counties experienced changes in the managed care organizations (MCOs) serving their Healthy Kids enrollees. These MCO exits involved the following plans: Clarendon, Health Options, Capital Health Plan, Vista Health Plan, Healthy Palm Beaches, and Jackson Memorial Health (JMH) Health Plan. When MCOs exit the market, children must transfer to remaining MCOs or to new MCOs in their counties. However, little is known about the short and long term impact of these transfers on the children's health care access, expenditures, and quality of care. Specifically, transferring to new MCOs could disrupt the children's continuity of care and pose barriers health care access.

Some information is available about the impact of MCO market exits on Medicaid enrollees but no information is available about SCHIP enrollees. However, SCHIP enrollees are largely served by the same MCOs serving the Medicaid population and thus the available studies may have some applicability to understanding the potential impact of MCO exits on children in SCHIP.[1] MCOs exiting the Medicaid market are more likely to also serve a commercial population than those remaining. Moreover, MCOs serving commercial populations are less likely to newly enter the Medicaid market than those serving Medicaid only populations.

There is a general belief that MCOs serving both commercial and Medicaid enrollees deliver better quality of care due to their commercial enrollment. However, at least one study focusing on the quality of care provided in Medicaid only MCOs versus MCOs serving Medicaid and commercial populations found no difference in the quality of care in the area of immunizations, childhood preventive care, prenatal care, and cervical cancer screening.[2]

The focus of this evaluation is on the MCO changes in Miami-Dade County. JMH Health Plan was not awarded the Healthy Kids contract during a competitive bidding process and their enrollees transferred to either Amerigroup or Staywell in January 2004. Specifically, the purpose of this evaluation is to examine the following:

1) Whether children switching to Amerigroup or Staywell differed in terms of their health status and health care expenditures at the time of the transfer,
2) Continuity in the children's primary care providers (PCPs) post the transfer from JMH Health Plan, and
3) Family satisfaction with their children's new MCO after transferring from JMH Health Plan.

The Setting

The JMH Health Plan offers different benefit plans, tailored to the specific needs of small businesses, large corporations, government agencies, and other organizations in South Florida. Plan members can choose from 2,300 physicians in the South Florida area and from 22 area hospitals.[3] The JMH Health Plan is part of a large academic health center. Although no longer serving the Healthy Kids Population, they continue to serve Medicaid enrollees, including children in the Children's Medical Services (CMS) Integrated Care System, a special managed care program for SCHIP recipients meeting CMS medical eligibility criteria for enrollment.

Staywell is part of the WellCare Group of Companies, which serves enrollees in public insurance programs in five different states. For 15 years, WellCare has provided government-sponsored health plans including Medicare, Medicaid, SCHIP, and others.[4] In Florida, Staywell participates in the Healthy Kids Program in 13 counties.

Amerigroup is a multi-state managed healthcare company focused on serving enrollees in publicly sponsored programs including Medicaid, SCHIP, and FamilyCare. The Company operates in Texas, New Jersey, Maryland, Illinois, Florida, and the District of Columbia. Amerigroup also recently announced the acquisition of CarePlus Health Plan, one of the largest for-profit Medicaid managed care companies in New York City.[5]

During the competitive bid process, Staywell and Amerigroup requested monthly premiums of approximately $84 per child compared to $99 per child requested by JMH Health Plans. About 25,000 children in Miami-Dade County were affected by this change. The Florida Healthy Kids Corporation sent letters to families informing them of the change in MCOs and JMH Health Plans also worked with families to facilitate a successful transfer.

Data Sources

The following data sources were used:

1) Enrollment files provided by the Healthy Kids Corporation. The enrollment files contain information about the child's age, gender, family income, the MCO in which they are enrolled, and the number of months the child was enrolled in the program. This information was used to a) identify children who disenrolled after leaving JMH Health Plans; b) identify children transferring to Staywell and Amerigroup, 3) select a random samples of families to participate in a telephone survey about their transfer experiences, and 4) to calculate health care expenditures and health care uses on a per member per month (PMPM) basis.

2) Health care claims and encounter data submitted by all of the MCOs participating in the Florida Healthy Kids Program. The person-level claims/encounter data contained Physician's Current Procedural Terminology (CPT) codes and International Classification of Diseases, 9th Revision (ICD 9-CM) codes. Claims and encounter information was used from January 1, 2003 through December 1, 2003 to classify children's health status, health care expenditures, and health care use rates for the Healthy Kids enrollees overall and for children enrolled in JMH Health Plan prior to their transfer to either Staywell or Amerigroup. In

addition, health care claims and encounter data from January 1, 2004 through March 31, 2004 were examined to provide preliminary information about the children's health care use and expenditures post-transfer. This narrow time frame was used to allow at least a six month lag in the claims and encounter data. After reviewing the available information, there is insufficient claims and encounter history to report on expenditures post-transfer until at least three quarters of data are available with a six month lag (approximately March 2005).

3) Telephone survey data from a random sample of families whose children transferred from JMH Health Plans. A random sample of families whose children transferred to Staywell and a random sample of families whose children transferred to Amerigroup were selected for possible participation in telephone surveys about their transfer experiences. Overall, 25% of families could not be located using the contact information contained in the enrollment files. Of those located, 10% refused to participate in the study. The overall cooperation rate was 78%.

   Surveys were conducted in both English and Spanish. There were 300 completed surveys per health plan. Those who agreed to participate were not significantly different from those who refused or could not be located in terms of child age, child gender, and family income.

   The sample size of 300 completed surveys per MCO was selected to provide a reasonable confidence interval for the survey responses. The survey used in this study is comprised of many different types of questions and the confidence interval information provided is based on selected items with uniformly distributed responses. The information presented is provided as a "worst case" guideline only. Using a 95 percent confidence interval, the survey responses provided in this report are within ±5.5 percentage points of the "true" response.

Measures Used

The Clinical Risk Groups (CRGs) was used to classify enrollees' health status. This system classifies individuals into mutually exclusive clinical categories by reading ICD-9-CM diagnosis codes from all health care encounters, except those associated with providers known to frequently report unreliable codes (e.g., non-clinician providers and ancillary testing providers).[6] It assigns all diagnosis codes to a diagnostic category (acute or chronic) and body system, and assigns all procedure codes to a procedure category. Each individual is grouped to a hierarchically defined core health status group, and then to a CRG category and severity level, if chronically ill.

Chronic and acute illnesses are generally classified only if there has been at least two outpatient encounters for that diagnosis separated by at least a day. There are a few diagnoses that require only one outpatient encounter based diagnosis, and these include the codes for mental retardation, Down's Syndrome, blindness, and procedural codes such as chemotherapy and renal dialysis. Enrollees in the program for 6 months or longer are included in the analyses. Some continuity of enrollment is required to classify individuals accurately. A census of all children meeting the enrollment criteria were included in these analyses.

The CRG health status categories are defined below:

- Healthy includes children who were seen for preventive care and for minor illnesses. This category also includes children who were enrolled but did not use health care services during the classification period.
- Significant Acute Conditions are those acute illnesses that could be precursors to or place the person at risk for developing a chronic disease. Examples in this group are head injury with coma, prematurity, and meningitis.
- Minor Chronic Conditions (both single minor and multiple minor) are those illnesses that can usually be managed effectively throughout an individual's life with typically few complications and limited effect upon the individual's ability, death and future need for medical care. This category includes attention deficit / hyperactive disorders (ADHD), minor eye problems (excluding near-sightedness and other refractory disorders), hearing loss, migraine headache, some dermatological conditions, and depression.
- Moderate Chronic Conditions are those illnesses that are variable in their severity and progression, but can be complicated and require extensive care and sometimes contribute to debility and death. This category includes asthma, epilepsy, and major depressive disorders.
- Dominant Chronic Conditions are those illnesses that are serious, and often result in progressive deterioration, debility, death, and the need for more extensive medical care. Examples in this group include diabetes, sickle cell anemia, chronic obstructive lung disease and schizophrenia.
- Chronic Pairs and Triplets are those individuals who have multiple primary chronic illnesses in two (Pairs), or three or more body systems (Triplets).
- Metastatic Malignancies include acute leukemia under active treatment and other active malignant conditions that affect children.
- Catastrophic Conditions are those illnesses that are severe, often progressive, and are either associated with long term dependence on medical technology, or are life defining conditions that dominate the medical care required. Examples in this group include cystic fibrosis, spina bifida, muscular dystrophy, respirator dependent pulmonary disease and end stage renal disease on dialysis.

For these analyses, the CRG categories were grouped as follows: (1) Healthy, (2) Significant Acute, (3) CSHCN – Minor Conditions (CRG health status categories #3 and #4), (4) CSHCN – Moderate Conditions, (CRG health status category #5), and (5) CSHCN – Major Conditions, (CRG health status categories #6, #7, #8, and #9). These are referred to as the "collapsed" CRG categories.

The telephone survey conducted with families included a question series from the Primary Care Assessment Tool (PCAT)[7] addressing the children's usual source of care and whether that usual source of care changed when transferring to the new health plan. Questions about families' satisfaction with their current health plan were obtained using the Consumer Assessment of Health Plans Survey Version 3.0 (CAHPS).[8] The CAHPS was chosen for use in this evaluation because it is currently used for other state Medicaid evaluations and the National Commission on Quality Assurance (NCQA) 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 and
- Children's Supplemental Questions for Those With Chronic Conditions.

The question series about employment, access to employer-based coverage, and sociodemographic characteristics were developed by the Institute for Child Health Policy and has been used in more than 25,000 surveys with Medicaid and CHIP enrollees in Texas and in Florida. The items were adapted from questions used in the National Health Interview Survey,[9] the Current Population Survey,[10] and the National Survey of American Families.[11] The entire telephone survey takes approximately 35 minutes to complete.

The ***Practice Management Information Incorporated (PMIC)*** listing of physician fees was linked to the CPT codes. The PMIC contains information from millions of paid claims nationally. The reported paid amount at the 50th percentile was used for each CPT code. In addition, a per diem of $1,500 was assigned to each day of an inpatient stay. A wholesale price index was used to assign charges to the pharmacy data. The MCOs participating in the Healthy Kids Program do not provide their actual paid amounts, therefore it was necessary to use the fee schedule.[12]

Results

Description of the Sample

Twenty-four thousand and thirty-four children were identified as members in JMH Health Plan using the enrollment files. These children exhibited different behaviors at the time of transition from JMH Health Plan to Amerigroup or StayWell (see Table 1). Forty-one percent of the children enrolled in Amerigroup and 32% enrolled in StayWell as of January 1, 2004. About 9% of the children disenrolled prior to transferring to either of the MCOs and had not re-enrolled as of September 1, 2004. An additional 13% transferred to one of the two MCOs but then disenrolled after the transfer. About 2% of the children disenrolled but then re-enrolled in one of the two MCOs. Finally, about 3% enrolled in one MCO and transferred to the other MCO.

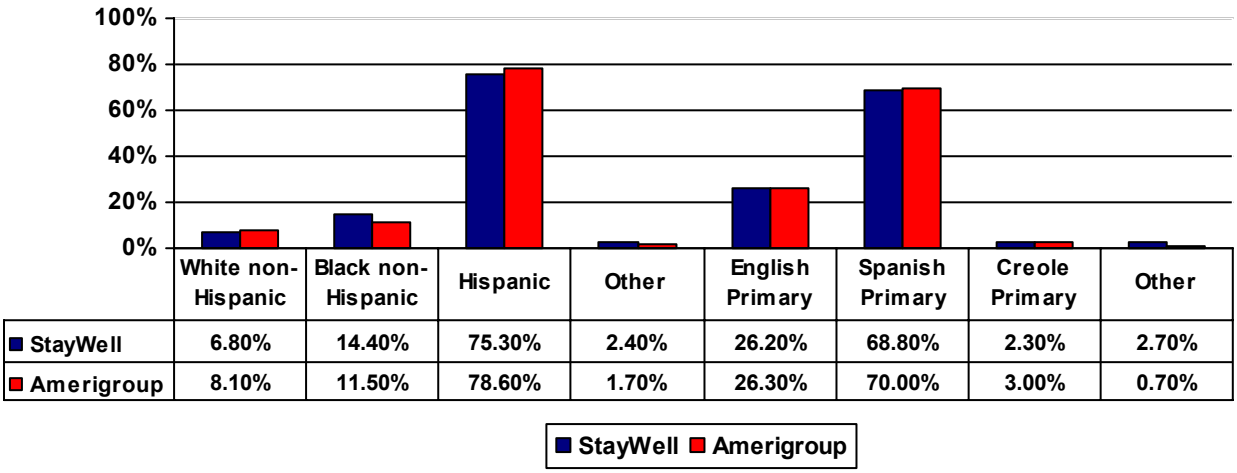
Table 1. Children's Enrollment Patterns After Leaving JMH Health Plan
January 1, 2004 To September 1, 2004; N=24,034

Enrollment Patterns After Leaving JMH Health Plan	Frequency	Percent
Transferred to Amerigroup and then disenrolled	1572	6.50
Switched to Amerigroup and remained enrolled	9878	40.84
Transferred to Amerigroup then to StayWell	315	1.30
Transferred to StayWell and then disenrolled	1356	5.61
Transferred to StayWell and remained enrolled	7766	32.11
Transferred to StayWell then to Amerigroup	385	1.59
Disenrolled	2163	8.94
Disenrolled then re-enrolled in Amerigroup	299	1.24
Disenrolled then re-enrolled in Staywell	300	1.24

Using the telephone survey results, almost 80% of children in both MCOs were Hispanic (see Figure 1). About 70% of respondents indicated that Spanish was the primary language spoken in the home. No significant differences were noted between the MCOs in the enrollees' race/ethnicity or primary language.

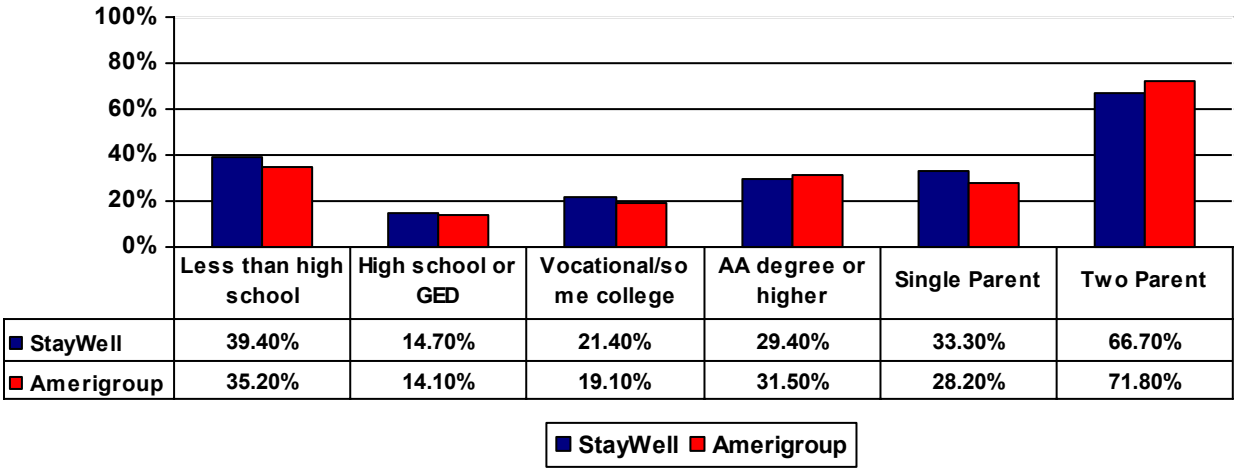
The respondents' education and the household type (single versus two parent) did not different significantly between the enrollees in the two MCOs (see Figure 2). More than one-third of respondents did not have a high school education. However, about 30% of respondents had an Associate's Degree or greater. Almost 70% of children in both MCOs lived in two-parent households.

Figure 1. The Children's Race/Ethnicity and Primary Language Spoken in the Home N=600 (300 per MCO)



	White non-Hispanic	Black non-Hispanic	Hispanic	Other	English Primary	Spanish Primary	Creole Primary	Other
StayWell	6.80%	14.40%	75.30%	2.40%	26.20%	68.80%	2.30%	2.70%
Amerigroup	8.10%	11.50%	78.60%	1.70%	26.30%	70.00%	3.00%	0.70%

Figure 2. Respondent Education and Household Type N=600 (300 per MCO)



	Less than high school	High school or GED	Vocational/some college	AA degree or higher	Single Parent	Two Parent
StayWell	39.40%	14.70%	21.40%	29.40%	33.30%	66.70%
Amerigroup	35.20%	14.10%	19.10%	31.50%	28.20%	71.80%

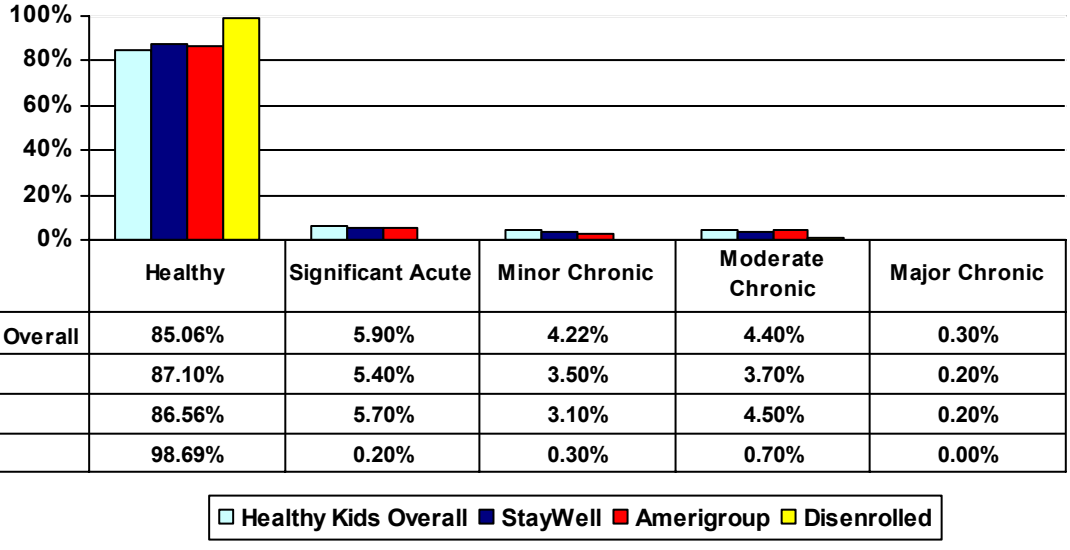
The Enrollees' Health Status

The enrollees' health status was classified using claims and encounter data from *JMH Health Plan for the time period of January 1, 2003 through December 31, 2003.* After the enrollees' were classified, their enrollment files were examined to determine if they transferred to StayWell, transferred to Amerigroup, or disenrolled. Enrollees who disenrolled and then re-enrolled or those who switched between MCOs after exiting JMH Health Plan were not included in the health status analyses.

The health status of those transferring to StayWell or Amerigroup was compared to the health status of Healthy Kids enrollees throughout the rest of the State and to those who disenrolled upon leaving JMH Health Plans. Overall, about 85% of children in the Healthy Kids Program are healthy, compared to 87% of those transferring to StayWell and 87% of those transferring to Amerigroup (see Figure 3). About 99% of those who disenrolled and never entered one of the two new MCOs were classified as healthy. Statewide about 6% of the enrollees have significant acute conditions and the remainder (about 9%) have chronic conditions (predominantly minor and moderate chronic conditions). A similar pattern is observed for both StayWell and Amerigroup.

There is not a sufficient claims history post the transfer to accurately classify the enrollees' health status during their year after entering StayWell and Amerigroup. However, the health status analyses presented in this report, indicate that children leaving JMH Health Plan to enter the new MCOs were primarily healthy and did not differ significantly in terms of health status from children in the Healthy Kids Program throughout the rest of the State.

Figure 3. Enrollee Health Status Classified Prior of the Transfer Using the Clinical Risk Groups (January 1, 2003 through December 31, 2003)



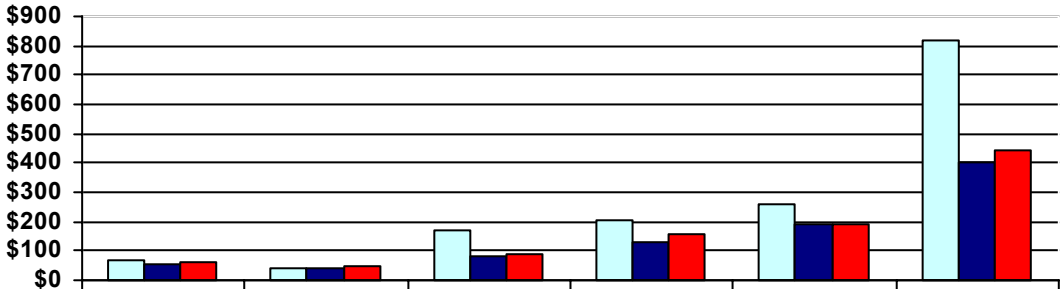
	Healthy	Significant Acute	Minor Chronic	Moderate Chronic	Major Chronic
Healthy Kids Overall	85.06%	5.90%	4.22%	4.40%	0.30%
StayWell	87.10%	5.40%	3.50%	3.70%	0.20%
Amerigroup	86.56%	5.70%	3.10%	4.50%	0.20%
Disenrolled	98.69%	0.20%	0.30%	0.70%	0.00%

The Enrollees' Health Care Expenditures

As previously described, StayWell and Amerigroup received enrollees from JMH Health Plan that were of similar health status (see Figure 3). Although the health status of enrollees going to the two plans did not differ significantly, there can be a range of health care expenditures within health status categories.

Figure 4 illustrates that the health care expenditures among the transfers for the time period January 1, 2003 through December 31, 2004 (prior to the transfer) were similar for the two MCOs. Enrollees transferring to Amerigroup were slightly more expensive overall on a PMPM basis than those going to StayWell but the results were not statistically significant. The overall PMPM health care expenditures were lower for the transfers than for the Healthy Kids enrollees in other areas of the State.

Figure 4. Average Enrollee Health Care Expenditures PMPM* By Health Status Group Prior to the Transfer (January 1, 2003 through December 31, 2003)



	Overall	Healthy	Significant Acute	Minor Chronic	Moderate Chronic	Major Chronic
Healthy Kids Overall	$66.24	$43.72	$171.55	$203.74	$256.74	$819.44
StayWell	$53.40	$42.99	$83.39	$130.69	$189.40	$401.78
Amerigroup	$59.23	$47.43	$89.49	$153.70	$188.48	$444.71

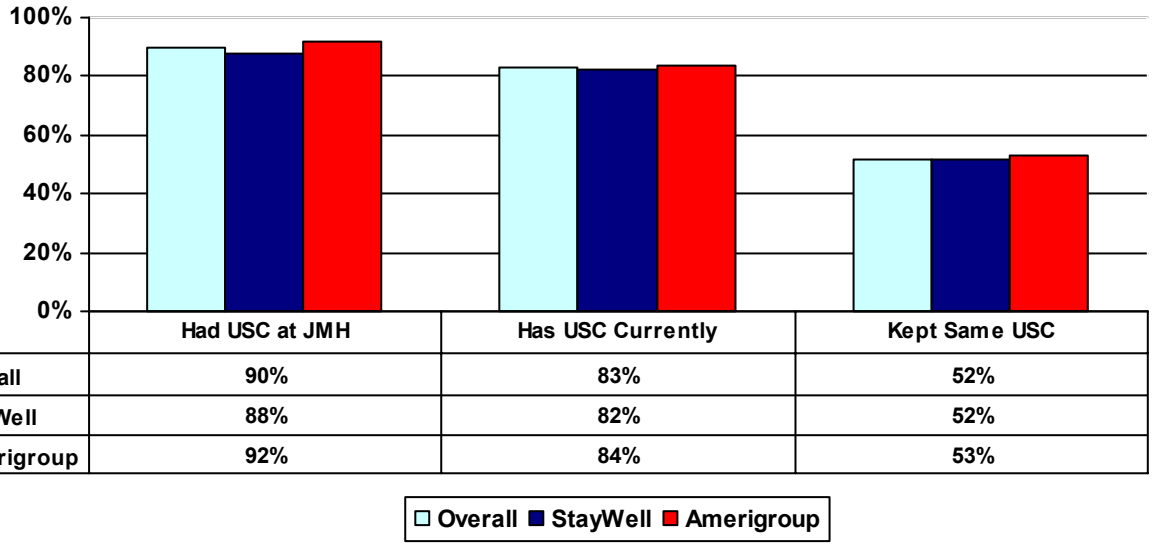
The PMIC national fee schedule at the 50Th percentile linked to CPT codes was used and a $1,500 per diem was assigned to each day of an inpatient stay. The MCOs participating with the Healthy Kids Program do not provide paid amounts with their person-level data. The PMPM amounts reflect health care expenditures only and do not include administrative and other costs that the MCOs include in their premium amounts.

The Enrollees' Continuity in Their Usual Source of Care

Respondents were asked a series of questions about their children's usual source of care while they were enrolled with JMH Health Plans and after transferring to StayWell or Amerigroup. The responses are contained in XX below and reported for the surveyed group overall and for those transferring to StayWell and for those transferring to Amerigroup.

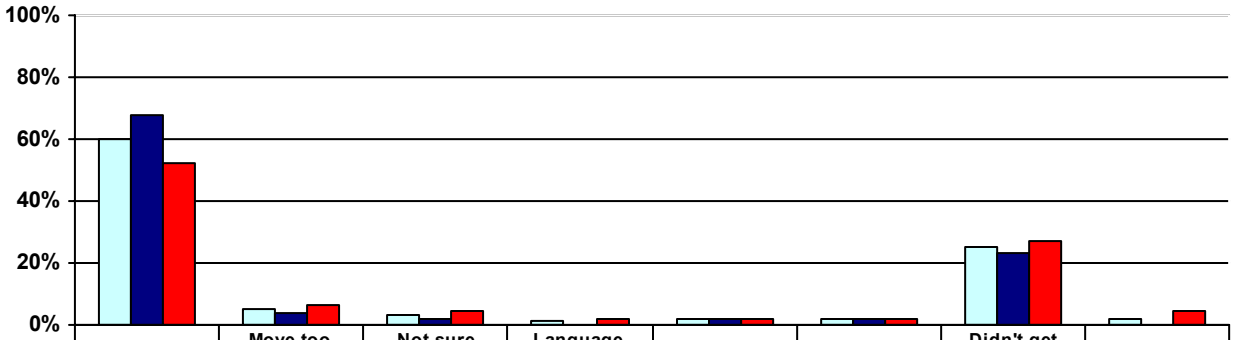
While enrolled in JMH Health Plans, 90% of children had a usual source of care that was either a usual person or place (see Figure 5). After transferring 83% overall have a usual source of care. Eighty-two percent of those transferring to StayWell have a usual source of care compared to 84% of those in Amerigroup. Slightly over one-half of the children were able to keep their same usual source of care after transferring to their new MCO.

Figure 5. Enrollee Continuity in Their Usual Source of Care (USC) N=600 (300 per MCO)



Families were asked why they did not select a usual source of care after transferring. The majority of parents indicated that their children were healthy and did not need a usual source of care (see Figure 6). The next most common response was that the respondent "didn't get around to it." Responses were similar between the MCOs (StayWell and Amerigroup).

Figure 6. Reasons for Not Selecting a Usual Source of Care (USC) Post-Transfer N=600 (300 per MCO)



	Child not sick	Move too much	Not sure where to go	Language barrier	Transportation	Cost	Didn't get around to it	Office hours
Overall	60.00%	5.00%	3.00%	1.00%	2.00%	2.00%	25.00%	2.00%
StayWell	67.50%	3.80%	1.90%	0.00%	1.90%	1.90%	23.00%	0.00%
Amerigroup	52.10%	6.30%	4.20%	2.10%	2.00%	2.10%	27.00%	4.20%

Table 2 shows the families' responses when asked about their satisfaction with their usual source of care pre and post transfer. While at JMH Health Plans, 93% of respondents were satisfied to very satisfied with their children's usual source of care. Among those who obtained a new usual source of care for their children post-transfer, overall, 89% were satisfied to very satisfied with the new source of care. Satisfaction was somewhat lower in StayWell among those families whose children received a new usual source of care compared to those in Amergroup (84% versus 92% satisfied to very satisfied; respectively).

Table 2. Families' Satisfaction with Their Children's Usual Source of Care

Item and Response	Overall	StayWell	Amerigroup
How satisfied were you with your doctor/place at JMH Health Plans? N=540			
Very satisfied	59%	59%	58%
Satisfied	34%	33%	35%
Dissatisfied	4%	5%	4%
Very dissatisfied	3%	2%	3%
How satisfied are you with your new doctor or place? Asked only of those with a new doctor or place after transfer	N=101	N=81	N=72
Very satisfied	45%	49%	40%
Satisfied	44%	35%	52%
Dissatisfied	9%	11%	8%
Very dissatisfied	2%	5%	0%
Would you prefer the usual source of care that you have now or the one you had while at JMH Health Plans? Asked only of those with a new doctor or place after transfer			
JMH Health Plans USC	57%	58%	56%
One I have now	43%	42%	44%

Table 3 shows the families' satisfaction with their children's specialty care post-transfer to StayWell or Amerigroup. There were no significant differences between the MCOs in terms of families' responses about specialty care. Thirty percent of respondents said their children needed to see a specialist with 21% of those reporting "big problems" in getting a referral and about 24% reporting "big problems" in actually getting to see a specialist. However, the majority experienced small to no problems at all.

In comparison, based on survey results from the State Fiscal Year 2003-2004 KidCare Evaluation, 35% of families thought their children needed to see a specialist with 15% reporting "big problems" in getting a referral and 16% reporting "big problems" in actually seeing a specialist. Again, statewide, the majority of Healthy Kids enrollees experienced small to no problems at all in access to specialty care. The KidCare Evaluation relied on a statewide sample, therefore specific information about JMH Health Plans is not available for comparison purposes.

Table 3. Families' Satisfaction with Their Children's Specialty Care

Item and Response	Overall	StayWell	Amerigroup
In the last 6 months, did you or a doctor think your child needed to see a specialist?	N=600	N=300	N=300
Yes	30%	30%	30%
No	70%	70%	70%
In the last 6 months, how much of a problem, if any, was it to get a referral to a specialist that your child needed to see? Asked only of those who thought the child needed a specialist	N=180	N=90	N=90
A big problem	21%	21%	21%
Somewhat of a problem	21%	19%	24%
Not a problem at all	58%	60%	56%
In the last 6 months, how much of a problem, if any, was it to see a specialist that your child needed to see?	N=180	N=90	N=90
A big problem	24%	22%	25%
Somewhat of a problem	20%	18%	21%
Not a problem at all	57%	60%	54%
In the last 6 months, did your child see a specialist?	N=300	N=300	N=300
Yes	24%	23%	21%
No	77%	79%	76%

Discussion and Recommendations

The majority of children (about 87%) transferring from JMH Health Plans were healthy with PMPM health care expenditures of about $53 to $59 PMPM. The health status of the transferring enrollees was not significantly different between the two MCOs, indicating that both MCOs received a generally healthy case-mix of children. Some children disenrolled from the Healthy Kids Program and did not transfer to one of the new MCOs. Ninety-nine percent of those children who disenrolled were healthy.

It is not known if the children who disenrolled would have done so if JMH Health Plans retained the contract. In general, the healthiest children tend to disenroll from the Healthy Kids Program so the finding that 99% of the disenrollees from JMH Health Plans were classified as healthy using the CRGs is consistent with the pattern observed statewide. However, it is possible that MCO changes prompt families to reconsider whether they will keep their children in the Healthy Kids Program. When future MCO changes occur, families should be 1) encouraged to keep their

children enrolled, even if the children are healthy, 2) educated about the benefits of health insurance for all children, and 3) educated about the benefits or primary and preventive care regardless of their children's health status.

Significantly fewer children had a usual source of care post-transfer when compared to their JMH Health Plans experience (83% versus 90%; respectively). Families whose children did not have a usual source of care post-transfer indicated that their children were not sick and did not need a usual source of care or that they "did not get around to it." During a time of a transfer, attention is given to notifying families about the MCO change. However, perhaps a stronger focus needs to be placed on assisting families in finding a new usual source of care and in educating families about the importance of a usual source of care, even for children who are healthy.

It is not known if the MCO transfers and reductions in the percentages of children with a usual source of care will pose barriers to health care access in the short-term (one year after the transfer) and in the long-term (two or more years post-transfer). The Institute for Child Health Policy (ICHP) is examining the impact of health plan exits from the public insurance market in one other state on children's health care use and expenditures and in the first year after the transfer. Results from that study indicate that children's health care expenditures decline upon transfer from the old to the new plan. The reasons for this decline are not known but could include: 1) efficiencies on the part of the new MCOs, 2) barriers to health care access due to changing a usual source of care or not understanding the new MCO procedures for obtaining services, and/or 3) reductions in the child's unmet health care needs during enrollment in the first MCO contributing to reduced future health care expenditures. The study results from the other state include one year of health care claims and encounter data post-transfer. It is not know if the reduced expenditures will be sustained beyond the first year.

It is recommended that the Miami-Dade analyses continue so that the children's health care expenditures can be examined 9 to 12 months post-transfer (March 2005-June 2005). In addition, these health care expenditure analyses should be combined with an assessment of changes in the children's health status using the CRGs and with an analysis of the quality of the health care that they received pre and post the transfer. Quality of care indicators such as preventive care visits, access to primary care practitioners, and receipt of appropriate asthma medications should be assessed. Given the frequency with which MCOs change in the public insurance market nationally and how little is known about the impact of such changes on program enrollees, the current and proposed analyses are very important not only for Florida and the Healthy Kids Program but also nationally.

References

[1] Gold M, Mittler J, Draper D, Rousseau D. Participation of plans and providers in Medicaid and SCHIP managed care. State Children's Health Insurance Program. *Health Affairs* 2003;22(1):230-40.

[2] Felt-Lisk S, Dodge R, McHugh M. *Trends in Health Plans Serving Medicaid: 2000 Data Update*. Kaiser Commission on Medicaid and the Uninsured. November, 2001; http://www.kff.org/insurance/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13885

[3] Description of JMH Health Plan. http://www.jmhhp.com/N_About_Us.html Accessed October 31, 2004.

[4]Description of StayWell. http://www.wellcare.com/HealthPlans/Florida/StaywellHealthyKids/Home.aspx Accessed October 31, 2004.

[5]Description of Amerigroup http://www.amerigroupcorp.com/newsroom/2004_stories/041026.asp Accessed October 31, 2004.

[6] Neff JM, Sharp V, Muldoon J, Graham J, Popalisky J, Gay, J. Identifying and Classifying Children with Chronic Conditions Using Administrative Data with the Clinical Risk Group Classification System. *Journal of Ambulatory Pediatrics,* 2001; 2(1): 72-29.

[7] Cassady CE, Starfield B, Hurtado MP, Berk RA, Nanda JP, Friedenberg LA. Measuring Consumer Experiences with Primary Care. *Pediatrics* 2000;105 (4 Pt 2): 998-1003.

[8] Agency for Health Care Research and Quality. Consumer Assessment of Health Plans 3.0 Survey and Reporting Kit. Rockville, Maryland: US Department of Health and Human Services.

[9] Centers for Disease Control and Prevention, National Health Interview Survey, <http://www.cdc.gov/nchs/nhis.htm>

[10] U.S.Census Bureau; "Current Population Survey: Design and Methodology;" published March 2002; <http://www.census.gov/prod/2002pubs/tp63rv.pdf>

[11] Urban Institute, National Survey of America's Families, <http://www.urban.org/Content/Research/NewFederalism/NSAF/Overview/NSAFOverview.htm>

[12] Practice Management Information Incorporated. 2000. *Physician Fees*. Los Angeles, California: James B. Davis, Publisher.