FOCUS ON CHILD HEALTH POLICY

National Center on Financing for CSHCN

ISSUE 2

State Strategies for Financing Care for CSHCN: How well do they work?

In 2001, an estimated 12.8% of children in the United States had a special health care need.[1] The Maternal and Child Health Bureau (MCHB) defines children with special health care needs (CSHCN) as children "who have or are at elevated risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount not usually required by children."[2] Because CSHCN often require more health care services than other children, these children can be particularly costly to care for.

State Medicaid and Children's Health Insurance Programs (SCHIP) are interested in payment strategies that facilitate adequate care for their enrollees, particularly children with chronic conditions.[3] This issue is particularly important for state programs because of the large percentages of CSHCN that they insure. Medicaid provides health insurance coverage for one-third of all CSHCN[4] and while exact figures are not available for SCHIP, some studies indicate that the percentage is higher than expected when compared to general population estimates. For example, the prevalence of CSHCN in SCHIP in New York, Florida, and Kansas (17%, 18%, and 25%; respectively) is higher than the most recent estimates of prevalence of CSHCN in these states from the National Survey of Children with Special Health Care Needs (12%, 13% and 15%).[5]

States use a variety of strategies to provide adequate reimbursement for health plans caring for CSHCN including:[6]

- Adjusting capitated payments to health plans to reflect the enrollee's age, gender, and location of residence.
- Adjusting capitated payments to health plans to reflect the enrollee's age, gender, location of residence, and health status. Health status is determined with the aid of commercially available software packages such as the Adjusted Clinical Groups (ACGs), the Chronic Disability Payment System (CDPS), the Clinical Risk Groups (CRGs), and others. This strategy is used in 7 states.
- Carving-out certain physical health conditions (e.g., AIDS) for specific payment arrangements, such as fee-for-service. Eight states employ this strategy.
- Allowing for reinsurance, which allows the health plan to transfer the financial risk of an enrollee to a reinsuring entity after annual expenditures for the enrollee attain a specified threshold. This threshold can vary from as little as $5,000 per enrollee per year (in Arizona) to as much as $200,000 per enrollee per year (in Pennsylvania). Many states require health plans to purchase a private policy or public reinsurance offered through the state.

Despite the use of these and other reimbursement strategies, states have little information about how well these strategies align the payments made to health plans on behalf of enrollees with the costs of providing health care to the enrollees. If payments to health plans do not adequately reflect the likely costs of caring for CSHCN, health plans may have an incentive to avoid CSHCN, thereby reducing access to care for this vulnerable population.

"If payments to health plans do not adequately reflect the likely costs of caring for CSHCN, health plans may have an incentive to avoid CSHCN."

We examined the ability of the four payment strategies listed above to match the payments made to health plans on behalf of enrollees with the plans' expenditures on the enrollees.

We used information on children enrolled in Medicaid in three states and SCHIP in two states during the 1999 – 2003 period. We report here our findings for one Medicaid Managed Care Program and one SCHIP initiative; which are representative of our findings with the other states. These findings are also relevant for commercial operations, which often use the same strategies analyzed here. The details of our overall findings are available in a comprehensive report which can be found at www.ichp.ufl.edu.

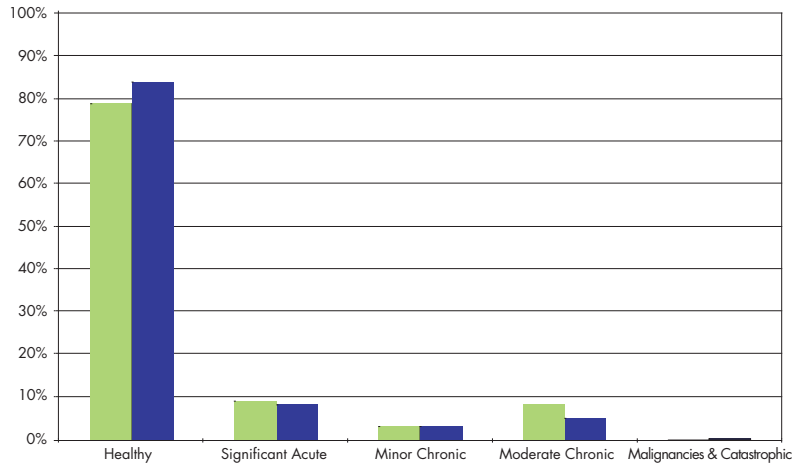
Comprehensive Health-Based Risk Adjustment

We used the Clinical Risk Groups (CRGs) as an indicator of a child's likely consumption of health care services. The CRGs are a categorical clinical system that classifies individuals according to their diagnosed health status.[7] The CRGs include nine core health status groups: healthy, significant acute, minor chronic, multiple minor chronic pairs, single dominant or moderate chronic, multiple significant chronic pairs, chronic triplets, catastrophic, and metastatic malignancy. For simplicity, we collapsed these categories into the following six groups: healthy, significant acute, minor chronic, moderate chronic, and malignant and catastrophic conditions. Children over 1 year of age must be in the program for 6 months or longer to be classified by the CRGs and those under 1 year of age must be enrolled for 3 months or longer. Health care expenditure and reimbursement information about new enrollees is not provided in this issue brief but is contained in the larger report.

We examined the incremental ability of CRGS to predict future health care expenditures relative to predictions based only on demographic (i.e., age and gender) factors. Then, assuming that the payment to a health plan for an enrollee reflects the best estimate of the plan's future health care expenditures for that enrollee, we examined the ability of health-based risk adjustment to reduce the variability in net payments to health plans. The net payment to a health plan is the difference between the payment made to the plan on behalf of an enrollee and the plans' expenditure on health care for the enrollee.

Figure 1 shows the distribution of children in each of the health status categories. **Figure 2 and 3** show that when risk adjustment is based on enrollee demographic characteristics only, the per member per month

Figure 1 **Percentage of Children in Each Clinical Risk Group Category: Medicaid and SCHIP***



*The percentage of children identified as having a malignant or catastrophic condition is less than 1% of the enrollees and, as a result, does not appear on this graph.

Figure 2 **Distribution of Capitated PMPM Payments by Risk Group Using Demographic and Health-Based Risk Adjustment:**

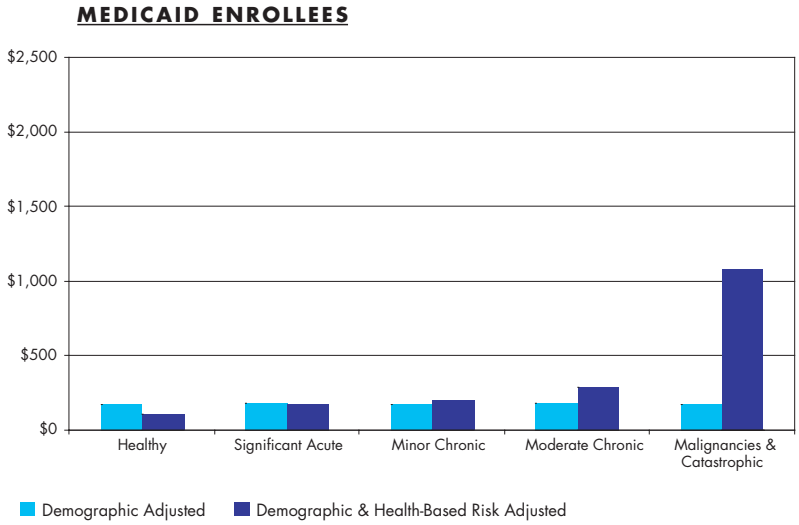


Figure 3 **Distribution of Capitated PMPM Payments by Risk Group Using Demographic and Health-Based Risk Adjustment:**

SCHIP ENROLLEES

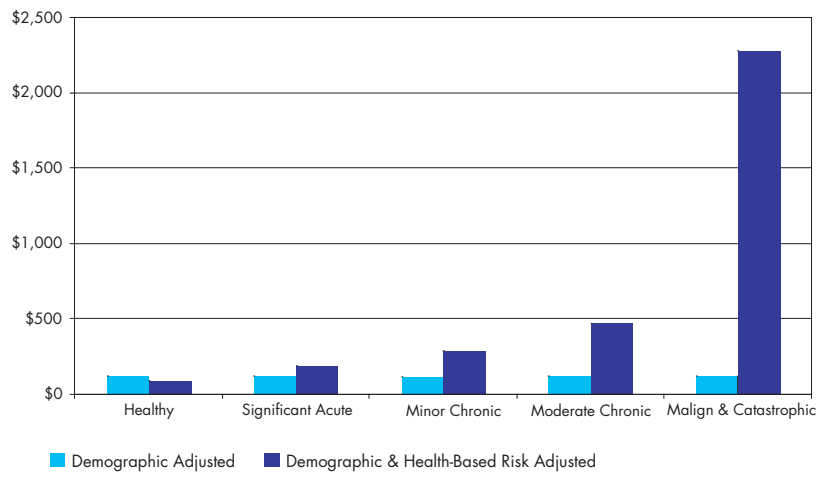
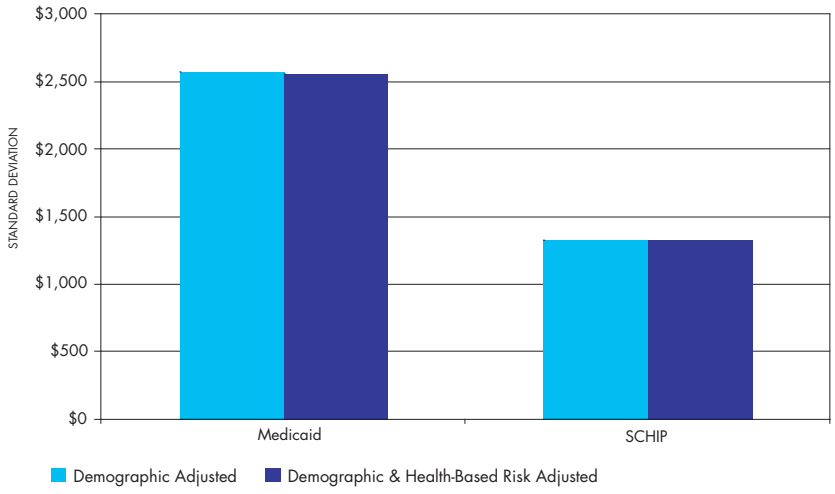


Figure 4 **Variability in PMPM Net Payments by Program and Risk Adjustment Strategy**



(PMPM) payment for a child in SCHIP, for example, is $112, whether the child is healthy or has a moderate chronic condition. However, when demographic and health-based risk adjustment strategies are used, the PMPM payment for a healthy child in SCHIP is $100, while the corresponding payment for a child with a moderate chronic condition is approximately $500. Although the specific PMPM amounts differ for Medicaid, the qualitative conclusion is the same: Demographic and health-based risk adjustment strategies used in combination significantly tailor PMPM payments to the health status of the enrollee.

Figures 2 and 3 reveal that when capitated payments to health plans are adjusted to reflect enrollee health status, substantially higher payments are made for children with the most severe health problems. Consequently, health-based risk adjustment limits the financial loss that a health plan is likely to incur when caring for the sickest children. However, the PMPM payments for the different health status categories are **average** payments for all children in that particular category. Substantial research has demonstrated that within chronic condition categories, children's health can vary significantly.[8] This variability in severity within health status categories and the attendant variability in health care expenditures can result in significant financial losses to health plans, and motivate them to avoid the least healthy enrollees.

Health-based and demographic risk adjustment strategies do not address variability in PMPM health care payments when used alone.

Figure 4 reveals that even when using health-based and demographic risk adjustment strategies, health plans caring for Medicaid Managed Care enrollees could experience variation in PMPM net payments of $2,500 that is either positive or negative. The variability in net payments is less pronounced, but still substantial, for the SCHIP population when compared to the Medicaid Managed Care population.

Condition Carve-Outs

To examine the extent to which condition carve-outs better align capitated payments to ultimate expenditures on an enrollee – and thereby reduce the variability in net payments to health plans – we carved out children with malignant and catastrophic conditions from the capitated payment. In our model, the care for these children was financed on a fee-for-service basis. **Table 1** reports the number of children in SCHIP and the Medicaid Managed Care Program that were carved-out using this approach and the total annual dollar amount associated with their care. In both cases, less than one-third of 1% of the enrollee pool is included in the carve-out. However, the children, as a group, account for nearly 4% of SCHIP expenditures and about 1.5% of Medicaid Managed Care expenditures.

While the carved-out total health care expenditures are substantial, **Figures 5 and 6** show that when it is used alone, a condition carve-out does not help to more closely align payments with health care expenditures in the other chronic condition categories. For example, in Medicaid Managed Care when the malignant and catastrophic condition carve-out is used alone, the capitated payment for a child with moderate chronic conditions is about

Figure 5 **Distribution of Capitated PMPM Payments by Risk Group Using a Malignant and Catastrophic Condition Carve-Out & Health-Based Risk Adjustment:**

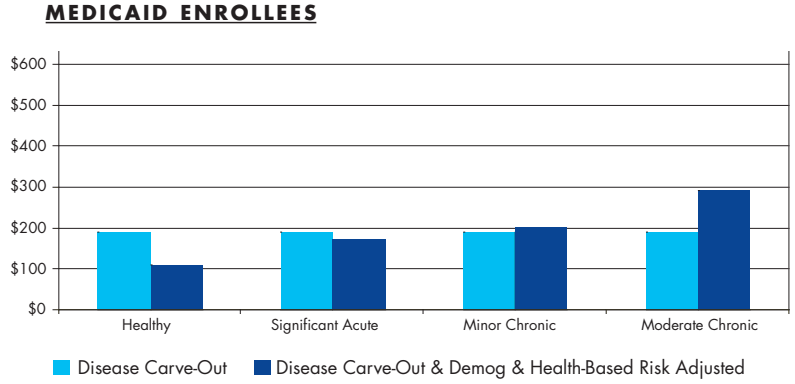


Figure 6 **Distribution of Capitated PMPM Payments by Risk Group Using a Malignant and Catastrophic Condition Carve-Out & Health-Based Risk Adjustment:**

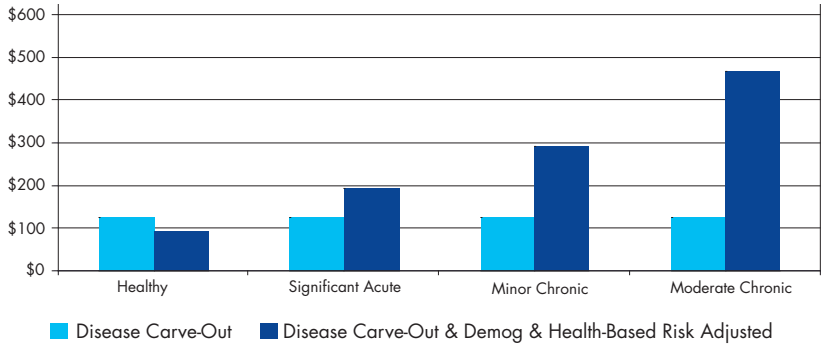


Table 1 **Malignant and Catastrophic Condition Carve-Out**

Number of Children and Their Annual Health Care Expenditures

	Medicaid	SCHIP
Number of Children in the Pool	245	580
Percent of All Children	0.07%	0.12%
Total Annual Charges	$8,480,216.47	$23,835,174
Percent of All Charges	1.45%	3.95%

Figure 7 **Variability in PMPM Net Payments by Program and Risk Adjustment Strategy**

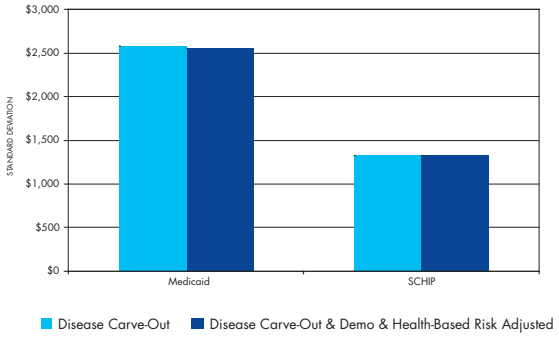


Figure 8 **Distribution of Capitated PMPM Payments by Risk Group Using Reinsurance at $75,000 and Health-Based Risk Adjustment:**

MEDICAID ENROLLEES

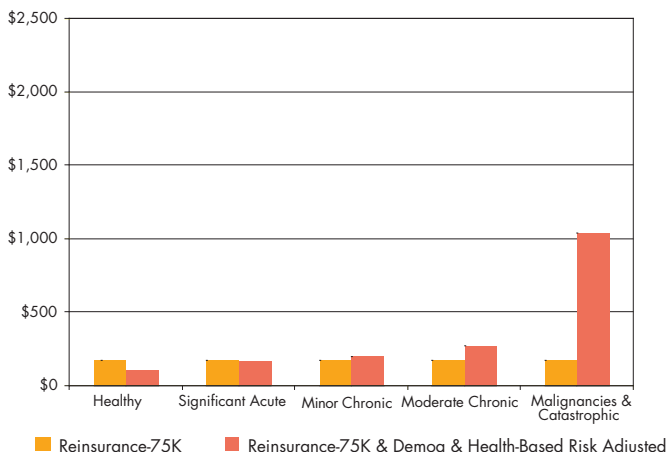
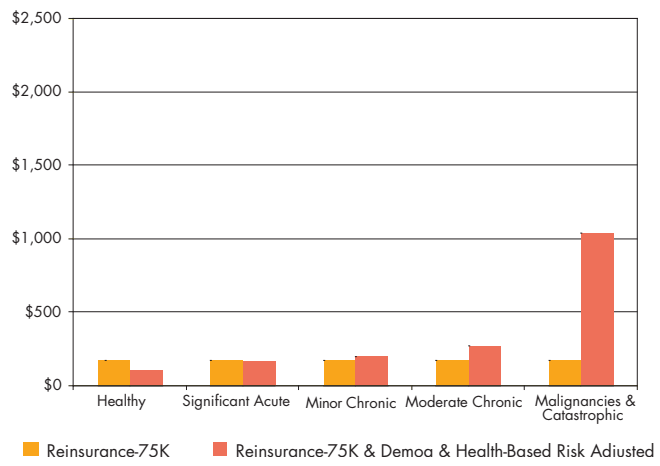


Figure 9 **Distribution of Capitated PMPM Payments by Risk Group Using Reinsurance at $75,000 and Health-Based Risk Adjustment:**

SCHIP ENROLLEES



$180 PMPM – the same as the capitated payment for a healthy child.

In contrast, when the condition carve-out is combined with health-based risk adjustment, the capitated payment for the child with moderate chronic conditions is almost $300 PMPM, where as it is about $100 PMPM for the healthy child. Even though condition carve-outs may alleviate the financial risk associated with caring for the most severely-ill children, these carve-outs typically do not address the full range of chronic conditions that children experience, leaving the health plans at substantial financial risk in caring for the CSHCN not included in the carve-out.

In addition, as **Figure 7** reveals, when the condition carve-out is used alone or in combination with health-based risk adjustment, it does not reduce substantially the variability in net payments to a health plan. In Medicaid Managed Care, a health plan could gain or lose $2,500 to $2,800 PMPM in net payments because of the wide variability in health care expenditures for the CSHCN remaining in the overall pool and not included in the carve-out.

Reinsurance

To illustrate the ability of reinsurance to reduce the variability in net payments, consider the reinsurance strategy that caps the financial risk to a health plan at $75,000 annually per enrollee. (Our findings with $50,000 and $100,000 reinsurance thresholds are similar to those reported here.) The reimbursement strategy assumes that capitated rates are used to cover all charges below the reinsurance threshold. Charges above this threshold are assumed to be financed on a fee-for-service basis by the reinsuring entity and not absorbed by the health plan.

Table 2 provides information on the number of children that would be placed in a reinsurance pool and their charges beyond the $75,000 reinsurance threshold in SCHIP and Medicaid Managed Care.

Table 2 **Reinsurance at $75,000**

Number of Children and Their Annual Health Care Expenditures

	Medicaid	SCHIP
Number of Children in the Reinsurance Pool	718	451
Percent of All Children	0.21%	0.09%
Total Annual Charges	$57,483,644.89	$46,140,773
Percent of All Charges	9.85%	7.64%

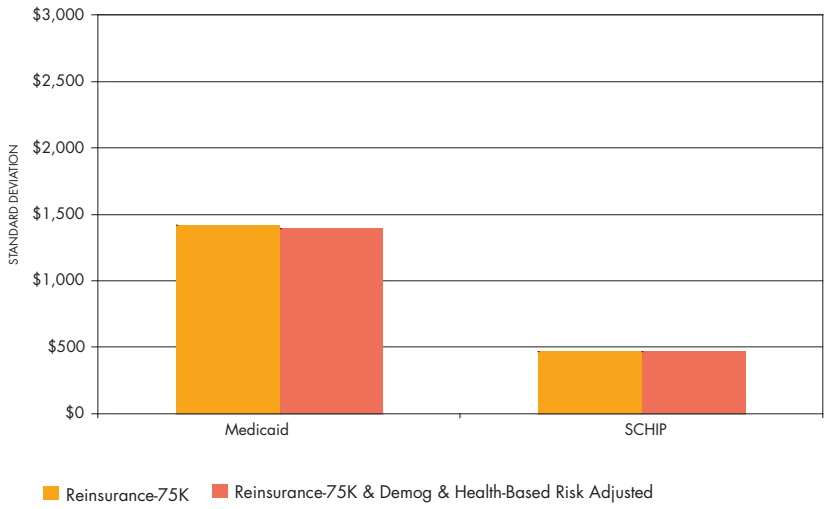
Less than one-third of 1% of the enrollee pool is affected by the reinsurance strategy. However, these children are a costly group. The annual health care expenditures for children who reached the $75,000 threshold accounted for more than 8% of total SCHIP expenditures and more than 10% of Medicaid expenditures.

Figures 8 and 9 show that reinsurance does not closely align capitated payments to health care expenditures, particularly for children in the chronic condition categories. For example, when only reinsurance is used, the PMPM payment in SCHIP is $118, whether the child is healthy or experiences a chronic condition. Reinsurance plus risk adjustment based on health status provides higher payments for children in the chronic condition categories, as seen in Figures 8 and 9.

> "Health-based risk adjustment and reinsurance together reduced payment variability substantially."

Figure 10 reveals that although reinsurance does not more closely align capitated payments to health care expenditures, it does reduce substantially the variability in net payments to health plans. For example, when using only demographic factors and health status to risk adjust capitated payments (without reinsurance), the standard deviation in net PMPM payments is approximately $1,400 in SCHIP and exceeds $2,500 in Medicaid. Similar variability in net payments arises when carve-outs are employed. In contrast, when reinsurance with a $75,000 threshold is used, the variability in net payments PMPM declines to less than $500 for SCHIP and to less than $1,500 for Medicaid Managed Care.

Figure 10 **Variability in PMPM Net Payments PMPM by Program and Risk Adjustment Strategy**



Policy Implications

States use many different strategies to adjust payments for different groups of enrollees in public insurance programs. Many states rely on simple age, gender, and geographic adjustments. We found that these adjustments do not protect health plans from financial risk when caring for CSHCN. If plans and providers are not adequately reimbursed for the care they provide to CSHCN, they may be motivated to avoid caring for these children in order to protect themselves from potentially devastating financial losses.

None of the three major reimbursement strategies (health-based risk adjustment, condition carve-outs, and reinsurance) in our study fully aligned health care payments with expenditures. This was the case whether the strategies were used in isolation or in combination with other strategies. However, risk-adjusting capitated payments to reflect health status did serve to more closely match payments to health care expenditures. Furthermore, reinsurance served to substantially reduce the variability in net payments to health plans.

Our primary finding is that reinsurance, coupled with risk-adjusted capitated payments based on health status, better aligns health care payments to enrollee health status and substantially reduces the variability in net payments to health plans. This finings suggests that reinsurance and risk-adjusted capitated payments based on health status together can help to promote better access to essential health care for CSHCN.

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