DOCUMENT RESUME

ED 455 346 UD 034 331

AUTHOR Almeida, Ruth; Hill, Ian; Kenney, Genevieve
TITLE Does SCHIP Spell Better Dental Care Access for Children? An Early Look at New Initiatives. Occasional Paper Number 50. Assessing the New Federalism: An Urban Institute Program To Assess Changing Social Policies.
INSTITUTION Urban Inst., Washington, DC.
SPONS AGENCY Annie E. Casey Foundation, Baltimore, MD.; David and Lucile Packard Foundation, Los Altos, CA.; John D. and Catherine T. MacArthur Foundation, Chicago, IL.; Mott (C.S.) Foundation, Flint, MI.; McKnight Foundation, Minneapolis, MN.; Commonwealth Fund, New York, NY.; Weingart Foundation, Los Angeles, CA.; Fund for New Jersey, East Orange.; Lynde and Harry Bradley Foundation, Milwaukee, WI.; Joyce Foundation, Chicago, IL.; Rockefeller Foundation, New York, NY.; Kellogg Foundation, Battle Creek, MI.; Robert Wood Johnson Foundation, Princeton, NJ.; Henry J. Kaiser Family Foundation, Menlo Park, CA.; Ford Foundation, New York, NY.
PUB DATE 2001-07-00
NOTE 40p.; Also funded by the Stuart Foundation.
AVAILABLE FROM Urban Institute, 2100 M Street, N.W., Washington, DC 20037. Tel: 202-833-7200; Fax: 202-429-0687; Web site: http://www.urban.org.
PUB TYPE Reports - Evaluative (142)
EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Child Health; *Dental Health; Health Insurance; Low Income Groups; *State Programs
IDENTIFIERS Access to Health Care; *Childrens Health Insurance Program; Medicaid

ABSTRACT

Dental disease is one of the most prevalent illnesses facing children in the United States today. Eighty percent of untreated dental disease in permanent teeth is found in roughly 25 percent of 5- to 17-year old children, most of whom come from low-income and other vulnerable populations. The State Children's Health Insurance Program (SCHIP) offers states an opportunity to expand health insurance and, by extension, financial access to dental care. This paper analyzes whether and how the coverage and delivery of dental services is changing under SCHIP, examining key differences between new separate SCHIP initiatives and traditional and expanded Medicaid programs. Data from telephone interviews and site visits with 18 states indicated that states did not focus particular attention on dental issues during SCHIP program development, though dental health coverage constituted a fundamentally important component of child health programs. All but one state elected to cover dental benefits. The extent of dental coverage under SCHIP was quite broad, although not as comprehensive as Medicaid dental coverage. Copayments on dental services were nominal in most separate SCHIP programs. Under separate SCHIP programs, some states raised dental payment levels above Medicaid's in an effort to raise dental provider participation, while other states paid about the same for dental services. In two states, early SCHIP dental program successes hastened reform efforts under Medicaid dental programs. Results suggest that improvements in access may be occurring

under separate SCHIP programs that are paying dental providers at market rates when compared with Medicaid. (Contains 15 references.) (SM)

Does SCHIP Spell Better Dental Care Access for Children? An Early Look at New Initiatives

Ruth Almeida
Ian Hill
Genevieve Kenney

Occasional Paper Number 50

SCHIP
State Children's Health Insurance Program Evaluation

Assessing the New Federalism
An Urban Institute Program to Assess Changing Social Policies

The Urban Institute
2100 M Street, N.W.
Washington, DC 20037
Phone: 202.833.7200
Fax: 202.429.0687
E-Mail: paffairs@ui.urban.org
http://www.urban.org

This paper is part of the Urban Institute's *Assessing the New Federalism* project, a multiyear project to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil is the project director. The project analyzes changes in income support, social services, and health programs. In collaboration with Child Trends, the project studies child and family well-being.

This occasional paper is part of a comprehensive evaluation of the State Children's Health Insurance Program, primarily funded by the Robert Wood Johnson Foundation and the David and Lucile Packard Foundation as part of the Urban Institute's *Assessing the New Federalism* project. Additional financial support came from The Annie E. Casey Foundation, the W.K. Kellogg Foundation, The Henry J. Kaiser Family Foundation, The Ford Foundation, The John D. and Catherine T. MacArthur Foundation, the Charles Stewart Mott Foundation, The McKnight Foundation, The Commonwealth Fund, the Stuart Foundation, the Weingart Foundation, The Fund for New Jersey, The Lynde and Harry Bradley Foundation, the Joyce Foundation, and The Rockefeller Foundation.

The nonpartisan Urban Institute publishes studies, reports, and books on timely topics worthy of public consideration. The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders.

The authors would like to thank the many state and local officials who participated in our study and provided valuable insights into their experiences designing and implementing SCHIP. In particular, we are indebted to the SCHIP and Medicaid directors (and their staffs) of our 18 study states, who were instrumental in helping us plan our site visits, provided significant background information, and gave generously of their time by participating in our interviews.

We would like to thank our colleagues for their input and suggestions on this report, including Barbara Ormond, John Holahan, and Alan Weil at the Urban Institute, and Burt Edelstein at the American Academy of Pediatrics.

Finally, we would like to express our gratitude to the various funders that supported this effort, including the Robert Wood Johnson Foundation and the David and Lucile Packard Foundation.

About the Series

Assessing the New Federalism is a multiyear Urban Institute project designed to analyze the devolution of responsibility for social programs from the federal government to the states, focusing primarily on health care, income security, employment and training programs, and social services. Researchers monitor program changes and fiscal developments. In collaboration with Child Trends, the project studies changes in family well-being. The project aims to provide timely, nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia, available at the Urban Institute's Web site (http://www.urban.org). This paper is one in a series of occasional papers analyzing information from these and other sources.

Contents

Executive Summary

Tooth decay is one of the most prevalent chronic illnesses facing children in the United States today (Edelstein and Douglass 1995). Almost 60 percent of children ages 5 to 17 have dental disease in their primary or permanent teeth (NCHS 1996). Moreover, dental disease is concentrated in low-income populations. Poor children have five times more untreated dental disease than children in higher-income families (Vargas, Crall, and Schneider 1998). Eighty percent of untreated dental disease in permanent teeth is found in roughly 25 percent of 5- to 17-year-old children, most of whom come from low-income and other vulnerable populations (Kaste et al. 1996).

The State Children's Health Insurance Program (SCHIP) provides states with an opportunity to expand health insurance and, by extension, financial access to dental care. In this paper we analyze whether and how the coverage and delivery of dental services is changing under SCHIP. In particular, we focus on the key differences between new separate SCHIP initiatives and traditional and expanded Medicaid programs. This study begins to address these issues based on a qualitative analysis of the implementation experiences of the 18 states in our sample.

Key Findings

- ***The Policy Debate.*** The study findings suggest that states did not focus particular attention on dental issues during SCHIP program development. However, policymakers generally agreed that dental coverage constituted a fundamentally important component of a child health program. It is noteworthy that although dental service coverage is optional under SCHIP separate programs, all but two states (Colorado* and Delaware) with a separate health insurance program have chosen to include dental services in their benefit package, and with the sole exception of Florida, all offer dental coverage statewide. The states analyzed here mirror this national trend—17 of the 18 study states have elected to cover dental benefits.
- ***Scope of Benefits Coverage.*** In addition to near-universal inclusion of dental benefits, we found the extent of dental coverage under SCHIP to be quite broad, although not as comprehensive as Medicaid dental coverage. Preventive and diagnostic services are covered by virtually all states, including coverage of professional oral exams, teeth cleanings, fluoride treatments, and bitewing x-rays. Advanced dental care services are less likely to be covered under separate SCHIP

* In early 2000, Colorado's legislature approved the inclusion of dental benefits in its SCHIP program pending a feasibility study. If implemented, this would leave only one state—Delaware—that chose not to provide dental benefits under a SCHIP expansion.

programs. Most states cover extractions and some endodontic services, but few cover periodontic, prosthodontic, or orthodontic services. Virtually all states impose limits on preventive services, such as two exams and cleanings per year; however, these limits are consistent with guidelines from the American Academy of Pediatric Dentistry. In addition, three of the study states (Alabama, Michigan, and Texas) have annual dollar limits on their dental benefits.

- ***Cost-Sharing Arrangements.*** Despite increased flexibility to impose cost sharing under separate SCHIP programs, copayments on dental services were nominal in most separate programs among the study states. Copays in the study states range from $0 to $10 for dental visits. No states were imposing premiums or coinsurance intended specifically for dental services.

- ***Service Delivery and Payment Arrangements.*** As policymakers have learned from their Medicaid experiences, covering dental services does not guarantee that children will be able to gain access to them. We found that several states were using SCHIP as an opportunity to test new delivery systems for dental services. Under separate programs, more states are using managed care arrangements to deliver dental services than is typical under Medicaid. The decision to use managed care was made with the primary goal of improving access—by using managed care, states are purchasing a clearly established and identified network of providers. Furthermore, separate programs are more likely than Medicaid programs to contract directly with dental managed care plans than with general managed care plans. However, because most general managed care plans subcontract to dental managed care plans, virtually all children are receiving care from a dental managed care plan. Almost without exception, states reported paying managed care plans on a capitated basis, either through all-inclusive capitation amounts paid to general managed care plans or through partial capitation amounts paid to dental plans. Importantly, though, regardless of the arrangement, general health plans and dental plans were reported as paying individual dentists on a fee-for-service basis.

  States using managed care can impose certain network standards upon plans through their contracts. We found that the states' most common contracting requirements addressed provider-to-enrollee ratios, traveling times and distances, and waiting periods for appointments. Finally, most respondents in states with separate programs believed that the managed care networks were affording good access to dental services and were an improvement over Medicaid.

- ***Payment Amounts.*** For years the most common complaint lodged by dentists against Medicaid has been that the program pays fees well below dentists' usual and customary fees. Our findings suggest that under separate SCHIP programs some states have raised dental payment levels above Medicaid's in an effort to raise dental provider participation. In contrast, other states appear to be paying about the same for dental services under their separate SCHIP and Medicaid programs.

- ***Other Efforts to Enhance Provider Participation.*** Although low fees are the most common reason cited by dentists for not participating in Medicaid, other Medicaid policies, such as cumbersome administrative and billing procedures, as

well as high rates of missed appointments by Medicaid recipients, have also undermined support for the program in the provider community. We found that a number of strategies were being undertaken to address these issues, including simplifying billing procedures, reducing prior-authorization requirements, and expanding dental hygienists' scope of practice. We did not find any strategies to address the issue of missed appointments by Medicaid recipients.

- ***Impact of SCHIP Dental Programs on Medicaid Programs—the "Spillover" Effect.*** In two states—Alabama and Michigan—officials reported that the early successes of their SCHIP dental programs had hastened reform efforts under their state's Medicaid dental program. In Alabama, the success of the ALL Kids dental program has prompted fee increases for dental services under Medicaid, while in Michigan, the state has established a pilot project that replicates the MIChild dental delivery system for a portion of its Medicaid enrollees.
- ***Early Measures of Provider Supply and Service Use.*** Although data on supply and use are preliminary and were not submitted in a consistent manner across states, the data suggest that improvements in access may be occurring under separate SCHIP programs that are paying dental providers at market rates when compared with Medicaid. For example, Michigan's separate SCHIP program reports that 90 percent of licensed dentists are enrolled as providers in the two largest SCHIP dental plans, compared with 27 percent of licensed dentists enrolled as participating providers in Medicaid. In California, 70 percent of children enrolled in the largest separate SCHIP dental plan received a dental service within their first six months of enrollment. In contrast, in 1999, only 36 percent of Medicaid enrollees in California received dental care.

Conclusions and Policy Implications

This study has found that, although it is not a requirement under SCHIP legislation, nearly every separate SCHIP program is offering dental coverage, and benefits appear to be fairly comprehensive. Although not as broad as Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, coverage under most separate SCHIP programs includes all basic preventive, diagnostic, and restorative services, and cost-sharing requirements appear to be quite low. Some states with separate programs are using different delivery systems for dental care than those used under Medicaid. These approaches often reflect state policymakers' explicit decision to deliver dental services under SCHIP through managed care arrangements in an effort to secure a network of dentists who can be available to serve SCHIP enrollees. Some separate SCHIP programs appear to be supporting their delivery systems with higher payment rates, although this trend was not seen for all states. The use of different delivery systems supported by competitive payments appears to be contributing to improved provider participation and better access to dental care in some state SCHIP programs. Early evidence from two states in particular—Alabama and Michigan—shows higher rates of dental provider participation in SCHIP compared with Medicaid. However, as promising as these SCHIP initiatives appear, widespread improvements in oral health for low-income children will occur only if the improvements seen in some separate SCHIP programs also occur in the Medicaid program.

THE URBAN INSTITUTE

Does SCHIP Spell Better Dental Care for Children? An Early Look at New Initiatives

Tooth decay is one of the most prevalent chronic illnesses facing children in the United States today (Edelstein and Douglass 1995). Almost 60 percent of children ages 5 to 17 have dental disease in their primary or permanent teeth (National Center for Health Statistics [NCHS] 1996). Moreover, dental disease is concentrated in low-income populations. Poor children have five times more untreated dental disease than children in higher-income families (Vargas et al. 1998). Eighty percent of untreated dental disease in permanent teeth is found in roughly 25 percent of children ages 5 to 17 years old, mostly in low-income and other vulnerable populations (Kaste et al. 1996).

The State Children's Health Insurance Program (SCHIP), newly authorized under Title XXI of the Social Security Act, provides states with an opportunity to expand health insurance and, by extension, financial access to dental care. Under SCHIP, states may choose to expand Medicaid for higher-income children, develop a new separate health insurance program, or combine these approaches. States that expand Medicaid are required to provide the full Medicaid benefit package, which includes comprehensive dental coverage. In contrast, states that implement a separate program are allowed the flexibility to design new benefit packages that may, or may not, include dental benefits. This flexibility also permits these states to design new service delivery systems, establish new payment rates and methods, and impose cost sharing on enrollees, all of which may have implications for the manner in which dental care is covered and provided.

The purpose of this paper is to analyze whether and how the coverage and delivery of dental services is changing under SCHIP. In particular, this paper focuses on the key differences between new separate SCHIP initiatives and traditional and expanded Medicaid programs.

This study was conducted as part of the Urban Institute's *Assessing the New Federalism* project and, more specifically, its evaluation of the impact and implementation of SCHIP. The qualitative component of the Institute's SCHIP evaluation involved site visits (four to five days in length) to 15 states and in-depth telephone interviews in 3 additional states, selected based on their diversity in size, population characteristics, geographic location, and SCHIP policies. The study states are listed below.[1]

THE URBAN INSTITUTE

SCHIP Study States

Alabama	Michigan	North Carolina
California	Minnesota	Ohio
Colorado	Mississippi	Pennsylvania
Connecticut	Missouri	Texas
Florida	New Jersey	Washington
Massachusetts	New York	Wisconsin

During the site visits, interviews were conducted with a broad range of key informants. At the state level, we interviewed SCHIP, Medicaid, and Title V/Maternal and Child Health officials; governors' health policy staff; state legislators involved with child health policy; representatives of provider groups (such as the American Academy of Pediatrics and the primary care association); and representatives from leading child advocacy organizations. At the local level; we interviewed representatives from clinic- and office-based pediatric providers, managed care organizations, social services departments responsible for SCHIP or Medicaid eligibility determination, and community-based organizations involved with outreach. To ensure the consistent gathering of information across sites, we used a set of detailed interview protocols that explored a broad range of SCHIP implementation issues, including those related to children's access to dental care.

To better understand the degree to which states were using SCHIP as an opportunity to try new approaches to dental service coverage and delivery, we designed a specific study component to collect information on these issues. After completing our site visits, we conducted supplemental telephone interviews with SCHIP and Medicaid officials in 14 states[2] to obtain detailed information on (1) the policy debates that surrounded the inclusion or exclusion of dental benefits under SCHIP, (2) the scope of dental services covered, (3) the delivery systems used to furnish dental care under SCHIP and Medicaid, (4) the payment arrangements implemented to finance this dental coverage and provision under SCHIP and Medicaid, and (5) other efforts to enhance the participation of dental providers in SCHIP and Medicaid.

The results of this inquiry are contained in this report, which is organized as follows:

- The "Background: Oral Health Status, Utilization, and Barriers to Care" section provides information from the research literature on children's need for and access to dental services, as well as the historical role of Medicaid in furnishing dental services to low-income children.
- "SCHIP Dental Coverage and Provision Policies" details the specific dental policies implemented by states under their SCHIP initiatives, comparing and contrasting separate SCHIP programs with Medicaid programs, where appropriate. Findings are presented on the state-level policy debate that surrounded dental

coverage under SCHIP, benefit package designs, cost-sharing arrangements, service delivery and payment arrangements, payment amounts, and efforts to enhance provider participation.

- "Early Measures of Provider and Supply Service Use" presents preliminary data gathered from the study states on provider participation and dental service utilization under SCHIP.
- "Conclusions and Policy Implications" summarizes our findings and their implications for future policy.

Background: Oral Health Status, Utilization, and Barriers to Care

The issue of children's oral health has recently received a great deal of national attention. Heightened awareness and concern has been evidenced by the publication of numerous reports and studies documenting children's oral health status, particularly that of low-income children. Most recently, the Surgeon General released a report calling attention to the disparities in oral health between low- and higher-income individuals, noting that, despite tremendous advances in understanding and treating oral and gum diseases, some populations, notably poor children, are disproportionately affected (U.S. Department of Health and Human Services [HHS] 2000a).

It is clear from many studies that low-income children are not receiving dental care even near the levels recommended by the American Academy of Pediatric Dentistry (AAPD 1999) and the Maternal and Child Health Bureau of the U. S. Department of Health and Human Services (Kenney, Ko, and Ormond 2000; Edelstein, Manski, and Moeller 2000; Vargas et al. 1998). Data from the 1997 National Survey of America's Families (NSAF) showed that nearly twice as many low-income children as higher-income children reported unmet dental needs and that low-income children were 15 percentage points more likely than higher-income children to have had no dental visits in the preceding year. Low-income children were also much less likely to have had two annual visits compared with higher-income children—42 percent versus 60 percent, respectively (Kenney et al. 2000). Similarly, data from the 1996 Medical Expenditure Panel Survey (MEPS) showed that half as many 11- to 18-year-olds from lower-income households as children from higher-income households had at least one dental visit (Edelstein et al. 2000). Such disparities in utilization led the government to include improvements in preventive dental care use among low-income children and adolescents as one of its Healthy People 2010 Oral Health goals (HHS 2000b).

What is preventing low-income children from accessing appropriate levels of care? Factors that have been identified as possible barriers to access can be broadly categorized into two groups: demand factors (i.e., the underlying reasons that families do or do not seek dental care) and supply factors (i.e., the availability and geographic distribution of dental providers across the country).

There is evidence that inability to pay is a barrier to obtaining care. Although insurance coverage for dental services has been increasing throughout the 1990s, for every child under 18 without medical insurance, there are at least two children without dental insurance (Vargas, Isman, and Crall forthcoming). Children from families without dental insurance are three times more likely to have unmet dental needs than children with either public or private insurance (HHS 2000a). In addition, for children with private dental insurance, copayments and deductibles can be considerable, and private dental packages often only cover a narrow range of dental services. Low-income families with privately insured children may be deterred from obtaining needed care for their children due to potentially high out-of-pocket cost.

There is also some evidence that consumers' lack of knowledge about recommended levels of dental care is a barrier. Although this is a difficult area to assess with precision, low-income parents have many competing demands and may not be able to place a high priority on obtaining preventive dental care for their children. Issues such as taking time off from work to take a child to the dentist or arranging for transportation, while inconveniences for higher-income families, may constitute significant barriers to obtaining care for lower-income families. In addition, low-income parents, particularly those with less education, may be less aware than higher-income, more-educated parents of the recommended levels of preventive dental care (Kenney et al. 2000).

Supply factors are also likely to prevent low-income children from getting recommended levels of dental care, especially for those who lack comprehensive benefits or who are covered by Medicaid. In both cases, the supply of dentists willing to provide service seems inadequate (U.S. General Accounting Office [GAO] 2000).

Children without dental coverage have fewer resources from which to obtain free dental care than they would for free medical care. For example, in 1998, just over half of federally funded Community and Migrant Health Centers provided dental services, with long waiting periods for appointments reported (GAO 2000). Most health centers are limited in their capacity to expand their dental service provision because of the expense of obtaining dental facilities and equipment and the difficulty in recruiting providers. Other public programs that offer free or subsidized dental services to the low-income population are the National Health Services Corps and the Indian Health Service dental program. However, these programs are small in scope and none have sufficient capacity to address the large existing need.

A central issue for children with Medicaid coverage has been gaining access to care. In 1997, prior to SCHIP, 39 percent of low-income children were covered by public insurance, primarily the Medicaid program (Brennan, Holahan, and Kenney 1999). Through Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, states are required to provide dental screening, diagnostic, preventive, and treatment services to all Medicaid-covered children regardless of whether the state has elected to cover dental benefits under its Medicaid program. This protection translates, on paper, into comprehensive dental coverage for children. Unfortunately, for most Medicaid-covered children, this coverage has not resulted in actual care: The Health Care Financing Administration (HCFA) reports that just 21 percent of children on Medicaid received a dental assessment in 1997 (HCFA 1997). Although the data from HCFA may underrepresent dental utilization

by Medicaid children, they are consistent with analyses of both Medicaid claims and household survey data that indicate that Medicaid-covered children receive fewer dental visits than recommended (Kenney et al. 2000, GAO 2000, Edelstein et al. 2000).

Supply constraints appear to contribute significantly to children's poor access to dental care under Medicaid, as states historically have struggled to recruit and retain adequate numbers of dentists to participate in the program. Recognizing the significance of this issue, the General Accounting Office recently released a study to examine the reasons for poor access to dental services among children enrolled in Medicaid and SCHIP (GAO 2000). Low provider participation was identified as a primary cause, with reasons cited including traditionally low reimbursement rates, administrative hurdles and red tape, and reported high rates of patients not keeping their appointments. The complaints about the program appear to have some basis in fact. The GAO compared 1999 state Medicaid payment rates with the average regional fees that dentists charged for 15 selected procedures and found that Medicaid rates were well below dentists' usual fees. Tremendous variation in reimbursement levels was found across states, with several states paying as little as one-third of dentists' usual fees for certain procedures. Administrative burdens associated with the Medicaid program include excessive paperwork, frequent denials of claims, preauthorization requirements, and use of outdated forms or billing systems (GAO 2000). Finally, a common complaint from dentists is that Medicaid patients fail to show up for their appointments at a higher rate than do private-pay patients. The American Dental Association (ADA) reports that one-third of Medicaid patients failed to keep their appointments; however, the ADA does not track a similar statistic for privately insured patients (GAO 2000). Because Medicaid prohibits billing a patient for a missed appointment (as dentists are able to do under private insurance), the cost of Medicaid "no-shows" is higher than the cost of private patients who miss appointments, even if no-show rates are similar.

With the advent of SCHIP, states have been afforded another opportunity to address the need for improved access to dental care. This opportunity, however, challenges states to understand the roots of low utilization among the low-income population, to learn from prior problems associated with the Medicaid program, and to design initiatives that promise not just to provide coverage but to ensure access.

SCHIP Policies on Dental Coverage and Provision

This section describes the choices states made in designing and implementing their dental programs through separate programs financed under SCHIP, and compares these policies and experiences with those under Medicaid. Key informants were asked about a variety of major policy issues, including the discussions surrounding the decision whether to include dental coverage in the benefit package, the scope of covered dental services, the delivery systems used to provide services, reimbursement rates and methods, and other efforts to improve and enhance access to dental services. Informants were asked about how dental systems under separate state programs

compared with those of Medicaid, and finally, were queried about what they had learned from the implementation of dental initiatives under SCHIP.

The Policy Debate—Was Dental Care a Salient Issue?

Given the well-documented problems surrounding low-income children's access to dental care, including the Medicaid program's shortcomings in extending widespread access to eligble children, we were interested in exploring whether dental care coverage was prominent among the issues debated by policymakers as states designed their SCHIP programs. In no state was dental access described as a dominant issue. Rather, the topics that tended to garner attention included the broad choice of whether to use Title XXI authority to expand Medicaid or to create a separate program, outreach and eligibility strategies to maximize enrollment, the extent to which cost sharing should be imposed on families, and strategies for preventing SCHIP from crowding out private insurance coverage.

At the same time, however, state officials acknowledged that there had been widespread agreement among SCHIP designers that dental coverage constituted a fundamental component of a child health program, with similarly widespread support for the inclusion of dental benefits in most states' SCHIP benefit packages. For example, it is noteworthy that, despite their status as an optional benefit under SCHIP separate programs, dental benefits have been included by virtually all states. Of the 33 states that chose to implement a separate health insurance program, all but two—Colorado[3] and Delaware—chose to include dental services in their benefit package, and all but one of these states—Florida—have offered dental coverage statewide. The states studied in this analysis mirror this national trend—17 of the 18 states have elected to cover dental benefits.

In most of our study states, key informants told us that the inclusion of dental benefits in their program was not controversial; in fact, many noted that the issue of dental coverage was not even brought up during their state's policy debate. The reasons for this were varied. Once again, some states were occupied with the larger debate over expanding coverage through Medicaid versus separate program strategies, while many others viewed dental care, along with vision and hearing services, as "core pieces of kids' health care." For example, when officials in North Carolina were designing their SCHIP program, a Medicaid expansion was initially promoted based on the premise that Medicaid provided the best benefit package for children. For a variety of reasons, however, the state instead opted to implement a separate program using the state employees' health plan as a benchmark. Importantly, though, dental, vision, and hearing services were added to make the package more appropriate for children. Finally, for some states, the inclusion of dental benefits was not controversial because SCHIP was being modeled after an existing package that already included dental services. For example, California modeled its SCHIP benefit package after the state employees' package, the California Public Employees' Retirement System (CalPERS), which contained a dental benefit.

Among those included in this study, two states were exceptions to the general pattern—Florida and Colorado. Initially, dental service coverage under Florida's separate SCHIP program was optional on a county-by-county basis, while under Col-

orado's separate program dental services were not covered at all. However, both states have since taken steps to expand dental coverage for children. The reasons for the initial exclusion, and subsequent inclusion, of dental services are broadly similar in the two states: Both were building their SCHIP program on existing health insurance programs that, while not including dental benefits, were still widely regarded as successful models of state-designed health insurance programs for children. In crafting these programs, policymakers in both states noted that their aim was to offer a primary and preventive medical care product that would not be too costly and, thus, would be politically viable. The following two vignettes describe in detail the process by which Florida and Colorado have moved to cover dental benefits in their SCHIP programs.

Florida's KidCare Program

When policymakers were developing the state-funded Healthy Kids program, the precursor to KidCare, in the early 1990s, their aim was to design a program with an emphasis on preventive services. The decision to exclude dental services was not explicit; the combination of cost constraints and lack of dental-community participation in the planning process contributed to dental benefits being left out of the original benefit package. In 1994, Healthy Kids made dental benefit coverage the option of individual counties. By the time federal SCHIP legislation passed, 11 of Florida's 67 counties had opted to provide these benefits, with 75 percent of the enrolled population living in these 11 counties. The scope of the benefit package was limited to two cleanings per year, two x-rays per year, and a 25 percent discount on other dental services. The dental program's premium was $3 per member per month, and all services were subject to a $5 copay.

The passage of Title XXI, with its spotlight on children's health and the promise of the enhanced matching funds from the federal government, sparked more widespread interest among state legislators in expanding dental coverage under the Healthy Kids component of KidCare. In the summer of 2000, the legislature authorized a pilot project to provide an expanded set of dental services to Healthy Kids enrollees. The benefits are to mirror those of Medicaid, and implementation is to occur over a 24-month period beginning in July 2000. In accordance with the Title XXI legislation, copayments will be eliminated and the dental component premium will be dropped.

Colorado's Child Health Plan

Colorado's SCHIP program built upon the state's Colorado Child Health Plan (CCHP), which was implemented in the early 1990s to provide preventive and primary care services to low-income children in rural areas of the state. At first, CCHP did not include dental benefits. When the federal SCHIP legislation was passed, Colorado chose CCHP as its basis for a SCHIP program, and began examining options for broadening the benefit package so that it met Title XXI specifications.

The choice of the benefit package was heavily influenced by the policy context in which SCHIP was debated and implemented. Three interconnected issues influenced the selection of a benefit package. First, the state is, in general, politically conservative. Second, as Medicaid had grown to be the second-largest program in the state's budget, there were concerns about the cost of a new insurance program—and dental was perceived to be an expensive service. Third, the state was firmly committed to creating a program that resembled a commercial insurance product to the greatest extent possible, and most private policies did not cover dental benefits. To this end, the state followed a conservative path and chose a benefit package equivalent to that mandated by the state for the small group insurance market—the most common benefit package offered in the state, and one which does not cover dental benefits.

During the first two years following the implementation of CCHP, considerable attention began to be focused on children's oral health problems. In 2000, the governor appointed the new Dental Access Commission to examine strategies for improving access to dental services under both Medicaid and SCHIP. The Colorado legislature also began addressing the issue and, in early 2000, passed a bill adding a dental benefit to the SCHIP program. The state plan was to begin covering dental services in 2001, if an adequate network of providers was recruited to contract with CCHP.

Scope of Benefits Coverage

To what extent are SCHIP programs working to improve children's access to dental care? A fundamental measure is whether states have included dental coverage in their benefit packages. As mentioned above, 17 of the 18 study states have covered dental benefits in some form. Once again, this finding is noteworthy given the optional nature of dental coverage for non-Medicaid expansions. If a state opts for a Medicaid expansion it must provide the Medicaid benefit package, which, with the protection of EPSDT, covers all medically necessary services for children, including dental services. States that opt for a separate state program must, at a minimum, provide a benefit package that is the same as or actuarially equivalent to the benefits offered under one of three benchmark plans: the Blue Cross/Blue Shield plan available to federal employees; the health plan offered to state employees; or the state's most popular HMO plan. Importantly, though, the federal employees' package does not include dental benefits. Typically, under state employees' plans and typical commercial products, dental benefits are either offered on an optional basis for an additional premium payment or excluded altogether.

To gauge the extent of coverage adopted by separate SCHIP programs, we analyzed coverage policies with respect to three major categories of services: preventive and diagnostic; restorative; and advanced dental care services. The major service categories encompass 14 subcategories. The preventive and diagnostic services category comprises the following subcategories: professional oral exams, teeth cleanings, sealants (which protect teeth's chewing surfaces), fluoride treatments, space maintainers, and full-mouth and bitewing x-rays. Restorative services comprise fillings and crowns. Advanced care services comprise simple and complex extractions, endodontics (services to treat tooth-pulp diseases), periodontics (services to replace gum diseases), prosthodontics (services to replace missing teeth), and orthodontics (services to prevent or correct irregularities of the teeth).

We found that virtually all states cover preventive and diagnostic services, as seen in table 1. Of the 15 separate SCHIP dental packages analyzed here,[4] virtually all cover professional oral exams, teeth cleanings, fluoride treatment, and bitewing x-rays. In contrast, other preventive services are covered less often; for example, only eight of the dental packages cover space maintainers. Restorative services are, for the most part, as well-covered as preventive and diagnostic services: 12 of the 15 benefit packages cover fillings and stainless steel crowns.

Advanced care services are less likely to be covered under separate SCHIP programs. Most states cover extractions, and some cover endodontic services, but few cover periodontic or prosthodontic services. Orthodontic services, which are needed by children more often than the other advanced care services, are covered by four states only under certain circumstances. California, Connecticut, and Massachusetts cover orthodontic services for children with severe or handicapping malocclusion[5] but not for less complex "bad bites." Mississippi covers only orthodontic services, crowns, or prosthodontic services to treat conditions arising from an accident or if recommended by a physician or dentist to treat severe craniofacial anomalies or severe malocclusion.

Table 1. *Dental Benefits in Separate SCHIP Programs, 2000*

Service	AL	CA	CO	CT	FL[a]	MA	MI	MS	NC	NY	NJ[b]	NJ[c]	PA	TX	WA
Preventive and Diagnostic Services															
Professional oral exams	✓	✓		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prophylaxis (teeth cleanings)	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sealants	✓	✓		✓		✓	✓	✓	✓	✓	✓		✓	✓	✓
Fluoride treatment	✓	✓		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Space maintainers	✓	✓				✓	✓			✓	✓		✓		✓
Full-mouth x-rays	✓	✓		✓	✓	✓		✓	✓	✓	✓		✓	✓	✓
Bitewing x-rays	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Restorative Services															
Amalgam restoration (fillings)	✓	✓		✓		✓	✓	✓	✓	✓	✓		✓	✓	✓
Stainless steel crowns	✓	✓		✓		✓	✓	✓[e]	✓	✓	✓		✓	✓	✓
Advanced Care Services															
Extractions	✓	✓		✓		✓	✓	✓[f]	✓	✓	✓		✓	✓	✓
Endodontics	✓	✓		✓		✓	✓		✓	✓	✓		✓	✓	✓
Periodontics	✓	✓				✓				✓	✓				✓
Prosthodontics	✓	✓		✓		✓		✓[e]		✓	✓				✓
Orthodontics		✓[d]		✓[d]		✓[d]		✓[e]							
Total	**13**	**14**	**0**	**12**	**3**	**14**	**10**	**11**	**10**	**13**	**13**	**3**	**11**	**10**	**13**

Source: Urban Institute State Children's Health Insurance Program Evaluation.
Notes:
a. Florida's dental benefit is not offered on a statewide basis.
b. New Jersey's KidCare Parts B and C.
c. New Jersey's KidCare Part D.
d. Covered only to treat severe or handicapping malocclusion.
e. Covered only to treat conditions arising from an accident or if recommended by a physician or dentist for treatment of severe craniofacial anomalies or severe malocclusion.
f. Covered only for impacted teeth.

Almost all states impose limits on preventive and diagnostic services, such as two exams and cleanings per year. These limits are consistent with guidelines from the AAPD. X-rays tend to be limited to one set of full-mouth x-rays every one to two years and one set of bitewing x-rays every six months to a year. Fillings are typically covered when they are made of silver amalgam; composite resin fillings (enamel-colored or white fillings) are typically restricted to anterior teeth only.

Three of the study states have annual dollar limits on their dental benefits. Alabama imposes an annual limit of $1,000 per child and Michigan imposes a $600 per child annual limit. Texas has a more complex cap structure: Preventive services are subject to a $172 cap per 12–month period for children ages 1 through 12, and a $181 cap for children ages 13 through 18; "therapeutic services," defined as non-preventive services, such as fillings and crowns, are subject to a $300 cap per enrollment year for children of all ages. Thus, the cap for dental services is $472 for children ages 1 through 12 and $481 for children ages 13 through 18.

THE URBAN INSTITUTE

Two states stand out as having particularly narrow dental benefit packages: Florida and Texas. As described above, Florida currently has a "screen and clean" benefit that covers cleanings and x-rays only, with a 25 percent discount for any treatment service identified by x-rays. (Once again, however, Florida is in the process of substantially expanding the scope of its dental benefit to mirror a Medicaid dental benefit.) Texas, although appearing on paper to cover a broad range of services, is the only state to impose limits on preventive services that are more restrictive than AAPD recommendations. In addition to having a per-child cap on expenditures associated with dental services Texas limits coverage of oral exams and teeth cleanings to once every 12 months, while AAPD guidelines recommend children obtain these services once every 6 months (AAPD 1999).

One component of New Jersey's KidCare program is also rather narrow, limiting dental coverage to oral exams, cleanings, and fluoride treatment for children under the age of 12. However, only a small proportion of KidCare recipients are enrolled in this component of the state's separate SCHIP program.

Cost-Sharing Arrangements

The Title XXI legislation allows states adopting separate programs considerable flexibility to impose cost sharing. States that opted for Medicaid expansions, unless operating under an 1115 waiver, are severely restricted in the type and amount of cost sharing they can require. Under separate programs, states cannot impose copayments on preventive services but can charge premiums and require deductibles and coinsurance, with certain limitations.

Despite fewer restrictions on cost sharing, copayments on dental services were nominal in most separate programs among the study states. As seen in table 2, copays in the study states range from $0 to $10 for dental services. We did find three states that are charging copays for preventive dental services. As mentioned above, SCHIP legislation prohibits states from charging copays for preventive services, but it does not specifically address preventive dental services. Dental visits can include both preventive and nonpreventive services. It appears that some states are charging families copays for dental office visits that include preventive services. No states were imposing premiums or coinsurance specifically with respect to dental services.

Service Delivery and Payment Arrangements

As policymakers have learned from their experiences with Medicaid, covering dental benefits does not guarantee that children will be able to gain access to these services. Therefore, we were particularly interested in whether SCHIP programs were adopting the same service delivery and payment arrangements used in Medicaid or whether they were using different arrangements. We examined whether (1) SCHIP programs were using managed care or fee-for-service arrangements for dental care delivery, (2) managed care contracts were with mainstream health plans or dental care plans, (3) managed care plans were receiving capitated or fee-for-service payments, and (4) contracts contained any access provisions specific to dental care. We also asked state officials to comment on the perceived adequacy of dental care

Table 2. *Copays for Dental Services under SCHIP Programs*

State	Preventive Dental Services ($)	Restorative Dental Services ($)
Alabama	0	5
California	0	0–5
Colorado[a]	—	—
Connecticut	0	0
Florida[b]	5–10	—
Massachusetts	0	0
Michigan	0	0
Minnesota	0	0
Mississippi	0	5[c]
Missouri	5	5–10
New Jersey	0	0
New York	0	0
North Carolina	0	0
Ohio	0	0
Pennsylvania	0	0
Texas	2–10	2–10
Washington	0	0
Wisconsin	0	0

Source: Urban Institute State Children's Health Insurance evaluation.
Notes:
a. In 2000, Colorado authorized the addition of a dental benefit to its separate SCHIP program if an adequate provider network can be recruited.
b. Florida is modifying the dental benefit package offered under Healthy Kids, a component of its SCHIP program, to include restorative dental services and eliminate copays on preventive services.
c. No copay is charged for fillings.

provider networks under SCHIP compared with Medicaid. Indeed, our findings suggest that policymakers in many states have designed and implemented new, alternative arrangements in a concerted effort to better translate dental coverage into access.

Use of Managed Care

States creating new programs could choose to use the same delivery system as the Medicaid dental program or to design a new system. We found that several states were using SCHIP as an opportunity to employ new delivery systems for dental services, while other states relied on the preexisting Medicaid dental care delivery system. Traditionally, dental services under Medicaid have been provided on a fee-for-service basis, as the study states reflected. Under Medicaid (both Title XIX and Title XXI expansion programs), 9 of the 18 study states are using fee-for-service arrangements, exclusively to deliver dental services, as shown in table 3. There has been some movement in Medicaid to incorporate dental services into managed care arrangements but this phenomenon has not been widespread—8 of the 18 study states are using a combination of fee-for-service and managed care arrangements, and

Table 3. *Dental Service Delivery Arrangements for Children in SCHIP and Medicaid Programs*

State	Separate SCHIP programs		Medicaid (both SCHIP and regular Medicaid)	
	Fee-For-Service	Managed Care	Fee-For-Service	Managed Care
Alabama	X		X	
California		X	X	X
Colorado	Dental not covered		X	
Connecticut		X		X
Florida[a]		X	X	
Massachusetts	X		X	
Michigan		X	X	
Minnesota	No separate program		X	X
Mississippi	X		X	
Missouri	No separate program		X	X
New Jersey		X	X	X
New York		X	X	X
North Carolina	X		X	
Ohio	No separate program		X	X
Pennsylvania[b]		X	X	X
Texas		X	X	
Washington	X		X	
Wisconsin	No separate program		X	X
Total	**5**	**8**	**17**	**9**

Source: Urban Institute State Children's Health Insurance Program evaluation.
Notes:
a. In Florida's Medicaid program, a small number of children were receiving dental services under a managed care system. Since state officials noted this was a very small proportion of children, we classified Florida as using fee-for-service arrangements exclusively under Medicaid.
b. In Pennsylvania's SCHIP program, state officials noted that a small number of children were receiving dental services on a fee-for-service basis. As was the case with Florida, state officials noted this was a very small percentage of enrolled children and thus we classified this state as using managed care arrangements exclusively under SCHIP.

only 1 state is using managed care exclusively to deliver dental services under Medicaid.

In contrast, under separate programs, more states are using managed care arrangements to deliver dental services. Of the 13 states providing dental services under separate programs, 8 are using managed care arrangements exclusively, while 5 are using fee or service arrangements exclusively.

The choice of service delivery arrangement is important because it has implications for how families locate and select a dentist for their child. Key informants provided two scenarios for selecting dentists, depending on whether dental services were being provided under fee-for-service or managed care arrangements. For children in fee-for-service dental systems, no clear entity is responsible for linking families with participating dentists. Some respondents reported that families who want to get an

appointment with a dentist must call the SCHIP or Medicaid program office, or a local social services office, to obtain a list of participating dentists in their county. Then, families must call the dentists on the list and find out whether they are accepting new patients. In contrast, all states using a managed care system to furnish dental services reported that, when families enroll either into the SCHIP program or into the managed care plan, they are given a handbook that lists available providers. As in the fee-for-service dental system, families are still required to call dentists listed in the plan handbook to find out whether they are accepting new patients. In a managed care system, however, if families need assistance locating a dentist, they can usually call a member services phone number provided by the plan and speak with a representative who can help. Some states also reported that plans will make dental appointments for a child if requested by the family.

Contracting Arrangements

The entities with which states contract to deliver services under managed care differ between Medicaid and SCHIP programs. Generally, states using managed care can contract with a general managed care plan to provide or arrange for all services, including dental. The general managed care plan can then either subcontract with a dental managed care plan or contract with individual dentists or dental groups. Alteratively, states can contract directly with dental managed care plans that are exclusively responsible for providing dental services.

Of the eight states in our study that use managed care in their separate SCHIP programs, five (Connecticut, Florida, Pennsylvania, New Jersey, and New York) contract with general managed care plans, and three (California, Michigan, and Texas) contract with dental managed care plans. Of the eight states using managed care in their Medicaid programs, seven are using general managed care plans (Connecticut, Missouri, Ohio, Pennsylvania, New Jersey, New York, and Wisconsin), while only one (California) is contracting directly with a dental managed care plan.

The decision to contract directly with dental managed care plans instead of general managed care plans seems to have been made with a view to improving access to services. Officials in states that elected to do this believed that dental plans may have greater experience and success with locating clients for their semi-annual exam or cleaning than the Medicaid program. Furthermore, whereas a general managed care plan might be evaluated on a host of quality or utilization measures relating to a variety of service types (e.g., measures pertaining to medical or ancillary therapy services), dental managed care plans are, obviously, judged solely on how well they provide dental services, giving them a potentially greater incentive to provide required dental care to their enrollees.

From the enrollee's perspective, there may not be much difference between managed dental care under Medicaid and under SCHIP. In all but one (New Jersey) of the seven states using general managed care plans to furnish Medicaid dental services, the general managed care plan subcontracts with a dental managed care plan to actually provide services. Thus, among states using managed care in either Medicaid or separate programs, virtually all children are receiving care from a dental managed care plan.

In addition to being more likely to use managed care arrangements to provide dental services than Medicaid programs, separate programs were also somewhat more likely to contract directly with a dental managed care plan. Under both types of programs, states reported paying managed care organizations on a capitated basis—with all-inclusive capitation amounts paid to general plans, and partial capitation amounts paid to dental plans.[6] Regardless of the arrangement, however, general health plans and dental plans reportedly paid individual dentists on a fee-for-service basis.

Dental Access Contract Requirements

States using managed care can impose certain network standards upon plans through their contracts. To determine how prevalent these requirements are, we asked states about the nature of their contracting specifications. We found that the most common contracting stipulations used by states were provider-to-enrollee ratios and requirements with respect to traveling times or distances and waiting times for appointments. For example, New Jersey, under both its separate program and its Medicaid expansion, requires each plan to have one full-time equivalent primary care dentist per 1,500 enrollees. New Jersey is also the only study state to require pediatric dentists to be included in a plan's network, although the exact number of pediatric dentists required is not specified. Connecticut, which has a combination program that uses managed care for both its separate SCHIP program and its Medicaid expansion, requires one dental provider per 739 enrollees.

Michigan's separate program, MIChild, is notable for its dental service appointment policy, which prohibits plans from treating MIChild enrollees differently from other insured or self-pay patients. Specifically, the state requires dentists participating in MIChild plans who are accepting new insured or self-pay patients to also accept new MIChild patients. Similarly, if a privately insured or self-pay patient is able to get an appointment with a plan dentist in three weeks, then the dentist must apply this same waiting period to a MIChild patient.

Several states have requirements with respect to travel times and distances, and waits for appointments, that apply to all providers, including dentists. Missouri, under its Medicaid expansion, requires plans to provide an appointment for urgent, serious care at any time; for urgent care on the same day; for urgent, nonroutine care within two days; and for routine care within thirty days. Missouri also requires that each plan enrollee have access to a provider within 30 miles of his or her home, with allowances made for plans serving rural counties. Wisconsin, under its Medicaid expansion, requires plans to provide access to primary dental care within 35 miles and 90 days. Florida's separate program requires that plans provide an appointment for preventive care within four weeks and for emergency care the same day. Florida also requires that each plan enrollee have access to a plan provider within 20 miles or 20 minutes from his or her home.

Network Adequacy

Most state officials in separate programs believed that the managed care networks afforded good access to dental services and were an improvement over Medicaid.

Certain states, such as Michigan and California, reported that their SCHIP systems had significantly increased the number of dentists available to children and that this increased supply had led to greater access to care. A few states, such as New York, reported that it was still a challenge to develop adequate networks for SCHIP enrollees living in rural areas in the state. In contrast, Connecticut, which is using essentially the same dental system for Medicaid and its separate program, reported that the managed care system, like the fee-for-service system, is not providing good access to dental services.[7] State officials speculated that this was due to the low reimbursement rates being paid under both Medicaid and SCHIP.

Officials had mixed views of network adequacy under SCHIP in the small number of states that used fee-for-service arrangements for their separate programs. In Alabama, where fee-for-service systems are used for both SCHIP and Medicaid, state officials reported significantly more dentists were participating in ALL Kids, leading to higher utilization rates among the SCHIP enrollees compared with those in Medicaid. Mississippi officials, on the other hand, could not yet assess the adequacy of the state's SCHIP dental network, reporting that it was too early in the program's history to reach any conclusions.

The few states using managed care to deliver dental services under Medicaid also gave mixed reviews. Officials in Missouri, whose Medicaid program uses managed care in urban portions of the state and fee-for-service in rural regions, reported that dentists are more willing to participate in the managed care system than in the fee-for-service system, due in part to the higher fees being paid by managed care plans. In Wisconsin, where the Medicaid program also uses both managed care and fee-for-service to deliver dental services, state officials believe that managed care holds the promise of better access because plans contracting with the state must agree to provide access to primary care dentists to all enrollees. However, state officials also acknowledge that access, as measured by utilization of dental services, is similar across the two systems. Representatives from Pennsylvania's Medicaid program, which also uses both managed care and fee-for-service arrangements, also reported some difficulty establishing adequate dental networks in the state.

Finally, the traditional fee-for-service Medicaid system was almost universally described as having an inadequate number of providers. Respondents repeatedly described the main problem as "not having enough dentists." For some states, the shortage was specific to the Medicaid program, while other states had an overall shortage of dentists. Many states, including Colorado, Florida, New York, and Alabama, noted that dentist shortages were particularly acute in rural areas.

Among the states in our study, three emerged as having taken notable steps under their separate SCHIP programs to redesign dental care delivery and payment arrangements to improve children's access. Two of these states—California and Michigan—used managed care strategies, while one—Alabama—introduced a new fee-for-service arrangement. All three states reported supporting their new initiatives with competitive payment amounts. These states' early experiences are summarized in the following vignettes.

Alabama's ALL Kids Dental Program

Like many states, Alabama has a history of providing poor access to dental services under Medicaid. Importantly, though, at the time of SCHIP implementation, the state was beginning to take steps aimed at improving dental access. In 1998, the state created a task force that brought together dentists from across the state to identify the concerns that discouraged dentists from signing up as Medicaid providers. The task force identified three primary concerns: low fees, missed appointments, and an outdated or confusing billing system. With the proceeds from the tobacco settlement, the Medicaid agency planned to increase fees, offer training to help providers with billing software, and recruit new providers.

When developing its SCHIP program, Alabama adopted the benefit package of its largest commercial HMO, United Health Care, for its separate program. State policymakers chose to implement a separate SCHIP program in combination with a Medicaid expansion. Most agreed that, although in theory the Medicaid package was richer than the coverage chosen for ALL Kids, access to some services in the Medicaid program, including dental, was so severely limited due to lack of participating providers that in fact that Medicaid program was far more restrictive than it appeared on paper. The SCHIP dental package includes all major preventive, diagnostic, and restorative services. It also covers endodontic, periodontic, and prosthodontic services, but does not cover orthodontic services.

Alabama has contracted with Blue Cross/Blue Shield (BC/BS), the largest insurance carrier in the state, to use its preferred providers network (PPO), which includes a dental network to serve ALL Kids enrollees[8]. The BC/BS network includes about 70 percent of the state's active licensed dentists and at least one dentist in each county. To help ensure access to care, the state's contract with BC/BS requires that if a dental practice participating in the BC/BS PPO network is accepting new private or self-pay patients, then it must accept ALL Kids enrollees as well.

The state uses a fee-for-service system to pay BC/BS, with fees significantly higher than those under Medicaid. For example, a periodic oral evaluation is reimbursed at $17 under ALL Kids, compared with $13 under Medicaid; a teeth cleaning is reimbursed at $29 under ALL Kids, compared with only $16 under Medicaid; and a silver filling is reimbursed at $49 under ALL Kids, compared with only $27 under Medicaid.

Within the first three months of enrollment, BC/BS reminds all enrollees to get a dental and medical appointment. Then BC/BS staff check to see whether a claim has been filed for a dental appointment. If not, staff will follow up with the family to encourage them to make an appointment. The state had planned to call these families, but found that the volume of calls made the strategy unfeasible, and is revisiting how to handle this procedure.

ALL Kids officials report that they saw some early evidence of pent-up demand for dental services and that overall utilization of dental services has been higher than under Medicaid. The state reports that 20 percent of ALL Kids expenditures in fiscal year 1999 and 35 percent of claims in calendar year 1999 were for dental services.

Alabama's SCHIP program shows promise for improving access to dental services for low-income children because of the strong commitment from state leaders to improve dental access under Medicaid and to use SCHIP as a standard that Medicaid could emulate. Prior to SCHIP implementation, the state had already stated its commitment to using funds from the tobacco settlement to increase Medicaid fees. In September 2000, the governor announced a significant increase in Medicaid reimbursement rates, including a $6.4 million increase for children's dental services. The increase raises dental fees from 60 percent to 100 percent of BC/BS rates.

California's Healthy Families Dental Program

California implemented a separate state program, Healthy Families, because of the strong anti–Medicaid sentiment in the state and the desire of state policymakers to develop a plan that resembled private insurance. While the federal SCHIP legislation was being developed, California policymakers began formulating ideas about how the state SCHIP program should look. They recognized that a private insurance component would be a sine qua non for the approval of any expansion, because the governor at the time was a strong opponent of any entitlement program expansions. The decision made was to use a private insurance model, namely the state employee health benefits plan, CalPERS, which included a dental benefit. The result was minimal controversy over including dental services in the package.

The dental package includes all major preventive, diagnostic, and restorative services. The package also covers endodontic, periodontic, and prosthodontic services, but does not cover orthodontic services except in cases of severe malocclusion. No copayment is required for preventive and most restorative services. A $5 copay is required for oral surgery, endodontic services, crowns, prosthodontic services and other complex procedures.

The state uses dental managed care plans to deliver services, and currently contracts with five dental plans across the state. The state negotiated per-child-per-month capitated payment amounts with each plan. Healthy Families will not release the amount of its capitation rate allocated for dental services, but the state tried to set its payment rates to be comparable with those in the private market. Three of the plans reimburse providers on a capitated basis for most services, and the other two reimburse providers on a fee-for-service basis. Families select a dental plan during the enrollment process. The application packet provides information on the available dental plans and their providers, and a toll-free phone number is available for families to call for help selecting a dentist.

Delta Dental, the plan with the largest number of Healthy Families enrollees, has seen higher-than-anticipated utilization. The plan, which enrolls about 60 percent of Healthy Families enrollees, reports that of these, about 70 percent had a visit within the first six months of enrollment. This rate is about 11 percent higher than seen in an average employer-sponsored group. About 60 percent of these visits have been for preventive services, and the rest for restorative care. The plan reports that the fees it pays its dentists are higher than the Medicaid fee schedule.

State officials and residents are very pleased with the dental program under Healthy Families. Respondents reported that dental benefits were a major inducement for families to sign up their children for Healthy Families. State officials acknowledge that it has been difficult to develop and maintain adequate provider networks in rural areas and, as a result, it has funded several Rural Health Demonstration Projects to promote increased access to dental services. Under this project, plans bid for funding for projects such as rate enhancements for rural dentists, mobile dental vans, and additional dental staff at rural clinics.

Michigan's MIChild Dental Program

Michigan's decision to implement a managed dental care system for its SCHIP population was shaped by the state's experience providing dental services under Medicaid. In common with many other Medicaid dental programs, Michigan's program had a history of limited provider participation and poor access. Dentists complained of high administrative burdens, low fees, and a reported high rate of no-shows, while enrollees complained of having to travel great distances to see a dentist or not being able to find a dentist who would see them at all.

In 1997, before SCHIP, the state established the Medicaid Dental Task Force to provide recommendations for increasing dentist participation in Medicaid to improve access. The task force made two main recommendations: Increase fees and increase the use of managed care. In response to these recommendations, the state has twice raised fees for all dental services provided to children under age 21, to 70 percent of usual, customary, and reasonable (UCR) reimbursement. In spite of these increases, Medicaid participation has not increased enough to improve access.

With the passage of SCHIP, Michigan chose its state employee's health plan as its benchmark for the MIChild program. The dental benefit package includes preventive, diagnostic, and restorative services. Dental benefits are capped at $600 per child per year.

MIChild uses managed dental plans to deliver services to all its enrollees. Currently the state contracts with four plans, two of which cover the majority of MIChild enrollees. Plans are paid a capitated per-month-per-member amount. For the most part, plans are paying individual dentists on a fee-for-service basis at 100 percent of UCR levels, unless this amount exceeds the 80th percentile of the average reimbursement for that service by all participating dentists.

The MIChild application packet includes information about participating dental plans, with families required to select a dental plan and a managed care plan in order to enroll. Families can call a toll-free number run by the state's enrollment broker, Maximus, for assistance in selecting a dental plan.

Michigan requires that participating plans prohibit their dentists from discriminating across payer types in terms of access. If a plan dentist is accepting new patients, he or she must also accept MIChild patients. Similarly, if a private-pay patient is able to get an appointment with a dentist in three weeks, then a MIChild enrollee must be able to do the same. In addition, enrollees are provided with a member identification card that looks very similar to the one given to commercial enrollees. In this way, MIChild enrollees look no different than private-pay patients.

The state decided to use a managed care system because it believed that this would guarantee access. The largest two plans, with the vast majority of MIChild enrollees, report that 90 percent of the state's active licensed dentists participate in one or both plans. Early reports from the dental plans show very high utilization levels in the first year of the program, perhaps reflecting pent-up demand for dental services. BC/BS, which enrolls about 55 percent of MIChild enrollees, reports that 74 percent of its members received at least one preventive care visit between October 1, 1998 and December 31, 1999. Similarly, Delta Dental, which enrolls about 41 percent of MIChild enrollees, reports that 75 percent of the members in its Premier program and 55 percent of MIChild members in its Preferred program had a preventive care visit between August 1, 1998 and July 31, 1999.

Michigan officials are very pleased with the MIChild dental program thus far. In fact, they have recently begun a Medicaid pilot dental project patterned after MIChild. Early evidence shows an increase in utilization of dental services among Medicaid children participating in the pilot project.

Payment Amounts

Given that for years, the most common complaint lodged by dentists against Medicaid has been that the program pays fees well below dentists' customary fees, we were interested in learning whether SCHIP programs were increasing fees in hopes of attracting more dentists. We collected information on fees for three procedures commonly performed on children: periodic oral examinations, teeth cleanings, and amalgam fillings. We also collected information on the percentage of UCR reimburse-

ment that states were paying for dental services and the capitation amount that they were paying managed care plans for dental services. Available comparable data suggests that some, but not all, states have increased payment amounts for dental services under SCHIP to levels above those of Medicaid.

Although some state SCHIP officials reported that their programs paid more for dental services than did their states' Medicaid programs, it was difficult to document the exact difference in payment amounts. The ideal way to examine this issue would be to compare the fees paid for the same procedure under both a state's separate SCHIP program and its Medicaid program. However, this comparison is difficult to make for a variety of reasons, including the following:

- In states where Medicaid is using a fee-for-service system and the separate state program is using a managed care system, capitation payments cannot be compared with fee-for-service reimbursement amounts.
- In states where both programs are using managed care, if the dental benefit packages are different, the differences in capitation rates may reflect the composition of the packages rather than the generosity of payment amounts. Also, some states will only make public a global capitation rate—the single rate paid to plans for all capitated services—and will not indicate what portion of that capitation is actuarially associated with dental expenditures.[9]
- In states where both programs are using fee-for-service arrangements, often the separate state program has purchased a dental network through an indemnity insurer and the rates paid to providers by that insurer are proprietary.

Four states (Alabama, Michigan, New York, and North Carolina) provided us with comparable data that showed that separate SCHIP programs are paying more for dental services than Medicaid programs, while two states (Connecticut and Massachusetts) are paying about the same across the two programs. Alabama uses a fee-for-service system for Medicaid, while under its separate SCHIP program—ALL Kids—the state contracts with the Blue Cross/Blue Shield network to provide services. Blue Cross/Blue Shield, in turn, pays its providers on a fee-for-service basis. As table 4 shows, the fees being paid under the separate state program are significantly higher than those being paid under Medicaid program.[10] For a periodic oral exam, for example, the fee paid under ALL Kids is about 30 percent higher than the comparable fee

Table 4. *Reimbursement Rates for Selected Dental Procedures in Alabama*

Procedure	Separate SCHIP Program (ALL Kids)	Medicaid
Periodic oral evaluation (D0120)	$17	$13
Prophylaxis (teeth cleaning) (D1120)	$29	$16
Amalgam restoration: one surface, primary tooth (filling) (D2110)	$49	$27

Source: Urban Institute State Children's Health Insurance Program evaluation.
Note: American Dental Association (ADA) standard procedure codes are in parentheses.

THE URBAN INSTITUTE

under Medicaid. For cleanings and fillings, the difference is even larger: ALL Kids is paying about 80 percent more than Medicaid for these two services.

Although unable to report fee information, North Carolina and Michigan provided the percentage of UCR reimbursement that their programs were paying for dental services, and New York was able provided the capitation amounts paid for dental services under managed care. North Carolina reported that under its separate state program, Health Choice, dentists are reimbursed at 90 to 95 percent of UCR levels. In contrast, under Medicaid dentists are reimbursed at 60 percent of UCR rates for the most common procedures, and at 40 percent for less-common procedures. Michigan's SCHIP program reported that plans are paying dentists on a fee-for-service basis at 100 percent of UCR reimbursement levels,[11] compared with an average of 70 percent of UCR reimbursement levels under Medicaid. New York reported that, under its separate SCHIP program, it pays an average capitation amount of $12.25 per member per month to plans for dental services, while under its Medicaid program it pays an average of $7.00 per member per month.

In contrast, Connecticut and Massachusetts appear to be paying about the same amount for dental services under their separate SCHIP and Medicaid programs. Massachusetts, which uses the same fee-for-service delivery system and dental benefit package for its separate SCHIP and Medicaid program, reimburses dental services according to the state's Medicaid fee schedule under both programs. Connecticut uses a similar managed care delivery system and dental benefit package across its separate SCHIP and Medicaid program. The state reports that, although the overall capitation rate paid to plans varies across the two programs, the amount of the capitation rate for dental services is the same. Plans are free, however, to choose the amount they spend on dental services.

Other Efforts to Enhance Provider Participation within Medicaid

Although the most common reason cited by dentists for not participating in Medicaid is low fees, cumbersome administrative and billing procedures, as well as high rates of missed appointments by Medicaid recipients, are also often associated with participation problems. Therefore, while acknowledging that increasing payment levels might constitute a necessary step toward improving participation, we also examined whether SCHIP and Medicaid programs were taking additional steps to improve dental provider participation. We found that a number of strategies were being undertaken, including those described below.

- ***Simplifying billing procedures.*** Several states, including Colorado, Massachusetts, Missouri, and Wisconsin, permit electronic billing by dentists. Some states, including Pennsylvania and Wisconsin, have recently switched to the most up-to-date version of the Current Dental Terminology (CDT) procedure codes. Although other insurance carriers allow dentists to bill using a standard claim form developed by the ADA, Medicaid programs have often required that dentists use a Medicaid claim form for Medicaid patients. Many states, however, reported that they had recently changed this policy and now allow dentists to use standard ADA forms to submit Medicaid claims. (This change was reported by officials in Michigan, Missouri, Ohio, and Wisconsin.) In one state, Wisconsin,

dentists can call the state's fiscal agent's office to speak to a staff person who is specifically trained to answer dental policy and billing questions. In the near future, dentists in Missouri will be able to submit claims online, allowing dentists to immediately find out whether their claims are error-free.

- ***Reducing prior authorization requirements.*** Officials in several states, including Colorado, Massachusetts, Michigan, Missouri, and Wisconsin, also mentioned that they had reduced the number of procedures for which prior authorization was necessary, or made it easier for dentists to obtain prior authorization for selected procedures. Massachusetts, for example, has modified its prior authorization requirements for emergency dental services so that dentists can now provide these services and request "prior" authorization after the services are renendered.
- ***Expanding dental hygienists' scope of practice.*** A few state officials also described efforts to increase dental hygienists' scope of practice in order to increase access. For example, Connecticut and Missouri have updated their Medicaid regulations to allow dental hygienists who have met specific training and experience requirements to provide certain dental services under the general supervision of dentists or in areas with a shortage of dental professionals.

In sum, states have recognized the need to improve dental access and have undertaken a variety of measures to make it more attractive for dentists to participate in Medicaid and SCHIP and easier for them to see patients once enrolled. It is worth noting that none of the efforts described here were aimed at addressing the problem of Medicaid enrollees' perceived high rates of missed appointments. State officials questioned whether strategies are available to effectively address this problem.

Impact of SCHIP Dental Programs on Medicaid Programs—The "Spillover" Effect

In two states—Michigan and Alabama—officials reported that the early successes of their SCHIP dental programs had hastened reform efforts under their state's Medicaid dental program.

- In Michigan, the early success of the dental program under MIChild has prompted more serious reform efforts in the Medicaid dental program. The state has appropriated $10.9 million to improve access to dental services for Medicaid children. The money will be spent on two initiatives: funding safety-net providers to expand dental service capacity; and funding a 22-county pilot project using Delta Dental to provide Medicaid dental benefits through a PPO arrangement. The pilot project, which began in May 2000, will enroll about 50,000 children in a mix of rural and urban counties. The state will pay dental managed care plans a capitation rate of $11.49 per member per month. An early report shows that 33 percent of Medicaid children enrolled in the pilot project used a dental service between May and December 2000, compared with 18.4 percent of Medicaid children under 21 years of age during the same months of 1999 (Eklund, Clark, and Feigal 2001). State officials are optimistic that if the pilot project continues to work well, it can be expanded to include all of Medicaid.

- In Alabama, where reform efforts around the Medicaid program were in process before SCHIP implementation, the success of the ALL Kids program has prompted the state to move quickly to increase fees under Medicaid. In September 2000, the governor announced a significant increase in Medicaid reimbursement rates, including a $6.4 million increase for children's dental services. The increase will raise dental fees for children from 60 to 100 percent of Blue Cross/Blue Shield rates to help ensure equitable access to care.

Early Measures of Provider Supply and Service Use

Given the significant number of states that are implementing new dental service models under their separate SCHIP programs, we used supply and use indicators as proxies for access. We requested information on the percentage of the state's licensed dentists participating in SCHIP and Medicaid and on the percentage of participating providers billing for at least one service. We also requested information on the proportion of all expenditures and claims for dental services and on the proportion of all children who received any dental service. Although data are preliminary and were not submitted in a consistent manner by states, they suggest that improvements in access may be occurring under separate SCHIP programs when compared with Medicaid.

Provider Participation

In the two states that could provide such data for their separate programs and for Medicaid, it appears that the percentage of dentists participating in SCHIP is much larger than the number participating in Medicaid (see table 5). Specifically, the separate programs in Alabama and Michigan reported dental participation rates of between 70 and 90 percent, while the Medicaid programs in these states reported participation rates of just over 25 percent. In Alabama, 71 percent of the state's dentists are providers in the Blue Cross/Blue Shield network with which the state contracts for dental services, while only 26 percent of the state's licensed dentists participate in Medicaid. Similarly, in Michigan, state officials report that the two largest dental plans with which MIChild contracts enroll 90 percent of the state's dentists, while just 27 percent of licensed dentists in the state participate in Medicaid. These large differences in provider participation may be attributable to the fact that both these states are using a non-Medicaid model of dental service delivery.

Participation rates in two other states suggest that some Medicaid programs have been able to achieve high rates of participation. Although Florida and Missouri have Medicaid dental participation rates similar to Alabama's—19 percent—Ohio and Wisconsin report that between 58 and 65 percent of the state's dentists are participating Medicaid providers.[12]

Table 5. *Participating Dental Providers in Separate SCHIP and Medicaid Programs*		
	Percent of Licensed Dentists Who Are Participating Providers	
State	**SCHIP separate program**	**Medicaid**
Alabama	71	26
Michigan	90*	27
Florida	Data not provided	19
Missouri	No separate program	19
Ohio	No separate program	65
Wisconsin	No separate program	58

Source: Urban Institute State Children's Health Insurance Program evaluation.
Notes:
* An asterisk indicates percentage of the state's licensed dentists enrolled as providers in the two largest SCHIP dental plans.
Data were not provided or state officials were not interviewed in California, Colorado, Connecticut, Massachusetts, Minnesota, Mississippi, New Jersey, New York, North Carolina, Pennsylvania, Texas, and Washington.

Utilization

Preliminary data from a few states provide evidence that children enrolled in separate SCHIP programs may be using dental services at higher rates than has traditionally been seen under Medicaid, but reported utilization rates varied tremendously across states. As table 6 shows, California's largest SCHIP dental plan, Delta Dental, reported that about 70 percent of enrolled children had received a service within six months of enrolling in the program. In contrast, although not a perfectly comparable measure, an estimated 36 percent of children enrolled in Medicaid had been seen by a dentist in 1999. Similarly, Michigan reported that 74 percent of children enrolled in its largest MIChild dental care plan received a preventive care service between October 1998 and December 1999, while the annual EPSDT report showed that just 25 percent of children enrolled in Medicaid received a dental assessment in fiscal year 1997.

The experiences of New York and Connecticut suggest more modest gains. In Connecticut's separate SCHIP program, 31 percent of children had a dental visit between July and December 1999, compared with 34 percent of Medicaid children between October 1998 and September 1999. The similarity in these rates is less surprising when one recalls that Connecticut uses virtually the same dental delivery system for both its separate SCHIP program and its Medicaid program. New York reported that 17 percent of children enrolled in Child Health Plus received a dental service in 1999, compared with 13 percent of EPSDT eligibles in fiscal year 1997, as noted in its 1997 EPSDT report.

Table 6. *Utilization of Dental Services in SCHIP and Medicaid Programs*

State	Percentage of Children with a Dental Visit	
	SCHIP Separate Program	Medicaid
California[a]	70	36
Michigan[b]	74	25
Connecticut[c]	31	34
New York[d]	17	13

Source: Urban Institute State Children's Health Insurance Program evaluation.
Notes:
a. California's SCHIP figure is the percentage of children enrolled in the program's largest dental plan, Delta Dental, who received a dental service within the first six months of enrollment. California's Medicaid figure is for calendar year 1999 and is based on a 10 percent sample of enrollees.
b. Michigan's SCHIP figure is the percentage of children enrolled in the program's largest SCHIP dental plan who received a preventive dental visit between October 1998 and December 1999. Michigan's Medicaid figure is for fiscal year 1997 and was obtained from the state's 1997 Annual EPSDT report.
c. Connecticut's SCHIP figure is for six months (July through December 1999) and its Medicaid figure is for one year (October 1998 and September 1999).
d. New York's SCHIP figure is for 1999 and its Medicaid figure is for fiscal year 1997 and was obtained from the state's 1997 Annual EPSDT report.
Data not provided or state officials not interviewed in Alabama, Colorado, Florida, Massachusetts, Minnesota, Mississippi, Missouri, New Jersey, North Carolina, Ohio, Pennsylvania, Texas, Washington and Wisconsin.

Conclusions and Policy Implications

This study has found that, although dental coverage is not a requirement under Title XXI, nearly every separate SCHIP program is offering it, and benefits appears to be fairly comprehensive. Although not as broad as Medicaid's EPSDT program, coverage under most separate programs includes basic preventive, diagnostic, and restorative services, and cost-sharing requirements appear quite low.

Some states with separate programs are delivering dental care through methods not traditionally used under Medicaid. These approaches often reflect state policymakers' decision to deliver dental services under SCHIP through managed care arrangements, representing a departure from the fee-for-service systems largely relied on under Medicaid. State officials reported that the decision to use managed care for dental care was made primarily with the goal of improving access rather than to contain costs or to "privatize" a government-sponsored health insurance program. By using managed care arrangements, states are purchasing a clearly established and identified network of providers and with it, they hope, better access. Furthermore, contracts with managed care organizations provide states, at least in theory, with an entity that can be held accountable for ensuring that enrolled children are receiving covered services. Whether managed care plans will succeed in improving access to dental care will depend, in large part, on the extent to which states hold the plans accountable for meeting their contractual obligations and the adequacy of the capitation rates paid to plans.

Separate SCHIP programs appear to be supporting their new delivery systems with higher payment rates. In some cases, we could identify states that were paying higher rates to SCHIP plans than to Medicaid plans. In other cases, we found that managed care plans were paying dentists fee-for-service rates that were higher than those traditionally paid by Medicaid. In these cases, it appeared that the higher rates were set to help ensure an adequate supply of providers participating in managed care networks. Policymakers hope that the higher payment levels will translate into improved dental provider participation and, in turn, greater access to dental services for children. However, it is important to note that raising payment levels has been a priority for many Medicaid programs in recent years. Virtually every Medicaid official we spoke with reported that payment increases had been proposed numerous times in the past but that various political and fiscal constraints prevented their approval or resulted in only nominal increases. The relatively small size of SCHIP programs compared with Medicaid may have made fee increases more palatable to state legislators because the budgetary impact is not nearly as large.

The use of different delivery systems supported by higher payments appears to be contributing to improved provider participation and better access to dental care in some separate SCHIP programs. Although the available data are limited, early evidence from two states in particular—Alabama and Michigan—shows much higher rates of provider participation in SCHIP than in Medicaid. However, both the limitations of state data systems and the constraints surrounding encounter data from managed care plans demand that these findings be viewed with caution, as it was difficult to rigorously compare either dentist participation or child dental service utilization rates between separate SCHIP programs and Medicaid programs. Moreover, we should be cautious in concluding that increased provider participation has a causal effect on use of services; some of the higher utilization under separate SCHIP programs may result from higher demand for dental services by the higher-income parents of children enrolled in SCHIP, who are likely to be better educated than the parents of Medicaid-covered children.

The important question of whether improvements in dental provider supply and dental service use among SCHIP enrollees lead to improved oral health outcomes will be difficult to answer. None of the study states had plans to track oral health outcomes to assess the impact of different delivery systems on the oral health of children. Furthermore, in most states, enrollment in separate SCHIP programs is small relative to enrollment in Medicaid, so it is unlikely that substantial improvements in oral health indicators would result from improvements occurring exclusively among the SCHIP population. In addition, many low-income children are covered by employer-based or other private health insurance for their medical care, but do not have a comprehensive dental benefit. Because these children are privately insured, they are not eligible for SCHIP and cannot avail themselves of dental coverage under SCHIP. Expanding SCHIP to furnish dental services on a wraparound basis to privately covered low-income children without dental coverage could help achieve broader improvements in children's oral health.

It is probably more realistic to conclude that widespread improvements in oral health for low-income children will occur only if the improvements seen in some separate SCHIP programs also occur in Medicaid. Some spillover has already occurred

in Michigan and Alabama, where the early successes of dental programs under SCHIP have spurred policy improvements in Medicaid. Other improvements may result from increased focus on Medicaid dental issues within HCFA. Responding to recent national attention focused on poor access to dental services under Medicaid, the HCFA administrator issued a letter to state Medicaid directors indicating that the agency will attempt to spur state-level reform by increasing its technical assistance and oversight role with respect to dental access (HCFA 2001). In 2001, HCFA plans to launch a series of reviews of state practices in the areas of outreach, reimbursement, provider participation, and claims processing, which could trigger reforms within Medicaid.

Large-scale improvements in Medicaid dental programs may be difficult to achieve across many states, however, because of the higher costs that would be associated with expanding supply or increasing fees in Medicaid programs. Recent growth in state Medicaid spending could dim the prospect of widespread reform. Finally, dental providers would also have to be willing to participate in Medicaid in much larger numbers and, in turn, be willing to serve larger numbers of Medicaid children than they have in the past.

In sum, under SCHIP, some states have relied on different models for delivering dental services to children than under Medicaid. It appears that states that have supported these models with competitive payment rates have experienced early success in their dental programs. The question now is whether states will choose to maintain this level of effort under SCHIP and to make comparable investments within Medicaid.

Appendix A

Study States' Insurance Program Choices

Table A1. *Type of SCHIP Program*

State	Medicaid Expansion	Separate Health Insurance Program	Combination
Alabama			X
California			X
Colorado		X	
Connecticut			X
Florida			X
Massachusetts			X
Michigan			X
Minnesota	X		
Mississippi			X
Missouri	X		
New Jersey			X
New York			X
North Carolina		X	
Ohio	X		
Pennsylvania		X	
Texas			X
Washington		X	
Wisconsin	X		

Appendix B

Key SCHIP and Medicaid Contacts in the Study States

Alabama — Gayle Sandlin and Sherry Goode

California — Sandra Shewry and Robert Isman

Colorado — Barbara Ladon, Dean Woodward, Linda Rad, and Karen Snell

Connecticut — David Parella

Florida — Rose Naff and Nancy Ross

Massachusetts — Mark Reynolds, Pat Canney, Janet Pearlman, and Deborah Oser

Michigan — Denise Holmes, Chris Farrell, and Kyle Boyer-Straley

Minnesota — Mary Kennedy

Mississippi — Theresa Hanna and Geneva Cannon

Missouri — Greg Vadner, Robin Rust, Pam Victor, and Judy Wardell

New Jersey — Michelle Walsky

New York — Judy Arnold, Elizabeth McFarland, and Rebecca Gray

North Carolina — June Milby and Victoria Talton-Parrish

Ohio — Sukie Barnum, Robin Colby, and Katie Stevenson

Pennsylvania — Patricia Stromberg and Linda Shatzer-Miller

Texas — Jason Cooke

Washington — Steven Wish and David Hanig

Wisconsin — Peggy Bartels and Mary Laughlin

References

American Academy of Pediatric Dentistry (AAPD). 1999. Reference Manual, 1999–2000, Special Issue. "Periodicity of Examination, Preventive Dental Services, and Oral Treatment for Children." *Pediatric Dentistry* 21(5).

Brennan, Niall, John Holahan, and Genevieve Kenney. 1999. "Health Insurance Coverage of Children." In *Snapshots of America's Families.* Washington, D.C.: The Urban Institute.

Edelstein, Burton L., and Chester W. Douglass. 1995. "Dispelling the Myth That 50 Percent of U.S. Schoolchildren Have Never Had a Cavity." Public Health Reports 110, September/October.

Edelstein, Burton L., Richard J. Manski, and John F. Moeller. 2000. "Pediatric Dental Visits during 1996: An analysis of the Federal Medical Expenditure Panel Survey." *Pediatric Dentistry 22:* 17–20.

Eklund, Stephen A., Sarah J. Clark, and Robert Feigal. 2001. "Evaluation of Changes in Utilization and Services under the Healthy Kids Dental Demonstration Program." Report to the Michigan Medical Services Administration. Departments of Dentistry, Pediatrics, and Public Health. University of Michigan, Ann Arbor, MI. February 16.

Health Care Financing Administration (HCFA), U.S. Department of Health and Human Services. 1997. *Annual EPSDT Participation Report, FY 1997.* Washington D.C.: HCFA .

———. 2001. Letter to State Medicaid Directors from Timothy Westmoreland. January 18.

Kaste, Linda M., Robert H. Selwitz, Richard J. Oldakowski, Janet A. Brunnelle, Deborah M. Winn, and Laura J. Brown. 1996. "Coronal Caries in the Primary and Permanent Dentition of Children and Adolescents 1–17 Years of Age: United States, 1988–1991." *Journal of Dental Research* 75 (special): 631–41.

Kenney, Genevieve M., Grace Ko, and Barbara A. Ormond. 2000. "Gaps in Prevention and Treatment: Dental Care for Low-Income Children." Washington, D.C.: The Urban Institute. *Assessing the New Federalism* Policy Brief B-15.

National Center for Health Statistics (NCHS). 1996. "Current Estimates from the National Health Interview Survey, 1996." Series 10, No. 200. Hyattsville, MD: Public Health Services.

U.S. Department of Health and Human Services (HHS). 2000a. Oral Health in America: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health.

——— (HHS). 2000b. *Healthy People 2010: Understanding and Improving Health,* 2d ed. Washington, D.C.: U.S. Government Printing Office, November.

U.S. General Accounting Office (GAO). 2000. *Factors Affecting the Use of Dental Services.* GAO/HEHS-00-149. Washington, D.C.: GAO, September.

Vargas, Clemencia M., James J. Crall, and Donald A. Schneider. 1998. "Sociodemographic Distribution of Pediatric Dental Caries: NHANES III, 1988–1994." *Journal of the American Dental Association* 129, September.

Vargas C.M., R. Isman, and J.J. Crall. Forthcoming. *Journal of Public Health Dentistry.*

THE URBAN INSTITUTE

Notes

1. For a breakdown of which study states implemented a Medicaid expansion, developed a separate health insurance program, or used a combination of the two approaches, see appendix A.
2. These states are Alabama, California, Colorado, Connecticut, Florida, Massachusetts, Michigan, Mississippi, Missouri, New York, North Carolina, Ohio, Pennsylvania, and Wisconsin.
3. In early 2000, Colorado's legislature approved the inclusion of dental benefits in its SCHIP program pending a feasibility study. If implemented, this would leave only one state—Delaware—that chose not to provide dental benefits under a SCHIP expansion.
4. This includes New Jersey, which has three components to its separate program: New Jersey KidCare Part B (covering children from 133 to150 percent of the federal poverty level [FPL]), Part C (covering children from 151 to 200 percent of the FPL), and Part D (covering children 200 to 350 percent of the FPL). Parts B and C have a Medicaid dental benefit and Part D has a limited dental benefit. The majority of separate SCHIP enrollees belong to Parts B and C.
5. A malocclusion is a condition where the upper and lower teeth are incorrectly positioned when the mouth is closed.
6. States paying all-inclusive capitation rates to general health plans were unable to identify for us the portions of those capitations that actuarially accounted for dental costs.
7. Connecticut's separate program contracts with three general managed care plans, while its Medicaid program contracts with four managed care plans. State respondents noted that basically the same network of dentists was serving both groups of children and that the state's contracts under both SCHIP and Medicaid were quite similar with regard to network requirements. Global capitation rates paid by the state do vary across the SCHIP and Medicaid programs, but these differences reflect cost-sharing requirements and benefit package differences rather than dental payment amounts. Further, the state does not determine what the managed care plan pays its dental subcontractor.
8. In the first year of the program, the state also contracted with PrimeHealth, an HMO, to provide ALL Kids services on a capitated basis in 10 southwestern counties. In these counties, enrollees had a choice of enrolling with PrimeHealth or BC/BS. As of October 2000, the state no longer contracted with PrimeHealth, leaving BC/BS as the sole ALL Kids carrier in the state.
9. Even if a state does make public the amount of the capitation rate that is for dental services, that amount does not indicate how much is actually being spent on dental services, since managed care plans can choose to spend more or less on particular services within their capitation rate.
10. In September 2000, the governor announced a significant increase in Medicaid reimbursement rates, including a $6.4 million increase for children's dental services. The increase will raise dental fees from 60 percent to 100 percent of BC/BS rates.
11. Plans reimburse dentists at 100 percent of UCR reimbursement levels unless this exceeds the 80th percentile of the average reimbursement level for that service among participating plan dentists.
12. Provider participation does not necessarily mean that these dentists are actually treating Medicaid or SCHIP patients. To fully understand the implications of high or low provider participation rates, it is important to also measure the extent to which participating dentists provide a large number of services to SCHIP and Medicaid enrollees. We attempted such an examination and requested data on the percentage of providers that billed for a "significant" amount of services. (The definition of a "significant" was left to the discretion of state officials and typically was defined as dentists who submitted at least $10,000 worth of claims in the past year.) Unfortunately, SCHIP programs were unable to provide these data and we received such measures only from Medicaid programs, so we were not able to compare the experiences of SCHIP and Medicaid programs. The findings from Medicaid programs are mixed, but often show that although a fairly high proportion of enrolled providers bill for at least one service, small proportions of providers are billing for a significant amount of services. For example, 23 percent of Colorado's dentists are enrolled as Medicaid providers, but only 12 percent of these were billing more than $10,000 worth of claims to Medicaid. Similarly, in Pennsylvania, 24 percent of the state's licensed dentists participate in Medicaid, but only 19 percent of these are billing more than $10,000 worth of claims. On the other hand, in Michigan, only 27 percent of the state's licensed dentists are Medicaid participating providers, but 68 percent of these billed Medicaid for over $5,000 worth of claims. In Massachusetts' combination program, only 19 percent of the state's dentists participate as Medicaid/SCHIP providers, but 70 percent of these billed more than $10,000 worth of claims. Finally, in Wisconsin, 58 percent of the state's dentists are participating in Medicaid, but a relatively low proportion of these providers (28 percent) are billing more than 100 claims per year. To better understand whether high dental participation rates under SCHIP are, in fact, indicative of active participation, SCHIP programs will need to collect data on the intensity of dentists' participation.

About the Authors

Ruth A. Almeida is a research associate with the Urban Institute's Health Policy Center, where she focuses on insurance coverage for children and the implementation of the State Children's Health Insurance Program (SCHIP).

Ian Hill is a senior research associate with the Urban Institute's Health Policy Center, where he is directing the qualitative component of the Institute's SCHIP evaluation and overseeing the development of a series of cross-cutting papers on states' implementation experiences under SCHIP. For more than 17 years, he has directed federal and state evaluation and technical assistance contracts related to Medicaid, maternal and child health, children with special health care needs, and managed care. Mr. Hill has served as associate director of Health Systems Research, Inc., as a senior policy analyst at the National Governors' Association, and as a Presidential management intern at the Health Care Financing Administration.

Genevieve Kenney is a principal research associate in the Urban Institute's Health Policy Center. Her research focuses on how public policies affect access to care and insurance coverage for pregnant women and children. Dr. Kenney is a co-director of the Urban Institute's SCHIP evaluation.

THE URBAN INSTITUTE

U.S. Department of Education
Office of Educational Research and Improvement (OERI)
National Library of Education (NLE)
Educational Resources Information Center (ERIC)

NOTICE

REPRODUCTION BASIS

☑ This document is covered by a signed "Reproduction Release (Blanket) form (on file within the ERIC system), encompassing all or classes of documents from its source organization and, therefore, does not require a "Specific Document" Release form.

☐ This document is Federally-funded, or carries its own permission to reproduce, or is otherwise in the public domain and, therefore, may be reproduced by ERIC without a signed Reproduction Release form (either "Specific Document" or "Blanket").