




**SCHIP DENTAL PERFORMANCE OVER
THE FIRST 10 YEARS: FINDINGS FROM
THE LITERATURE AND A NEW ADA
SURVEY**

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Introduction

As the State Children’s Health Insurance Program (SCHIP) neared its 10th anniversary, the American Dental Association (ADA) undertook this study to determine SCHIP’s impact on the delivery of dental services to targeted “working poor” children. Part I of this study reviews and synthesizes dental care findings of published SCHIP performance reports. Part two describes findings of a new ADA survey that collected information from key informants in each of the states. Based on findings, policy options to improve the program are described.

Upon SCHIP enactment in 1997, states were offered three options for covering children of “working-poor” families. These are children from families with incomes between the federal poverty level (currently \$20,650 for a family of four¹) and two times that level. Their parents are typically employed in jobs that often do not offer health insurance benefits or benefits for dependents. States could:

1. expand their existing Medicaid programs (the “SCHIP Medicaid-expansion” states);
2. develop novel coverage programs that mimic private health coverage (the “SCHIP Stand-alone” states); or
3. use both approaches, most often expanding Medicaid for specific age or income categories and then layering on novel SCHIP coverage for additional children (the “SCHIP Combination” states).

Some states that elected the novel coverage option designed their plans to

closely resemble Medicaid. We have classified these as “Medicaid look-alike” states. “Stand-alone,” “Combination,” and “Look-alike” programs are collectively referred to as “non-Medicaid expansion” states.

The hallmark term applied to SCHIP at the time of enactment was “flexibility.” In expanding health coverage to a new group of vulnerable children, Congress provided states with options not allowed in Medicaid. Congress allowed “benchmark” coverage that emulates commercial coverage. It allowed states to experiment with “coverage that meets [states] unique needs,” and to “determine what works.” One example of this flexibility was to designate dental services as “optional,” thereby leaving it to the states to determine whether and how dental coverage would be provided. This study closely examines how states responded to this option.

Of particular interest to the ADA is the design and performance of non-Medicaid expansion programs, particularly those that build on commercial plans. Considerations include whether a sufficient range of pediatric dental services are covered, if the allowable frequency, scope and duration of procedures are adequate, whether new plans are better able than Medicaid to ensure network adequacy, and whether these plans deliver sufficient levels of care.

Unlike Medicaid, new SCHIP programs are allowed to “cap” benefits for optional services by limiting the dollar amount available for optional care. Thus, the ADA sought to determine the robustness of SCHIP dental coverage and whether caps limit the provision of needed care.

States are also allowed to impose higher cost sharing in SCHIP than in Medicaid, to limit the extent and uniformity with which they report their performance, and to terminate optional benefits at any time. These were also of interest as the ADA evaluates the quality and performance of dental coverage under novel SCHIP programs.

Finally, the ADA is interested in learning more about how states administer SCHIP dental programs, how well these programs are perceived to meet the needs of beneficiaries and providers, and what lessons have been learned from a decade of SCHIP experience.

Part I: Literature Review

There are few data on SCHIP dental program performance because states are not required to report on dental program performance and only a small number of objective studies have been published. The Centers for Medicare and Medicaid Services (CMS), which regulates SCHIP, requires each state “to include in its SCHIP plan an assurance that the State will collect data, maintain records, and furnish reports that will allow the Secretary to monitor program administration and to evaluate and compare the effectiveness of State plans.” However, it requires reporting on only the four services mandated by SCHIP: well baby/well child care, immunizations, laboratory tests, and hospitalizations. The Agency for Healthcare Research and Quality (AHRQ) requires reporting on coverage including the “number of children covered by age, income, and type of delivery system” and the

numbers of uninsured children. States must also report on outreach and crowd-out—the phenomenon of private coverage being displaced by public coverage when public insurance is made available. They also report on progress in reducing uninsurance rates and progress toward *state identified* strategic objectives and performance goals. Only those few states that elected to designate dental care as a strategic objective are obligated to report on dental program performance.

Not only can states elect which optional services they choose to report, but they also determine what measures and methodologies to utilize in assessing those services. Even when states elect to report on dental performance, their reports are not typically comparable. Nonetheless, this report collects all available state and national reports on dental SCHIP performance and seeks to synthesize them in ways that describe the program’s overall impact.

OBJECTIVES

This literature review (1) collects all relevant published information on dental SCHIP performance from both the peer reviewed and health policy literature; (2) identifies those studies that reflect the experience of non-Medicaid SCHIP programs; (3) assesses non-Medicaid SCHIP dental programs’ performance quantitatively; and (4) reports on findings that hold value for maintaining, stabilizing, or improving SCHIP dental program performance and impact.

METHODS

A structured PubMed literature searchⁱ was conducted with time limits from the program’s enactment in 1997 to April 2007. To identify articles that are not indexed by PubMed, a second search was performed using the Google search engine and the same series of search terms. Articles from both searches were obtained and germane articles that they referenced also were obtained. Search findings were checked against bibliographies assembled independently by the authors who have monitored the SCHIP literature since the program’s inception.

Articles were subjected to inclusion and exclusion criteria listed in Table 1.

Table 1: Inclusion and Exclusion Criteria

Criterion	Inclusion Criteria	Exclusion Criteria
Design	Quantitative study design	Qualitative study design
Timing	Post-date SCHIP authorization	Pre-date SCHIP authorization
Differentiation	Specific analysis of SCHIP alone	Failure to differentiate between Medicaid and SCHIP findings
SCHIP type	Address SCHIP Stand-alone programs or Stand-alone portion of Combination plans	Address Medicaid-expansion SCHIP programs only

RESULTS

Thirty-three unique publications were identified including 19 from the peer-

ⁱ On the terms “SCHIP and dental,” “SCHIP and oral health,” “SCHIP dental care,” “SCHIP dental utilization,” “SCHIP dental services,” and “SCHIP dental performance.”

reviewed literature. Fifteen were excluded: eight for lack of data, five for failure to distinguish between Medicaid and SCHIP experience, one for describing a state program that predated SCHIP, and one for multiple reasons. One additional article could not be obtained. Of the 17 remaining articles, 10 were single state studies, one reviewed multiple states’ experiences, and six were national studies (Table 2). The 10 single-state studies reported on seven states: IA (3 studies), NC (2 studies), and CA, CO, IN, KS and PA (1 study each). Five of these are Stand-alone states (CA, CO, KS, NC, PA) and two are Combination states (IN, IA). There is no way to determine how representative these studies are of experiences among other non-Medicaid SCHIP states. National studies either assessed SCHIP programs performance directly or used income as a proxy for SCHIP eligibility.

Researchers employed a variety of methods and measures to report the impact and performance of dental programs. These include:

1. an access measure: the percent of enrolled children whose parents report that they have a “usual source of dental care”;
2. various utilization measures: the number or percent of enrolled children who had a dental visit in the last year, the number of SCHIP dental claims filed, reductions in delayed dental care due to cost, counts of various types of dental services rendered, and total payments for dental care;
3. two oral health status measures: the percent of

enrolled children for whom parents reported an unmet need for dental care and improvements in oral health status; and

4. dentist participation measures: the number or percent of dentists in the state who provided services that are billed to SCHIP.

Some reports related one or more of these outcomes to explanatory variables including beneficiaries' age, race and ethnicity, family income level, medical insurance status, length of enrollment in SCHIP, and payment rates to dentists.

Table 2: Articles on SCHIP Stand-alone programs meeting inclusion criteria

State-level studies
1. California: Isong U, Weintraub JA. Dental Check-up of California's State Children's Health Insurance Program. <i>Pediatr Dent</i> 2006;28:316-324.
2. Colorado: Kempe A, Beaty BL, Crane LA, Stokstad J, Barrow J, Belman S, Steiner JF. Changes in Access, Utilization, and Quality of Care After Enrollment Into a State Child Health Insurance Plan. <i>Pediatrics</i> 2005;115:364-371.
3. Indiana: Hughes RJ, Damiano PC, Kanellis MJ, Kuthy R, Slayton R. Dentists' participation and children's use of services in the Indiana dental Medicaid program and SCHIP. Assessing the impact of increased fees and administrative changes. <i>JADA</i> 2005;136:517-523.
4. Iowa: Damiano P, Momany ET, Crall JJ. Determining Dental Utilization Rates for Children: An Analysis of Data from the Iowa Medicaid and SCHIP Programs. <i>J of Pub Health Dent Spring</i> 2006;2:97-103.
5. Iowa: Damiano PC, Momany ET, Flach SD, Carter K, Jones MP. Dental care: Access, Use and Cost of Services for Children in <i>Hawke-i</i> . Report to the Iowa Department of Human Services. University of Iowa Public Policy Center. May 2005.
6. Iowa: McBroome K, Damiano PC, Willard JC. Impact of the Iowa S-SCHIP program on access to dental care for adolescents. <i>Pediatr Dent</i> 2005;27(1):47-53.

Table 2: Articles on SCHIP Stand-alone programs meeting inclusion criteria—Cont.

7. Kansas: Fox MH, Moore J, Davis R, Heintzelman R. Changes in reported health status and unmet need for children enrolling in the Kansas Children's Health Insurance Program. <i>Am J of Pub Health</i> 2003; 93:579-581.
8. North Carolina: Brickhouse TH, Rozier RG, Slade GD. The Effect of Two Publicly Funded Insurance Programs on Use of Dental Services for Young Children. <i>HSR: Health Services Research</i> . 2006;41:6.
9. North Carolina: Mofidi M, Slifkin R, Freeman V, Silberman P. The impact of a state children's health insurance program on access to dental care. <i>JADA</i> 2002;133:707-714.
10. Pennsylvania: Lave JR, Keane CR, Lin CJ, Ricci EM. The impact of dental benefits on the utilization of dental services by low-income children in western Pennsylvania. <i>Ped Dent</i> . 2002;24(3):234-40.
11. Multiple States: Shulman S, Kell M, Rosenbach M. SCHIP Takes a Bite Out of the Dental Access Gap for Low-Income Children. Final Report. Mathematica Policy Research, Inc. Nov. 2004.
National studies
1. Agency for Healthcare Research and Quality, draft Medical Expenditure Panel Survey databook.
2. Davidoff A, Kenney G, Dubay L. Effects of the State Children's Health Insurance Program Expansions on Children with Chronic Health
3. Duderstadt KG, Hughes DC, Soobader MJ, Newacheck PW. The impact of public insurance expansions on children's access and use of care. <i>Pediatrics</i> . 2006;118(4):1676-82.
4. Hughes DC, Duderstadt KG, Soobader M, Newacheck PW. Disparities in Children's Use of Oral Health Services. <i>Public Health Reports</i> July-Aug 2005;120:455-462.
5. Wang H, Norton EC, Rozier RG. Effects of the State Children's Health Insurance Program on Access to Dental Care and Use of Dental Services. <i>HSR: Health Services Research</i> in press.
6. Watson MR, Manski RJ, Macek MD. The impact of income on children's and adolescents' preventive dental visits. <i>JADA</i> 2001;132:1580.

FINDINGS OF STATE STUDIES

1. Under SCHIP, fewer children have unmet needs for dental care

There is a well established association between low income and children’s unmet need for dental care. Reported barriers include cost, transportation, time away from work or school, and lack of understanding the dental care system.^{2,3,4,5} Dental coverage in SCHIP appears to facilitate access to care as unmet need declined in all study states that reported on this measure (Table 3).

Table 3: Summary table of SCHIP impact on unmet need for dental care

State	Finding
IA	Unmet need for dental care declined 61% (from 23% to 9%). 91% of children reportedly had their dental care needs met. ²
KS	Unmet need for dental care declined 70% (from 40% to 12%). ⁶
NC	School-aged children with an unmet need declined 58% (from 43% to 18%). ⁷
PA	Unmet need and delayed care declined 77%, from 43% to 10%. ⁸
CO	Because CO did not include a dental benefit in SCHIP from the start, unmet need for dental care remained high. Of children enrolled for one year, 37% continued to have such need. ⁹
Multi-state	A multi-state study ¹⁰ assessed changes in unmet need in six states, four with Stand-alone programs (AL, KS, PA, TX) and two with Combination programs (FL, NH). While decreases in unmet need were reported in all states, declines were statistically significant only in two Stand-alone states, KS and PA.

Importance of having both medical and dental coverage: Unique among these states is CO which initially provided medical but not dental coverage. Even without dental coverage, SCHIP resulted in decreased unmet need for dental care. Unmet need declined by 21%, from 47% to 37%.⁹ Yet unmet need in CO remained considerably higher than in states that provided both medical and dental coverage.

Reasons for continued unmet need after SCHIP implementation: Despite marked improvements generated by non-Medicaid SCHIP programs, unmet need continued at rates ranging from nine to 18%. Reasons given by parents for continued unmet need after one year in NC’s SCHIP Stand-alone program included SCHIP’s failure to pay for needed care (reported by 44% of respondents with unmet need), inability to obtain a dental appointment with a participating dentist (36%), and lack of personal financial resources to pay for uncovered services (31%).⁷ The imposition of cost-sharing and coverage limits in SCHIP Stand-alone programs appears to hinder families’ ability to meet their children’s dental needs.

Choice of administrator: Many states administer their SCHIP dental programs through third party entities, including administrative-services only organizations (ASOs), dental benefit managers (DBMs), and dental managed care organizations (DMOs). These, in turn, may be contracted directly by the state or may be subcontracted by medical managed care organizations (MCO). Success in reducing unmet need varied only modestly by plan in IA where its three contractors reported reducing unmet need by 65% to 9%, by 65% to 8%, and by 71% to 6%.¹¹

2. Under SCHIP, more children utilized dental Care

Dental visits are essential for establishing a child’s “dental home” and for providing preventive and restorative services during the years of growth and development. Regardless of the measure used, states with non-Medicaid SCHIP dental programs reported improvements in dental access (Table 4).

Table 4: Summary table of SCHIP impact on dental care utilization

State	Finding
CA	Children with SCHIP coverage were as likely as children with employer-sponsored dental insurance to have a dental visit and twice as likely as children in Medicaid. ¹²
IA	By 2003, more than 2/3rds of enrolled children had a dental visit in a year compared with only about half in 2000 – an increase of more than 30%. ¹¹
KS	The percentage of children who had a dental visit in a year increased 26% (from 61% to 77%).
NC	The percentage of children with a dental visit in a year increased 33% (from 39% to 52%) and those who had never seen a dentist decreased by 54% (from 13% to 6%). ² Toddlers and preschoolers in SCHIP were 1.6 times more likely than their peers in Medicaid to obtain a dental visit ¹³ , perhaps due to the higher dentist reimbursement rates in SCHIP.

Detailed SCHIP studies by Peter Damiano and colleagues at the University of Iowa have shown improvements in dental utilization based on both parent reports and dental claims. Variation by plan showed only modest differences among the three contractors who reached utilization levels of 70% (after increasing 37% from 51%); 69% (after increasing 28% from 54%); and 63% (after increasing 26% from 50%)

between 2002 and 2003.¹¹ When analyzed by types of services provided, children enrolled in “*Hawke-I*” in 2001 were most likely to have a diagnostic visit (92%), followed by a preventive visit (85%), restorative visit (32%), and complex treatment visit (16%).¹⁴ When analyzed by beneficiary age,² children of all ages showed improvements in utilization with remarkably high levels attained for infants, toddlers, and preschoolers compared to national norms³ and typically lower levels for adolescents.¹⁵ The percentage of children, by age, having a dental visit following enrollment in *Hawke-i* increased from 77% to 88% for ages 1-6, 68% to 84% for ages 7-12 and 60% to 72% for ages 13-18.

Standardized measures are needed to compare across time and geography: Utilization findings are very sensitive to the methods employed in their calculation. The IA group compared four methods of evaluating the same claims dataset and reported utilization rates that vary from 31% to 58% depending upon how the total number of children (the denominator) was defined.¹⁴

1. The federal “Medicaid Form CMS-416” method in which the denominator includes all children enrolled at any time during the year yielded a rate of 35%.
2. The Health Plan Employer Data and Information Set (“HEDIS”) in which the denominator includes all children enrolled for 11 or 12 months in the year of record and on the last day of the year of record yielded a rate of 55%.

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3. The “full time equivalent” method in which the denominator is the total of months for all children enrolled at any time divided by 12 months yielded a rate of 58%.
4. The “new enrollee” method which includes only children newly enrolled in the year of record yielded a rate of 31%.

Other states with non-Medicaid dental plans reported utilization rates ranging from 34% in CO to 55% in WV to 76% in AL. Analysts of the multi-state study conclude that this “wide range reflects the various approaches states took to measuring dental utilization, the differences among state programs, and the substantial flexibility that states have in reporting utilization measures in their annual SCHIP reports.”¹⁰ Taken together, these findings further reinforce the need for standardized reporting procedures to be used across time and across states in order to adequately measure and compare the impact of SCHIP dental programs on children’s use of dental services.

Utilization increases with length of time in SCHIP: The length of time enrolled in SCHIP correlates strongly with dental utilization. The IA group demonstrated that for every month of continuous enrollment, the odds of having a dental visit increases. Three percent of children enrolled for one month, 22% of those enrolled for 4 months, 45% of those enrolled for 8 months, and 57% of those enrolled for 12 months had a dental visit.¹⁴ Children enrolled for 11-12 months had higher utilization rates than those who were in the program at any time during the year. A NC study of young children in both Medicaid and SCHIP¹³ similarly

confirmed that the likelihood of having a dental visit in a year increases significantly with length of time enrolled in a program. These findings strongly support the policy of “continuous eligibility” in which states enroll children for a full year regardless of whether their family’s financial situation improves during that year.

Well funded and designed SCHIP programs appear to out-perform Medicaid dental programs: The success of North Carolina’s *Health Choice* Stand-alone program is evidenced by the increase numbers of parents who claim that their child had a dental visit in the year before (48%) and year after (81%) enrollment in SCHIP.⁷ Young children in SCHIP were 1.5 times more likely than children in Medicaid to have had a dental visit in the past year.¹³ The authors conclude that “These findings suggest that SCHIP dental programs resembling private insurance models and reimbursing dentists close to market rates hold the potential to partially address problems associated with dental access for low-income children.” Market-level rates for dental services were also shown in IN to markedly improve utilization in both Medicaid and SCHIP, with SCHIP outperforming Medicaid (31.7% versus 25.4% in 1999; 33.7% versus 31.4% in 2000).¹⁶ Higher utilization in SCHIP may also reflect that SCHIP children are from higher income families that face fewer social, environmental, employment and logistic barriers to accessing care than do lower income families.

3. Under SCHIP, more children have a regular source of dental Care

Various measures employed by three states to monitor improvements in having a regular source of care all point

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to improvements under SCHIP (Table 5).

Table 5: Summary table of SCHIP impact on usual source of dental care

State	Finding
IA	The percentage with a regular source of care increased 9% (from 81% to 88%). The percentage whose dental care was delayed due to cost also declined 63% (from 27% to 10%). ²
NC	School-aged children with a usual source of care increased 17%, from 77% to 90%. ⁷
PA	Overall dental visits increased by 42% with preventive care increasing by 50%. ⁸

In 2000-2001, there were significantly fewer reported delays in dental care for all children in IA following SCHIP enrollment for one year (27% to 10%), with the largest reduction among 7 to 12 year olds (35% to 11%).² These improvements occurred across all three IA plans.¹¹

The high level of preventive care in PA’s SCHIP program similarly suggests that children are accessing a regular source of care since those without a regular care are more likely to see a dentist for emergency or restorative services rather than preventive services.

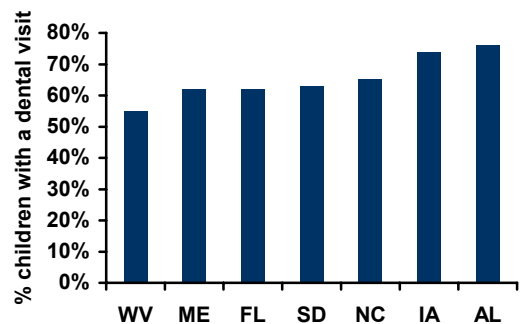
The most direct measure of improved access to a usual source of dental care comes from NC where it was chosen as a program performance measure. In NC, even more parents claim to have a usual source of care than those who report taking their child to the dentist in the past year.

4. State-by-state variations in SCHIP dental programs yield wide variations in performance

Despite reports of enhanced dental care in non-Medicaid SCHIP programs, state flexibility in designing and implementing dental SCHIP programs yields significant variation in overall performance. This is evident both in studies that assess parental reports of dental visits and those that assess dental claims.

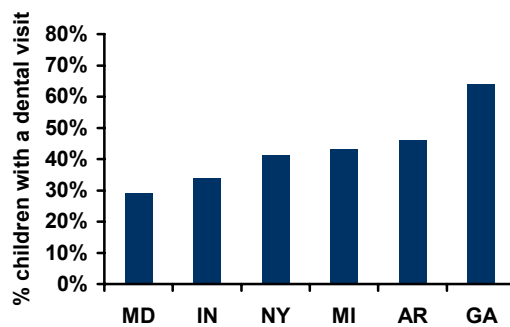
A 2004 CMS-sponsored review revealed that states vary in what services are covered, how their dental benefit is administered (e.g. managed care or not), and how much they pay dentists.¹⁰ As a result, the percentage of parents reporting that their child had a dental visit in the past year ranged from 76% for AL children and FL teens to 62% for younger children in FL, 74% for children in IA, 65% in NC, 63% in SD, 62% in ME, and 55% in WV (Figure 1). Similar variation is seen when dental visits are verified through the more stringent measure of claims filed by dentists: from GA at 64% to AR at 46%; MI at 43%; NY at 41%; to MD at 29%. A separate study in IN reported 34% children with a claims-validated dental visit (Figure 2).¹⁷

Figure 1: Dental visits reported by SCHIP parents



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Figure 2: Dental visits reported by claims



FINDINGS OF NATIONAL STUDIES

Three independent studies employed data from the federal National Health Interview Survey (NHIS) to assess parental reports of dental utilization. All corroborate SCHIP's effectiveness in improving dental care.

- The University of North Carolina study¹⁸ reported that "SCHIP implementation significantly lowered the chances of experiencing a financial barrier to needed dental care for children from a low-income family" and that "children who are enrolled in SCHIP or Medicaid were much more likely to report having had a dental visit in the past 6 or 12 months compared with their uninsured counterparts." This study confirmed that there is greater need for dental care in the first year after enrollment than in subsequent years because of accumulated need. The researchers note that having SCHIP coverage is more important than the type of SCHIP coverage as SCHIP

plans of different designs all showed improvements.

- The University of San Francisco study¹⁶ examined all children in families with incomes between 100% and 200% of poverty as a proxy for SCHIP enrollment. It found that the percentage of US children who lack dental care dropped by 12% for this cohort. There was, however, no decrease in unmet need due to cost.
- The study by researchers at the Urban Institute and the University of Maryland focused on children with special healthcare needs.¹⁹ They report that SCHIP coverage led to a reduction of 7% in unmet need for dental care among children with chronic illnesses and disabilities.

Federal Medical Expenditure Panel Survey data (MEPS) show that since SCHIP enactment, the percentage of US children with publicly funded coverage increased 44%, suggesting that SCHIP succeeded at both covering more children and stimulating enrollment of more children into Medicaid. Between 1996 and 2004, dental utilization by children with public coverage increased 21%, while uninsured children showed no change in use of dental services. The average number of dental visits per child covered by public insurance also increased, with the number of visits increasing by 7%.²⁰

Taken together, these national studies substantiate state findings that extending dental coverage to children from "working-poor" families

improves access to dental care, comprehensiveness of dental care, and overall child oral health.

Part II: ADA Survey of State SCHIP Programs

In order to further understand the impact of SCHIP on dental care for children from modest-income families, ADA fielded a “key-informants” survey in April and May of 2007. A twenty-six item, internet-based questionnaire was developed to ascertain the organizational and management structure, benefits, provider and beneficiary characteristics, and experiences of non-Medicaid state SCHIP programs in delivering dental services to children. The survey included both objective/quantitative questions about SCHIP operation, administration, and performance, as well as subjective questions designed to elicit opinions about program experience and ideas for improving future performance.

METHODS

Survey subjects: The survey was fielded to leaders in each state and the District of Columbia for a total of 204 targeted subjects. The four categories of key informants were selected to obtain a range of views from an array of perspectives, interests, and needs. The key informants were:

1. Medicaid dental program managers: State agency personnel with responsibility for managing the Medicaid dental program. Individuals were identified with the assistance of the National

Maternal and Child Health Resource Center and CMS.

2. SCHIP dental program managers: State agency personnel with responsibilities for managing the SCHIP dental program. Individuals were also identified with the assistance of the National Maternal and Child Health Resource Center and CMS.
3. State Dental Directors: The chief dental public health officer in each state health department as identified by the Association of State and Territorial Dental Directors.
4. State Dental Association Executive Director: The most senior staff person within each state-level constituent organization as identified by the ADA.

Extensive efforts were made to verify that the identified individuals held their designated positions at the time that the survey was fielded and that correct contact information was available for each potential respondent. Determinations regarding who should be included in the study were made by one investigator (DS) when either a single individual was responsible for more than one key-informant position or when multiple people staffed a single key-informant position. Some positions were noted to be vacant. Subjects’ requests that the survey be copied to their superiors and/or colleagues were honored in order to assist respondents in collecting and releasing requested information.

Survey content: The survey was built from a series of hypotheses to be tested with

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regard to program design and experience in non-Medicaid SCHIP programs. Iterations of proposed questions were vetted between the investigators and among ADA staff. A final draft of the questionnaire was then tested with several SCHIP dental program managers and final modifications made. The survey instrument was formatted by ADA staff for web-based dissemination.

Survey distribution and response rate: The final survey was emailed on April 18, 2007 in a message from ADA Executive Director, Dr. James Bramson. His message (appended) encouraged participation and invited key informants to click on an embedded link to the survey. The email was copied to the colleagues identified by the targeted informants but the survey link was modified so that they could view but not respond to the survey. None of the invitational emails was returned because of incorrect address and it was assumed that all reached their targets although some may have been re-routed by spam filters.

State Medicaid and SCHIP informants were encouraged to respond through requests made at a Medicaid SCHIP Dental Association (MSDA) meeting by CMS Chief Dental Officer, Dr. Conan Davis, and by MSDA president, Christine Farrell. State agency respondents were further encouraged through messages posted to the "KidsOralHealth listserv." After 46 responses were received within the two-week requested response period, a second email invitation was sent to non-responders together with a "frequently asked questions" document that answered questions raised by informants. Among these was an inquiry regarding collaboration among

informants within a state. Informants were encouraged to collaborate on objective questions while submitting separate surveys in order to capture subjective and opinion responses. Since the survey was designed to garner far more information from SCHIP Stand-alone and Combination plans than from Medicaid-expansions, another FAQ regarded how Medicaid Look-alike programs should respond. Informants from Look-alike states were encouraged to complete the entire survey in order to identify modifications that states may have made when building on Medicaid precedent. However, not all did so. The FAQs were distributed online through the KidsOralHealth listserv, the ADA Executive Director's listserv, and through additional emails to non-responders.

By the extended deadline of four weeks, 70 responses had been received and after further telephone and email correspondence (by DS), a total of 110 were received at six weeks representing the views of 157 informants for an adjusted Informant response rate of 70%. Forty-nine of 50 states and DC filed at least one on-time response. Combined responses were received from 40 states, most often from Medicaid and SCHIP Informants responding together (n=33). In four states all four Informants responded collectively.

Survey design: The questionnaire was designed so that respondents skipped questions or were directed to additional questions depending upon their prior responses. For example, if respondents selected "yes" when asked if the state engaged a third party to manage the state's separate SCHIP program, a pop-up question asked them to select the type of third party.

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Similarly, when asked at the outset of the survey to choose the type of SCHIP plan implemented by their state, respondents who selected “Expanding Medicaid” were directed to skip all questions related to non-Medicaid plans. The survey also included pop-up definitions for important, ambiguous, or potentially contentious terms. Informants were encouraged to download a copy of the survey and record their responses on paper prior to entering the information on-line both to facilitate data collection and to honor situations where clearance by their organization was felt necessary. The ADA is indebted to the many Informants that devoted the time and attention to produce such a robust response.

RESULTS

As the study seeks to assess non-Medicaid SCHIP dental programs, the analysis first considered how respondents categorized their SCHIP plans so that non-Medicaid SCHIP plans could be identified. There was, however, considerable variation among Informants in response to this question (Table 6).

Table 6: Type of SCHIP plan reported by key informants

Type of SCHIP plan	SCHIP informant	Medicaid informant	State Dental Director informant	Constituent Dental Society informant
Medicaid expansion	31%	31%	18%	33%
SCHIP Stand-alone	47%	44%	39%	27%
Combination	18%	13%	8%	6%
No response	4%	12%	35%	33%

Based on information obtained from CMS and from examining the details of states’ dental programs, the investigators concluded that 19 states administer their *dental* programs as SCHIP Stand-alone programs in forms other than Medicaid Look-alikes, while an additional eight states (for a total of 27) administer their dental program as a Combination Medicaid program.ⁱⁱ One other state, NJ, also has an SCHIP Combination program for a total of nine such states, but data were received too late for NJ’s inclusion in these analyses. An additional seven states have Look-alikes. It is these 34 states that this study addresses. The 19 Stand-alone programs are AL, AZ, CA, CO, CT, KS, MI, MS, MT, NV, NY, NC, PA, TX, UT, VA, WA, WV and WY. Of these, the literature review provided quantitative performance information for five (CA, CT, KS, NC and PA) as described above. The eight Combination programs were identified in DE, FL, ID, IN, IA, KY, NH and ND. Of these, state-specific reports are available in the literature for IN and IA. The seven Medicaid Look-alike programs were identified in GA, IL, MD, ME, OR, SD and VT. Of these, there were no published reports that provide quantitative performance assessment.

ⁱⁱ Note that this classification of “SCHIP Stand-alone” programs, although based on CMS information, differs substantially from CMS’s classification scheme. This study includes only Stand-alone programs that provide *dental* services, and excludes SCHIP Stand-alone programs classified as such by CMS if the Stand-alone was perceived as irrelevant for the provision of dental services, e.g. it focused on “unborn children.”

**FINDINGS FROM THE
NON-MEDICAID SCHIP
PROGRAMS**

Responses: A total of 98 usable responses were received from non-Medicaid SCHIP programs (64 from Stand-alone, 20 from Combination, and 14 from Look-alike programs). Six responses were excluded from analysis because Informants mischaracterized their state SCHIP programs in ways that directed them away from questions about non-Medicaid programs.

SCHIP name: To avoid stigma associated with Medicaid and to market their programs to the target population and to providers, most non-Medicaid SCHIP programs have adopted program names that avoid welfare connotations. Examples abound including “All Kids (IL),” “KidCare (FL),” “HealthWave (KS),” “MI-Child (MI),” “Health Choice (OK),” “NV CheckUp (NV),” “HUSKY B (CT),” “Healthy Kids Now (WA),” “Hawk-i (IA),” “PeachCare (GA),” “Healthy Steps (ND),” and “Healthy Kids Silver (NH).”

Third party contracting: All but four SCHIP Stand-alone states reportedly contract out their SCHIP Stand-alone dental programs but at least one respondent in each of eight such states did not know whether contracting was employed. There was also significant discordance among Informants regarding the type of contractor employed. Overall, of the 15 states that engage contractors, at least one respondent in the state reported that ASOs were utilized in 11 states; DBMs were utilized in nine states and MCOs

in six states.ⁱⁱⁱ In three of the six MCO states, the MCO subcontracted to a DBM for dental services. Companies that function as ASOs include non-profits such as Blue Cross, Delta Dental, and a Public Employee Health Plan as well as for-profits such as Maximus, EDS, Doral, and Wells Fargo. The Public Employee Health Plan initially required that SCHIP-participating dentists also be participants in its dental plan for state employees, but this requirement was subsequently dropped at dentists’ request. Almost all DBMs were either Deltas or one of the Blues while the few MCO states engaged primarily one of the Blues or their affiliates. In only two states the DBM reportedly provided dental services through its own dental facility and/or directly employed dentists, rather than exclusively through a network of private dentists. In only three states the DBM was reportedly placed at financial risk for treatment volume in excess of projections. Combination plans and Medicaid Look-alikes also use a variety of contracting strategies with nine of 13 plans engaging contractors, primarily ASOs and DBMs. Only one of each of these plan types report assigning financial risk to their dental vendors while most put the medical managed care company at risk.

ⁱⁱⁱ For the purposes of the survey, *ASO*, or *Administrative Services Organization*, is defined as a company or organization that provides a number of dental and administrative and management duties, which may include, for example, claims processing or data analysis, but not a full range of dental benefits management, and assumes no financial risks. *DBM*, or *Dental Benefits Manager*, is defined as a dental management company or insurer that provides dental plan administrative and management duties that may include network development, fraud and abuse monitoring, fee negotiation, claims management, etc. *MCO*, or *Medical Care Organization*, is defined as a medical benefits administration company that assumes responsibility for the dental program either directly or by subcontract to a DBM.

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Covered services: All 19 Stand-alone states cover basic diagnostic, preventive, and restorative services with the exception of space maintainers in three states. Covered services in all 19 states include examinations, prophylaxes, topical fluoride applications, sealants, radiographs (both bitewing and full mouth series), intra-coronal restorations (composites and amalgams), stainless steel crowns, pulpotomies, endodontic treatments, and extractions. Prosthodontic and periodontal services, which are less typically required by children but may be important for some adolescents are not covered in six and seven states respectively. Orthodontic care is the least universally available service as 11 Stand-alone states reportedly do not include orthodontic services. In sharp distinction to Stand-alone programs, Combination and Look-alike plans had no uncovered services with the exception of orthodontic care in three of the eight Combination plans. Thus, building a new program alongside Medicaid or by mimicking Medicaid assures a greater range of services compared to building a novel program based on normative commercial coverage.

Service limitations: No Stand-alone state that responded to a question regarding limitations on examinations reported less than two examinations per year and one allows examinations “as needed.” One state reportedly limits prophylaxes and topical fluoride applications to one per year while all other states allow for at least two and one state allows for three fluoride treatments. Like commercial dental plans, constraints on sealant placements are common but vary widely. All states cover permanent molar sealants while fewer cover premolars and many do not cover

primary teeth. Some states impose age limits, e.g. topping out at age 14 in two states while many impose frequency limitations as high as 5 years (one state) or even once in a lifetime per tooth (at least four states). Bitewing radiographs are limited to one pair annually in five states, while full mouth series of radiographs are limited, as in many commercial plans, to one set every three years (at least six states) or once every five years (two states). Also analogous to commercial plans, some states impose limits on the frequency of restoration replacement (e.g. as often as annually in two states, biannually in one state, triannually in four states and once every five years in one state) or the material to be used (e.g. one state limits posterior intra-coronal restorations to amalgam while another allows placement of posterior composites but requires families to pay the difference in charges). A small number of states explicitly exclude pulpotomies in conjunction with root canal therapy, two do not cover surgical extractions, and one does not cover prophylactic extraction of third molars. A mix of typical limitations is applied to endodontic services. Examples include restriction to permanent teeth, anterior teeth, only upon prior authorization, partial treatment only and prohibition of re-treatment. Periodontal treatments, when covered, typically have temporal or treatment extent limitations (five states) or require prior authorization (one state) while in another state they must be shown to be “medically necessary.” Prosthodontic services are affected by a smattering of restrictions based on time, frequency, age, materials, and prior authorization, but one state explicitly authorizes obturators for children with cleft palates. Regarding orthodontic treatment, few states provide for

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routine coverage while the majority of those that cover orthodontic services limit services to children with handicapping malocclusions and/or craniofacial disturbances.

All but one Combination or Look-alike plan allows for two examinations and two prophylaxes a year, but three states limit topical fluoride treatments to one annually and some managed care companies may limit the frequency of preventive treatments. As in Stand-alone states, there is a great variation in sealant limitations by age, allowable teeth, and frequency of replacement. Age limits cited by states range to 15, 17, and 20 years. Allowable teeth range from all primary and permanent posterior teeth to permanent molars only. Resealant frequency ranges from every three years to every four years, five years, or lifetime. One state limits sealants to one tooth per six month period of coverage.

As in Stand-alone programs, the allowable frequency for bitewing radiographs varies within both Combination and Look-alike plans with four of nine reporting states limiting these films to once annually, and additional states leaving it to the DBMs to determine allowable frequency. Full mouth series of radiographs also have typical limitations of one year (in one of 10 reporting state), three years (in seven states), or five years (in two states). Compared with Stand-alone programs, few Combination plans and Look-alikes appear to impose limitations on types or frequencies of placements for intra-coronal restorations, stainless steel crowns, pulpotomies, extractions, endodontic treatment of permanent teeth, and periodontal and prosthodontics treatment (although prior authorization commonly is

required). When offered, orthodontic treatment is targeted to those children with a handicapping malocclusion as determined through a prior authorization process in most Combination and Look-alike states.

Taken together, the limitations in SCHIP Stand-alone plans are reasonably consistent with commercial dental benefit industry standards, but may fail profoundly to meet the needs of the small subset of individual children with complex oral presentations. They appear to be designed primarily to limit cost exposure and are sufficiently complex to require practitioners to learn their own state's sets of limitations in order to well prepare parents to understand the limits of their coverage. The substantial set of restrictions noted in some states may explain why some SCHIP beneficiary families continue to experience unmet need due to the cost even though covered by SCHIP. Conversely, SCHIP plans that are tied to Medicaid either through Combination programs or Look-alikes have far fewer limitations and appear better situated to meet all children's needs.

Respondents opined that these limitations do not inhibit care for the majority of children but do occasionally hamper needed care, particularly for endodontic and orthodontic services (Table 7). In distinction, all Combination and Look-alike states reported that benefits are sufficient to meet children's needs.

Table 7: Coverage adequacy and suggested improvements

I. Some respondents call for additional coverage

- Could cover endodontics for permanent teeth.
- No provision for posterior tooth endodontics and no permanent crowns.
- Endodontic treatment, composite anterior crowns, permanent crowns for under 16 years excluded. Twelve-year-old who falls and fractures 8,9 for example could not have endo and appropriate crowns.
- There are some additional services that could be added on a prior-authorization basis. State began with a conservative benefit program in 1998, with no services added since.
- Add cost effective orthodontia.
- Benefits offered are generally comprehensive with the exception of orthodontic services.
- Orthodontics and other specialties are too restrictive.

II. Some respondents call for design improvements

- It is sufficient for most children but approximately 23% of children who had dental services in FFY 2006 met or exceeded the maximum payment.
- They should increase the cap limit to at least \$600. There are many families that have to pay the rest out of pocket or at a reduced rate as determined by the dentist that never gets reported to the state. The state may have no idea just how much additional [cost is involved].
- Families should be helped to finance out-of-pocket costs through health savings accounts.

III. Some respondents consider benefits to be sufficient

- Full range of services is available.
- Range of benefits does not seem to be a problem because there are methods for addressing those out of the normal parameters cases. Dentists may obtain special approval for some cases such as orthodontics, etc.
- Sufficient to meet needs, but could be improved somewhat.
- The SCHIP program has the same range of services as our Medicaid program does. We believe that the range of covered services is good.
- Based on infrequency of complaints from participants and providers, benefit is adequate.
- Benefits are adequate and pretty close to what children need from a restorative standpoint.

Dollar caps on services: Seven SCHIP Stand-alone states reported caps on their dental benefit at a fixed dollar amount. Listed from most constraining to least, the annual dollar limits are \$350 in MT, \$500 in CO, \$575 in TX, \$600 in MI, \$1000 in AL and WY, and \$1500 in MS. At the time of the survey, only WY provided a “safety valve” through its “marginal dental program” which is managed by its health department. MT was reportedly planning to institute in July 2007 financial assistance to families when expenses exceed its cap and CO terminated a supplemental program funded by Delta Dental after “pent-up” demand was satisfied in the initial years of its program. CT caps orthodontic care at \$723 while TX imposes a complex tiered system of caps that are specific to types of service provided and longevity in the program.

Among Combination plans, four additional states report caps ranging from \$600 in NH, to \$800 in FL, and \$1000 in both IA and ND. None offers a mechanism for additional support when the cap is reached. No Medicaid Look-alike plans impose caps. Overall, Stand-alone and Combination plans are more likely to impose caps than are Look-alike plans, but, of all states, only one-in-five (n=11) utilize caps as cost controls.

Payment methods and rates to dentists: SCHIP Stand-alone states typically pay on a fee-for-service basis, with a fixed fee schedule most predominant (n=14 of 19). Other fee-for-service modalities include *negotiated fees* in four Stand-alone programs, three Combination programs, and in one Look-alike program. One Stand-alone state and one Combination state report basing fees on charges, with the Combination state employing a unique

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arrangement by paying dentists 85% of usual and customary fees. Similarly, six of seven reporting Combination states pay on a fixed fee schedule as do five of six Look-alike states. Some capitation approaches are also noted to exist as a subset of four Stand-alone plans and in one Combination and one Look-alike plan.

Three Stand-alone states note that their SCHIP fee schedules are coincident with Medicaid fee schedules and an additional six states report that the fees are about the same as Medicaid. Among Stand-alone states, only two states have at least one responder who reported that fees paid in SCHIP are “much more” than fees paid in Medicaid, while at least some respondents claim that fees are “somewhat more” in SCHIP than Medicaid in an additional seven states. This mixed pattern is very similar in Combination states where four of eight responding states report that fees are exactly the same as in Medicaid, three report that they are the same or somewhat more, and only one respondent reports that the fees are much more than in Medicaid. All Look-alike states that use a fee schedule pay the same for Medicaid and SCHIP. Some states that engage managed care allow fees to be negotiated between dentists and the plans and report somewhat higher payments in SCHIP than in Medicaid. No state, regardless of type of plan, reports that fees are lower in SCHIP than in Medicaid. Taken together, these findings suggest that—as in Medicaid—dentist reimbursements tend to be low yet SCHIP tends to be regarded as “paying better” than Medicaid, particularly in Stand-alone SCHIP programs.

Conversely, no state reports that SCHIP pays dentists “somewhat more” or “much more” than dentists’ customary fees. Four states (two Stand-alone plans; two Combination plans) report paying “about the same” as customary fees. Most states, regardless of plan type, regard payment rates in SCHIP to be “somewhat less” or “much less” than customary fees. Among Stand-alone states, five report “somewhat less” payments while five report that fees are “much less.” Among Combination plans, three report “somewhat less” while one reports “much less.” Among Look-alike plans, one reports “somewhat less” while two responses are split between “somewhat” and “much less.”

SCHIP Informants were not more likely than Dental Association Executive Directors to regard SCHIP fees as more favorable than Medicaid fees. In the nine states in which both responded to this question, seven were in agreement (with one pair agreeing that SCHIP pays much more than Medicaid, one pair agreeing that SCHIP pays somewhat more than Medicaid, four pairs agreeing that SCHIP pays the same as Medicaid, and two pairs agreeing that they did not know). In the two states where there was disagreement, the Dental Association Executive Director considered payment in SCHIP to be more favorable than did the SCHIP dental program manager.

When comparing payment levels in SCHIP to usual and customary fees, there was greater disagreement between SCHIP program managers and Dental Association Executive Directors. In the same nine states in which there is complete response from both the SCHIP dental program manager and the Executive Director,

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five were in agreement regarding SCHIP fees relative to usual fees (two pairs claiming that they are the same, two pairs that they are somewhat less, and one pair claiming that they are much less). In the remaining four states there was disagreement. In three of the four states, the Executive Director considered fees lower than the SCHIP manager.

Dentists' participation in SCHIP: Seventeen of 19 Stand-alone states reported the numbers of dentists that filed at least one SCHIP claim in a recent year. The reported number was divided by the total numbers of dentists in the state (as noted by the State Health Facts website²¹) to derive an estimate of the percentage of dentists available to SCHIP beneficiaries. One state was excluded from the analysis because it appears to have reported the total number of dentists in the state rather than the number that provided at least one SCHIP beneficiary with care. As noted in Table 8, of the remaining 16 Stand-alone states, the percentage of dentists in each state that filed at least one SCHIP claim varied greatly, from 14% to 67%. No correlation was noted between a state's self-assessed payment rate relative to usual fees and the percentage of participating dentists. States that reported paying "much less" than customary fees are bolded in the following chart while those that reported paying "less" or "about the same" as customary fees are italicized.

Table 8: Percentage and ratios of dentists that filed at least one SCHIP claim in each of the remaining 16 Stand-alone states

State	% of state dentists active in SCHIP	All dentists to beneficiary ratio	SCHIP dentists to beneficiary ratio	Multiple of SCHIP dentist ratio to all dentist ratio
A	4%	6	147	24.5
B	13%	28	214	7.6
<i>C</i>	<i>16%</i>	<i>16</i>	<i>99</i>	<i>6.2</i>
<i>D</i>	<i>19%</i>	<i>26</i>	<i>138</i>	<i>5.3</i>
E	23%	31	136	4.4
<i>F</i>	<i>27%</i>	<i>29</i>	<i>106</i>	<i>3.7</i>
G	30%	5	17	3.4
<i>H</i>	<i>35%</i>	<i>35</i>	<i>101</i>	<i>2.9</i>
I	36%	16	44	2.8
<i>J</i>	<i>47%</i>	<i>29</i>	<i>62</i>	<i>2.1</i>
<i>K</i>	<i>49%</i>	<i>20</i>	<i>41</i>	<i>2.1</i>
<i>L</i>	<i>49%</i>	<i>34</i>	<i>69</i>	<i>2.0</i>
<i>M</i>	<i>60%</i>	<i>58</i>	<i>96</i>	<i>1.7</i>
<i>N</i>	<i>61%</i>	<i>20</i>	<i>34</i>	<i>1.7</i>
<i>O</i>	<i>61%</i>	<i>28</i>	<i>45</i>	<i>1.6</i>
<i>P</i>	<i>67%</i>	-	-	-

While the dentist-to-beneficiary ratio is quite favorable, ranging from one dentist for five covered children to one dentist for 58 covered children, the participating dentist-to-beneficiary ratio is less favorable, ranging from one dentist for every 34 children to one dentist for every 214 children. The final column of the table above demonstrates the multiple of these two ratios and indicates the number of times by which the number of SCHIP-participating dentists would need to be multiplied to derive an equitable distribution of dentists in each state. For example, one state would need 24.5 times more dentists participating in SCHIP in order to bring the availability of dentists for child beneficiaries in line with the ratio of all

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dentists to child beneficiaries. While this state clearly is an “outlier” at 24.5 times, equitable availability of dentists in SCHIP Stand-alone programs would require considerably more dentists to participate. These ratios are believed to be more favorable than the ratios in Medicaid, suggesting that dental plans developed to mimic commercial coverage may engage larger numbers of dentists than do Medicaid plans.

A similar analysis with analogous results for Combination states is shown in Table 9.

Table 9: Percentage and ratios of dentists that filed at least one SCHIP claim in Combination states

State	% of state dentists active in SCHIP	All dentists to beneficiary ratio	SCHIP dentists to beneficiary ratio	Multiple of SCHIP dentist ratio to all dentist ratio
A	15%	22.2	150.2	6.8
B	30%	14.0	46.9	3.4
C	37%	5.7	15.5	2.7
D	65%	13.5	20.8	1.5
E	69%	7.9	11.3	1.4
F	87%	13.9	16.0	1.2

Sufficient information was not available from respondents to conduct this analysis for Medicaid Look-alike states.

Copayments: One hallmark of commercial coverage is the common requirement that families pay out-of-pocket for costs of deductibles, copayments, and disallowed services. However, 11 of the 19 states with SCHIP Stand-alone dental programs do not charge copayments and none of the Combination or Look-alike plans charge copayments.

Number of beneficiaries receiving dental care: Fourteen Stand-alone states reported the number of SCHIP beneficiaries who received a dental service in a year. The percent with a dental visit was calculated by dividing this number by the total number of enrolled beneficiaries. The percentage with a visit ranged from 29% to 88%^{iv} and averaged 50% by states and 52% when data from all of the states was pooled. These percentages are higher than typically reported for children in Medicaid.

The seven Combination states that provided utilization data had a similar average of 52% utilization and an aggregate utilization of 49% with a range from 43% to 74%. Average utilization in the three Medicaid Look-alikes was 46% and 49% for pooled data with a range from 36% to 56%. In general, regardless of plan type, states with small populations have higher utilization rates than states with large populations. These data must be viewed with caution, however, as states may have varied in how they report data.

Network adequacy: As perceived by respondents, network adequacy was characterized as “less than adequate” in five of 19 Stand-alone states, “less than adequate or adequate” in an additional five states, both “less-” and “more than adequate” in one state, “adequate” in six states, and “adequate or more than adequate” in one. No correlation was noted between reported network adequacy and the percentage of beneficiaries who were reported to have had at least one dental visit. The reasons offered by respondents for network inadequacy (Table 10) range

^{iv} 29%, 38%, 40%, 44%, 44%, 45%, 47%, 48%, 49%, 54%, 57%, 68%, 78%, 88%

widely and include low payment rates; inadequate numbers, distribution, or availability of dentists; managed care company business practices and reticence of dentists to participate with managed care plans; dentists' antipathy to the beneficiary population and/or to caring for children; and high cancellation rates by beneficiaries.

Table 10: Reasons cited for network inadequacy

It could always be more adequate, though generally, the PPO network meets most of the current needs. 75% of the state's general and pediatric dentists are in the network covering most all of the state.

Low reimbursement, health plans not credentialing dentist in order to keep down costs. Dentist shortage.

Limited number of dentists, especially in rural areas.

My general impression is that there are not enough SCHIP providers, much like Medicaid providers. Not nearly enough.

Low fees, dislike of managed care.

38% of licensed/practicing dentists participate in the SCHIP program. While that's better than Medicaid participation, I can't imagine 38% being adequate.

Delta Dental does not allow non-participating dentists to treat SCHIP patients. You have to sign up for Delta's other plans in order to participate. There are several need areas of our state where there are not enough dentists to treat these Dentists fear of treating poor populations. Reimbursement rates are not what dentists want. No show rates or poor scheduling to meet SCHIP clients' needs.

Rural/frontier areas of State have no dentists. Reimbursement rates do not entice dentists to serve this population.

Dental reimbursement rates became exactly the same as Medicaid reimbursement rates. This resulted in an overall decrease in reimbursement to providers. Our data has shown evidence of providers dropping out of the program.

Unwillingness of dentists to participate in managed care plans and offers of discounted fees

Providers have been slow to enroll in the program

Table 10: Reasons cited for network inadequacy—Cont.

Generally able to meet current needs. A few areas are less than adequate and ongoing recruitment efforts/strategies are being implemented.

Reimbursement rate

1. Inadequate number of dentists willing to see children.
2. Providers complain of missed appointments and lower reimbursement.

Dental offices are very busy seeing private patients, often don't take children, aren't Delta providers, failed appointments.

Network adequacy in Combination and Look-alike plans was similarly regarded as marginal at best with half of eight Combination states reporting "less than adequate" and half reporting adequate and two of three Look-alike states reporting "less than adequate" and one reporting adequate. Respondents listed only lack of dentists and lack of dentists participating in the program as the reasons for network inadequacy.

SCHIP network adequacy compared to Medicaid network adequacy: Of the 18 Stand-alone states that responded to this question, one characterized the SCHIP network as "somewhat less adequate" than the Medicaid network, one as "the same as" the Medicaid network, five as "somewhat more adequate" than the Medicaid network, two were split between "somewhat more" and "much more," seven consider the SCHIP network "much more adequate" and two were divisively split with one informant considering the network "somewhat less adequate" and the other "somewhat more adequate." Reasons cited for SCHIP networks being more adequate than Medicaid networks are listed in Table 11. Predominant among these explanations is the higher social

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status of SCHIP beneficiaries reflected as their having greater competence in utilizing dental care, greater value for dental care, and being more informed about the program, more educated, and having greater familiarity with preventive services. Suggested explanations also extend to dentists' greater engagement through higher fees, attraction to commercial-style dental programs, and lack of stigma.

Table 11: Reasons cited for more robust networks in SCHIP than Medicaid

Medicaid network claim reimbursement is not as user friendly.

Historically, SCHIP recipients are higher utilizers of health care services than Medicaid recipients.

SCHIP population has become more informed about the benefits dental services. Medicaid rates are so low, may dentists will not accept Medicaid patients.

I would expect slightly higher utilization in SCHIP because the members are somewhat higher income and better educated than Medicaid.

Pediatric dentists' reimbursement is such that most pediatric dentists accept patients. Even though reimbursement for general dentists is very low, the patient population is more responsible.

Several factors: more dentists; the population is slightly different (higher income, higher education of parents, etc); much more aggressive marketing of the dental benefit.

Payments are faster, at a much higher level of reimbursement, and it is easier for an SCHIP patient to get to the dentist since there is less travel involved.

For children who need to go to the OR for extensive dental restorations for ECC, there is an inadequate supply of pediatric dentists who will do this. For outpatient services, the people who enroll in the SCHIP Programs appear to have a better understanding.

These clients and their families are familiar with preventive care and seek services more often.

SCHIP has a higher reimbursement rate than Medicaid and more dentists are willing to see the patients.

They use the dental insurer participating network.

Table 11: Reasons cited for more robust networks in SCHIP than Medicaid—Cont.

The number of dental providers is greater and this in turns provides better access, even in rural areas.

SCHIP reimbursement is higher than Medicaid reimbursement. (However, SCHIP reimbursement is capped but Medicaid is not.)

Reimbursement rates for covered SCHIP dental services were closer to UCR rates in the local market.

Unknown

All MCOs in SCHIP must offer dental services. Not all Medicaid Managed Care plans offer dental. Some Medicaid dental is offered fee-for-service.

Because the SCHIP program is based upon a Commercial product, the provider network is greater and access to services is better.

Significantly higher reimbursement, expanded scope of service, no Medicaid stigma, higher dental IQ

Parents make dental appointments for SCHIP children.

SCHIP pays more for preventive services, SCHIP children are in higher SEC., co-pay is allowed

When Combination and Look-alike states compared SCHIP utilization to Medicaid utilization, all but one, regarded the level of care to be at least as high, if not higher in SCHIP than in Medicaid. Only one state regarded utilization to be "much more" in SCHIP and attributed that to a more highly educated target population.

Enrollment facilitators: Eighteen of 19 SCHIP Stand-alone states provide for 12 month continuous eligibility while one provides for six month eligibility upon enrollment and re-enrolment. Only two states are reported to engage in presumptive eligibility, the CMS-allowed practice of allowing care providers "to make temporary eligibility determination on behalf of the state so that limited or full health care benefits can be made available to certain applicants before the standard

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eligibility process is completed.”²² All Combination and Look-alike plans feature 12 month continuous eligibility and none offers presumptive eligibility.

Overall program assessment: All respondents—including those with Medicaid Expansion programs—were asked to provide an overall assessment of their SCHIP program performance (Table 12).

Table 12: Overall assessment of SCHIP performance

Overall Assessment	Response of Key Informant by Type				
	SCHIP Dental Program Managers n=45	Medicaid Dental Program Managers n=20	State Dental Directors n=36	State Dental Association Executive Directors n=34	All Respondents n=135
mostly successful, model for other states	20%	10%	11%	15%	15%
moderately successful	33%	65%	39%	21%	36%
neither successful or not, a work in progress	7%	5%	6%	6%	6%
no answer	38%	10%	31%	56%	36%
don't know	2%	10%	14%	3%	7%

While these findings are open to a variety of interpretations, it is notable that among all Informants nearly half either chose not to respond to this question or stated that they don’t have an opinion, while those who did respond found the program to be quite settled and performing either moderately or very well. Differences in response between Informant types are striking with the largest groups of non-responders being association Executive Directors, followed by State Dental

Directors and SCHIP program managers and Medicaid program managers. The difference between favorability rating between state SCHIP and Medicaid program managers may indicate a higher regard for non-Medicaid expansion type of SCHIP programs or may be an artifact of the small number of responders.

Suggestions for SCHIP improvements: Suggestions were received from 43 Informants (11 SCHIP directors, 12 Medicaid directors, 14 State Dental Directors, and 6 state dental association Executive Directors). See Table 13.

These suggestions cover a wide range of potential policy and programmatic enhancements to the SCHIP dental program, regardless of which type of plan a state engages. Although the question asked about “national level improvements,” many of the suggested reforms are possible at the state level without further federal engagement.

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Table 13: Suggested policy and program improvements

Improvement	# Citing this improvement
SCHIP authorization	
permanently authorize SCHIP	4
reauthorize SCHIP this year	3
Funding	
stabilize or increase total funding	12
incentivize states to improve dental programs	3
increase federal match for dental care	1
Benefits	
make SCHIP benefit equal to Medicaid benefit	3
mandate dental services	3
do not make SCHIP benefit equal to Medicaid benefit	1
establish guarantee package for prevention	1
Evaluation and Reporting	
require data reporting by states	2
improve reporting by vendors	1
show value via evaluation	1
Coverage	
expand eligibility	7
incentivize care of people with special needs	3
add adults	1
SCHIP management	
streamline coordination between Medicaid/SCHIP to help families	3
engage physicians to promote oral health of young children	2
require beneficiary education and case management	1
share data between Medicaid and SCHIP programs	1
Public health	
raise awareness about oral health	3
enhance liaison with Medicaid and SCHIP	2
require dental exam for school entry	1
Dentist participation	
incentivize dentist participation in SCHIP	5
raise rates	2
increase # rural dentists	1
have ADA survey dentists re participation and require CE on the target population	1

Specific policy fixes advanced by the ADA: The American Dental Association and 11 additional national dental organizations have endorsed a series of *SCHIP Principles* that call on Congress to improve SCHIP dental coverage during reauthorization in three ways:

1. Move dental services from an optional benefit to a required benefit.
2. Allow states to offer dental coverage to income-eligible children who have private medical coverage but no dental coverage (the so-called “dental wrap”).
3. Require that states report on the performance of their dental programs in a uniform way; consistent with current reporting requirements in Medicaid.

These three policy recommendations were vetted with Informants and 82 responses were received.

1. Making dental care required in SCHIP: 66% said yes to the question “Do you think that separate SCHIP dental services should be changed from an 'optional' to a 'required' benefit under federal law?” while 15% said no and 19% said they did not know.
2. Offering the dental wrap: 62% said yes to the question, “Do you think that states should be allowed to provide dental coverage through the separate SCHIP to children who are currently ineligible because they have private medical insurance through employer

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coverage?” while 16% said no, and 22% said they did not know.

3. Mandating reporting: 60% said yes to the question, “Do you think that states should be required to report on separate SCHIP dental program performance to the federal government, e.g., using Medicaid, HEDIS, or other reporting methods?” while 18% said no, and 22% said they did not know.

Fifteen unique comments were received regarding mandatory reporting. Of these,

- four states reported already using an annual performance measure;
- three were guarded or negative claiming that reporting should not be mandatory, that mandatory reporting should be conditional on a dental requirement in SCHIP, or that more information was needed;
- two endorsed the Medicaid Form CMS-416 measure for its robustness;
- two were positive because reporting would allow comparability across states while two were positive because mandatory reporting would improve consistency of reporting; and
- two suggested that mandatory reporting would have utility in program management by either encouraging dentists to

participate or to guide program reform.

IMPLICATIONS FOR SCHIP REAUTHORIZATION

This review and analysis well substantiates that the SCHIP dental benefit has been valuable to beneficiaries by increasing their use of dental services, decreasing the occurrence of unmet need, and providing more children with a usual source of care. While a number of programmatic and policy improvements have been suggested, the SCHIP dental program is widely regarded as successful—regardless of how administered and regardless of the Informants’ position. Overall, there is strong agreement on the value, importance, and success of the program and an encouragement for its continuation.

There is substantial support among Informants for the call to stabilize the dental benefit by requiring that dental services be covered in SCHIP, for the “dental wrap” that would expand coverage to children who have medical but no dental insurance, and for requiring states to report their SCHIP dental performance to the federal government.

Regarding differences between program types, the intention by Congress to allow states “flexibility” is readily apparent in the SCHIP Stand-alone programs but much less so in the Combination plans and Look-alikes. The Stand-alone plans most closely mimic commercial dental coverage and distinguish themselves from Medicaid-expansions and Medicaid-based plans (Combinations and Look-alikes) by imposing more restrictions on care, by

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capping the dollar value of the dental benefit, and by relying significantly on vendors for program administration. There is little evidence, however, of financial risk-sharing at the level of the dental plan and almost none at the level of the dentist.

Some anxiety is noted among Informants who offered suggestions to improve SCHIP at the federal level as the highest number of responders (13) called for assuring sufficient funding either through the funding formula or through an enhanced federal matching rate specifically for dental services.

SCHIP has clearly improved the oral health and dental care of children from working-poor families. The literature and new ADA survey validate the ADA's policy positions for further program refinement.

About the Authors

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Donald A. Schneider, DDS, MPH, is a retired officer of the Commissioned Corps of the United State Public Health Service (PHS). His last PHS assignment (1997-2002) was as Chief Dental Officer, centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration, where he served as the principal advisor to the Agency on all matters concerning the oral health of beneficiaries in Medicaid, Medicare and the State Children's Health Insurance Program. Dr. Schneider currently provides consultation on issues of health policy and dental public health from his home in Sarasota, Florida.

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The American Dental Association thanks all of the survey respondents for participating in the survey as well as Dr. Conan Davis, Christine Farrell, Matthew Mikkelsen and Janice E. Kupiec for their assistance with the project.

Appendices

**ATTACHMENT A: E-MAIL
TO KIDS ORAL HEALTH
LISTSERVE, SENT
4/19/07**

By now, many of you have received the ADA's Survey of Separate SCHIP Dental Programs. (If you think you should have received it given your role in the state but did not, please check your SPAM folder to see if your e-mail settings bounced it to that mailbox, or contact me).

We have received today a number of questions about the survey which we think might be applicable to others. We hope the following responses to those queries will facilitate your completing the survey. Please contact me if you have additional questions.

1. Question: My state does *not* have a Separate SCHIP. Do I need to complete the survey?

Answer. Yes. Survey respondents need to complete the web-linked contact information section and return the survey. This process will enable us to be sure that there have been no recent changes in states which, historically, have not had a Separate SCHIP. By answering the questions on the second page of the web-linked survey and clicking "Next", you will be directed automatically to the final page. You will not see any of the remaining questions. On the final page you must click the "Finish" button to submit the survey.

2. Question: My state *does* have a Separate SCHIP, but it does *not* offer any dental benefits. Do I need to complete the survey?

Answer: Yes. All survey respondents in this situation need to complete the web-linked contact information section and Question #1 and 2, and submit the survey. This process will enable us to be sure that there have been no recent changes in dental benefit status in states that have a Separate SCHIP. On the web-linked survey, if you answer Question #2 by saying "No" or "Don't know," and click "Next", you will be directed automatically to the final page. You will not see any of the remaining questions. On the final page you must click the "Finish" button to submit the survey.

3. Question: Our state has a Separate SCHIP that offers dental benefits. Can we collaborate on our answers and have only one person submit the survey, or do all Informants in a state complete the survey?

Answer: While, in general, collaboration among a state's Key Informants in responding to the survey is a good idea, Questions #14, 15, and 18-to-the-end have "opinion" components. (Question #15 has both a factual and an opinion part.) Because there is potential that the survey researchers will compare Informant group responses (e.g., State Dental Directors vs. SCHIP Dental Program Managers) on at least some of the opinion questions, it would be best if each Informant completed these responses independently; almost as if this were a secret ballot (although you may want to jointly debate your potential responses beforehand).

Each Informant also needs to complete the first page contact information and questions #1 and #2 in order to be able to proceed to the rest of the survey. (If you don't answer questions #1 and 2 to indicate that

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there is a Separate SCHIP offering dental benefits, you will be directed automatically to the final page of the survey.)

Since most of the questions between 1 and 17 really have only one correct response, those may be completed by a single person who would note--in the first "Comment Box" under Question 1--that they are completing these questions for the rest of the state's respondents. The other Informants then skip these questions, or use the default values or say "don't know," if prompted for a response. It would be helpful if Informants also let us know--in the "Comment Box" under Question 1--that the "knowledge" questions are being completed by (name of person).

4. Question: My state has a Separate SCHIP, but it operates as a Medicaid "Look-alike," or uses the same policies, procedures and provider network as Medicaid. Do we need to complete the survey? If so, how do we answer a question that does not offer a neutral response option, such as "about the same?"

Answer: You should complete the entire survey, but please also indicate, either in the "Comment Box" under Question 1 or on the final page that your state's Separate SCHIP functions as a Medicaid "Look-alike." For most survey questions seeking comparisons between the Separate SCHIP and Medicaid, a neutral response choice such as "About the same" or "Neither successful nor a failure" is available. If the neutral choice is selected, you will not be prompted for additional comments on that question. For other questions, such as Question #5, 14, or 19, which do not offer a neutral response and ask, respectively, about

covered benefits, network adequacy, or SCHIP innovations, your responses likely will describe Medicaid coverage, Medicaid network adequacy or Medicaid innovations, if no substantial variation from SCHIP exists.

I hope these responses are helpful.

Don

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Consultant in Health Policy and Dental Health

ATTACHMENT B: E-MAIL TO CONSTITUENT DENTAL SOCIETIES, SENT 4/20/07

By now, constituent dental society executive directors should have received the ADA's *Survey of Separate SCHIP Dental Programs*.

We have received a number of questions about the survey which might be applicable to others. The following responses to those inquiries should facilitate your completing the survey. We hope to receive a response from each person who received the survey, and look forward to your participation. If you have any further questions, please contact Dr. Donald Schneider via e-mail.

1. Question: I don't have information available to answer all the questions, or many questions do not apply. Do I need to complete the survey?

Answer: Yes, we would like to receive a survey from each individual to whom it was sent. If you cannot answer a question, select "Don't Know" or leave it blank. Please note that the survey is programmed to control the questions available for viewing, based on responses to earlier questions. As a

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result, many of the questions on the survey preview PDF may not appear in the online survey if your does not have a separate SCHIP dental program.

2. Question: My state does *not* have a Separate SCHIP. Do I need to complete the survey?

Answer. Yes. Survey respondents need to complete the web-linked contact information section and return the survey. This process will enable us to be sure that there have been no recent changes in states which, historically, have not had a Separate SCHIP. Although the survey preview PDF displays all the questions in the survey, when you complete it online, only the questions relevant to the situation in your state (as indicated by your responses to the first set of questions) will appear. By answering the questions on the second page of the web-linked survey and clicking “Next”, you will be directed automatically to the final page. You will not see any of the remaining questions. On the final page you must click the “Finish” button to submit the survey.

3. Question: My state *does* have a Separate SCHIP, but it does *not* offer any dental benefits. Do I need to complete the survey?

Answer: Yes. All survey respondents in this situation need to complete the web-linked contact information section and Question #1 and 2, and submit the survey. This process will enable us to be sure that there have been no recent changes in dental benefit status in states that have a Separate SCHIP. On the web-linked survey, if you answer Question #2 by saying “No” or “Don’t know,” and click “Next”, you will be directed automatically to the

final page. You will not see any of the remaining questions that appear on the survey preview PDF. On the final page you must click the “Finish” button to submit the survey.

4. Question: This survey was sent to four people in my state, including me. Do you want one response per state, or should each person respond?

Answer: We would like to receive a survey from each individual to whom it was sent, even if some of their responses are identical. We understand that, in most of the questions between 1 and 18 for states with separate SCHIP dental programs, there is only one “true” answer per state, and your answers may duplicate those of others from your state. Please note that there is a series of opinion questions near the end of the survey that require an independent response; we do not expect the responses to these questions to be consistent between all key informants within a state.

5. Question: Our state has a Separate SCHIP that offers dental benefits. Can we collaborate on our answers and have only one person submit the survey, or do all Informants in a state complete the survey?

Answer: While, in general, collaboration among a state's Key Informants in responding to the survey is a good idea, Questions #14, 15, and 18-to-the-end have “opinion” components. (Question #15 has both a factual and an opinion part.) Because there is potential that the survey researchers will compare Informant group responses (e.g., State Dental Directors vs. SCHIP Dental Program Managers) on at least some of the opinion questions, it would be best if each Informant completed these

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responses independently; almost as if this were a secret ballot (although you may want to jointly debate your potential responses beforehand).

Each Informant also needs to complete the first page contact information and questions #1 and #2 in order to be able to proceed to the rest of the survey. (If you don't answer questions #1 and 2 to indicate that there is a Separate SCHIP offering dental benefits, you will be directed automatically to the final page of the survey.)

Since most of the questions between 1 and 17 really have only one correct response, those may be completed by a single person who would note--in the first "Comment Box" under Question 1 --that they are completing these questions for the rest of the state's respondents. The other Informants then skip these questions, or use the default values or say "don't know," if prompted for a response. It would be helpful if Informants also let us know--in the "Comment Box" under Question 1 --that the "knowledge" questions are being completed by (name of person).

6. Question: My state has a Separate SCHIP, but it operates as a Medicaid "Look-alike," or uses the same policies, procedures and provider network as Medicaid. Do we need to complete the survey? If so, how do we answer a question that does not offer a neutral response option, such as "about the same?"

Answer: You should complete the entire survey, but please also indicate, either in the "Comment Box" under Question 1 or on the final page that your state's Separate SCHIP functions as a Medicaid "Look-alike." For most

survey questions seeking comparisons between the Separate SCHIP and Medicaid, a neutral response choice such as "About the same" or "Neither successful nor a failure" is available. If the neutral choice is selected, you will not be prompted for additional comments on that question. For other questions, such as Question #5, 14, or 19, which do not offer a neutral response and ask, respectively, about covered benefits, network adequacy, or SCHIP innovations, your responses likely will describe Medicaid coverage, Medicaid network adequacy or Medicaid innovations, if no substantial variation from SCHIP exists.

I hope these responses are helpful.

Don

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