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**SCHIP Takes a Bite Out  
of the Dental Access Gap  
for Low-Income Children**

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# **SCHIP TAKES A BITE OUT OF THE DENTAL ACCESS GAP FOR LOW-INCOME CHILDREN**

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**T**he introduction of the State Children's Health Insurance Program (SCHIP) in 1997 created a new vehicle for extending dental coverage to low-income children.<sup>1</sup> Historically, low-income children have had difficulty accessing dental services. Children in low-income families are less likely to have private coverage than children in higher-income families, may face institutional barriers to dental care if eligible for Medicaid, and often lack dental insurance completely (U.S. Department of Health and Human Services 2000a). The decision by nearly every state to offer a dental benefit under SCHIP has improved the chances that low-income children who were previously uninsured have access to dental care.

This report explores the link between SCHIP insurance coverage and access to dental care. In addition, it examines the barriers that still exist to improving access to and utilization of dental care among low-income children enrolled in SCHIP, as well as how states are responding to these challenges. The evidence we present shows that, for low-income children enrolled in the program, SCHIP participation is associated with improved utilization of dental care and with reduced unmet dental needs and delay of care. Through SCHIP, states have taken an important first step toward closing the dental care gap between high- and low-income children.

## **DENTAL CARE IS INTEGRAL TO CHILDREN'S HEALTH**

Access to preventive and restorative dental care is integral to the overall health and well-being of children. Good dental care contributes to healthy growth and positive educational, economic, and social outcomes (U.S. Department of Health and Human Services 2000a). Each year, more than 1.6 million school days are lost due to acute dental conditions, an average of 3.1 days per 100 students (Adams et al. 1999). Low-income children are

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<sup>1</sup>In this report, low-income denotes children in families earning less than 200 percent of the Federal Poverty Level (FPL), unless otherwise specified.

disproportionately likely to be among those who have untreated dental disease (Edelstein 2002; and Vargas et al. 1998).

The American Academy of Pediatric Dentistry (AAPD) recommends that all children age 2 and older receive at least two preventive dental visits each year (American Academy of Pediatric Dentistry 2003). National data suggest that U.S. children, especially low-income children, were far from reaching this goal in the years prior to the introduction of SCHIP. According to 1996 data from the Medical Expenditure Panel Survey (MEPS), only 31 percent of low-income children ages 2 to 18 had a dental visit in the previous year. This is substantially lower than the percentage of children ages 2 to 18, at all income levels, who had a dental visit in the past year (47 percent), thus demonstrating a significant disparity in dental care access by income (Agency for Healthcare Research and Quality 2003).<sup>2</sup> Given that even the general child population falls short of meeting the AAPD goal, a more appropriate benchmark against which to track the progress of the SCHIP program may be the Healthy People 2010 goal that at least 57 percent of low-income children receive a preventive dental visit each year (U.S. Department of Health and Human Services 2000b).<sup>3</sup>

### **INSURANCE IS KEY ELEMENT IN ACCESS TO CARE**

Inadequate access to dental insurance accounts for much of the disparity in access to care (U.S. Department of Health and Human Services 2000a).<sup>4</sup> In 1996, before the introduction of the SCHIP program, 26 percent of low-income children— compared to 52 percent of children from all income brackets—had private dental coverage (Manski et al. 2001). Although some low-income children had access to dental care through the Medicaid program, Medicaid coverage does not appear to confer the same advantage as private dental coverage. During 1996, low-income children with Medicaid coverage were one-third less likely to receive a dental visit than low-income children with private coverage (Manski et al. 2001),<sup>5</sup> a difference most likely due to institutional barriers to dental care within the Medicaid program (U.S. Government Accounting Office 2000).<sup>6</sup> Still, the benefit of having

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<sup>2</sup>Other data sources report substantially higher rates of dental visits. For example, according to data from the 2001 National Health Interview Study, approximately 73 percent of all U.S. children and 62 percent of poor and near-poor children reported having a dental visit in the previous year (National Center for Health Statistics 2001). However, MEPS data has been shown to be a more accurate measurement of overall dental utilization, as well as being the metric used to set the Healthy People national goals (Macek et al. 2002).

<sup>3</sup>The Healthy People 2010 goals were developed to provide attainable public health goals for the U.S. population. The annual dental preventive care goal for low-income children was established to be slightly higher than the current rate of annual preventive care among children of any single income group (U.S. Department of Health and Human Services 2000b).

<sup>4</sup>Lack of provider availability and low caregiver prioritization of dental care are also generally found to be associated with poor access to dental care (Kenney et al. 2000).

<sup>5</sup>This particular finding concerns children living in families under 133 percent of FPL.

<sup>6</sup>These data predate implementation of the SCHIP program. More recent studies of children's dental utilization rates by insurance status (such as Kenney et al. 2003) aggregate Medicaid and SCHIP utilization into a single rate. Consequently, little is known about how dental access and utilization may differ in the Medicaid and SCHIP programs.

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any dental insurance is clear. Only 19 percent of uninsured children in families below 133 percent of FPL received dental care during 1996, compared to 28 percent of those with Medicaid coverage, and 43 percent of those with private dental coverage (Manski et al. 2001).

### **SCHIP'S POTENTIAL TO CLOSE THE LOW-INCOME GAP**

Enacted in 1997 to provide health insurance coverage to low-income uninsured children, SCHIP offers states a unique opportunity to address the lack of dental coverage within this population. Under SCHIP, states are required to offer general medical benefits comparable to benchmark plans in their state. Dental care is one of several optional services that states can add to their core medical packages. As of 2003, every state but Delaware had chosen to offer some type of dental coverage. Most SCHIP programs cover both preventive and diagnostic care in accordance with AAPD recommendations as well as some level of restorative care. By statute, SCHIP programs may not collect a copayment for preventive services and few states require cost-sharing for restorative care. In those states that do collect a copayment, the amount ranges from \$2 to \$5. Only one state plan requires coinsurance (Rosenbach et al. 2003; and Wooldridge et al. 2003).<sup>7</sup> Many states cited the importance of dental care to child health and development as their primary rationale for adoption of the benefit.

### **METHODOLOGY**

To better understand how state SCHIP programs may be increasing access to and utilization of dental care among low-income children, we reviewed annual state SCHIP reports submitted to the Centers for Medicare & Medicaid Services (CMS). Title XXI does not require states to report a standard set of performance measures for their SCHIP programs. Instead, states may document whatever measures they believe best represent progress toward access and utilization goals.<sup>8</sup> Twenty-seven states reported at least one type of dental access or utilization measure in their 2000, 2001, 2002, or 2003 annual reports.<sup>9</sup> From these annual state reports, and reviews of published literature and internet sources, we compiled two types of evidence: (1) studies documenting change in dental care access and utilization upon SCHIP enrollment in eight states, and (2) point-in-time dental visit rates within 21 state SCHIP programs, which we compare to the Healthy People 2010 goal for low-income children. We supplemented these materials with focus group and site visit

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<sup>7</sup>One of Utah's dental plans requires coinsurance equal to 20 percent of the allowed charge for restorative services. Utah's other plan requires a copay of \$3 for all services (Utah Department of Health 2003).

<sup>8</sup>CMS began requesting that states voluntarily report core performance measures in their federal fiscal year 2003 annual reports. Dental care is not one of those proposed as a core measure.

<sup>9</sup>While the most commonly reported dental measure in the state annual reports was the percentage of SCHIP-enrolled children who received dental care in a 6- or 12-month period (reported by 21 of the 27 states including dental measures), a few states also reported on other measures, such as claims per 1000 members, dental visit counts, and frequency of untreated tooth decay.

evidence obtained through Mathematica Policy Research's (MPR's) national evaluation of SCHIP.

#### **CHANGES IN ACCESS AND UTILIZATION IN CONJUNCTION WITH SCHIP ENROLLMENT**

As shown in Table 1, we identified evaluations in eight states that document change in dental care access and utilization under SCHIP. Each of these studies compared dental access and use in the SCHIP program to a period before enrollment in the program using one of the following three types of research designs:

- The Iowa, Kansas, North Carolina, and Pennsylvania evaluations used a **pre/post** design in which a single cohort of SCHIP enrollees was surveyed at two points in time. The first survey, occurring soon after SCHIP enrollment, asked about the cohort's dental utilization and access during the year preceding SCHIP enrollment. These results were then compared to those of a second survey, occurring a year later, which asked about the cohort's experiences while enrolled in SCHIP. The Pennsylvania evaluation (Lave et al. 2002) used 1995 data concerning access and utilization in a pre-SCHIP public insurance program, which was for low-income children in western Pennsylvania.
- The Florida, New Hampshire, and Texas evaluations used a **non-equivalent comparison** design in which concurrent surveys were conducted with two cohorts: "continuous" enrollees (those enrolled in the SCHIP program for six or more months) and "new" enrollees (those enrolled for fewer than three months). The experiences of the continuous enrollees over the prior year (or, in one case, six months) while enrolled in SCHIP were then compared to the experiences of new enrollees over the year prior to their SCHIP coverage. These evaluations were all conducted by the same lead investigator.
- The Alabama evaluation used a **retrospective** design in which a cohort of enrollees was surveyed within one year of SCHIP enrollment about their experiences accessing dental care while enrolled in SCHIP, compared to their experiences accessing care during the year before they were enrolled.

Results from these eight states suggest that both access to and utilization of dental care improved in conjunction with SCHIP enrollment. After enrolling in SCHIP, more families reported that their children received a dental visit in the past year, had a usual source of dental care, experienced a reduction of unmet dental needs and delayed access to care, and increased the total number of dental visits. While all but one of the documented improvements exceeded 10 percent, the magnitude of these changes varied depending on the study and measure. For example, the percentage of children with any dental visit in the

**Table 1. Change in Access and Utilization of Dental Services under SCHIP: State Findings**

State	Study Authors	Study Design <sup>a</sup>	Any Dental Visit	Usual Source of Dental Care	Reduction of Unmet Dental Need	Reduction of Delay of Dental Care	Number of Dental Provider Contacts
Alabama	Mulvihill et al. (2000)	Retrospective			+ <sup>b</sup>		
Florida	Shenkman et al. (2000, 2003)	Non-equivalent comparison	+ <sup>b,c</sup>		+ <sup>b,d</sup>		
Iowa	Damiano (2003)	Pre/post	+	+	+	+	
Kansas	Fox et al. (2003)	Pre/post	+		+		
New Hampshire	Shenkman (2002)	Non-equivalent comparison			+ <sup>b</sup>		
North Carolina	Mofidi et al. (2002)	Pre/post	+	+	+		
Pennsylvania	Lave et al. (2002)	Pre/post	+	+	+ <sup>e</sup>	+ <sup>e</sup>	+
Texas	Shenkman (2003)	Non-equivalent comparison			+ <sup>b</sup>		

Notes: Improvements in access and utilization upon SCHIP enrollment are represented by the “+” symbol. If the study employed significance testing, a “+” symbol denotes a significant difference was found at the 0.05 level or lower. Those studies not employing significance testing are noted otherwise. Shading denotes measures that were not included in these particular studies. All measures reflect dental access and utilization within the past year, unless otherwise noted.

<sup>a</sup>Four state evaluations (Iowa, Kansas, North Carolina, Pennsylvania) measured changes in dental access and utilization upon SCHIP enrollment using a pre/post design, surveying enrollees within 3 months of their initial enrollment and again after at least 11 months of enrollment. Three other state evaluations (Florida, New Hampshire, Texas) measured access and utilization using a non-equivalent comparison design by simultaneously surveying new and continuous enrollees to compare their dental access and utilization over the previous year. One other state evaluation (Alabama) used a retrospective design by surveying a single cohort of established enrollees about their access and utilization experiences under SCHIP, compared to their experiences before they were enrolled in the program.

<sup>b</sup>These results were not subject to significance testing.

<sup>c</sup>This measure, presented in the 2000 report only, reflects dental access and utilization in the past six months.

<sup>d</sup>2003 report only.

<sup>e</sup>These measures were asked as a single question (“whether the child experienced unmet needs or delayed care”).

past year increased between 44 and 50 percent across four states, while unmet need was reduced 28 to 86 percent across the eight states.<sup>10</sup> Because the methods used to document these changes were not uniformly rigorous, they should be interpreted with caution. However, in the aggregate, these results are in accordance with data comparing a Medicaid population to an uninsured population collected prior to SCHIP's implementation, as cited earlier (Manski et al. 2001). They are also in agreement with more recent national data indicating that children covered by Medicaid or SCHIP are 1.5 times more likely to have had a dental visit in the past year, compared to uninsured children (Kenney et al. 2003). In sum, the results from Table 1 support the promising role of SCHIP in improving dental access and utilization among low-income children.

### **ANNUAL AND SEMI-ANNUAL DENTAL VISIT RATES IN SCHIP PROGRAMS**

Another way of looking at dental access within the SCHIP program is to consider point-in-time estimates of dental utilization across states. Table 2 presents the most recent data for each of the 21 states reporting some form of this measure. As shown, there is wide variation in rates of semi-annual and annual dental visits reported by the 21 states—from a low of 17 percent of children receiving a visit in the past year in Wisconsin, to a high of 76 percent of children receiving a visit in the past year in Alabama and among older children in Florida. 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. The measurements presented in Table 2 vary by type of program, reporting year, data source, data characteristics, and sampled population. Some of these differences, such as age (Florida) and type of visit (Wisconsin), have a clear influence on the reported rate. When possible, we have noted these differences in the table and table notes.

The Healthy People 2010 goal provides a national benchmark against which to compare 12-month dental utilization rates in the SCHIP program. Of the 17 states that reported 12-month dental visit rates, 7 appear to have surpassed the goal of 57 percent of low-income children reporting at least one dental visit each year (Figure 1).<sup>11,12</sup> It is important to note that some differences across states may be due to methodological variation. Seven of the

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<sup>10</sup>The 44 percent increase in any dental visits refers to an increase from 48 percent to 69 percent in Iowa (Damiano 2003). The 50 percent increase in any dental visits refers to an increase from 40 percent to 60 percent in Pennsylvania (Lave et al. 2002). The 28 percent reduction in unmet need refers to a decrease from 25 to 18 percent among older children in Florida (Shenkman et al. 2003). The 86 percent reduction in unmet need refers to a decrease from 53 percent to 7 percent in Alabama (Mulvihill et al. 2000).

<sup>11</sup>The Healthy People 2010 goal refers to preventive care visits only, whereas the rates presented in Figure 1 reflect any type of dental visit. However, we assume that the overwhelming majority of reported visits contained some degree of preventive care assessment or guidance, in accordance with general dental practice.

<sup>12</sup>Of the five states reporting six-month data, one (North Dakota) reported a rate surpassing the 12-month goal of Healthy People 2010.



**Table 2. Dental Visit Rates in State SCHIP Programs: Percent of Children Receiving a Dental Visit in the Past Six Months or the Past Year**

State	Program Type <sup>a</sup>	Reporting Year	Data Source	Data Source Notes (where reported)	Percent Receiving Dental Care in Past Six Months	Percent Receiving Dental Care in Past Year
Alabama	COMBO	2001-2002	Survey	Response rate: 55% Population: S-SCHIP only		76% <sup>b</sup>
Alaska	M-SCHIP	2001	Survey	n = 1,072 Response rate: 64% Population: Medicaid and SCHIP combined	52%	
Arkansas	M-SCHIP	1999-2000	Claims	Ages 4-21 Population: Medicaid and SCHIP combined		46%
Arizona	S-SCHIP	2000-2001	Claims	Ages 3-18		36%
Colorado	S-SCHIP	2002-2003	Claims	Ages 0-18		34%
Florida	COMBO	2001-2002	Survey	Ages 5-19 n = 382 Response rate: 67% Population: S-SCHIP only		62% (ages 5-10) 76% (ages 11-19)
Georgia	S-SCHIP	2000	Survey; Claims	Ages 2-18 Response rate: 70% <sup>c</sup>	44% <sup>c</sup>	64% <sup>d</sup>
Iowa	COMBO	2000-2001	Survey	n = 2,005 Response rate: 39% Population: S-SCHIP only		74%
Kentucky	COMBO	2001-2002	Survey	n = 1,958 Response rate: 34% Population: Medicaid and SCHIP combined	53%	
Maine	COMBO	1999	Survey	n = 298 Response rate: 60% Population: all publicly insured children <sup>e</sup>		62%
Maryland	M-SCHIP	2000	Claims	Ages 3-20 Population: Medicaid and SCHIP combined		29%
Michigan	COMBO	2001	Claims	Ages 4-19 Population: S-SCHIP only		43%
Montana	S-SCHIP	2002	Survey	n=392 Response rate: 41%	50%	
New York	COMBO	2002	Claims	Ages 4-21 Population: S-SCHIP only		41%
North Carolina	S-SCHIP	1999-2000	Survey	Ages 6-18 n = 439 Response rate: 74%		65%
North Dakota	COMBO	2001	Survey	n = 629 Response rate: 50%	64%	
Ohio	M-SCHIP	2001	Claims	Ages 4-21 Population: Medicaid and SCHIP combined		41%
South Dakota	COMBO	2001-2002	Survey	n = 302 Response rate: 34%		63%
Tennessee	M-SCHIP	1999-2000	Claims	Population: Medicaid and SCHIP combined		33% <sup>b</sup>
West Virginia	S-SCHIP	2000-2001	Survey	n = 4,473 Response rate: 35%		55%
Wisconsin	M-SCHIP	2000	Claims	Ages 3-21 Population: managed care only		17% <sup>b</sup>

Source: State Title XXI Annual Reports from 2000 through 2003.

Notes: M-SCHIP denotes that the state operates a Medicaid expansion program; S-SCHIP denotes that the state operates a separate child health program; COMBO denotes that the state operates both an M-SCHIP and an S-SCHIP program. Some states reported dental visit rates for a subpopulation of their SCHIP program (for example, only S-SCHIP enrollees in a COMBO program) or for a broader population (for example, Medicaid and SCHIP enrollees combined in an M-SCHIP program), as described under “population” in the Data Source Notes column.

<sup>a</sup>Reflects type of program during reporting year specified. Two states, Alabama and Maryland, have since changed the structure of their programs. Alabama switched from a COMBO program to an S-SCHIP program as of October 2002. Maryland switched from an M-SCHIP program to a COMBO program as of July 2001.

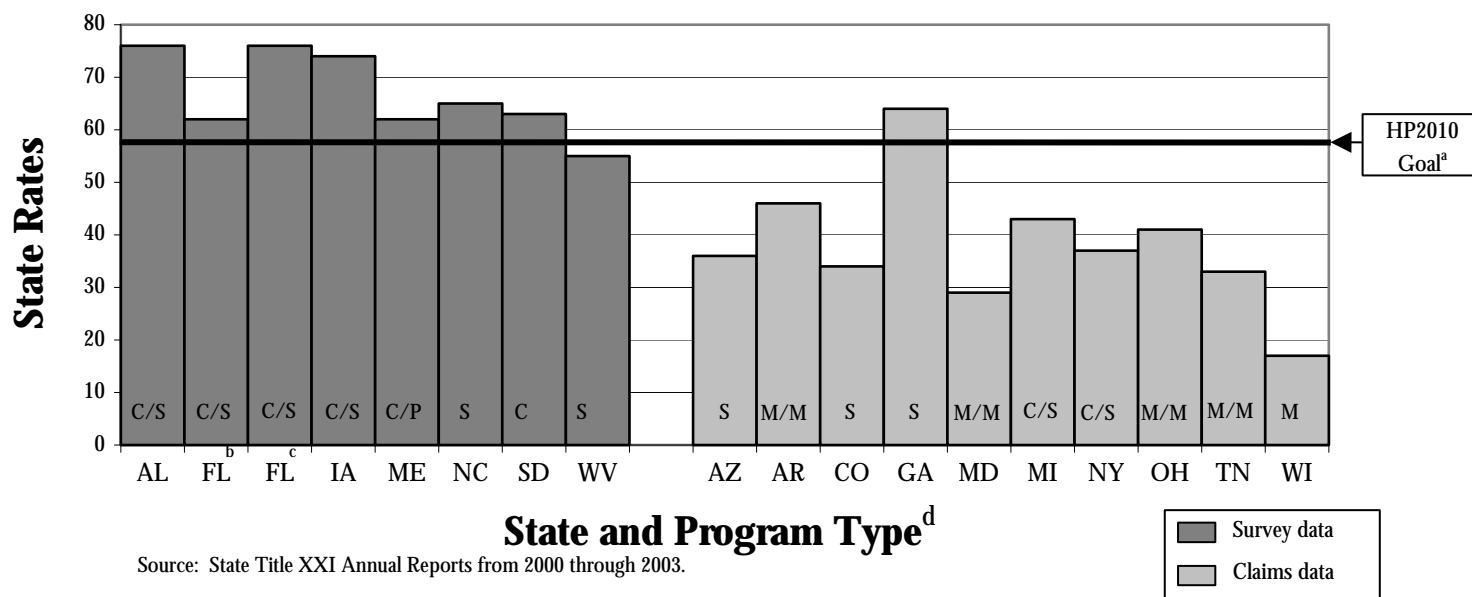
<sup>b</sup>Preventive care visits or examinations only.

<sup>c</sup>Survey data.

<sup>d</sup>Claims data.

<sup>e</sup>Includes children enrolled in SCHIP, Medicaid, Tricare, Medicare, and Indian Health Service.

**Figure 1. State Rates of Dental Visits Among SCHIP Enrollees Over Past 12 Months, in Comparison to Healthy People 2010 National Goal**



Source: State Title XXI Annual Reports from 2000 through 2003.

<sup>a</sup>Healthy People 2010 goal that 57 percent of low-income children will receive annual preventive dental care by 2010. This goal is part of the U.S. Department of Health and Human Services' Healthy People 2010 initiative to establish national public health goals (U.S. Department of Health and Human Services 2000b).

<sup>b</sup>Ages 5-10.

<sup>c</sup>Ages 11-19.

<sup>d</sup>Reflects type of program during reporting year specified in Table 2. M = Medicaid expansion program; S = separate child health program; C = combination program. For those states reporting rates for different populations within these programs: C/S= data reported for S-SCHIP only; C/P = data reported for all publicly insured children; M/M = data reported for Medicaid and SCHIP population combined. See Table 2 notes for detail.

states relied on survey data to calculate annual rates, while 10 used claims data. All but one of the states that reported rates exceeding the Healthy People goal relied on survey data that may be more prone to over-reporting bias when compared to claims data.<sup>13</sup>

There was also substantial variation in utilization rates by program type. None of the states with Medicaid expansion SCHIP (M-SCHIP) programs appear to have reached the Healthy People 2010 goal. In contrast, two of the five separate child health (S-SCHIP) programs and five of the seven combination SCHIP programs surpassed the goal.<sup>14</sup> As shown in Figure 1, all of these M-SCHIP programs relied on claims data, whereas the five combination programs surpassing the goal reported survey data, as did one of the two S-SCHIP programs.<sup>15</sup> Therefore, it is not possible to discern if these distinctions reflect the reporting differences of these programs or a program type effect.

### **FAMILIES' EXPERIENCES ACCESSING SCHIP DENTAL SERVICES**

Tables 1 and 2 suggest that the implementation of SCHIP has improved low-income children's access to and utilization of dental services, but that utilization rates vary substantially across states. Focus groups conducted with parents of SCHIP enrollees in seven states further illustrate families' diverse experiences accessing dental care through SCHIP.<sup>16</sup>

Overall, SCHIP enrollees were grateful for the program's provision of dental coverage, with several parents reporting that the dental benefit was instrumental in their decision to apply to SCHIP. Once enrolled, families receiving dental services reported satisfaction with SCHIP's preventive care benefits. A South Carolina parent described dental care for her child under SCHIP as a "wonderful experience," and a Kentucky parent reported that the benefits gave her "peace of mind." A Pennsylvania mother described a similar sentiment: "The idea of not getting care because you can't afford it – it's heart-breaking for a parent...I've grown up with [poor dental care] – my children shouldn't have to. And they

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<sup>13</sup>Several studies suggest that surveys tend to report higher rates of utilization, in comparison to claims data, due to recall error (see, for example, Fowles et al. 1997, 1999; May and Tontell 1998; and Thompson et al. 2001).

<sup>14</sup>Some states reported dental visit rates for a subpopulation of their SCHIP program (for example, only S-SCHIP enrollees in a COMBO program) or for a broader population (for example, Medicaid and SCHIP enrollees combined in an M-SCHIP program). Of the seven combination programs shown in Figure 1, five reported rates for the S-SCHIP component only and one reported a rate based on a sample of all publicly insured children in the state. Of the five Medicaid expansion programs shown in Figure 1, four reported rates for a combined Medicaid and SCHIP population. See Table 2 notes for detail.

<sup>15</sup>This is likely due to the claims-based reporting requirements of the Medicaid program.

<sup>16</sup>These focus groups were conducted in the following seven states from April 2003 to January 2004 as part of MPR's national evaluation of SCHIP: Georgia (S-SCHIP), Kansas (S-SCHIP), Kentucky (Combination), Maryland (Combination), Ohio (M-SCHIP), Pennsylvania (S-SCHIP), South Carolina (M-SCHIP), and Utah (S-SCHIP).

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have, because I've been neglectful taking them because I couldn't afford it. Now I can and I am just very glad for that.”

A Georgia parent expressed how easy it was to access dental care under SCHIP: “I...got a list of dentists and just called one up [to make an appointment].” Another South Carolina parent reported that SCHIP “covered every bit of the dental cleaning. [The provider] gave me a printout for what [my child] had to have done in the future, which was about \$1,400 worth of stuff. And she said, your insurance will cover all of it.” An Ohio parent whose child used SCHIP dental services reported that “everything has worked out fine so I’m really pleased and impressed.”

Although anecdotal, other comments from focus group participants help to shed light on areas for program improvement. The challenges families faced in accessing coverage were focused on a lack of awareness about the dental benefit, the scope of the benefit package in some states, and difficulties identifying and accessing available providers.

**Awareness of dental benefits.** Parents in some states were not aware that SCHIP coverage included dental benefits. Multiple participants reported hearing about the dental benefit through word of mouth or did not know about the coverage until attending the focus groups. Several South Carolina parents described dental coverage under SCHIP as a “secret.” One Ohio parent commented about “the lack of information given out at the initial application... [my caseworker] gave you the impression that medical was all your kids [got]...but medical to me meant medical—not dental...” Another Ohio parent reported that she “didn’t realize all the stuff you could get. Vision, the dental. I didn’t realize—I thought it was just doctor visits, that’s it.”

**Scope of dental benefits.** Parents in two states cited limitations in covered services as problematic.<sup>17</sup> For example, some Kentucky participants questioned why the state’s benefit package limited SCHIP enrollees to one preventive visit per year, in contrast to the AAPD recommendation of preventive dental care every six months. “If they recommend every six months, then why can’t they pay for it every six months?” asked a Kentucky parent.

Utah parents expressed frustration over a temporary policy limiting restorative services such as fillings. “I found out that my five-year-old needed a filling and they were more than willing to pull the tooth, but not fill it,” reported one Utah parent. Parents described how these restrictions served as a deterrent from seeking any dental services at all. “Why even bother having cleanings and checkups if you can’t get the cavities taken care of?” questioned another Utah participant. Finally, some Utah participants felt that the state should have emphasized the limited scope of dental coverage under SCHIP when families enrolled in the

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<sup>17</sup>Parents in all seven focus group states consistently commented on the limited orthodontic coverage under SCHIP. A Kansas parent described the challenge of accessing orthodontic care under SCHIP: “[Even if you] have teeth coming out of the top of your head, they’re not going to help you out with that.” A parent in Ohio reported that she was told by several orthodontists “don’t waste your time – you will not get coverage for” this care. Because this paper focuses on access to preventive and restorative dental care under SCHIP, we do not explore the orthodontia issue further.

program. A Utah parent explained that, “we should be, as we all are, grateful that the program is here. But at the same time, [the state should] not even call it.... dental insurance. Just say dental cleanings. It’s not clear.” Since the focus groups were conducted in May 2003, many of the restorative services in Utah have been reinstated.

**Availability of providers.** Another prominent theme heard across the focus groups was the challenge of finding dental providers who accepted SCHIP. In the words of a Maryland parent, “they provide the service—they don’t provide the doctor.” A Pennsylvania parent listed her struggles in seeking dental care for her child as “number one, I had a hard time finding a dentist and number two, I had a very hard time getting an appointment for [my child] because they’re so full.” While privately-insured children at higher income levels often face similar difficulties in obtaining access to dental providers,<sup>18</sup> many SCHIP parents felt that their search for dentists was especially challenging because of SCHIP’s limited provider networks and low payment rates. Multiple parents reported calling “every dentist in the phone book” before finding an available SCHIP provider. As a Maryland parent explained, “You can’t find a dentist just for a regular cleaning. So it piles up to have dental problems, and then it escalates to where you need a specialist and there’s nothing [available] at all. I’ve had really bad problems with it.” Other families described how lists of participating dentists distributed by the state were often outdated and little guidance was offered in selecting providers. A Kentucky parent described how “you don’t like to have to choose someone because they’re the only one who will take you.”

Upon finding a provider, some parents reported restricted provider scheduling for SCHIP enrollees. For example, when a Kentucky parent tried to schedule an after-school appointment, she was told by her dentist’s receptionist that they “have our medical card patients come between the hours of ten and two.” An Ohio parent described how she was required by her children’s dentist to change to an inconvenient office location after she signed up for SCHIP.

Finally, some Kansas parents faced the challenge of shifting provider networks that affected their children’s continuity of care. Kansas families whose incomes fluctuated each month frequently alternated eligibility between SCHIP and Medicaid. Because the networks of providers in these programs are not equivalent, children often had to switch providers when their eligibility status changed. Parents felt that “there should be some way that [children] can stay seeing the same doctor once they’ve enrolled in [the SCHIP] program.”

## **STATE INITIATIVES TO IMPROVE DENTAL ACCESS UNDER SCHIP**

Site visit interviews conducted with state officials, dental providers, and professional associations in eight states, as well as a review of the American Dental Association’s recent compendium of state innovations for low-income children, indicate that SCHIP programs are attempting to address many of the coverage and access challenges described by focus

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<sup>18</sup>The Oral Health America National Grading Project assigned a ranking of C- in the category of Access to Care for all Americans (Oral Health America 2003).

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group participants.<sup>19</sup> States are working to overcome these issues through widespread efforts to increase payment rates and streamline claims and administrative procedures. Many states are also increasing access by implementing enhanced case management, developing novel provider recruitment practices, and widening the provider pool by making more dental providers eligible to participate in SCHIP. States have frequently chosen to combine initiatives across their SCHIP and Medicaid programs, as many of the programs use the same fee schedule and provider networks (U.S. Government Accounting Office 2000). Innovations in both programs hold promise for improving dental access and utilization among SCHIP participants.<sup>20</sup>

**Increasing payment rates.** In response to dental provider complaints about low payment, a substantial number of states have increased their dental payment rates in recent years.

- In 2000, the state of South Carolina collaborated with its state dental association to increase payment rates with the goal of enlisting more SCHIP and Medicaid providers. This effort led to a significant jump in provider participation, with most newly enlisted dentists agreeing to accept 50 or more Medicaid and SCHIP enrollees.
- A Kentucky rate increase during 2000-2001 prompted many providers who were already participating to increase their panel sizes to include more SCHIP enrollees, although this did not appear to significantly increase the total provider count.

**Streamlining administrative procedures.** Responding to dental provider complaints about the administrative burden of SCHIP and Medicaid, a majority of states have reduced the level of paperwork and documentation required of participating dentists.

- Several states, such as Kentucky, have shortened SCHIP and Medicaid provider registration forms. Other states, such as Ohio, have uploaded their registration forms onto the Internet to ease completion.

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<sup>19</sup>The site visit interviews were conducted in the following eight states from September 2002 to March 2003, as part of MPR's national evaluation of SCHIP: Georgia, Kansas, Kentucky, Maryland, Ohio, Pennsylvania, South Carolina, and Utah. Reported innovations are a synthesis of site visit interviews and the American Dental Association's "State Innovations to Improve Access to Oral HealthCare for Low-Income Children: A Compendium" (2003). Examples of earlier state innovations are described in the National Conference of State Legislatures' "Increasing Dentists' Participation in Medicaid and SCHIP" (2001).

<sup>20</sup>Although not included in our site visit interviews, California has recently implemented a comprehensive initiative to improve access to and utilization of dental services among SCHIP enrollees. The initiative involves one-on-one health education and case management follow-up with families to ensure that parents keep their children's dental appointments and follow care guidelines. The initiative also plans to use mobile dental vans that circulate among preschools in low-income areas to provide children with a "dental home" (Centers for Medicare & Medicaid Services 2003).

- Many states have streamlined claims processing by accepting the standardized ADA claim form and implementing electronic billing procedures for both Medicaid and SCHIP.
- Some states, such as South Carolina, have also improved patient eligibility confirmation procedures by adopting plastic eligibility swipe-cards and automatic phone systems to confirm eligibility.

**Reducing missed appointments and non-compliance.** Some states are responding to provider complaints about missed appointments and non-compliance among SCHIP and Medicaid enrollees by expanding their case management services for enrolled populations to coordinate dental appointments and offer transportation services.

- One of the case study counties in Ohio dedicates a caseworker to coordinate dental appointments for SCHIP and Medicaid enrollees based on dental providers' schedules and availability. This county consequently reduced its no-show rate to less than 10 percent each month.
- Maryland funded a rural demonstration project to evaluate the barriers that low-income populations face in accessing dental care. The effort combined provider outreach with patient case management and education. Under this initiative, the no-show rate dropped to less than 5 percent among the targeted patient population.

**Increasing provider awareness of SCHIP.** States are encouraging dental providers to expand their practices incrementally to SCHIP and Medicaid enrollees through statewide outreach campaigns.

- The State of Georgia and the Georgia Dental Association initiated the "Take Five" program in October 2001, encouraging dentists to accept at least five new Medicaid or SCHIP patients each year. Coincident with this campaign, the state increased its payment rates (in 2000 and again in 2002), which proved crucial to expanding provider capacity to serve the new SCHIP enrollees.
- Alabama's ALL-Kids SCHIP program, which delivers dental services through Blue Cross/Blue Shield (BC/BS), expanded provider networks by requiring dentists who accept new privately insured patients under BC/BS to also accept ALL-Kids enrollees.
- Many states are collaborating with dental associations to promote opportunities for dentists to voluntarily provide care to low-income children. These initiatives are aimed at helping dentists recognize unmet need within their communities and expanding their publicly-insured patient panels. For example, dentists in many states participate in national "Give Kids a Smile" day, providing volunteer dental



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services for low-income populations and public awareness efforts about dental care under SCHIP and Medicaid.

**Expanding the eligible provider pool.** Several states are looking beyond dentists now practicing to increase provider participation in SCHIP and Medicaid through recruitment of recent dental graduates and hygienists.

- Multiple states have established loan repayment incentives for dental providers who demonstrate a commitment to treating SCHIP and Medicaid enrollees. For example, recent dental graduates working in North Dakota's underserved areas and Connecticut's dental providers serving in community health centers have the opportunity to waive a portion of their dental school fees.
- The Kansas legislature recently passed a bill that expands hygienists' eligibility to deliver preventive care to children enrolled in the SCHIP and Medicaid programs.

## CONCLUSION

Our review of published and unpublished literature, including data from annual state SCHIP reports, suggests that access to dental care for low-income children is improving under SCHIP. While wide variation remains in the progress of state SCHIP programs toward national goals for pediatric dental care, the decision of states to offer the optional dental benefit through SCHIP is an important first step in reducing the gap in dental access between low-income children and those of higher income levels. Overall, children enrolled in SCHIP appear to have greater access to dental care and utilization as compared to before they entered the program, consistently evidencing improvements in utilization and reductions in unmet need and delayed care.

The relative success of state SCHIP programs in increasing access to dental care prompts further questions about what features of the programs are associated with improved access. For example, does type of plan (S-SCHIP, M-SCHIP, combination), delivery system (managed care or fee-for-service), or target population (such as age of child or income) affect access to dental care? In addition, to what extent does data source (for example, claims or survey) account for the variation in rates? Finally, comparisons of dental access between the SCHIP and Medicaid programs may suggest whether performance varies across these two programs.

Despite budgetary constraints, states have continued to demonstrate their commitment to providing dental services to low-income children through SCHIP. While our focus group results suggest that some barriers still remain to families accessing dental services through SCHIP, interviews with both providers and dental associations reflect that states are aware of and working towards promising innovations to address these challenges. Through these efforts, SCHIP programs appear to be working toward reducing the dental access gap experienced by previously uninsured, low-income children.

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