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Access to Care for S-CHIP Adolescents

Prepared by
Harriette B. Fox
Margaret A. McManus
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Maternal and Child Health Policy Research Center
for
The Kaiser Commission on
Medicaid and the Uninsured

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THE HENRY J. KAISER FAMILY FOUNDATION

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The Kaiser Commission on Medicaid and the Uninsured serves as a policy institute and forum for analyzing health care coverage and access for the low-income population and assessing options for reform. The Commission, begun in 1991, strives to bring increased public awareness and expanded analytic effort to the policy debate over health coverage and access, with a special focus on Medicaid and the uninsured. The Commission is a major initiative of the Henry J. Kaiser Family Foundation and is based at the Foundation's Washington, D.C. office.

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EXECUTIVE SUMMARY

This issue brief examines access to care for adolescents under the State Children's Health Insurance Program (S-CHIP). The brief is based on a study of S-CHIP programs in five states, of which three—California, Connecticut, and Utah—opted to enroll S-CHIP eligible children into new private health insurance arrangements, and two—Maryland and Missouri—chose to insure them through Medicaid. For each state, we conducted one or more site visits, meeting with the S-CHIP program director and senior staff; the medical director and other key staff from the two managed care organizations with the largest S-CHIP enrollment; key staff from their behavioral health subcontractors or the state's behavioral health plan; a variety of physical and mental health care providers; and families. We also conducted a detailed analysis of all relevant S-CHIP documents and available enrollment, capitation, and quality data.

Our major study findings with respect to adolescents suggest that states generally have not focused special attention on the unique service needs of this population in designing their S-CHIP programs. This was true in both the Medicaid and non-Medicaid states in our study. Many of the access problems that adolescents confronted were no different than those confronted by younger children, although adolescents seemed to face more difficulties accessing appropriate preventive interventions.

- **Primary care.** Primary care was readily available to S-CHIP adolescents, but concerns were raised about primary care providers' training and experience in serving this population and the availability of multidisciplinary practice arrangements. One of the key factors affecting participation by adolescent providers was low reimbursement rates, which was mentioned in both Medicaid states and one non-Medicaid state. Reimbursement was also cited as a specific barrier to the delivery of a comprehensive adolescent preventive care visit.
- **Family planning services.** Access to family planning services did not appear to be a problem for adolescents. In two of the non-Medicaid states, the lack of family planning clinics in the plans' networks and the routine mailing of benefit statements to parents reportedly deterred some adolescents from using network providers. These adolescents, however, were able to receive confidential, free care from non-participating clinic providers.
- **Dental care.** Access to dental care was seriously affected by the limited participation of dentists in all but one state, which contracted with a single dental plan and used commercial rates. Although inadequate reimbursement was the main reason for low participation, dentists also mentioned their dissatisfaction with public insurance and managed care. Authorization for routine or acute dental care did not appear to be a barrier to care.
- M**ental health services.** For adolescents seeking mental health services, finding a participating provider willing to take an S-CHIP patient was difficult in most plans. In particular, severe shortages of psychiatrists, due largely to low reimbursement rates, created access problems in all five states. Although initial evaluations were not difficult

to obtain, mental health providers often assigned more serious diagnoses for adolescents engaging in high-risk behaviors or manifesting early signs of a mental health disorder, in order to gain approval for ongoing therapy.

- **Prescription drugs.** Difficulty in obtaining certain types of prescription drugs considered important for adolescents was raised as a problem by adolescent providers, usually with respect to commercial plans in non-Medicaid states. Providers voiced complaints in two states about restrictions on certain antibiotics, non-sedating antihistamines, and psychotropics, and in four states about restrictions on the number and form of contraceptives covered.
- **Other access components.** States and plans sometimes implemented policies without particular consideration of the adolescent population. Although health risk assessments for new enrollees were required in three states, none addressed adolescent service use or unmet needs. In addition, parental consent laws and plan billing communication to families in four states sometimes had the effect of limiting adolescents' access to family planning and mental health services. Cost-sharing requirements were apparently not a significant barrier to care, however, probably because many adolescent providers in three of the four states that imposed cost sharing were willing to forego collection.

Introduction and Methods

This report, prepared for The Kaiser Commission on Medicaid and the Uninsured, is part of a larger study focusing on implementation issues and challenges during the first year of S-CHIP operation in five states. Our goal was to understand how program arrangements and plan requirements influence the delivery and quality of care for S-CHIP participants and the ease of program implementation for states. In particular, we wanted to assess the differences between Medicaid and non-Medicaid programs. Other topics addressed in separate reports in this series are state administration and accountability, managed care contracting, and access to care by children with special health care needs.

Our study states were California, Connecticut, Maryland, Missouri, and Utah. Three of the five states—California, Connecticut, and Utah—developed non-Medicaid programs. The other two—Maryland and Missouri—chose to serve S-CHIP children through Medicaid. The following is a description of the programs, current as of their first year of S-CHIP implementation.

- **California's** non-Medicaid S-CHIP program, Healthy Families, began offering coverage to children in families with incomes above Medicaid eligibility levels[1] and below 200 percent of the federal poverty level on July 1, 1998. The program is unique in that it is administered by a quasi-governmental entity, the Managed Risk Medical Insurance Board. Healthy Families participants, all of whom are charged monthly premiums and copayments, receive a benefit package modeled after the insurance program for state employees. Children with intensive physical or mental health needs were eligible for supplemental benefits which, along with their other specialty services, were furnished at no cost through two wrap-around programs operated by the state's Title V program, California Children's Services (CCS), and the county mental health systems. At the end of its first year of operation, Healthy Families was serving 138,869 children.
- **Connecticut's** non-Medicaid S-CHIP program, HUSKY B, which serves children in families with incomes above Medicaid eligibility levels, began enrolling them on July 1, 1998. The program is administered by the state Medicaid agency. Its participants, all of whom are charged copayments, receive the state employees' benefit package. Those with incomes above 225 percent of poverty are required to pay monthly premiums; those with incomes above 300 percent of poverty may buy into the program at full cost. Supplemental services furnished through HUSKY Plus Physical or HUSKY Plus Behavioral are available at no cost to children in families with incomes below 300 percent of poverty who have physical or mental health needs. After one year of operation, 3,543 children were participating in HUSKY B.

[1]Prior to S-CHIP, California's Medicaid eligibility levels were set at 200 percent of poverty for infants, 133 percent of poverty for children ages 1 to 6, and 100 percent of poverty for children ages 6 to 15.

[2]Prior to S-CHIP, Connecticut's Medicaid eligibility levels were set at 185 percent of poverty for children up to age 15 and 100 percent of poverty for children ages 15 to 19.

- **Utah's** non-Medicaid S-CHIP program, CHIP, opened enrollment on August 1, 1998 to children in families with incomes above Medicaid eligibility levels[3] and below 200 percent of the federal poverty level. The state's Medicaid agency administers the program, which provides benefits actuarially equivalent to the state employees' benefit package. Although the program does not impose any premium charges, it requires all participants to pay copayments and those with higher incomes to pay coinsurance for certain services. One year after implementation, CHIP was serving 10,279 children.
- **Maryland's** Medicaid S-CHIP program, the Maryland Children's Health Insurance Program (M-CHIP), began offering coverage to all children below 200 percent of the federal poverty level[4] on July 1, 1998. Participants receive full Medicaid benefits with no cost-sharing obligations. Children with one of 33 physical diagnoses may opt out of managed care enrollment and enroll in the Rare and Expensive Case Management Program. According to the state, approximately 57,000 children were participating at the end of M-CHIP's first year of operation; however, because of a previously approved Medicaid waiver program that provided limited benefits, the state receives the enhanced federal match for only 14,975 children, those with incomes between 185 and 200 percent of poverty.
- **Missouri's** Medicaid S-CHIP program, MC+ for Kids, became operational on July 1, 1998, offering coverage to all children in families with incomes below 300 percent of the federal poverty level.[5] Because Missouri operates its Medicaid program under an approved Section 1115 research and demonstration waiver, the state was allowed to modify its existing Medicaid waiver to include S-CHIP participants. All MC+ for Kids participants are charged copayments, and those in families with incomes above 235 percent of poverty are required to pay monthly premiums. Participants receive full Medicaid benefits, with the exception of nonemergency transportation. At the end of its first year of operation, MC+ for Kids was serving 68,475 children.[6]

In addition to selecting states that would enable us to compare Medicaid and non-Medicaid approaches, we required that the study states be operating their S-CHIP programs for at least one year and that they set their upper income eligibility level no lower than 200 percent of the federal poverty level. We also sought to obtain geographic representation and some variation in covered services, cost-sharing requirements, and administrative structure. For example, California and Connecticut have relatively modest cost-sharing requirements, at least for physical health, under their non-Medicaid programs and supplement their basic benefit package with coverage for children with intensive needs. Utah, by contrast, operates a non-Medicaid program that more

[3]Prior to S-CHIP, Utah's Medicaid eligibility levels were set at 133 percent of poverty for children up to age six and 100 percent of poverty for children up to age 19.

[4]Prior to S-CHIP, Maryland's Medicaid eligibility levels were set at 185 percent of poverty for infants, 133 percent of poverty for children ages 1 to 6, 100 percent of poverty for children ages 6 to 16, and 34 percent of poverty for children ages 16 to 19.

[5]Prior to S-CHIP, Missouri's Medicaid eligibility levels were set at 185 percent of poverty for infants, 133 percent of poverty for children ages 1 to 6, and 100 percent of poverty for children ages 6 to 19.

[6]Missouri was the only one of the five states not to serve S-CHIP participants through managed care on a statewide basis. Missouri's program operated on a fee-for-service basis in certain rural areas of the state.

closely mirrors traditional health insurance. In addition, California uses a quasi-public entity to administer its program, while the other four states rely on their Medicaid administrative structure.

At the outset of the project, we developed a detailed set of core research questions. These questions primarily addressed the intent and effect of various state and plan policies such as state contract requirements regarding benefits, provider networks, and quality assurance and plan payment and authorization policies for important covered services. From these core questions, we developed a model survey instrument for each of the groups to be interviewed. Based on our analysis of each state's S-CHIP plan and contract documents, we modified each instrument to reflect state-specific program arrangements. Each interview took approximately two hours to conduct and was later followed up by additional telephone interviews and data requests to verify or clarify the information provided.

For each state, we conducted our site visits between September 1999 and February 2000, meeting with the S-CHIP program director and senior staff; the medical director and other key staff from the two managed care plans with the largest S-CHIP enrollment; providers; and families whose children have special needs. Interviews with S-CHIP officials took place in the state agency offices, and other interviews were conducted in the communities where the state's two largest S-CHIP plans were based. Providers and families typically attended the group interviews from surrounding areas. Only in California, because of its size, was our sample of providers and families limited to a certain geographic area (Los Angeles).

The study is essentially a qualitative study that attempts to glean from the various perspectives of the state, the plans, providers, and families what the first year's experience of the five S-CHIP programs has been—what aspects of the program appear to be working well and what aspects are causing difficulties or confusion. Our findings are not based on large administrative data sets, chart reviews, or consumer satisfaction surveys, although we sought to obtain such data when they were available. Rather, the findings are based primarily on the opinions and insights of key decision makers as well as providers and families affected by state and plan policies. Often the responses of different groups were at odds, and understanding the complete picture was difficult. In these instances, we attempted to piece together what were the facts and underlying issues. The reader should keep in mind that our findings are based on a small sample of S-CHIP programs and therefore may not be generalizable to the experiences of other programs. In addition, our findings are current only as of the date of our site visit. All five S-CHIP programs have now begun their third year of operation, and, as enrollment has grown and plans and providers become more experienced with the program, substantial changes have likely occurred.

This issue brief on adolescents is divided into four sections. The first provides a profile of adolescent health needs. The second examines provider network availability for adolescents. The third examines service coverage and access for this population with respect to primary care, dental care, family planning services, and mental health services. The fourth section examines certain overall access issues for adolescents, including health risk assessments, cost sharing, and confidentiality. The appendix provides a short summary of each state's S-CHIP program and also includes three tables. Appendix Table I provides a summary of the five states' S-CHIP programs. Table II describes their benefits in detail, and Table III describes their cost-sharing requirements.

Profile of Adolescents

One in seven adolescents ages 13–18 were uninsured in 1996; among those in families with incomes between 100 and 200 percent of the federal poverty level, 25.9 percent were uninsured.[7] Risk of being uninsured among adolescents in this income group was highest for older adolescents, Hispanics and other minorities, and adolescents residing in the South, as shown in Table I.

Table I

Sociodemographic Characteristics of Uninsured Adolescents, Ages 13 through 18, with Family Incomes between 100–199 Percent of the Federal Poverty Level, 1996

Sociodemographic Characteristics	Number of Uninsured (in thousands)	Percent of Uninsured
Age		
All Adolescents	1,116	100.0%
13–15 years	543	48.6
16–18 years	573	51.4
Sex		
Male	586	52.5
Female	530	47.5
Race and Ethnicity		
White, not Hispanic	670	60.1
Black, not Hispanic	120	10.7
Hispanic	269	24.1
Other	57	5.1
Living Arrangements		
With both parents	688	70.1
With one or no parent	293	29.9
Region of Residence		
Northeast	176	15.8
Midwest	169	15.2
South	559	50.1
West	211	18.9

Source: Special tabulations from the 1996 National Health Interview Survey prepared for the Maternal and Child Health Policy Research Center by Yun-Yi Hung and Paul Newacheck of the University of California, San Francisco.

[7] Of the uninsured adolescent population, 43.0 percent had family incomes between 100 and 200 percent of the federal poverty level, 38.3 percent had family incomes below 100 percent of poverty, and 18.7 percent had family incomes at or above 200 percent of poverty, according to data from the 1996 National Health Interview Survey, analyzed by Yun-Yi Hung and Paul Newacheck of the University of California, San Francisco.

The health needs of adolescents are substantially different from those of younger children. While health problems in younger children are due primarily to acute physical illnesses and developmental conditions, those of adolescents are due mainly to conditions associated with behavioral rather than biological factors. In fact, almost 70 percent of adolescent morbidity and mortality is caused by the following six risk factors: intentional and unintentional injuries, drug and alcohol use, sexually transmitted diseases and unintended pregnancies, tobacco use, inadequate physical activity, and poor dietary habits.[8] These leading causes of morbidity and mortality in adolescents are almost entirely preventable.[9]

Adolescents commonly require the following types of health care services:

- Risk assessment, anticipatory guidance, and counseling as part of comprehensive preventive and primary care delivered in office-based practices or hospital, school, or community-based clinics are critical services for adolescents. They are needed by all adolescents to address their higher likelihood of risk-taking behaviors, including alcohol use (among 50 percent of high school students), cigarette smoking (among 35 percent), and marijuana use (among 27 percent).[10]
- Dental care, including preventive, diagnostic, restorative, and emergency treatment, is also required by all adolescents. Almost four out of ten adolescents, ages 15–18, with family incomes between $10,000–$20,000 have untreated cavities in their permanent teeth, which can result in pain as well as problems with eating and speaking.[11]
- Reproductive health, pregnancy, and sexually transmitted disease services may also be required. A large proportion of teens are sexually active; 50 percent of all high school students have had sexual intercourse, and by senior year almost 25 percent have had four or more sexual partners.[12] Although the adolescent pregnancy rate has been declining, 21 percent of sexually active teens become pregnant each year. In addition, about a quarter of sexually active adolescents become infected with a sexually transmitted disease.[13]
- Mental health services, including evaluation, outpatient counseling, medications, and case management, are another type of intervention that adolescents may require. Approximately 25 percent of adolescents have a diagnosable mental health problem, with depression being the most common.[14] Other disorders common in adolescence include anxiety disorders, conduct disorders such as attention deficit hyperactivity disorder or

[8]Centers for Disease Control and Prevention. CDC Surveillance Summaries. *Morbidity and Mortality Weekly Report.* Vol. 47, No. SS-3, 1998.

[9]Issues pertaining to adolescents who have chronic or disabling conditions are considered as part of our issue brief on access to care by children with special health care needs.

[10]Centers for Disease Control and Prevention. CDC Surveillance Summaries. *Morbidity and Mortality Weekly Report.* Vol. 49, No. SS-5, June 9, 2000.

[11]General Accounting Office. *Oral Health: Dental Disease is a Chronic Problem Among Low-Income Populations.* Washington, D.C.: GAO, April 2000.

[12]CDC, 2000.

[13]Ozer EM, Brindis CD, Millstein SG, Knopf DK, Irwin CE. *America's Adolescents: Are They Healthy?* San Francisco, CA: University of California, San Francisco, National Adolescent Health Information Center, 1998.

[14]Kipke MD (Ed.). *Risks and Opportunities: Synthesis of Studies on Adolescence.* Washington, D.C.: National Academy Press, 1999.

oppositional defiant disorder, and eating disorders. Additionally, the adolescent suicide rate is especially high.[15]

Despite the number and severity of risk factors affecting adolescents, they have the lowest health service utilization rates of any age group.[16] Two recent studies on unmet need among adolescents reveal serious access problems. In the first study, almost one out of five adolescents who were at increased risk of physical and mental health problems reported that they had foregone health care in the past year. The main reasons for foregone health care among adolescents were the perception that the problems would go away (63 percent), followed by a fear of what physicians would say or do (16 percent), an inability to pay (14 percent), a concern about confidentiality (12 percent), an inability of parents to accompany the adolescents for care (12 percent), and difficulty making appointments (9 percent).[17] In the second study, almost one quarter of uninsured adolescents reported that they were unable to get needed medical, dental, prescriptions, eyeglasses, or mental health care. The most common type of unmet need was for dental care, reported by 19 percent of uninsured adolescents.[18]

Provider Networks

Primary Care Providers

In the five S-CHIP programs we studied, staff from both of the two largest managed care plans reported having a sufficient supply of primary care providers to serve the adolescent population. Six plans based this assessment on the providers' identification of the age groups they were interested in serving; they did not use specific criteria to designate primary care providers with experience and training in the care of adolescents.[19] Although a large proportion of primary care providers self-designated an ability to serve adolescents, concerns were raised in each of the five states about primary care networks for adolescents. We heard that adolescents could find primary care providers but few had the requisite skills, experience, and confidence to address adolescents' unique health care needs effectively. In Connecticut, Maryland, and Missouri, pediatricians who would treat S-CHIP adolescents often limited the overall number in their practices; one state excluded those at high risk in particular. Five plans, including two with age group designations, maintained a list of office-based adolescent medicine specialists, sometimes indicating those with board certification,[20] but the numbers were small. In the other five plans, there appeared to be no participating adolescent medicine specialists practicing in the community.

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[15]U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General.* Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

[16]Ozer EM et al., 1998.

[17]Ford CA, Bearman PS, Moody J. Foregone Health Care Among Adolescents. *JAMA*. 282(23): 2227–34, 1999.

[18]Newacheck PW, Brindis CD, Cart CU, Marchi K, and Irwin CE. Adolescent Health Insurance Coverage: Recent Changes and Access to Care. *Pediatrics.* 104(2):195–202, 1999.

[19]Although six of the plans we interviewed reported that they knew which providers were interested in serving adolescents, only two included this information in their provider directories. In these two plans, about 90 percent of primary care providers would serve the adolescent population.

[20]These five plans included information on adolescent medicine specialists in their provider directories. An additional two plans included information on adolescent medicine specialists, but all of the providers listed were hospital-based.

Multidisciplinary primary care for adolescents is often available at hospital-based clinics, where adolescent medicine specialists are most likely to practice, and at comprehensive school-based clinics. Few hospital-based adolescent clinics, however, were participating in plans' provider networks in the five study states. With the exception of the Utah plans, neither of which contracted with hospital-based adolescent clinics, plans' networks included only one or two such clinics even among plans that operated statewide. In addition, comprehensive school-based clinics were not participating as primary care providers in any of the plans we interviewed either because the state imposed restrictions on the type and number of services they could furnish or because the clinics lacked the capability to provide year-round, 24-hour care or perform necessary billing and reporting functions.

Several factors account for these network shortcomings. Nationwide, independent of S-CHIP, there is an inadequate supply of adolescent medicine specialists or primary care providers with the special skills and practice arrangements necessary to care for adolescents effectively.[21] Still, however, none of the five S-CHIP programs required plans to contract with or identify adolescent-oriented office-, clinic-, or hospital-based providers,[22] although the two Medicaid programs did include contract language that acknowledged the special role of school-based clinics.[23] State S-CHIP staff generally explained that adolescents did not constitute a special population that required its own set of contracting requirements.

In addition, low reimbursement rates were also a factor affecting the supply of adolescent primary care providers in the three states in which plans paid Medicaid or comparable rates: Connecticut, Maryland, and Missouri. Primary care providers in these plans perceived that rates did not compensate them fairly for the added time needed to treat adolescents. Compared with commercial rates, rates paid for S-CHIP enrollees in these states were substantially lower.[24] Rates in Missouri were lowest: one plan paid just over half of the commercial rate for preventive visits while the other paid less than a quarter, as shown in Table II. By contrast, rates paid by the plans we interviewed in California and Utah were either equal to or higher than commercial rates. Hospital-based adolescent clinics in California and Connecticut faced additional reimbursement problems in that most were unable to bill under a clinic category that would encompass multidisciplinary care or to bill separately for each member of a multidisciplinary care team.

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[21]Nationwide, the number of physicians board certified in adolescent medicine was 385 in 1999. In Anglin TM. *Provider Capacity for Serving Adolescents* Rockville, MD: Office of Adolescent Health, Maternal and Child Health Bureau, December 1999.

[22]Connecticut's S-CHIP legislation required that participating plans contract with school-based clinics as they are required to under Medicaid. However, the final Request for Proposals for S-CHIP did not include this provider requirement, and state program staff explained that school-based clinics are not as essential for the S-CHIP population as for the Medicaid population.

[23]Maryland, a state with a strong history of school-based clinics, allowed self-referral for four acute visits and one follow-up visit per acute visit, and Missouri encouraged plans in the Western region of the state, which includes Kansas City, to contract with school-based clinics.

[24]For Maryland, we could not obtain actual provider reimbursement rates for one plan because the plan subcontracted with numerous medical service organizations which, in turn, subcontracted with providers. In addition, we could not obtain commercial rates for Maryland's other plan because it did not serve the commercially insured and also was not under a parent company offering a commercial product.

Table II

Reimbursement Rates for Selected Preventive and Office Visit Codes Paid by S-CHIP and Commercial Plans in the Five Study States During the First Year of S-CHIP Implementation[1]

Plans		Adolescent Preventive Care (99384)[2]		Office Visits (99202)[2]	
		S-CHIP Rates	Commercial Rates[3]	S-CHIP Rates	Commercial Rates[3]
CA	Plan A	$80.85	$80.85	$55.19	$55.19
	Plan B	64	40.52	33.40	72.60
CT	Plan A	75	100	45	65
	Plan B	75	100	45	65
MD	Plan A	Not Available	40	Not Available	40
	Plan B	37	No Commercial	33	No Commercial
MO	Plan A	23	50	15	60
	Plan B	23	109.01	27	61.33
UT	Plan A	120	120	59	59
	Plan B	79.32	82.42	46.72	51.17

Source: Information obtained by the Maternal and Child Health Policy Research Center through detailed on-site and follow-up telephone interviews.

Notes: 1The programs were implemented in either July or August of 1998.

[2]Differences between S-CHIP and commercial reimbursement rates within and among plans could be explained by the use of Medicaid managed care versus commercial managed care fee schedules for S-CHIP providers, the subcontracting arrangements of HMOs versus PPOs, the impact of plan size and ownership, or other factors.

[3]Commercial rates are the fees paid under each plan's commercial product. In the case of Medicaid-only plans, they are the fees paid under a commercial product owned by the plan's parent company.

Dentists

Across our five study states, the number of dentists in plans' dental networks[25] varied widely—from 51 in one Missouri plan to 5,500 in the largest of California's four dental plans. Nevertheless, in all states but Utah, we heard from dentists, other providers, and usually plan officials as well that dental networks were not adequate to serve S-CHIP adolescents effectively. Dental network shortages were pervasive, reportedly involving both general and specialty dentists, regardless of the contracting arrangements used by the states or the managed care plans. Apparently Utah, which carved dental services out of its general managed care contracts and contracted with the state employees' dental plan, was immune from network shortage problems

[25]Separately capitated plans were used to serve S-CHIP participants in California and Utah. California contracted with four plans, and Utah with one. In Connecticut, Maryland, and Missouri, dental services were included in the general managed care contracts. One Missouri plan and both Maryland plans subcontracted with dental plans.

Table III

Reimbursement Rates for Selected Dental Codes Paid by S-CHIP and Commercial Plans in the Five Study States During the First Year of S-CHIP Implementation[1]

Plans		Comprehensive Oral Exam (0150)[2]		Sealants (1351)[2]		Bitewing X-Ray, Four Film (0274)[2]		Amalgam Restoration—One Surface, Permanent Tooth (2140)[2]	
		S-CHIP Rates	Commercial Rates	S-CHIP Rates	Commercial Rates	S-CHIP Rates	Commercial Rates	S-CHIP Rates	Commercial Rates
CA	Plan A[3]	$25	$40[4]	$9	$45	$18	$34	$39	$70
CT	Plan A	22	55	18	35	25	42	30	60
	Plan B	24	24	20	20	17	17[5]	29.65	33
MD	Plan A	14	28	10	23	17	23	30	28
	Plan B	17	Not available	13	Not available	19	Not available	30	Not available
MO	Plan A	26	Not available	23	Not available	18[5]	Not available	41	Not available
	Plan B	21	Not available	7.29	Not available	7.60[5]	Not available	15.50	Not available
UT	Plan A[6]	29	29	20	20	23	23	43	43

Source: Information obtained by the Maternal and Child Health Policy Research Center through detailed on-site and follow-up telephone interviews.

Notes: [1]The programs were implemented in either July or August of 1998.

[2]Differences between S-CHIP and commercial reimbursement rates within and among plans could be explained by the use of Medicaid managed care versus commercial managed care fee schedules for S-CHIP providers, the subcontracting arrangements of HMOs versus PPOs, the impact of plan size and ownership, or other factors.

[3]There are four capitated dental plans participating in S-CHIP. These rates are for the largest plan, which has more than 50 percent of S-CHIP enrollees and also administers the dental carve-out for the Medicaid managaed care program.

[4]This plan negotiates individually with each participating dentist. There is no established fee schedule. The rates provided are reportedly typical.

[5]Reimbursement rates for four-film bitewings are the same as the rates for two-film bitewings.

[6]There is one capitated dental plan participating in S-CHIP.

because dentists were being paid commercial rates and were simply receiving additional patients for treatment.

In the other states, low reimbursement rates were reportedly a major factor contributing to the shortage of S-CHIP dentists, by either discouraging them from participating or—as in California—discouraging them from accepting S-CHIP patients. Rates in several of the plans for which data were available were significantly lower than commercial rates; in two plans they were half as much or less, as shown in Table III. However, other factors apparently discouraged dentists from participating, evidenced by the experience of one Maryland plan that increased its rates for providers in selected underserved counties and still was unable to contract with additional dentists practicing in the area. Providers in the four states and plan officials in the two Medicaid states ascribed the reluctance of dentists to serve to the fact that they have sufficient business from commercial and self-pay patients and to their perception that this population, like others with publicly financed insurance, is irresponsible about keeping appointments. Providers

also noted that dentists may have a distaste for managed care in general and want to avoid burdensome paperwork requirements.

Family Planning Providers

Given the limited availability of adolescent medicine specialists and the fact that general pediatricians may be unwilling or unable to provide gynecological services, adolescents require access to family planning providers. The plans we interviewed in Connecticut, Maryland, and Missouri included Planned Parenthood clinics as well as office-based obstetricians and gynecologists in their networks. In California one plan contracted with Planned Parenthood clinics, and in Utah one contracted with two county health departments that provide family planning services. In none of the five study states, however, did plan officials and providers report any shortages of family planning providers in plan networks. This reportedly was because S-CHIP adolescents in networks without family planning clinics did not use network services; they obtained confidential, free care at non-participating clinics instead.

Mental Health Providers

The composition of the behavioral health networks[26] in our five study states varied somewhat. The five plans in Connecticut, Maryland, and Missouri—all but one of which were organized for Medicaid and S-CHIP business—contracted primarily with community mental health centers and other clinics for outpatient services. The four plans in California and Utah—all of which operated to serve commercially insured populations—primarily used their existing panels of independent mental health practitioners. Clinics that applied to join these panels in Utah were often refused, which presented problems for adolescents who prior to enrolling in S-CHIP were receiving subsidized care at mental health clinics. Nevertheless, nearly all of the plans we interviewed in the five states relied heavily on licensed clinical social workers and lesser trained therapists to treat S-CHIP adolescents. In the three states where plans contracted with clinics, licensed clinical social workers and family counselors as well as bachelors-level therapists working under their supervision made up the vast majority of clinic staff. In each of the other two states, there was one plan with a panel comprised predominately of therapists with similar training.

Across all five S-CHIP programs, mental health providers reported a severe shortage of participating psychiatrists in all communities to serve the adolescent population. In particular, they cited the lack of psychiatrists to serve Spanish-speaking adolescents and those in rural areas. These problems were pervasive and resulted in long waits for psychiatric referrals, typically ranging from three to six months, and difficulties obtaining medication management services. Because of these shortages, primary care physicians and, in Connecticut, nurses were

[26]Separate behavioral health plans were used to serve S-CHIP adolescents in all of the plans we interviewed except one in Utah. There was a total of nine plans providing behavioral health services in the five states we examined because Maryland had a single, state-regulated behavioral health plan that was not a subcontractor to the general managed care plans. The Utah and the Maryland plans were the only entities that assumed no financial risk for mental health services.

Table IV

Reimbursement Rates for Selected Mental Health Visit Codes Paid by S-CHIP and Commercial Plans in the Five Study States During the First Year of S-CHIP Implementation[1]

Plans		Diagnostic Interview (90801)[2]		Individual Therapy 20–30 Minutes (90804)[2]		Individual Therapy 45–50 Minutes (90806)[2]		Medication Management (90862)[2]	
		S-CHIP Rates	Commercial Rates[3]	S-CHIP Rates	Commercial Rates[3]	S-CHIP Rates	Commercial Rates[3]	S-CHIP Rates	Commercial Rates[3]
CA	Plan A	$122.81	$122.81	$69.26	$69.26	$108.53	$108.53	$53.19	$53.19
	Plan B	122.81	122.81	69.26	69.26	108.53	108.53	53.19	53.19
CT	Plan A	75	90	30	40	55	70	30	40
	Plan B	65	70	25	60	50	70	30	30
MD	Plan A	92	No Commercial	44	No Commercial	78	No Commercial	48	No Commercial
MO	Plan A	35	90	35	35	35	40	8	34.52
	Plan B	123	144	55	64	84	98	45	53
UT	Plan A	148	148	66	66	102	102	55	55
	Plan B	95	95	47.50	47.50	95	95	47.50	47.50

Source: Information obtained by the Maternal and Child Health Policy Research Center through detailed on-site and follow-up telephone interviews.

Notes: [1]The programs were implemented in either July or August of 1998.

[2]Differences between S-CHIP and commercial reimbursement rates within and among plans could be explained by the use of Medicaid managed care versus commercial managed care fee schedules for S-CHIP providers, the subcontracting arrangements of HMOs versus PPOs, the impact of plan size and ownership, or other factors.

[3]Commercial rates are the fees paid under each plan's commercial product. In the case of Medicaid-only plans, they are the fees paid under another commercial product owned by the plan's parent company.

often relied upon to prescribe and manage psychotropic medications, which many felt were beyond the scope of their practice.[27] Despite the fact that plans may have appeared to have an adequate supply of psychiatrists identifying themselves as able to serve the adolescent population, we heard repeatedly from several sources that network listings failed to account for the fact that psychiatrists severely restrict the number of S-CHIP adolescents they accept in their practices and may, in fact, see only one or two S-CHIP participants each year in order to remain on the network provider list. In California, Connecticut, and Missouri, for example, we were told that participating university-affiliated psychiatrists were refusing to accept S-CHIP patients. Although not as serious as the shortage of psychiatrists, we heard also that psychologists in four of the nine plans we interviewed were in short supply, as were other therapists in two plans.

Providers cited inadequate reimbursement, more than any other factor, as the major reason for low participation by psychiatrists. Psychiatrists' refusal to participate in all types of managed care because of insufficient payment was identified as a serious problem in four out of five of

[27]A national survey of more than 12,000 physicians, conducted in 1996–1997, found that about a quarter of primary care physicians felt that the scope of care that they were expected to provide was greater than it should be. St. Peter RE, Reed MC, Kemper P, and Blumenthal D. Changes in the Scope of Care Provided by Primary Care Physicians. *The New England Journal of Medicine.* 341(26):1980–5, 1999.

our study states, and a general shortage of psychiatrists was reported in the fifth state (Utah). While plans in California as well as Utah paid psychiatrists serving S-CHIP adolescents the same rates they paid to those serving the commercially insured, plans with commercial business in the other states paid rates that were substantially lower, as shown in Table IV. Moreover, providers frequently noted that S-CHIP plans reimbursed psychiatrists well below usual charges paid by self-pay patients. Another problem was that rate structures for clinics frequently created a strong incentive for them to retain clinical social workers, family counselors, and bachelors-level therapists rather than psychologists or psychiatrists. Both plans in Connecticut and one in Missouri paid a single rate for all clinic services, regardless of the therapists' professional training.[28]

Service Coverage and Access

Primary Care

All of the five S-CHIP programs' benefit packages included basic primary care services, including immunizations, well-child care, and physician office visits, and all required that well-child visits comply with the American Academy of Pediatrics' recommended periodicity schedule, which calls for preventive visits on an annual basis during adolescence. Only the two Medicaid S-CHIP programs, however, required any special adolescent health education or risk reduction interventions. As required by Medicaid's EPSDT provisions, both programs stipulated in their managed care contracts that health screenings include health education and anticipatory guidance for adolescents. Missouri's requirements were the most comprehensive. They stipulated that for children ages 11 to 19, providers must screen, offer anticipatory guidance and, for high-risk adolescents, provide counseling related to a wide range of topics dealing with peer relationships, safety, diet, substance abuse, violence, sexual activity, and sexually transmitted diseases.[29] Maryland required plans to use a particular screening tool for substance abuse, which caused providers some concern.[30]

Adolescent primary care providers, who were paid primarily on a fee-for-service basis in our study states, reported that without enhanced payments, they could not be expected to provide all components of a comprehensive well-child visit for the adolescent age group.[31] Such visits are very time consuming, particularly for girls, who may require gynecological examinations. Moreover, if

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[28]In Maryland, the clinic rate structure for the specialty mental health system did not distinguish between psychiatrists and psychologists.

[29]Missouri required adolescent health screenings performed at ages 11–14 to include anticipatory guidance in peer relations, hobbies, chores, firearms and homicide, suicide, vehicular accidents, sports injuries, seat belts and safety helmets, diet, sex education and family planning, contraception, smoking, alcohol and drugs, and body image. It also required preventive health visits for adolescents to include pap smears if the adolescent is sexually active. The requirements for the screens conducted at ages 16–17 and 18–19 were similar, with the additions of counseling and testing for venereal disease, chlamydia, and gonorrhea if the adolescent is sexually active and HIV counseling and testing for those at high risk as well as additional guidance on drinking and driving and violent behavior.

[30]Primary care providers in Maryland reported that the use of a specific screening tool was problematic because the questions did not elicit sufficient clinical detail. At the same time, asking detailed personal questions during an initial preventive visit was often difficult and could serve as a barrier to care for adolescents.

[31]The *Bright Futures* recommendations, developed by the federal Maternal and Child Health Bureau, and the American Medical Association's *Guidelines for Adolescent Preventive Services* (GAPS) both direct primary care providers to conduct a detailed assessment of adolescents' social, emotional, and physical development and provide anticipatory guidance.

high-risk behaviors are identified during a well-child visit that require follow-up monitoring and counseling, only the Medicaid S-CHIP plans had a mechanism to pay for these as interperiodic preventive health services. Also of concern to primary care providers who work in multidisciplinary settings was the fact that different members of the team usually could not each bill for the screening and counseling services they provide, rather the facility receives one payment.

Dental Care

All five S-CHIP programs' benefit packages included basic dental care, including preventive, diagnostic, and restorative services. Utah's program excluded more complex and expensive services, such as crowns, root canals, and orthodontia. Dentists in all of the five states felt that the benefit packages were comprehensive, although dental plan officials in Utah reported that its providers complained that their patients had needs that exceeded the covered services.

Access to dental care by adolescents was not affected by service authorization policies, as plans did not require authorization for routine dental care. Most plans imposed authorization requirements only for specialty services, such as oral surgery and other complex procedures. Dentists we interviewed voiced no complaints about plans' authorization policies, with the exception of the smaller dental plans in California. Because participating dentists were often difficult to find, however, adolescents confronted long waiting lists for dental services and frequently went without care. Still, dental plans in California and Utah, in fact, reported higher than expected utilization among the S-CHIP population.[32]

Family Planning

In all five S-CHIP programs we examined, benefits included gynecological exams, family planning counseling services, sexually transmitted disease (STD) testing, prescription contraception, and prenatal and maternity care. Routine HIV testing presumably was covered as well in four of the five states under STD testing since only one state, Utah, expressly excluded it. Abortions other than to save the life of the mother or in cases of rape or incest were covered only in Maryland.[33]

Access to family planning services did not appear to be a problem for adolescents in the five S-CHIP programs in our study. Predictably, there were no prior authorization requirements imposed by plans. However, in the California and Utah non-Medicaid programs, policies related to confidentiality often deterred adolescents from seeking family planning services from network providers. In both states, plans routinely mailed an explanation of benefits statement[34] to parents,

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[32]In Utah, the dental plan reported that utilization far exceeded its capitation amount. However, since the plan could not accept risk, the state reimbursed the plan for amounts in excess of the capitation payment. In California, however, the largest dental plan did not rebid to participate in the S-CHIP program beginning July 2000 in four counties that have more than 50 percent of the S-CHIP enrollment. The plan reported that it lost money in the first two years of the program as a result of high utilization, which reached 70 percent. In these four counties, new S-CHIP participants will have to select a dental HMO.

[33]Although California and Connecticut use state-only funds to pay for abortions for Medicaid participants in additional circumstances, they do not for S-CHIP participants. Maryland uses state-only funds to cover abortions for Medicaid and S-CHIP participants when a physician certifies that pregnancy will result in death or serious problems for the pregnant woman's present or future health status, which includes physical and mental health.

[34]While physicians may modify the reason for visits to protect confidentiality, explanation of benefits statements always accurately report laboratory tests.

and in Utah the S-CHIP program itself required that a parental consent form be signed in order for family planning services to be delivered. In addition, in the Missouri Medicaid program, the plans imposed policies pertaining to pharmacy services that sometimes resulted in adolescents' failure to obtain prescriptive contraceptives or other medications because family planning clinics could not participate in the pharmacy networks.

Mental Health Treatment

Although S-CHIP mental health benefits needed by adolescents without severe emotional disturbances or serious substance abuse problems were available in each of the five states, the amount of coverage varied considerably. The two Medicaid S-CHIP programs, as federally required, both offered a potentially unlimited package of medically necessary outpatient mental health services. The three non-Medicaid S-CHIP programs each specified visit limits. Connecticut and Utah covered 30 outpatient mental health visits,[35] while California covered 20.[36] Certain condition exclusions were also applied: California covered mental health services only for conditions that would significantly improve with short-term therapy; Utah excluded coverage for oppositional defiant disorder, conduct disorder, learning disabilities, situational disturbances, and stress disorder.

Regardless of the generosity of the benefit package, access to covered mental health services by adolescents was frequently hampered by plans' gatekeeping and referral systems. Although none of the nine[37] plans[38] required service authorization by a primary care provider, only three plans enabled S-CHIP enrollees to seek care directly from participating mental health providers without first calling the plan. Both plans in Connecticut permitted one or two initial visits without plan authorization, and one plan in Utah, which assumed no financial risk and had no behavioral subcontractor, permitted the maximum 30 visits. Mental health providers in these plans were listed in the network directories. The remaining six plans required enrollees to telephone the plan for service authorization or provider referrals, or both. Obtaining service authorization—which was for two to eight visits, depending on the plan—apparently was a routine matter, although it clearly presented challenges for adolescents seeking confidential care. Finding a provider was often more difficult. In Maryland's state-organized specialty mental health system, two plans in Missouri, and one plan in Utah, mental health providers could not be identified in a directory. In Maryland, the toll-free number for mental health services was not on

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[35]Plans in Connecticut were permitted to convert one inpatient mental health day to three outpatient visits, two intensive outpatient visits, two day treatment services, or one residential treatment day. However, only up to 35 of the 60 inpatient days could be converted.

Connecticut has since passed mental health parity legislation that affects the mental health benefit and copayment requirements under S-CHIP. Now there are no inpatient day or outpatient visit limits for mental health services, and the copayment requirement for oupatient mental health services is $5—except for certain conditions: mental retardation; learning, motor skills, and communication disorders; relational problems; and V-codes. For these conditions, the inpatient benefit still is limited to 60 days and the outpatient benefit to 30 visits, and higher copays and coinsurance charges still apply.

[36]California permitted plans to convert one inpatient mental health day to four outpatient visits.

[37]There was a total of nine plans providing behavioral health services in the five states we examined because Maryland had a single, state-regulated behavioral health plan that was not a subcontractor to the general managed care plans.

[38]Separate behavioral health plans were used to serve S-CHIP adolescents in all of the plans we interviewed except one in Utah. This plan and the Maryland plan were the only entities that assumed no financial risk for mental health services.

the plan membership card, and some adolescents and families were not even aware that S-CHIP provided mental health coverage.[39] In Utah, the plan's toll-free number for mental health services was on the membership card, but enrollees who called were reportedly given three or fewer providers to contact, and these providers frequently were not taking S-CHIP patients.[40]

All the S-CHIP plans we interviewed required mental health providers to submit detailed treatment plans with an acceptable diagnosis by the end of the initial therapy visits in order for treatment to continue. The number of additional visits authorized varied across the plans. Some approved visits based on the specifics of the diagnoses and treatment plans, while some routinely authorized a particular number of visits—most often four to six but, in one plan, 10 to 12—without regard to the severity of the problem. With the required paperwork completed, authorization did not appear to be a substantial barrier to outpatient care. Mental health providers did however express complaints that the documentation and authorization process was burdensome and time-consuming. Moreover, not all mental health diagnoses were considered acceptable. All but one of the nine plans we interviewed reported denying treatment authorization for adolescents with symptoms not yet diagnosed as a mental health disorder (V-codes), including sexual abuse, relational problems, and identity problems. In addition, all plans in our study restricted treatment authorization for adolescents engaging in high-risk behaviors, such as physical fighting, weapon carrying, and having unprotected intercourse with multiple partners, which account for the majority of morbidity and mortality among this age group. Importantly, though, both plans and providers reported that adolescents with mental health symptoms or high-risk behaviors likely received treatment because providers assigned more serious mental health diagnoses in order to obtain needed treatment,[41] even though providers raised concerns that this practice labeled adolescents inappropriately.

Prescription Drugs

While each of the five S-CHIP programs included a prescription drug benefit, the majority of the 10 plans we interviewed used formularies to limit the medications available to S-CHIP participants. Two of the plans—one Medicaid-only plan in Connecticut and one Medicaid-only plan in Missouri—had open drug formularies, as did the specialty mental health system in Maryland, permitting nearly all pharmaceuticals to be obtained by prescription. The other eight plans, all of which used pharmacy benefits managers, had restricted formularies; for a given class of drugs, only certain generic and brand name drugs might be available. Five of the eight plans required automatic generic substitution for all brand name drugs at pharmacies whenever

[39]Information about how to contact the mental health system in Maryland was included in the plans' member handbooks, but adolescents and their families apparently did not always have ready access to this information.

[40]A unique problem existed in California where S-CHIP adolescents had provider directories but often were mistakenly referred by their primary care providers, who confused Medicaid and S-CHIP policies, to the county mental health systems for services. In many instances, the counties did serve these adolescents.

[41]A national survey of more than 1,000 physicians and 700 nurses conducted in 1999 found that 26 percent of physicians reported often or sometimes exaggerating the severity of a patient's condition in order to get approval for care they thought was necessary. The Henry J. Kaiser Family Foundation and Harvard University School of Public Health. *Survey of Physicians and Nurses.* Menlo Park, CA: The Henry J. Kaiser Family Foundation, July 1999.

available. While two of these plans allowed physicians to override the generic substitution policy, they monitored the frequency with which physicians used the override option. In addition, five plans required step therapy for certain categories of drugs, stipulating that less expensive drugs be tried unsuccessfully before newer, more expensive ones would be approved. For approval of drugs not on the formulary or, in some cases, formulary drugs specifically designated, physicians had to obtain prior authorization from plans.

Adolescent providers often voiced concerns about their inability to prescribe four types of drugs commonly needed by adolescents: non-sedating allergy medications, antibiotics for sinus and upper respiratory infections, contraceptives, and psychotropic medications for selected mild and moderate mental health diagnoses. Complaints were voiced most frequently in California, Connecticut, and Utah and less often in Missouri and Maryland. With respect to allergy medications and antibiotics, provider concerns centered around step therapy requirements. Providers in two states complained that plans required step therapy using sedating antihistamines before non-sedating medications could be prescribed. Similarly, in two states they complained that brand name antibiotics could not be prescribed until they first used generic antibiotics, which they said sometimes were ineffective or caused allergic reactions. Although in specific cases providers could seek prior authorization to avoid step therapy, they reported that this was time-consuming and typically forced adolescents to leave their offices without a prescription in hand.

With respect to contraceptives and psychotropic medications, provider complaints were due more to the omission of specific medications on plans' formularies. Providers raised concerns in four states about the limited number of oral contraceptives covered and the restricted availability of oral contraceptives in brand name form. Being limited in the number of drugs covered was of concern to providers because of different side effects associated with specific contraceptive formulations and potential difficulties for adolescents forced to discontinue using a particular drug or manufacturer. Generic prescribing was thought to be problematic by some providers because of concerns about bioequivalency,[42] and by others because of difficulties demonstrating the drug dispensing system without generic package samples. Providers of psychotropic medications raised concerns in two states about not being able to prescribe certain brand name medications and not having access to medications available in sustained-release form, which they considered particularly important to adolescents wanting to maintain the confidentiality of their treatment at school.

Our analysis of plans' formularies generally corroborated provider concerns. We looked at coverage policies for the four types of prescription drugs in order to determine whether specific medications often considered important for inclusion in a formulary[43] were available. We found that among the

[42]According to the federal Food and Drug Administration, a generic drug is considered to be bioequivalent to a brand name drug if blood levels for the generic drug fall, on average, within a range of 80 to 125 percent of the blood levels for the brand name drug. The test should be based on a sample of 24 to 36 healthy volunteers, and the results must be at the 95 percent confidence level. Different approved generic drugs will have different measures of bioequivalency. In Center for Drug Evaluation and Research, Food and Drug Administration. *Approved Drug Products with Therapeutic Equivalence Evaluations (20th Edition)*. Washington, D.C.: Government Printing Office, 2000.

[43]For each type of drug, we obtained advice from members of national professional associations.

eight closed-formulary plans, more plans restricted access to non-sedating antihistamines and brand name antibiotics than excluded coverage for specific psychotropic medications or contraceptives. We also found that plans in non-Medicaid S-CHIP programs had more limited formularies than those in Medicaid S-CHIP programs. They were more likely to cover fewer of the important medications, have a greater reliance on generics, and require step therapy.

- **Non-sedating antihistamines.** In two of the eight plans with closed formularies, the three non-sedating antihistamines[44] considered important to have on a formulary were available, but only after two failed trials or unacceptable side effects with first-line medications. In two others, only two of the three non-sedating antihistamines were on the formulary, but they also required one documented failure with a first-line medication. The four remaining plans made two or three of the brand name non-sedating antihistamines available without any step therapy or prior authorization requirements.
- **Antibiotics for sinusitis and upper respiratory infections.**[45] The generic forms of three important antibiotics[46] were covered by all eight plans with closed formularies. However, for five important antibiotics without generic substitutes,[47] two plans required that before the drugs could be approved, a generically available antibiotic had to be used first unsuccessfully. One plan covered only three of the five brand name antibiotics and imposed the same type of step therapy requirement. The remaining five plans with closed formularies covered nearly all of the important brand name antibiotics without any requirements for step therapy or prior authorization.
- **Contraceptives.**[48] Almost all of the eight plans excluded Norplant[49] (a contraceptive implant), and half excluded DepoProvera (an injectable contraceptive). In addition, although we found that all eight plans covered at least seven and, in two instances, as many as 14 of 17 of the available low-dose monophasic contraceptives, one plan did not include any of the lowest dosage monophasics, and several allowed brand name prescribing for only three or four drugs in the monophasic category. There was a similar range of availability for six high-dose monophasic contraceptives but, overall, less coverage of six low-dose triphasics, which are not sold in generic form. All plans covered the triphasic combination dose.

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[44]These antihistamines are Allegra, Claritin, and Zyrtec.

[45]Members of the American Academy of Pediatrics recommended that for sinusitis or upper respiratory infections an acceptable formulary would have to include: Augmentin, either Cefzil or Ceftin; and either Biaxin or Zithromax. This would assure adequate coverage for penicillins, cephalosporins, and macrolides.

[46]These antibiotics are Amoxil, Bactrim, and Septra.

[47]These antibiotics are Augmentin, Biaxin, Ceftin, Cefzil, and Zithromax.

[48]Members of the American College of Obstetricians and Gynecologists recommended that an acceptable formulary would have to include coverage for at least one drug in the high-dosage monophasic category and at least one in the low-dosage triphasic category. In the category of low-dosage monophasics, which are used most frequently for adolescents, an acceptable formulary would have to include at least one drug with 20 mcgs estrogen, one with 30 mcgs estrogen, and one with 35 mcgs estrogen. Opinions about generics varied.

[49]This included two plans in Utah, however, where Norplant was expressly excluded from coverage under the S-CHIP program.

- **Psychotropic medications.**[50] Most of the eight closed-formulary plans[51] covered the three important stimulant medications for the treatment of attention deficit hyperactivity disorder,[52] sometimes requiring prior authorization; however, only one also provided coverage for both stimulant drugs available in sustained-release form,[53] while most of the others did not cover either. Only two plans covered the four important selected serotonin reuptake inhibitors (SSRIs)[54] for the treatment of depression, and although all but one of the remainder covered three, they usually required prior authorization for certain drugs or particular doses.[55] In contrast, most of the eight plans covered both of the important atypical antidepressants,[56] and all but one of these covered the drugs in the sustained-release form as well.[57] In addition, all the plans covered the three drugs recommended for the treatment of anxiety.[58]

[50]Members of the American Academy of Child and Adolescent Psychiatry recommended specific psychotropic medications that are most important to have on plans' formularies. Most stressed, however, that the broadest possible range of psychotropic medications should be available.

[51]We included the formularies used by Maryland's two largest managed care plans in this analysis because Maryland's S-CHIP adolescents were expected to receive primary mental health care from their primary care providers; many adolescents, therefore, obtained psychotropic medications through managed care plans rather than the specialty mental health system. Those who received their mental health services from the state's specialty mental health service system rather than their primary care provider would not be subject to any formulary restrictions for psychotropic medications.

[52]These stimulant medications are Adderall, Ritalin, and Dexedrine. (The Surgeon General's report on mental health mentions Cylert, which was sometimes covered, but this drug requires frequent liver function tests. U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General.* Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.)

[53]The two drugs available in sustained-release forms are Ritalin SR and Dexedrine Spansule.

[54]These SSRI drugs are Celexa, Paxil, Prozac, and Zoloft.

[55]However, one of the two plans we interviewed that had an open formulary did have a step therapy requirement for two of the four SSRIs it covered.

[56]These atypical antidepressants are Effexor and Wellbutrin.

[57]The sustained-release forms of these drugs are Effexor XR and Wellbutrin SR.

[58]These anxiety medications are Ativan, BuSpar, and Klonopin.

Other Components of Health Care Access

Health Risk Assessments

Identifying new adolescent enrollees with significant health risks can assist plans in anticipating their service needs. Both the Medicaid states and one non-Medicaid state in our study had health risk assessment requirements for their S-CHIP programs. These assessments, however, were designed primarily to identify children with diagnosed health problems rather than those engaging in high-risk behaviors. Although each of the health risk assessment forms included one or more questions that could have been useful in identifying underserved adolescents—those without a regular primary care doctor or those without a physician or dental visit in the last year—this information was not used to initiate outreach efforts or expedite appointments for adolescents who did not have special health needs. Moreover, providers were not informed of the assessment results. In Maryland and Missouri, health risk assessment forms were developed by the state Medicaid agencies and administered as part of the initial enrollment process. Responses to health status questions either were given directly by families who mailed in their applications or obtained by enrollment brokers. In Utah, the plans themselves were required to conduct a health risk assessment within ten days of plan enrollment using their own forms, but only one of the two Utah plans we interviewed had actually implemented this requirement.

Cost Sharing

Copayments and coinsurance can deter adolescents, particularly those who seek care on their own, from obtaining necessary health care services. Among the five S-CHIP programs in our study, four imposed cost-sharing charges at the time of service; Maryland was the only state that did not. Copayments, which were used in all of the four states, varied according to family income and type of service. The charge for most services was usually $5, but in Connecticut it was $25–50 for outpatient mental health.[59] Coinsurance requirements were applied only in Utah and ranged from 10 percent for lab and x-ray services to 50 percent for outpatient mental health and substance abuse services.[60]

Cost sharing did not appear to be a significant barrier to care, however. In all states but Utah, providers often reported that they were foregoing copayments. Many did this because they perceived that S-CHIP families were unable to pay.[61] Mental health clinic providers in Connecticut, for example, routinely used their sliding-fee schedules to assist S-CHIP adolescents unable to meet their cost-sharing obligations. Other providers failed to charge copayments

[59]California required S-CHIP enrollees with family incomes between 101–200 percent of poverty to pay $5 for most services. Connecticut required children with family incomes between 186–300 percent of poverty to payments ranging from $5 for a physician visit to $25–50 for an outpatient mental health visit. Missouri required children with family incomes between 186–225 percent of poverty to pay $5 for all services and $10 for those with family incomes between 186–300 percent of poverty. Utah required children in families with incomes between 101–150 percent of poverty to pay $5 for most services and for families with incomes between 151–200 percent of poverty, copayments ranged from $10 for physician visits to $30 for emergency room visits.

[60]Connecticut gave S-CHIP enrollees the option of paying either $50 or 50 percent of the service cost, whichever is less, for outpatient mental health visits between 21 and 30.

[61]Missouri's two largest plans paid providers the Medicaid reimbursement rate regardless of whether copayments were collected.

because they found collection a burden. In Missouri, for example, providers were unsure about the copayment requirement, and in California and Connecticut, hospital satellite and other clinic providers reported that they lacked the ability to store and track out-of-pocket payments. In all four states, hospital-based adolescent clinics that billed parents after the adolescent visit reported no access problems.

Confidentiality

Adolescents' ability to obtain confidential care for mental health, substance abuse, and obstetrical and gynecological services can affect their willingness to seek needed services. Although all five of our study states had laws granting adolescents the right to obtain services for sexually transmitted diseases without parental consent, laws governing parental consent for other adolescent services varied considerably. Parental consent for contraceptive services was required in Connecticut, Missouri, and Utah. For mental health services, parental consent was required in Missouri and Utah; and for substance abuse treatment, parental consent was required only in Utah. Confidentiality and privacy issues also arose as a result of plan policies and procedures. In California and Utah, following each health care encounter and, in Missouri, whenever a service was denied, reduced, or terminated, plans sent an explanation of benefits to parents, which effectively limited adolescents' ability to seek confidential care. In Maryland, mental health service utilization information was routinely shared with primary care providers without a signed release, even though mental health treatment information was, as in other states, subject to this privacy protection.[62]

[62]In Maryland, primary care providers were informed when one of their patients sought mental health treatment. They were not, however, subsequently informed of any prescribed psychotropic medications.

Conclusions

State and plan officials in the five study states perceived that adolescents' health care needs were generally being met through their S-CHIP programs. Yet, little attention was paid in the start-up phase to this population's unique needs for comprehensive preventive and primary care, dental care, gynecological and reproductive services, and mental health care. In all five states, S-CHIP adolescents reportedly experienced difficulties accessing mental health and dental services and comprehensive primary care services, and they often relied on other publicly funded programs for family planning services. To a large extent, this was due to insufficient reimbursement rates. For example, although reimbursement rates varied significantly among the ten plans in our study, most primary care providers thought that the S-CHIP rates did not cover the time adolescents required for a comprehensive visit or the multidisciplinary care often required by those in high-risk categories.

Because adolescents constitute a sizeable portion of the S-CHIP population, states and plans will need to consider ways to increase the participation of adolescent providers based in office, hospital, and school-based settings. In addition, they may want to examine alternative strategies for increasing the use of both physical and mental health services by adolescents, including expanding outreach, implementing quality of care measures pertinent to this population, and offering financial incentives to plans and providers.

APPENDIX

Overview of the Five Study States' S-CHIP Programs

California

California structured its S-CHIP program as a private initiative but also included a small S-CHIP expansion of Medicaid. Concerns that the stigma of Medicaid's association with welfare would discourage enrollment, former Governor Wilson (R) insisted that the S-CHIP program not be affiliated with Medicaid, either in terms of benefits or administration. The state implemented its new program, known as Healthy Families, in July 1998, with the expectation that 328,000 children would be eligible. At the end of the first year, 138,869 children were participating.

Eligibility. California provides S-CHIP eligibility under Medicaid to uninsured adolescents ages 16 to 19 in families with incomes up to 100 percent of the federal poverty level and S-CHIP eligibility under Healthy Families to all uninsured children in families with incomes up to 250 percent of the federal poverty level. During the first year of implementation, however, S-CHIP eligible children ages 14 to 19 in families with incomes up to 100 percent of poverty were covered under Medicaid and under Healthy Families at family income levels up to 200 percent of poverty.[1] To qualify as uninsured, participants must not have had insurance for three months prior to applying, although they can qualify immediately if they have reached the maximum benefit limits offered under employer-sponsored coverage.

Cost sharing is required for all Healthy Families enrollees. Families pay small monthly premiums that vary slightly depending on family income and are charged standard, private sector copayments for certain services.

Coverage. Healthy Families coverage is modeled after CalPERS, the benefit package available through the health insurance program for state employees and retirees. In addition to hospital and physician services, prescription drugs, vision services, and dental care, the benefits include various services offered with specific limitations. These are: skilled nursing care up to 100 days per benefit year; ancillary therapy services up to 60 consecutive calendar days per condition; outpatient mental health services up to 20 visits; inpatient mental health services up to 30 days; outpatient substance abuse crisis intervention and services up to 20 visits; inpatient detoxification; durable medical equipment that primarily serves a medical purpose; and home health care services with the exception of custodial care and long-term physical therapy and rehabilitation.

Enrollees who meet the medical eligibility criteria for California Children's Services (CCS), the Title V program for Children with Special Needs, or who are determined to be seriously emotionally disturbed by the county mental health system receive additional services outside of their managed care plan. Among CCS' benefits are physician subspecialty services, hospital services, ancillary therapy services, prescription drugs, durable medical equipment, medical nutrition therapy, specialty care center services, care coordination, and nonemergency

[1] Prior to S-CHIP, California's Medicaid eligibility levels were set at 200 percent of poverty for infants, 133 percent of poverty for children ages 1 to 6, and 100 percent of poverty for children ages 6 to 15.

transportation. The county mental health systems offer outpatient services, residential treatment services, intensive day treatment, medication support services, crisis intervention services, and targeted case management.

Managed Care Arrangements. Healthy Families is a statewide managed care program that requires all participants to enroll in a health maintenance organization (HMO) or exclusive provider organization (EPO), in addition to separate vision and dental plans. Carved out of the managed care contracts are all wrap-around services as well as dental and vision contracts. Rates for the capitated services vary by region but not age or gender. In most counties, enrollees have a choice of at least two plans, although seven counties have only one EPO available, and three have nine plans from which to choose.

Enrollees eligible for wrap-around benefits receive these services through different arrangements. The CCS programs in each county have their own providers that have met board certification and experience requirements, and the county mental health systems have their own providers—community agencies that contract with or are operated by the counties. In the program's first year, the CCS program received an annual appropriation of $9.7 million and the county mental health systems received an annual appropriation of $9.8 million.

Connecticut

Connecticut's non-Medicaid S-CHIP initiative, known as HUSKY Part B, was implemented in July 1998, along with an S-CHIP expansion of Medicaid, renamed HUSKY Part A. Governor Rowland (R) exerted considerable influence over the program, promoting a primarily private option because of concerns about the scope of EPSDT benefits, the inequity of imposing only nominal cost-sharing charges, and the unpredictability of long-term federal funding. As of June 30, 1999, 3,787 of the estimated 36,700 eligible children were participating in HUSKY B.

Eligibility. Using income disregards, Connecticut's S-CHIP program establishes HUSKY A eligibility for all uninsured adolescents ages 14 to 19 in families with incomes up to 185 percent of the federal poverty level and HUSKY B eligibility for uninsured children up to age 19 in families with incomes between 186 percent and 300 percent of the federal poverty level.[2] To qualify as uninsured, participants must not have had insurance for six months prior to applying for coverage, although there are certain exceptions to this rule, most notably self-employment. Monthly premiums are charged for children in families above 226 percent of poverty. In addition, families with incomes above 300 percent of poverty may purchase HUSKY B coverage for their children at the full group rate negotiated by the state. All HUSKY B participants, regardless of income, are required to pay copayments comparable to the private sector's for most services but higher than usual coinsurance for extended outpatient mental health services.[3]

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[2]Prior to S-CHIP, Connecticut's Medicaid eligibility levels were set at 185 percent of poverty for children up to age 15 and 100 percent of poverty for children ages 15 to 19.

[3]Connecticut has since passed mental health parity legislation that affects the mental health benefit and copayment requirements under S-CHIP. Now there are no inpatient day or outpatient visit limits for mental health services, and the copayment requirement for oupatient mental health services is $5—except for certain conditions: mental retardation; learning, motor skills, and communication disorders; relational problems; and V-codes. For these conditions, the inpatient benefit still is limited to 60 days and the outpatient benefit to 30 visits, and higher copays and coinsurance charges still apply.

Coverage. Children enrolled in HUSKY B receive the state employees' benefit package. In addition to hospital and physician services, skilled nursing, home health, prescription drugs, dental care, and durable medical equipment, the package provides other benefits on a short-term or limited basis. These include: short-term rehabilitation and physical, occupational, and speech therapies; inpatient mental health services up to 60 days; outpatient mental health services up to 30 visits with an option to convert inpatient days; inpatient substance abuse services up to 60 days and for alcohol abuse, 45 days; and outpatient substance abuse services up to 30 visits.

Enrollees who meet certain medical eligibility criteria may receive additional benefits that are limited or not included under the HUSKY B benefit package. These benefits are available through two supplemental "Plus" plans, with no cost-sharing obligations. Children eligible for these benefits remain enrolled in their managed care plans, which continue to be responsible for covered HUSKY B benefits. HUSKY Plus Behavioral offers in-home psychiatric services, mobile crisis services, care coordination, and extended outpatient and day treatment services. HUSKY Plus Physical covers multidisciplinary team consultations, orthodontics, nutritional therapy, hearing aids, specialized medical equipment and supplies, family support services, and extended ancillary therapy, home health, and physician consultation services.

Managed Care Arrangements. During HUSKY B's first year, Connecticut required all children participating in HUSKY B to enroll in one of five managed care plans, all of which are health maintenance organizations and operate statewide. These plans are capitated to provide all services included in the HUSKY B benefit package. The rates they receive vary by plan but not age or other risk factors.

The state has separate contractual arrangements for the Plus programs. Children qualifying for HUSKY Plus Physical receive services from the existing administrators of the Title V program for children with special health care needs. Those who qualify for HUSKY Plus Behavioral receive services from one of 12 child guidance and hospital clinics that contract with the Yale Child Study Center. In the program's first year, the HUSKY Plus programs each received an annual appropriation of $2.5 million.

Maryland

Maryland chose to implement a Medicaid expansion to cover its S-CHIP population because state advocates supported it, and the state Medicaid agency had only recently put into place a section 1115 demonstration waiver program and did not want to start anew with a non-Medicaid approach to S-CHIP. As a condition of approval by the House of Delegates, however, the agency was required to examine the feasibility of eventually developing a private health insurance option for S-CHIP children in families with higher incomes.[4] The state estimated that 60,000 children would become eligible for Medicaid, known as HealthChoice, as a result of S-CHIP and began enrolling the expansion population in July 1998. One year later, 57,000 S-CHIP children had HealthChoice coverage, under the Maryland Children's Health Insurance Program (MCHIP).

[4]The private option has not been implemented, and although the Medicaid agency concluded in December 1998 that the option was not feasible, the House of Delegates required the agency to reconsider its evaluation.

Eligibility. In Maryland, all uninsured children in families up to 200 percent of the federal poverty level are eligible for HealthChoice as S-CHIP participants.[5] However, the level at which S-CHIP eligibility begins, and therefore the size of the S-CHIP population, is viewed differently by the state and the federal government.[6] Prior to the implementation of S-CHIP, Maryland operated a limited-benefit health insurance program, known as KidsCount, under a section 1115 demonstration waiver program for children up to age 15 with family incomes up to 185 percent of poverty. KidsCount ended with the advent of S-CHIP, and participants became eligible for HealthChoice and the full range of Medicaid benefits. The state considers these children to be part of the S-CHIP population. However, despite KidsCount's limited benefits, HCFA does not consider any HealthChoice enrollee with a family income below 185 percent of poverty to be an S-CHIP participant. As a result, the state receives the enhanced matching rate only for enrollees with incomes between 185 and 200 percent of poverty.

Coverage. As HealthChoice participants, MCHIP children receive the full range of Medicaid benefits to which regular Medicaid beneficiaries are entitled. No cost-sharing obligations are imposed.

Managed Care Arrangements. HealthChoice operates as a mandatory, statewide managed care program, and nearly all S-CHIP participants are required to enroll in one of eight managed care organizations. These plans are health maintenance organizations that do not generally operate statewide. Plans contract to provide most Medicaid services. Personal care, early intervention services, and health-related special education services are carved out of capitated contracts and paid for on a fee-for-service basis. In addition, all mental health services are also carved out and paid for under a separate managed care arrangement, called Maryland Health Partners, which the state mental health agency regulates. Beginning in year two, the state also carved out all ancillary therapy services.

Each plan receives the same capitation rate, and the rates vary by enrollees' age, gender, and region. In addition, for S-CHIP participants for whom the state has six months of Medicaid fee-for-service data from 1997—approximately 20 percent of the S-CHIP population—the state uses Adjusted Clinical Groups (ACGs) to adjust rates by diagnosis. Maryland Health Partners is not at financial risk.

The only children excluded from managed care enrollment are those who qualify for the Rare and Expensive Case Management Program (REM).[7] For these children, all care is furnished on a fee-for-service basis.

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[5]Prior to S-CHIP, Maryland's Medicaid eligibility levels were set at 185 percent of poverty for infants, 133 percent of poverty for children ages 1 to 6, 100 percent of poverty for children ages 6 to 16, and 34 percent of poverty for children ages 16 to 19.

[6]Because we were interested in states' perspectives on S-CHIP implementation, we adopted the view of the state government. In our Maryland interviews we inquired about the experiences of newly enrolled children up to age 16 in families with incomes between 100 and 185 percent of the federal poverty level, as well as children in families with incomes between 185 and 200 percent of poverty. Enrollment of S-CHIP participants for whom the state received the enhanced matching rate was 14,975 in July 1999.

[7]REM covers 33 diagnoses, the majority of which are severe physical health problems, such as HIV, spina bifida, hemophilia, ventilator dependent conditions, cystic fibrosis, brain injury, and aplastic anemia.

Missouri

Missouri's S-CHIP program is part of a larger Medicaid expansion covering uninsured adults as well as children. The state had included its current S-CHIP population in a section 1115 demonstration waiver application to HCFA in 1994, although it was never implemented. With the availability of enhanced federal support under S-CHIP, Missouri expanded its Medicaid program, now known as MC+, in September 1999. Eligibility determinations were started several months earlier, and by July 1999, 42,251 of the projected 90,000 children were participating.

Eligibility. Missouri uses income disregards to make all uninsured children in families with incomes up to 300 percent of the federal poverty level eligible for MC+.[8] To qualify as uninsured, participants must not have had insurance for six months prior to the date of application.

Coverage. Children eligible under the expansion are entitled to the complete package of Medicaid benefits, with the exception of nonemergency transportation.[9] However, because S-CHIP participants technically are part of a demonstration waiver, Missouri has been able to require cost sharing greater than what would otherwise be permitted for Medicaid recipients. Beginning in January 1999, families with incomes between 226 percent and 300 percent of poverty are required to pay monthly premiums, identical to those for state employees, and all S-CHIP families are required to pay copayments for office visits and prescription drugs, although the amount varies depending on family income.

Managed Care Arrangements. Missouri does not require all S-CHIP participants to select a managed care organization. Children meeting SSI disability criteria are exempt, as are children living in certain areas of the state. These children, who comprise slightly more than half of the MC+ population, receive Medicaid services on a fee-for-service basis. All other S-CHIP children are required to enroll in one of the three or four managed care organizations that may operate in their region; there are nine operating in the state. All of these plans are health maintenance organizations, and most are provider-sponsored. The plans are capitated to provide nearly all Medicaid benefits; only early intervention services, health-related special education services, certain mental health services for children with severe emotional disturbances, and substance abuse services offered through the state's Comprehensive Substance Abuse and Rehabilitation Program (C-STAR) are carved out of their contracts.

Capitation rates for S-CHIP participants vary according to an enrollee's age, gender, and region, as they do for other Medicaid beneficiaries. The rates are slightly lower than the regular Medicaid rates, however, because the S-CHIP benefits do not include non-emergency transportation.

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[8] Prior to S-CHIP, Missouri's Medicaid eligibility levels were set at 185 percent of poverty for infants, 133 percent of poverty for children ages 1 to 6, and 100 percent of poverty for children ages 6 to 19.

[9] The state excluded this benefit for two reasons: one, it did not want to encourage crowd-out by offering a benefit package that was wholly unlike any offered in the commercial market and two, it reasoned that higher income enrollees would not have the same need for transportation as lower income enrollees.

Utah

Utah implemented a non-Medicaid S-CHIP program in August 1998. Reflecting Governor Leavitt's (R) philosophy that publicly subsidized health insurance should be comparable to private insurance otherwise available to families with similar incomes, the state modeled its program after the private plan for state employees. At the end of the program's first year of operation, the state had 10,729 children participating, more than half of the anticipated 20,000.

Eligibility. Eligibility for S-CHIP is open to all uninsured children up to age 19 in families with incomes at or below 200 percent of the federal poverty level.[10] To qualify as uninsured, a child must not have had insurance during the prior three-month period. Children in families with incomes between 100 and 150 percent of poverty participate in Plan A, and children in families with incomes between 151 and 200 percent of poverty participate in Plan B. Although benefits for both plans are the same, cost-sharing requirements differ. Under Plan A, families are subject to basic copayments for most services. Under Plan B, families are subject to more substantial copayments for office visits and prescription drugs as well as standard, private sector coinsurance for hospital and mental health services. However, neither group is required to pay premiums.

Coverage. Utah provides S-CHIP benefits that are actuarially equivalent to those given to state employees. In addition to hospital and physician services and prescription drugs, the benefit package includes: outpatient mental health treatment up to 30 visits per year for most diagnoses and inpatient mental health treatment up to 30 days per year for most diagnoses;[11] ancillary therapy services up to 16 visits per year to restore speech loss or correct impairments due to congenital defects or injury or sickness; durable medical equipment to assist medical recovery; home health services provided by registered nurses or licensed practical nurses other than custodial care, private duty nursing, and home health aide services; and a limited set of dental services.

Managed Care Arrangements. Children living in urban counties are required to enroll in one of four managed care organizations, each of which is a health maintenance organization. Children living in rural areas must enroll in a single preferred provider organization (PPO), established as one of the plan options for public employees. The PPO also provides dental services to S-CHIP enrollees statewide.

All S-CHIP-covered services, with the exception of dental care, are included in the capitation rate paid to managed care plans for S-CHIP participants. Utah pays a single, average monthly rate for each S-CHIP child, although it has separately negotiated a risk corridor arrangement with each of the five plans to provide a measure of stop-loss protection.

[10]Current Medicaid eligibility in Utah is set at 133 percent of poverty for children up to age six and 100 percent of poverty for children up to age 19.

[11]Diagnoses excluded from mental health coverage are learning disabilities, conduct disorder, and oppositional defiant disorder.

Appendix Table I

Overview of S-CHIP Programs in the Five Study States During the First Year of S-CHIP Implementation

	California	Connecticut	Maryland	Missouri	Utah
Program Name	Healthy Families	HUSKY B	Maryland Children's Health Insurance Program	MC+for Kids	CHIP
Program Type	Non-Medicaid[1]	Non-Medicaid[2]	Medicaid	Medicaid	Non-Medicaid
Implementation Date	7/1/98	7/1/98	7/1/98	7/1/98	8/1/98
Income Eligibility Levels					
Infants	200–250%	185–300%	185–200%	185–300%	133–200%
Children Ages 1–6	133–200%	185–300%	133–200%	133–300%	133–200%
Older Children	100–200%	185–300%	100–200%	100–300%	100–200%
First Year Enrollment	138,869	3,787	57,000	42,251	10,729
Benefit Package	Benchmark Plan (state employees)	Benchmark Plan (state employees)	Medicaid	Medicaid	Benchmark Plan (state employees)
Populations Excluded from MCO Participation	None	None	Children with rare and expensive physical conditions	Children meeting SSI disability criteria and all children in some areas of the state	None
Services Excluded from MCO Contract	Dental, vision, specialty services for children with severe physical health conditions, and non-hospital specialty services for children with severe emotional disturbances	None	Personal care, early intervention, health-related special education, and all mental health	Early intervention, health-related special education, substance abuse, and crisis intervention for children with severe emotional disturbances	Dental

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Appendix Table I *(continued from previous page)*

Overview of S-CHIP Programs in the Five Study States During the First Year of S-CHIP Implementation

	California	Connecticut	Maryland	Missouri	Utah
Wrap-Around Program Services	All specialty services (supplemental and basic) for children with severe physical health conditions, and all non- hospital specialty services (supplemental and basic) for children with severe emotional disturbances	Supplemental specialty services for children with severe physical health conditions (HUSKY Plus Physical), and supplemental specialty services for children with severe emotional disturbances (HUSKY Plus Behavioral)	Not applicable	Not applicable	None
Cost-Sharing Requirements					
Monthly Premiums	Yes	Yes	No	Yes	No
Copayments	Yes	Yes	No	Yes	Yes
Coinsurance	No	No	No	No	Yes
Number of Managed Care Plans	26 MCOs 4 dental plans 1 vision plan	5 MCOs	8 MCOs	9 MCOs	5 MCOs 1 dental plan

Source: Information obtained by the Maternal and Child Health Policy Research Center through analysis of the states' S-CHIP applications and state S-CHIP documents constituting the standard insurance contracts or RFPs and through detailed on-site and follow-up telephone interviews.

Notes: [1]California had a small expansion of its Medicaid program to include adolescents ages 16 to 19 up to 100 percent of the federal poverty level.

[2]Connecticut had a small expansion of its Medicaid program to include adolescents ages 14 to 19 up to 185 percent of the federal poverty level.

Appendix Table II

Benefits Offered by the Five Study States During the First Year of S-CHIP Implementation[1]

	California	Connecticut	Maryland	Missouri	Utah
Physician Services	Covered	Covered	Covered	Covered	Covered
Lab and X-ray Services	Covered	Covered	Covered	Covered	Covered
Preventive Care	Covered	Covered	Covered	Covered	Covered
Prescription Drugs	Covered	Covered	Covered	Covered	Covered
Family Planning Services	Covered except for abortion	Covered except for abortion	Covered	Covered except for abortion	Covered except for routine HIV testing, Norplant, and abortion
Outpatient Hospitalization	Covered	Covered	Covered	Covered	Covered
Inpatient Hospitalization	Covered	Covered	Covered	Covered	Covered
Outpatient Mental Health Services	Covered up to 20 visits/year for conditions that will significantly improve with short-term therapy, with additional visits available through conversion of inpatient mental health days (1:4)	Covered up to 30 visits/year, with additional visits available through conversion of inpatient mental health days (1:3)	Covered	Covered	Covered up to 30 visits/year (in combination with outpatient substance abuse), but excluding conditions such as conduct disorder, oppositional defiant disorder, and learning disabilities
Inpatient Mental Health Services	Covered up to 30 days/year for conditions that will significantly improve with short-term therapy	Covered up to 60 days/year	Covered	Covered	Covered up to 30 days/year (in combination with inpatient substance abuse), but excluding conditions such as conduct disorder, oppositional defiant disorder, and learning disabilities
Residential Treatment Facilities	Covered by converting inpatient mental health days (1:2) for conditions that will significantly improve with short-term therapy	Covered by converting inpatient mental health days (1:1)	Covered	Covered, at plans' option[2]	Covered by converting inpatient mental health days (1:1), but excluding conditions such as conduct disorder, oppositional defiant disorder, and learning disabilities

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Appendix Table II *(continued from previous page)*

Benefits Offered by the Five Study States During the First Year of S-CHIP Implementation[1]

	California	Connecticut	Maryland	Missouri	Utah
Outpatient Substance Abuse Treatment Services	Covered up to 20 visits/year	Covered up to 60 visits/year	Covered	Covered	Covered up to 30 visits/year in combination with outpatient mental health
Inpatient Substance Abuse Treatment Services	Covered for detoxification	Covered for drug abuse up to 60 days/year and for alcohol abuse up to 45 days/year	Covered	Covered	Covered up to 30 days/year in combination with inpatient mental health
Physical, Occupational, and Speech Therapy	Each therapy covered up to 60 consecutive days/ condition, additional visits available if condition will improve significantly	Covered on a short-term basis	Covered	Covered	Covered up to 16 visits/ year, but excluding therapies for children with developmental delay, and excluding speech therapy not required to treat an injury, sickness, or surgically corrected congenital condition
Optometry Services	Covered	Covered	Covered	Covered	Not covered
Eyeglasses	Covered	Covered	Covered	Covered	Not covered
Home Health Services	Covered for skilled nursing services and home health aide services, including PT, OT, and ST	Covered for skilled nursing services and home health aide services	Covered	Covered	Covered for skilled nursing services
Durable Medical Equipment and Other Devices	Covered except for therapeutic footwear and motorized wheelchairs	Covered except for hearing aids and motorized wheelchairs	Covered	Covered	Covered except for eyeglasses and therapeutic footwear
Dental Services	Covered except for orthodontia	Covered	Covered	Covered	Covered except for replacement restorations for other than decay or fracture, orthodontia, sealants except when placed on permanent molars through age 17

Source: Information obtained by the Maternal and Child Health Policy Research Center through analysis of the states' S-CHIP applications and state S-CHIP documents constituting the standard insurance contracts or RFPs.

Notes: [1]The programs were implemented in either July or August of 1998.

[2]Plans in Missouri were only encouraged to provide residential treatment services to avoid inpatient hospitalization; no conversion ratio was provided.

Appendix Table III

Cost-Sharing Requirements for S-CHIP Programs in the Five Study States During the First Year of S-CHIP Implementation[1]

Monthly Premiums	California	Connecticut	Maryland	Missouri		Utah	
101–150% FPL	$7 for 1 child[2] $14 for ≥2 children	Not applicable	None	None		None	
151–200% FPL	$9 for 1 child; $18 for 2 children; $27 for ≥3 children	None	None	None		None	
200–300% FPL	Not applicable	above 235% FPL: $30 for 1 child; $50 for ≥2 children	Not applicable	above 225% FPL: $65 per family		Not applicable	
>300% FPL	Not applicable	$113.87–$194.37, depending on plan selected	Not applicable	Not applicable		Not applicable	
Copayments/Coinsurance	**101–200%**	**>185%**	**None**	**186–225%**	**226–300%**	**101–150%**	**151–200%**
Physician Visits	$5	$5		$5	$10	$5	$10
Prescription Drugs	$5	$3 generic; $6 brand		—	$5	$2	$4; 50% nonformulary
Lab/X-ray	—	—		$5	$10	—	10%
Emergency Room Services	$5	$25		–	–	$5–$10	$30
Inpatient Hospital Services	—	—		$5	$10	—	10%
Outpatient Hospital Services	—	—		$5	$10	—	10%
Mental Health Services							
Outpatient Visits	$5	11–20 visits $25; 21–30 visits $50 or 50%		$5	$10	$5	50%
Inpatient Hospital Services	—	—		$5	$10	—	1–10 days, 10%; 11–30 days, 50%
Substance Abuse Services							
Outpatient Visits	$5	–		–	—	$5	50%
Inpatient Hospital Services	—	–		–	—	—	1–10 days, 10%; 11–30 days, 50%

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Appendix Table III *(continued from previous page)*

Cost-Sharing Requirements for S-CHIP Programs in the Five Study States During the First Year of S-CHIP Implementation[1]

	California	Connecticut	Maryland	Missouri		Utah	
Copayments/Coinsurance	**101–200%**	**>185%**	**None**	**186–225%**	**226–300%**	**101–150%**	**151–200%**
PT, OT, ST Services	$5	–		$5	$10	$5	$10
Audiology Services	—	$5 hearing exams		$5	$10	—	—
Optometry	$10	$5		$5	$10	—	—
Home Health	—	—		$5	$10	—	—
Durable Medical Equipment	—	—		—	—	—	20%
Eyeglasses	$25	lenses covered and up to $50 for frames		—	—	—	—
Dental	varies	varies		$5	$10	—	varies

Source: Information obtained by the Maternal and Child Health Policy Research Center through analysis of the states' S-CHIP applications and state S-CHIP documents constituting the standard insurance contracts or RFPs and through detailed on-site and follow-up telephone interviews.

Notes: [1]The programs were implemented in either July or August of 1998.

[2]California's Healthy Families participants who enroll in a community provider plan receive a discounted premium of $3 per child.

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