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State/Territory Name: Utah

State Plan Amendment (SPA) #: UT-23-0029

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Children and Adults Health Programs Group

June 10, 2024

Jennifer Strohecker
State Medicaid and CHIP Director
Director, Division of Integrated Healthcare
P.O. Box 143101
Salt Lake City, UT 84114-3101

Dear Jennifer Strohecker:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA), UT-23-0029, submitted on August 16, 2023, with additional information submitted on May 31, 2024, has been approved. This SPA has an effective date of July 1, 2023.

Utah continues to provide dental services under CHIP through a benchmark plan as permitted under Section 2103(c)(6) of title XXI of the Social Security Act. The state is making several dental code modifications through UT-23-0029 because the benchmark plan, the HMO with the largest commercial enrollment, has changed. For example, the state provided teledentistry during the public health emergency and this SPA will make it a permanent modality under the CHIP state plan. The state is also eliminating some codes, such as those previously covered that are not applicable to children, or codes that have been retired from the Code on Dental Procedures and Nomenclature (CDT Code).

Your Project Officer is Joyce Jordan. She is available to answer your questions concerning this amendment and other CHIP-related matters. Her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-3413
E-mail: Joyce.Jordan@cms.hhs.gov

If you have additional questions, please contact Meg Barry, Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,
/Signed by Sarah deLone/

Sarah deLone
Director

TEMPLATE FOR CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: The State of Utah

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))

_____
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following Child Health Plan for the Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following State officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name: Jennifer Strohecker	Position/Title: Medicaid Director, Director of Integrated Healthcare
Name: Jennifer Wiser	Position/Title: CHIP Director
Name:	Position/Title:

***Disclosure. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 09380707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.**

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

1.4. Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Original Plan
Effective Date: July 10, 1998

Implementation Date: August 1, 1998

SPA #UT-23-0029 Purpose of SPA: The purpose of this SPA is to update the CHIP dental benchmark plan and benefits.
Proposed effective date: July 1, 2023

Proposed implementation date: July 1, 2023

1.4- TC **Tribal Consultation** (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.
State Plan Amendment UT-23-0029 was presented to the Utah Indian Health Advisory Board meeting on June 9, 2023. Consultation was not requested.
TN No: Approval Date Effective Date

Section 6. Coverage Requirements for Children's Health Insurance

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan and proceed to Section 7 since children covered under a Medicaid expansion program will receive all Medicaid covered services including EPSDT.

6.1. The State elects to provide the following forms of coverage to children: (Check all that apply.) (Section 2103(c)); (42CFR 457.410(a))

Guidance: Benchmark coverage is substantially equal to the benefits coverage in a benchmark benefit package (FEHBP-equivalent coverage, State employee coverage, and/or the HMO coverage plan that has the largest insured commercial, non-Medicaid enrollment in the state). If box below is checked, either 6.1.1.1., 6.1.1.2., or 6.1.1.3. must also be checked. (Section 2103(a)(1))

6.1.1. ☐ Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

Guidance: Check box below if the benchmark benefit package to be offered by the State is the standard Blue Cross/Blue Shield preferred provider option service benefit plan, as described in and offered under Section 8903(1) of Title 5, United States Code. (Section 2103(b)(1) (42 CFR 457.420(b))

6.1.1.1. ☐ FEHBP-equivalent coverage; (Section 2103(b)(1) (42 CFR 457.420(a)) (If checked, attach copy of the plan.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is State employee coverage, meaning a coverage plan that is offered and generally available to State employees in the state. (Section 2103(b)(2))

6.1.1.2. ☐ State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is offered by a health maintenance organization (as defined in Section 2791(b)(3) of the Public Health Services Act) and has the largest insured commercial, non-Medicaid enrollment of covered lives of such coverage plans offered by an HMO in the state. (Section 2103(b)(3) (42 CFR 457.420(c)))

6.1.1.3. ☐ HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: States choosing Benchmark-equivalent coverage must check the box below and ensure that the coverage meets the following requirements:

- the coverage includes benefits for items and services within each of the categories of basic services described in 42 CFR 457.430:
  - dental services
  - inpatient and outpatient hospital services,
  - physicians' services,
  - surgical and medical services,
  - laboratory and x-ray services,
  - well-baby and well-child care, including age-appropriate immunizations, and
  - emergency services;
- the coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages (FEHBP-equivalent coverage, State employee coverage, or coverage offered through an HMO coverage plan that has the largest insured commercial enrollment in the state); and
- the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the additional categories in such package, if offered, as described in 42 CFR 457.430:
  - coverage of prescription drugs,
  - mental health services,
  - vision services and
  - hearing services.

If 6.1.2. is checked, a signed actuarial memorandum must be attached. The actuary who prepares the opinion must select and specify the standardized set and population to be used under paragraphs (b)(3) and (b)(4) of 42 CFR 457.431. The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to replicate the State results.

The actuarial report must be prepared by an individual who is a member of the American Academy of Actuaries. This report must be prepared in accordance with the principles and standards of the American Academy of Actuaries. In preparing the report, the actuary must use generally accepted actuarial principles and methodologies, use a standardized set of utilization and price factors, use a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan, apply the same principles and factors in comparing the value of different coverage (or categories of services), without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used, and take into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered

under the State child health plan that results from the limitations on cost sharing under such coverage. (Section 2103(a)(2))

6.1.2. ☐ Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431.

Guidance: A State approved under the provision below, may modify its program from time to time so long as it continues to provide coverage at least equal to the lower of the actuarial value of the coverage under the program as of August 5, 1997, or one of the benchmark programs. If "existing comprehensive state-based coverage" is modified, an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997, or one of the benchmark plans must be attached. Also, the fiscal year 1996 State expenditures for "existing comprehensive state-based coverage" must be described in the space provided for all states. (Section 2103(a)(3))

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

Guidance: Secretary-approved coverage refers to any other health benefits coverage deemed appropriate and acceptable by the Secretary upon application by a state. (Section 2103(a)(4)) (42 CFR 457.250)

6.1.4. ☐ Secretary-approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

Guidance: Section 1905(r) of the Act defines EPSDT to require coverage of (1) any medically necessary screening, and diagnostic services, including vision, hearing, and dental screening and diagnostic services, consistent with a periodicity schedule based on current and reasonable medical practice standards or the health needs of an individual child to determine if a suspected condition or illness exists; and (2) all services listed in section 1905(a) of the Act that are necessary to correct or ameliorate any defects and mental and physical illnesses or conditions discovered by the screening services, whether or not those services are covered under the Medicaid state plan. Section 1902(a)(43) of the Act requires that the State (1) provide and arrange for all necessary services, including supportive services, such as transportation, needed to receive medical care included

within the scope of the EPSDT benefit and (2) inform eligible beneficiaries about the services available under the EPSDT benefit.

If the coverage provided does not meet all of the statutory requirements for EPSDT contained in sections 1902(a)(43) and 1905(r) of the Act, do not check this box.

6.1.4.1. ☐ Coverage of all benefits that are provided to children under the the same as Medicaid State plan, including Early Periodic Screening Diagnosis and Treatment (EPSDT)

6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration waiver

6.1.4.3. ☐ Coverage that the State has extended to the entire Medicaid population

Guidance: Check below if the coverage offered includes benchmark coverage, as specified in §457.420, plus additional coverage. Under this option, the State must clearly demonstrate that the coverage it provides includes the same coverage as the benchmark package, and also describes the services that are being added to the benchmark package.

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage

6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage applicable only New York, Pennsylvania, or Florida (under 457.440)

Guidance: Check below if the State is purchasing coverage through a group health plan, and intends to demonstrate that the group health plan is substantially equivalent to or greater than to coverage under one of the benchmark plans specified in 457.420, through use of a benefit-by-benefit comparison of the coverage. Provide a sample of the comparison format that will be used. Under this option, if coverage for any benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in 457.431 to determine actuarial equivalence.

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Provide a sample of how the comparison will be done)

Guidance: Check below if the State elects to provide a source of coverage that is not

described above. Describe the coverage that will be offered, including any benefit limitations or exclusions.

6.1.4.7. ☐ Other (Describe)

Guidance: All forms of coverage that the State elects to provide to children in its plan must be checked. The State should also describe the scope, amount and duration of services covered under its plan, as well as any exclusions or limitations. States that choose to cover unborn children under the State plan should include a separate section 6.2 that specifies benefits for the unborn child population. (Section 2110(a)) (42CFR, 457.490)

If the state elects to cover the new option of targeted low income pregnant women, but chooses to provide a different benefit package for these pregnant women under the CHIP plan, the state must include a separate section 6.2 describing the benefit package for pregnant women. (Section 2112)

6.2. The State elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)

6.2.1. ☐ Inpatient services (Section 2110(a)(1))

6.2.2. ☐ Outpatient services (Section 2110(a)(2))

6.2.3. ☐ Physician services (Section 2110(a)(3))

6.2.4. ☐ Surgical services (Section 2110(a)(4))

6.2.5. ☐ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))

6.2.6. ☐ Prescription drugs (Section 2110(a)(6))

6.2.7. ☐ Over-the-counter medications (Section 2110(a)(7))

6.2.8. ☐ Laboratory and radiological services (Section 2110(a)(8))

6.2.9. ☐ Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))

6.2.10. ☐ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))

6.2.11. ☐ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)

6.2.12. ☐ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))

6.2.13. ☐ Disposable medical supplies (Section 2110(a)(13))

Guidance: Home and community based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.

6.2.14. ☐ Home and community-based health care services (Section 2110(a)(14))

Guidance: Nursing services may include nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services in a home, school or other setting.

6.2.15. ☐ Nursing care services (Section 2110(a)(15))

6.2.16. ☐ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16)

6.2.17. ☐ Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)

6.2.18. ☐ Vision screenings and services (Section 2110(a)(24))

6.2.19. ☐ Hearing screenings and services (Section 2110(a)(24))

6.2.20. ☐ Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))

6.2.21. ☐ Outpatient substance abuse treatment services (Section 2110(a)(19))

6.2.22. ☐ Case management services (Section 2110(a)(20))

6.2.23. ☐ Care coordination services (Section 2110(a)(21))

6.2.24. ☐ Physical therapy, occupational therapy, and services for individuals with speech,

hearing, and language disorders (Section 2110(a)(22))

6.2.25. ☐ Hospice care (Section 2110(a)(23))

Guidance: See guidance for section 6.1.4.1 for a guidance on the statutory requirements for EPSDT under sections 1905(r) and 1902(a)(43) of the Act. If the benefit being provided does not meet the EPSDT statutory requirements, do not check this box.

6.2.26. ☐ EPSDT consistent with requirements of sections 1905(r) and 1902(a)(43) of the Act

Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by State law; 2) performed under the general supervision or at the direction of a physician; or 3) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

6.2.27. ☐ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24))

6.2.28. ☐ Premiums for private health care insurance coverage (Section 2110(a)(25))

6.2.29. ☐ Medical transportation (Section 2110(a)(26))

Guidance: Enabling services, such as transportation, translation, and outreach services, may be offered only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

6.2.30. ☐ Enabling services (such as transportation, translation, and outreach services) (Section 2110(a)(27))

6.2.31. ☐ Any other health care services or items specified by the Secretary and not included under this Section (Section 2110(a)(28))

6.2-DC **Dental Coverage** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) The State will provide dental coverage to children through one of the following. Please update Sections 9.10 and 10.3-DC when electing this option. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)):

6.2.1-DC ☐ State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT[1]) codes are included in the dental benefits:

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services

6.2.1.1-DC Periodicity Schedule. The State has adopted the following periodicity schedule:

☐ State-developed Medicaid-specific
☐ American Academy of Pediatric Dentistry
☐ Other Nationally recognized periodicity schedule
☐ Other (description attached)

6.2.2-DC ☒ Benchmark coverage; (Section 2103(c)(5), 42 CFR 457.410, and 42 CFR 457.420)

6.2.2.1-DC ☐ FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT[2] codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2.2.2-DC ☐ State employee coverage; (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2.2.3-DC ☒ HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and

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[1] Current Dental Terminology, © 2010 American Dental Association. All rights reserved.

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applicable CDT codes)

Premier Access/Avesis
has the largest insured commercial enrollment and is the current benchmark.

Reference:
D0100-D0999 – Diagnostic
D1000-D1999 – Preventive
D2000-D2999 – Restorative
D3000-D3999 – Endodontics
D4000-D4999 – Periodontics
D5000-D5999 – Prosthodontics (Removable)
D6000-D6199 – Implant Services
D6200-D6999 – Prosthodontics, Fixed
D7000-D7999 – Oral and Maxillofacial Surgery
D8000-D8999 – Orthodontics
D9000-D9999 – Adjunctive General Services

Specifically, only the following dental services based on American Dental Association (ADA) codes are covered:

D0120	D1206	D2393	D3351	D5511	D6740	D7461	D7970
D0140	D1208	D2394	D3352	D5512	D6752	D7465	D7971
D0145	D1351	D2740	D3353	D5520	D7111	D7471	D7980
D0150	D1352	D2750	D3410	D5611	D7140	D7472	D7981
D0170	D1353	D2751	D3421	D5612	D7210	D7473	D7982
D0171	D1354	D2752	D3425	D5621	D7220	D7509	D7983
D0190	D1510	D2920	D3426	D5622	D7230	D7510	D8010
D0191	D1516	D2930	D3430	D5630	D7240	D7511	D7999
D0210	D1517	D2931	D3450	D5640	D7241	D7520	D8020
D0220	D1520	D2932	D3920	D5650	D7250	D7530	D8030
D0230	D1526	D2933	D4210	D5660	D7260	D7540	D8070
D0240	D1527	D2940	D4211	D5710	D7261	D7550	D8080
D0270	D1551	D2950	D4341	D5711	D7270	D7560	D8210
D0272	D1552	D2951	D4342	D5720	D7280	D7610	D8220
D0273	D1553	D2952	D4355	D5721	D7282	D7620	D8680
D0274	D1556	D2954	D4910	D5730	D7283	D7630	D8703
D0277	D1557	D2980	D5110	D5731	D7285	D7640	D8704
D0330	D1558	D3220	D5120	D5740	D7286	D7670	D8999
D0340	D1575	D3221	D5130	D5741	D7290	D7710	D9110
D0350	D2140	D3222	D5140	D5750	D7291	D7720	D9222
D0391	D2150	D3230	D5211	D5751	D7410	D7730	D9223
D0470	D2160	D3240	D5212	D5760	D7411	D7740	D9239

D0604	D2161	D3310	D5213	D5761	D7412	D7910	D9243
D0605	D2330	D3320	D5214	D5899	D7413	D7911	D9248
D0701	D2331	D3330	D5225	D5931	D7950	D7912	D9310
D0707	D2332	D3332	D5226	D5932	D7955	D7920	D9420
D0708	D2335	D3333	D5410	D7414	D7451	D9930	D9440
D0709	D2390	D3346	D5411	D7450	D7460	D9951	D9999
D1110	D2391	D3347	D5421	D5954	D7961	D9995	
D1120	D2392	D3348	D5422	D5955	D7962	D9996	

Applicable Notes from Benchmark Plan Schedule of Allowances
Procedures D3230 through D3920 include all test x-rays taken as part of the complete root canal procedure.

The following applies to D5000 – D5899 Prosthodontics (Removable). Dentures and partial dentures include relines. Allowances for dentures, partial dentures and relines include all adjustments for six-months. Fee for specialized techniques involving precision dentures, personalization or characterizations must be paid by the patient.

The following applies to D6200 – D6999 Prosthodontics, Fixed. Each retainer and each pontic constitutes a unit in a fixed partial denture.

The following applies to D7000 – D7999 oral and Maxillofacial Surgery. Extractions include local anesthesia, suturing, if needed, and routine postoperative care.

The following applies to D8000 – D8999 Orthodontics. Allowances include all appliances, adjustments, insertion, removal and post treatment stabilization (retention).

Additional Coverage Notes

a. When an Enrollee is pregnant, CHIP will pay for additional services to help improve the oral health of the Enrollee during pregnancy. The additional services each contract year include:
    i. one (1) additional oral exam and either one (1) additional routing cleaning or one (1) additional periodontal scaling and root planning per quadrant.
b. Written confirmation of the pregnancy must be provided by the Enrollee or her dentist when the claim is submitted.

6.2-DS ☐ **Supplemental Dental Coverage-** The State will provide dental coverage to children eligible for dental-only supplemental services. Children eligible for this option must receive the same dental services as provided to otherwise eligible CHIP children (Section 2110(b)(5)(C)(ii)). Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.

Guidance: Under Title XXI, pre-existing condition exclusions are not allowed, with the only exception being in relation to another law in existence (HIPAA/ERISA). Indicate that the plan adheres to this requirement by checking the applicable description.

In the event that the State provides benefits through a group health plan or group health coverage, or provides family coverage through a group health plan under a waiver (see Section 6.4.2.), pre-existing condition limits are allowed to the extent permitted by HIPAA/ERISA. If the State is contracting with a group health plan or provides benefits through group health coverage, describe briefly any limitations on pre-existing conditions. (Formerly 8.6.)

6.2.15. ☒ Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)

Scope of Coverage

Oral examinations, diagnostic services, preventive services, oral surgery that is dental in nature, restorative services, orthodontic and endodontic services are covered benefits. Oral examinations and other preventive services including cleaning and fluoride applications are limited to two per plan year.

Covered dental procedures under the Dental Plan are payable in an outpatient surgical facility for children five years of age and younger or a child who is at high risk due to other medical diagnosis.

Dental Anesthesia (as covered by the Health Plan)

Services including local, regional, general, and/or intravenous sedation anesthesia, are covered at participating facilities by the Health Plan when members meet one of the following criteria:

i. The member has a global development or intellectual disability, regardless of the chronological age of the member:

ii. The member, regardless of age, has a congenital cardiac or neurological condition and provides documentation that the dental anesthesia is needed to closely monitor the condition; or

iii. The member is younger than five years of age and:
    a. The proposed dental treatment involves three or more teeth; and
    b. The diagnosis is nursing bottle-mouth syndrome or extreme enamel hypoplasia.

Cardiac/Neurologic Conditions

i. Consideration of coverage will be given to members, regardless of age, with congenital cardiac or neurological conditions. The member must provide documentation describing that the need for dental anesthesia is due to an underlying medical condition and the associated requirement to closely monitor this condition.

ii. Dental anesthesia for conditions such as ADHD, situational anxiety, or fear of dentists is not covered by the Health Plan.

Limitations on Diagnostic and Preventative Benefits:

i. Routine oral examinations and cleanings (including periodontal cleanings) are provided no more than twice in any Contract Year. Note that periodontal cleanings are covered as a Basic Benefit and routine cleanings are covered as a Diagnostic and Preventative Benefit. See note on additional benefits during pregnancy.

ii. Full-mouth x-rays and panoramic x-rays are limited to once every five years

iii. Bitewing x-rays are provided for enrollees twice each contract year.

iv. Space maintainers are limited to the initial appliance only and to enrollees under age 14.

Limitations on Basic Benefits

i. Sealants are limited as follows:
ii. Sealant Benefits are available only to Enrollees through age 15.
iii. Sealants are limited to application to permanent molars with no caries (decay), without restorations and with the occlusal surface intact.
iv. Sealant Benefits do not include the repair or replacement of a sealant on any tooth within two (2) years of its application.

v. CHIP will not pay to replace an amalgam, composite, synthetic porcelain or plastic fillings or prefabricated stainless steel restorations within 24 months of treatment if the service is provided by the same Dentist.

vi. CHIP limits payment for stainless steel and porcelain crowns under this section to services on baby teeth. However, after consultant's review, CHIP may allow stainless steel and porcelain crowns on permanent teeth as a Major Benefit.

vii. Benefits for periodontal scaling and root planning in the same quadrant are limited to once in every 24-month period. See note on additional benefits during

pregnancy.

Limitations on Major Benefits:

i. CHIP will not pay to replace any crowns, inlays/onlays or cast restorations which the Enrollee received in the previous five (5) years under any CHIP program or any program of the Contract holder.

ii. Prosthodontic appliances that were provided under any CHIP program will be replaced only after five (5) years have passed, except when CHIP determines that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance not provided under a CHIP program will be made if CHIP determines it is unsatisfactory and cannot be made satisfactory.

iii. CHIP limits payment for dentures to a standard partial or denture (coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means.

iv. CHIP will not pay for implants (artificial teeth implanted into or on bone or gums), their removal or other associated procedures, but CHIP will credit the cost of a crown or standard complete or partial denture toward the cost of the implant associated appliance, i.e. the implant supported crown or denture.

Limitations on Orthodontic Benefits:

i. Payment for orthodontics is provided for a proportion of the upfront costs and then monthly thereafter.

ii. Orthodontic Benefits begin with the first payment due after the person becomes covered if treatment has begun.

iii. Benefits end with the loss of eligibility. Benefits end immediately if treatment stops or if the dental plan Contract is terminated, whichever occurs first. If a CHIP enrollee loses eligibility before the orthodontic treatment has been completed, the dental plan provider shall not increase the total amount owed for the service. The dental plan shall contractually obligate its provider network to follow this requirement.

iv. Benefits are not paid to repair or replace any Orthodontic appliance furnished, in whole or in part, under this program.

v. X-rays or extractions are not subject to the Orthodontic maximum.

vi. Surgical procedures are not subject to the Orthodontic maximum.

vii. Orthodontic benefits are only covered if the client scores 30 or greater on the Salzmann Index.

Limitations on All Benefits - Optional Services

a. Optional Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures. For example:
    i. A crown where a filing would restore the tooth;
    ii. A precision denture/partial where a standard denture/partial could be used;
    iii. An inlay/onlay instead of an amalgam restoration; or
    iv. A composite restoration instead of an amalgam restoration on posterior teeth.

b. If an enrollee receives Optional Services, Benefits will be based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service. The enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

Excluded Benefits

i. Services and supplies not listed in the scope of coverage, not recognized as essential for the treatment of the condition according to accepted standards of practice or considered experimental.

ii. Charges for cosmetic procedures, including but not limited to veneers and bleaching of teeth and procedures performed primarily for cosmetic reasons.

iii. Charges for services related to, performed in conjunction with, or resulting from a non-covered procedure.

iv. Charges for crowns, inlays and onlays on teeth that can be restored by direct placement materials.

v. Charges for replacement of crowns, bridges, inlays, onlays or prosthetic appliance within 5 years from the date of last placement.

vi. Charges for services that are applied toward the satisfaction of a deductible, if any.

vii. Charges for services subject to a waiting period.

viii. Charges for implants; myofunctional therapy; athletic mouthguards; precision or semiprecision attachments; treatment of fractures, cysts, tumors, or lesions; maxillofacial prosthesis; orthognathic surgery; TMJ dysfunction; cleft palate; or anodontia.

ix. Charges for orthodontia, unless included within the scope of coverage.

x. Charges for composite, resin or white fillings on posterior primary teeth. Benefit will be reduced to that of an amalgam or silver filling.

xi. Charges for the replacement of a filling within 24 months of placement, unless for specific health reasons.

xii. Charges for the replacement of retainers.

xiii. Charges for sealants not applied to permanent bicuspid or molar; applied at age 15 or older; applied 3 years from a previous sealant application; applied to a decayed tooth.

xiv. Charges for lab fees for higher metals or porcelain crowns, bridges, inlays or onlays.

General Exclusions

i. Charges in excess of the contracted Fee-for-Service schedule or the Reasonable and Customary rate, whichever applies.

ii. Charges for any treatment program which began prior to the date the Insured is covered under the policy.

iii. Services or supplies payable under any medical expense, auto or no-fault plan.

iv. Conditions covered under any Worker's Compensation Act or similar law.

v. Charges for services applied without cost by any municipality, county or other political subdivision or for which there would be no charge in the absence of insurance.

vi. Charges resulting from changing from one provider to another while receiving treatment, or from receiving treatment from more than one provider for one dental procedure to the extent that the total charges billed exceed the amount incurred if one provider had performed all services.

vii. Hospital facility charges for any dental procedure, including but not limited to emergency room charges, surgical facility charges, hospital confinement.

viii. Charges for drugs or the dispensing of drugs.

ix. Charges for oral hygiene instruction; plaque control; acid etch; prescription or take home fluoride; broken appointments; completion of a claim form; OSHA/Sterilization fees (Occupational Safety & Health Agency); or diagnostic photographs (except for orthodontic purposes).

x. Charges for services to replace teeth that were missing (extracted or congenitally) prior to the effective date of coverage on the Plan. This limitation ends after 36 months of continuous coverage on the Plan. Abutment teeth will be reviewed for eligibility of prosthetic benefits. This exclusion does not apply if the device covers one or more natural teeth lost or extracted while covered under the Plan, or if the prosthetic device was in place when the policy became effective.

xi. Services incurred during travel or activity outside the United States.

9.10. Provide a 1-year projected budget. A suggested financial form for the budget is below. The budget must describe: (Section 2107(d)) (42CFR 457.140)

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
  - Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc.
  - All cost sharing, benefit, payment, eligibility need to be reflected in the budget.

- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
    - Total 1-year cost of adding prenatal coverage
    - Estimate of unborn children covered in year 1

CHIP Budget

STATE:	**FFY Budget**
Federal Fiscal Year	**2023**
State's enhanced FMAP rate	**23.87%**
Benefit Costs	
Insurance payments	$0
Managed care	$21,939,400
Managed Care Payments (MCHIP)	$108,845,600
per member/per month rate	$197.27
Fee for Service	$0
Total Benefit Costs	**$130,859,500**
(Offsetting beneficiary cost sharing payments)	
Net Benefit Costs	**$122,282,900**
Cost of Proposed SPA Changes – Benefit	**$74,500**
Administration Costs	
Personnel	$566,300
General administration	$1,143,600
Contractors/Brokers	$2,800,000

STATE:	FFY Budget
	$0
Claims Processing	$0
Outreach/marketing costs	
Health Services Initiatives	
Other	$1,994,200
Total Administration Costs	**$6,504,100**
10% Administrative Cap	$13,587,000
Cost of Proposed SPA Changes	
Federal Share	$98,045,500
State Share	$30,741,500
Total Costs of Approved CHIP Plan	**$128,787,000**

NOTE: Include the costs associated with the current SPA.

The Source of State Share Funds: State General Funds/Tobacco Settlement Funds