

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations

SHO #09-012
CHIPRA # 7

October 7, 2009

RE: Dental Coverage in CHIP

Dear State Health Official:

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3, reauthorizes the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act (the Act). CHIPRA ensures that States are able to continue their existing CHIP programs and provides funding to expand health insurance coverage to additional low-income uninsured children including children already eligible for CHIP or Medicaid but not enrolled. The purpose of this letter is to provide general guidance on some of the provisions in section 501 of CHIPRA, including the dental benefit provisions and the State option to provide dental-only supplemental coverage, pending the issuance of regulations.

Required Dental Services

Section 2103(c)(5) of the Act, as added by section 501 of CHIPRA, requires that "child health assistance provided to a targeted low-income child shall include coverage of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions." This requirement applies to all child health assistance coverage described in section 2103 and is effective October 1, 2009.

Medicaid Expansions

States that provide title XXI coverage to children through a Medicaid expansion program are required to provide Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, as defined in section 1905(r) of the Act. The dental services provided under a Medicaid expansion program through EPSDT will be considered to meet the requirements of this provision.

Separate CHIP Programs

States that provide coverage in a separate CHIP program may choose between two methods of providing the dental services as required by section 2103(c)(5) of the Act. The State may define the services in the dental benefit package and demonstrate that the package includes all of the services required by the statute. In so doing, the State should specify the periodicity schedule with which preventative and restorative services, such as cleanings and fillings, would be provided, as well as whether these services are sufficient

to prevent further disease, as required by section 2103(c)(5). This applies to State-defined benefit packages and dental benchmark packages as described below.

Alternatively, the State may provide a dental benefit package that is equivalent to one of the three dental benchmark packages described in the CHIPRA statute. Under the statute, there is no option in new section 2103(c)(5) of the Act for proving actuarial equivalence or modifying the benefit package. States may, however, cover benefits in addition to the dental benchmark plan consistent with the standards in section 2103(c)(5).

In order to fully describe a State dental benefit package under a separate CHIP program, and ensure that the benefits are sufficient to meet the statutory requirements, a State should describe both the types of covered benefits and the covered amount or duration of those benefits. The amount or duration should also be expressed through identification of the periodicity schedule that the State will use in its program. The periodicity schedule sets the frequency by which certain services should be provided and will be covered. We encourage States to rely on nationally recognized standards, including Medicaid dental periodicity guidelines used for children under EPSDT or the guidelines from the American Academy of Pediatric Dentistry (AAPD). The link to AAPD's periodicity guidelines can be found at:

http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf.

State-Defined Dental Benefit Package

All States currently include some level of diagnostic and preventive dental services in their CHIP program. Under new section 2103(c)(5) of the Act, the dental benefit package must include “coverage of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.” States are not required to meet the EPSDT level of services to provide all medically necessary services under their CHIP plans. However, to be consistent with this dental benefit package requirement, a State-defined dental package must include coverage for dental services in each of the defined categories.

Dental Service Categories

The following categories of services identified by reference to the American Dental Association's “Current Dental Terminology (CDT) Code of Dental Procedures and Nomenclature” must be covered in the CHIP dental benefit package. Coverage of dental services within these categories must be consistent with a dental periodicity schedule adopted by the State and be medically necessary.

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) (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-D799)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services

States are not required to provide all services within each dental category, however, a State must be able to show that it is providing coverage consistent with the requirements of section 2103(c)(5). For example, under oral and maxillofacial surgery a State may elect to cover extractions (D7140) and extractions of impacted teeth (D7220-7241), but may choose not to cover tooth transplantation (D7272). States may not impose a limit on dental services that would be inconsistent with the statutory requirement to include coverage necessary to prevent disease, promote and restore oral health, and treat emergency conditions. Any such limits should comply with the State's chosen periodicity schedule. For example, a State may not limit a child to one cleaning per year if the periodicity schedule requires one cleaning every 6 months. However, a State may limit any service that is beyond the scope of coverage required by section 2103(c)(5), specifically those services that are cosmetic or not medical in nature.

Dental Benchmark Plan

A State may elect to meet the dental coverage requirements by providing dental coverage that is equal to one of the three benchmark dental benefit packages described below:

- **Federal Employee Health Benefits Program Children's Dental Coverage**— States may offer a dental benefit plan equal to those described at 5 U.S.C. 89A, which describes the requirements for supplemental dental coverage available to a Federal employee and that is selected most often by employees seeking dependent coverage in either of the previous two plan years. States must attach a copy of the plan benefits and the applicable CDT codes to their State plan amendment (SPA) request. For example, the supplemental MetLife dental plan is currently the plan most frequently selected by Federal employees seeking dependent coverage in either of the previous two plan years (2007-2009). MetLife's benefit information is provided in their brochure and can be accessed through the following link: <http://www.opm.gov/insure/health/planinfo/2009/brochures/MetLife.pdf> Should a different plan be chosen more frequently in the future, CMS will inform States of the change and provide plan benefit information.
- **State Employee Dependent Dental Coverage**—States may offer the dental benefits plan that is generally available to State employees in the State involved and has been selected most frequently by employees seeking dependent coverage in either of the previous two plan years. States must specify which plan in their State meets these criteria and attach a copy of the benefit package, including applicable CDT codes, when they submit their CHIP SPA to implement this provision.

- Coverage Offered Through Commercial Dental Plan—States may use the dental benefit plan that has the largest insured commercial, non-Medicaid enrollment of dependent covered lives of such plans that is offered in the State involved. States choosing this benchmark must specify which plan in their State meets these criteria and attach a copy of the benefit package, including applicable CDT codes, when they submit their SPA to implement this provision.

States that select one of the approaches described above must provide a benefit package that is equal to the dental services offered through the selected dental benchmark. The dental benefit package provided by the State must be equal to the scope, level, and type of services in the selected dental benchmark package in order to use this option. As discussed below, cost sharing must fall within the parameters required for CHIP. Any modifications to benefits render it no longer equal to the benchmark plan, and the State will have to revert to showing that their plan meets the requirements of a State-defined dental benefit package as previously discussed. As noted above, States may cover benefits in addition to the dental benchmark plan consistent with the standards in 2103(c)(5) of the Act.

Compliance with Current Regulations

As noted above, cost sharing for dental services must comply with Federal regulations at 42 CFR 457.520(b)(5), which requires that States not impose co-payments, deductibles, coinsurance, or other cost sharing with respect to “routine preventive and diagnostic dental services (such as oral examinations, prophylaxis and topical fluoride applications, sealants, and x-rays) as described in the most recent guidelines issued by the AAPD,” regardless of the cost-sharing requirements applied in the benchmark plan. States must also comply with 42 CFR 457.560(a) that requires that the calculation of the five percent of family income limit on cost sharing must be cumulative—including cost sharing for physical health and oral health if applicable.

Dental-only Supplemental Coverage

CHIPRA also added section 2110(b)(5), an important new provision which provides States with the option to provide dental-only supplemental coverage to children who have health insurance coverage through an employer but are uninsured or underinsured with respect to dental coverage. Such children are eligible to enroll in the dental-only supplemental coverage even if their group health plan or other health insurance coverage includes some dental benefits. This option is available to States that have a separate CHIP program.

The dental-only supplemental coverage would ensure that eligible children have overall dental coverage consistent with the State-defined dental package or is equal to the dental benefit plan provided to children who are eligible for the entire CHIP benefit package. The supplemental coverage will in essence make an eligible child “whole” for purposes of having dental services available to them that are not otherwise available under their current health insurance coverage. The supplemental coverage applies to children who have dental services covered by a group health plan or other health insurance coverage

only to the extent necessary to ensure that aggregate dental coverage would be the same as the dental coverage for other CHIP children. Consistent with section 2105(c)(6)(A) of the Act, the CHIP supplemental dental coverage would pay secondary to the child's private group health plan or other health insurance coverage.

In order to choose this option, States must comply with all other requirements of the Act regarding cost sharing (including 42 CFR 457.520(b)(5) and 457.560(a) as previously described) and the approved income eligibility level. CHIP regulations stipulate a cap of 5 percent of family income on total cost sharing for all health services. In addition, the State may not use a waiting list or numerical limitation in enrollment for the CHIP program (not just for dental coverage), and may not provide more favorable treatment to children eligible for the supplemental dental benefit under this option than provided to other enrollees under the State child health plan.

CMS looks forward to its continued work with States on the implementation and oversight of the CHIP program in ensuring that all eligible children have access to the dental coverage they need. Draft SPA template pages to implement these options are enclosed. These pages would be an Addendum to the CHIP State child health plan, describing dental coverage under the plan. CMS is in the process of obtaining the required Office of Management and Budget (OMB) clearance for the SPA templates. Given that States may need considerable time to complete these templates, CMS is sharing, in draft, the SPA template under the guidelines of the Paperwork Reduction Act (PRA) currently under OMB review. Until the PRA process is completed, States are not obligated to use the recommended template. After CMS obtains the necessary PRA clearance number from OMB, States will be required to complete the SPA template.

If you have any questions on the guidance provided in this letter, please send an email to CMSOCHIPRAQuestions@cms.hhs.gov or contact Ms. Maria Reed, Deputy Director, Family and Children's Health Programs Group, at 410-786-5647. We look forward to working with States to implement these important provisions.

Sincerely,

Cindy Mann
Director

Enclosures

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Enclosure

Questions and Answers Regarding CHIP Dental Coverage

Question 1: Will States be required to submit a SPA in order to comply with the new CHIPRA dental requirements?

Answer: Yes. CMS is anticipating that States will be able to submit a single compliance SPA for all CHIPRA provisions, including the dental requirements once the final regulation is published.

Question 2: Will States be required to provide dental benchmark packages?

Answer: No. States may choose to provide a State-defined dental benefit package or choose to provide a benefit equal to one of the three benchmark plans as outlined in the CHIPRA legislation.

STATE-DEFINED DENTAL BENEFIT PACKAGE

Question 3: If a State elects not to offer dental coverage that is equal to one of the benchmark plans, what standards will CMS use in determining whether or not the dental coverage provided under a separate program meets the requirements of the new section 2103(c)(5)(A) which requires generally that States provide “coverage of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function and treat emergency conditions.”

Answer: The State-defined dental benefit package must cover certain specified categories of benefits to assure that the benefit includes the statutorily-required “dental services necessary to prevent disease and promote oral health, restore oral structures to health and function and treat emergency conditions.” These services are represented by the range of Current Dental Terminology (CDT) codes listed in the SPA template. CMS will not ask States to list every individual code that will be covered; however, States will have to provide an assurance in their State plan that services within those codes will be available, to the extent necessary, to provide the required range of services.

Question 4: What types of services are considered to be amongst those that “restore oral structures to health and function” under mandatory dental benefits coverage?

Answer: The CDT codes that represent restorative, endodontic, periodontic, prosthodontic, oral and maxillofacial surgery, and orthodontic services could be considered to restore oral structures to health and function. These services could include, but not be limited to, root canals, treatment of gum disease, dentures, tooth extractions, and braces.

Question 5: Will orthodontia be required?

Answer: Orthodontia is required to the extent necessary to “prevent disease and promote oral health, [and] restore oral structures to health and function.” States are not required to pay for orthodontia that they determine is not medically necessary, such as services for cosmetic reasons.

Question 6: The definition in the CHIPRA legislation indicates that coverage includes dental services necessary to prevent disease and promote oral health, restore oral structures to health and function and treat emergency conditions. Please confirm that this definition is not the same as dental services under EPSDT and that we do not have to cover all medically necessary services.

Answer: There is no requirement that the dental benefits in CHIPRA must meet the EPSDT requirements of 1905(r). States may design their benefit package consistent with the statutory definition.

BENCHMARK PLANS

Question 7: One of the benchmark plans is the State employees plan. Many have orthodontic coverage as part of the package but it has a maximum allowable limit. If orthodontics is not necessary, can a State limit or change their benchmark coverage to exclude orthodontics?

Answer: Although a State can supplement the dental benefit package, if it modifies the benchmark (other than by supplementing), the State is no longer considered to be providing a benchmark plan. Such packages will be considered a State-defined benefit package. A State that elects one of the three possible benchmark plans may not change the coverage package it offers. States are not required to cover dental services that are determined not to be medically necessary.

Question 8: Will CMS allow a State to submit a dental “benchmark-equivalent” (actuarially equivalent) plan?

Answer: There is no authority in CHIPRA for CMS to accept a dental benchmark-equivalent plan. If a State chooses not to provide a plan that is equal to one of the benchmark plans, it should offer a State-defined benefit plan that includes “dental services necessary to prevent disease and promote oral health, restore oral structures to health and functioning and treat emerging conditions.”

SUPPLEMENTAL DENTAL COVERAGE

Question 9: Can children of State employees qualify for supplemental dental coverage (assuming that the State doesn’t contribute to the cost of health benefits coverage at all)?

Answer: Only States with separate CHIP programs will have the option to provide supplemental dental coverage to targeted low-income children who would be eligible for CHIP but for the fact that they have insurance. Children of State employees who are eligible for State health benefits coverage are not generally within the definition of a targeted low-income child. There is an exception under CHIP regulations at 42 CFR 457.310(c)(1) when the State makes no more than a nominal payment for the cost of coverage (\$10 or less per month). To the extent that this exception is met, children of State employees who have insurance could qualify for supplemental dental coverage through CHIP. Adult State employees (or other adults) cannot qualify for supplemental dental coverage.

States should be aware that they may not only provide children of State employees with the supplemental dental coverage. Should a State choose this option, they must cover all targeted low-income children in the state who meet the criteria.

Question 10: Does the “no waiting list” prerequisite for the offering of a supplemental dental coverage apply to the State’s CHIP program, to the State’s CHIP dental program or both?

Answer: A State may not offer supplemental dental coverage if it has implemented a waiting list for their CHIP medical or their CHIP dental program.

Question 11: Must a child have absolutely no dental coverage in their private or employee-sponsored insurance plan in order to qualify for a supplemental dental plan?

Answer: No. Supplemental dental coverage can be provided through the new CHIP option to children in order to supplement limited dental coverage in their private insurance plan.

COST SHARING

Question 12: On what are the premiums for supplemental dental coverage based? Can they be different from the combined medical/dental premiums?

Answer: States can have separate premiums for medical and dental coverage. As in cost sharing for medical care, States will have to develop a methodology for establishing cost sharing for dental care and submit it to CMS for approval. States will also need to inform the families that the combined cost sharing of CHIP dental and medical coverage may not exceed 5 percent of family income and how the family should work with the State to track their cost sharing so they do not exceed the limit. CMS is available to provide technical assistance if needed.

Question 13: Is cost sharing supposed to be at the level required in the benchmark or at the CHIP level?

Answer: Cost sharing for CHIP dental benefits is governed by the CHIP rules, not by the rules associated with the benchmark plan. As with the broader CHIP benefit package, States are permitted to establish cost-sharing requirements, as long as the combined cost sharing for CHIP dental and medical coverage does not exceed 5 percent of the family’s income as specified in 42 CFR 457.565 and receives approval for a State plan amendment to implement such cost sharing.

Enclosure

SPA Template: Addendum on Dental Benefits Under Title XXI

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

6.2.-D The State will provide dental coverage to children through one of the following. 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.-D ~ ☐ State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT) 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) (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-D799)**
- 8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)**
- 9. Emergency Dental Services**

6.2.1.2.-D ~ 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.-D ~ Benchmark coverage; (Section 2103(c)(5), 42 CFR 457.410, and 42 CFR 457.420)

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

6.2.2.2.-D ~ ☐ 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, please also attach a description of the services and applicable CDT codes)

6.2.2.3.-D ~ ☐ 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, please also attach a description of the services and applicable CDT codes)

Section 10. Annual Reports and Evaluations

Section 10.3-D ☐ Specify that the State agrees to submit yearly the approved dental benefit package and to submit quarterly the required information on dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website.

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 **0938-XXXX**. The time required to complete this information collection is estimated to average **(30 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 comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please note: this form has not been approved by OMB pursuant to the PRA and States are not obligated to use it.