

DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES

SUBJECT: Dental Rates Increase (20 CAR pt. 570)

DESCRIPTION:

Statement of Necessity

Act 1025 of 2025 requires the Division of Medical Services (DMS) to increase Medicaid reimbursement rates for oral and maxillofacial surgeons' dental services and anesthesia, pediatric dental services and anesthesia, and dental services for adults with special needs. These increases begin September 1, 2025.

Summary of Changes

Pursuant to Act 1025, DMS revises the Medicaid Dental Provider manual to reflect the rate increases. DMS also submits a corresponding Medicaid State Plan Amendment reflecting the changes.

PUBLIC COMMENT: A public hearing was held on this rule on October 15, 2025. The public comment period expired on November 1, 2025. The agency provided a public comment summary which, due to its length, is attached separately.

The proposed effective date is July 1, 2026.

FINANCIAL IMPACT: The agency indicated that this rule has a financial impact.

Per the agency, the total estimated cost to implement the rule is \$29,470,264 for the current fiscal year (\$8,413,830 in general revenue and \$21,056,434 in federal funds) and \$39,293,685 for the next fiscal year (\$11,352,000 in general revenue and \$27,941,685 in federal funds). The total estimated cost by fiscal year to a state, county, or municipal government to implement this rule is \$8,413,830 for the current fiscal year and \$11,352,000 for the next fiscal year.

The agency indicated that there is a new or increased cost or obligation of at least \$100,000 per year to a private individual, private entity, private business, state government, county government, municipal government, or to two or more of those entities combined. Accordingly, the agency provided the following written findings:

(1) a statement of the rule's basis and purpose;

Act 1025 of 2025 requires the Division of Medical Services (DMS) to increase Medicaid reimbursement rates for oral and maxillofacial surgeons' dental services and anesthesia, pediatric dental services and anesthesia, and dental services for adults with special needs.

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

Comply with Act 1025 of 2025.

(3) a description of the factual evidence that:

(a) justifies the agency's need for the proposed rule; and

(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

The rule mirrors the requirements of Act 1025 of 2025.

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

Not applicable.

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

Not applicable.

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

Existing limits and rates were considered too low by the provider community.

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

(a) the rule is achieving the statutory objectives;

(b) the benefits of the rule continue to justify its costs; and

(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

The Agency monitors State and Federal rules and policies for opportunities to reduce and control costs.

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically authorized to maintain an indigent medical care program (Arkansas Medicaid). *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

This rule implements Act 1025 of 2025. The Act, sponsored by Senator Clint Penzo, required the Arkansas Medicaid Program to increase reimbursement rates for certain dental services and to set an annual reimbursement cap for adult dental services.

DHS Responses to Public Comments Regarding Rule 309 - Dental Rates and Annual Limit Increase

DHS appreciates the input the dental community and others provided for this proposed rule. Because many comments are similar across the commenters, DHS has summarized the issues below and provided a response for each. The full public comments follow.

1. Commenters disagree with the interpretation of Act 1025's language in providing a higher reimbursement for "oral and maxillofacial surgeons' dental services." They objected to applying the higher reimbursement rates to all dental services performed by oral surgeons, rather than to all dental providers (including dentists) when providing oral surgery services.

Response: DHS appreciates the oral surgery services provided by dentists who are not oral surgeons. However, the plain language of the Act specifies dental services performed by oral surgeons. In keeping with the language of the law, we have opted to implement the law in compliance with the written language.

2. Commenters objected to the way DHS defined "adults with special needs". Some commenters recommended that DHS allow dentists to identify adults with special needs by using ICD-10 diagnoses codes on their claims. They noted that this designation could identify patients that are "high complexity" using a standard diagnosis code.

Response: Act 1025 references "adults with special needs" in two provisions: 1.) a reimbursement rate increase, and 2.) a service limit increase.

Service Limit Increase

CMS will not allow Medicaid, as part of a state plan, to establish one service limit for some adults and a separate limit for other adults. They have told DHS they will not allow a higher dental service limit for a group of individuals based on their diagnosis, i.e., special needs. While DHS assesses our options for implementing a service limit increase, we will move forward with a state plan amendment for the reimbursement rate increases that does not include the service limit increase.

Reimbursement Rate Increase

DHS will maintain its definition of "special needs" for the reimbursement rate increase pertaining to adults. Because the term "adults with special needs" was not defined in the Act, DHS elected to use the statutory definition of "intellectual and developmental disability" (§ 20-48-101). DHS believes this definition adequately identifies the adults who require sedation dentistry. If Medicaid were to use "high complexity," the term still would need to be defined, as there is not a generic diagnosis code indicating "high complexity". Additionally, Medicaid objects to allowing dental providers to independently make a medical diagnosis when the outcome results in a higher reimbursement for treating identified patients. The identification of special needs adults must be configurable in our billing system as well as auditable to ensure Medicaid serves as an appropriate steward of taxpayer dollars.

Based on guidance from CMS we have separated the provision increasing reimbursement rates from the provision increasing the annual service limit. The annual service limit provision will be introduced in a separate rule. For the reimbursement rate increases, there will be no prior authorizations required,

unless it is temporarily necessary to implement the policy by the effective date. The Medicaid billing system will be configured to identify beneficiaries that trigger the higher reimbursement rate.

We will provide billing guidance through Official Notices and other documents. Additionally, we will continue to provide billing support through our Provider Support Contractor, who can be reached at 877-650-2362.

3. Many commenters objected to changing the fees for orthodontic procedures using the methodology in the Act 1025 because it resulted in a decrease in orthodontic reimbursement rates.

Response: DHS followed the methodology specified in Act 1025 and applied it to all dental procedure codes, including orthodontic procedures. This resulted in a significant decrease in the reimbursement rates for orthodontia. We assume this decrease was not intended by the bill's drafters and supporters. Given this unintended consequence, DHS has decided against applying the rate methodology to orthodontic services using the logic that orthodontic services may be considered separate from other dental services and therefore are not contemplated in the Act.

4. Many commenters were concerned that pediatric dentists who provide oral surgery and sedation services to children and adults with special needs in Arkansas would not receive the rate increase for their services.

Response: Children's dental services will receive a rate increase, including oral surgery services. For adults, only dental services provided by oral surgeons will receive the increase unless the adult is considered "special needs."

Nicole Powell, DDS, MDS

President, Arkansas Association of Orthodontists

Comment: The Arkansas Association of Orthodontists has recently become aware of a bill that will negatively impact reimbursement rates for several of our most utilized orthodontic codes. While we fully support the spirit and intent of the bill as it stands and acknowledge it is a needed step in the right direction for many of our colleagues and their patients, we respectfully request one important modification: that orthodontic code reimbursement rates not be reduced from their current levels.

Our concern is that any reduction in reimbursement could make it increasingly difficult to sustain adequate provider participation, particularly among orthodontists who care for Arkansas's underserved populations. Should reimbursement rates decrease further, it is likely that many orthodontists will be forced to withdraw from the Medicaid network, creating an access-to-care crisis and leaving too few providers to meet the needs of these patients.

We urge you to leave the current Medicaid reimbursement rates the same as there is no specific provision in Act 1025 to change the orthodontic reimbursement rates. Maintaining the current reimbursement rates will help ensure continued access to essential orthodontic care for the families and children of Arkansas. Thank you for your attention and consideration.

Response: Please see the response to #3, above.

Dr. Kenton Ross, DMD, President
and Billy Tarpley, Executive Director
Arkansas State Dental Association

Comment: After reviewing the proposed rules provided by your agency, the Arkansas State Dental Association (ASDA) offers the following recommendations and requests:

1. ASDA disagrees with the DHS' interpretation of the language in ACT 1025 relating to "oral and maxillofacial surgeons' dental services", but we understand how that misinterpretation occurred.
 - a. To that end, we recommend that D7140 (simple extraction) and D7210 (surgical extraction) be made payable to all licensed dentists as well as oral and maxillofacial surgeons. These are routine tooth extraction codes used by all dentists and should not be designated to oral surgeons alone.
2. Regarding the identification of special needs patients, ASDA recommends that DHS allow dentists to make that designation with ICD-10 diagnoses codes placed in Box 34 of the ADA claim form.
 - a. This designation makes it clear that the patient is "high complexity" using a standard diagnosis code.
3. As there is no reference to changing the fees for orthodontic procedures, and the stated purpose of the Act is to increase reimbursement rates for certain dental services in the subtitle, the ASDA supports the position of the Arkansas Association of Orthodontists to leave orthodontic fees unchanged.

Response: Please see DHS's responses to #1-#3, above.

Clayton Owen, DDS, MS
Owen Orthodontics

Comment: I want to object to the lowering of fees for orthodontic treatment proposed in the new rates laid forth. The current rate of \$3800-4000 is already below the national average and all of our hard costs have gone up considerably in the last 20 years (fees have not increased since I have been doing Medicaid). With our current patient load, decreasing fees is going to run off most orthodontists that are doing this to help the kids. I have enjoyed treating children from all walks of life and we take fantastic care of our patients. The new fee "DECREASES" will keep many clinicians from helping and this will substantially increase the number of children that need to be seen.

Very few orthodontist treat medicaid because of the current fees— I have patients that drive from 2-3 hours away because there is not an orthodontist in their respective areas to treat them.

Many children with compromised dentitions and occlusion will go unseen and the negative sequelae that may follow can have harmful impacts in the future (impacted teeth with cyst formation, root

resorption of teeth, pathology that may not be detected due to the patient not having an orthodontist to evaluate).

Dentists are allowed to treat medicaid patients for braces, but I have had many that have referred to our office due to the difficulty, time and expense of treating them in their offices.

I think this is would be a very harmful outcome for many children and only serve to diminish their access to care if rates are lowered and the already low number of us treating will get even smaller.

Please reconsider for the sake of the children and I strongly oppose fee decreases!

I am good friends with Brian Evans (Speaker of the House)— he can attest to the care we take of the children from surrounding areas in Cabot and beyond.

Response: Please see DHS's response to #3 above.

Savanah Stewart, DDS, MS

Comment: My name is Savanah Stewart. I am an orthodontist and practice owner in Jonesboro, Arkansas. I am writing to express my concern for the recently proposed decrease in reimbursement by the state for orthodontic treatment.

Currently, Medicaid reimbursement fees are about 60% of my full case fee. I choose to accept Arkansas Medicaid in my office not to make a large profit, but because I enjoy making an impact in the lives of children in my community. I was born and raised in a neighboring rural community (Monette, AR) where most kids qualified for government assistance, and my mother was an elementary school principal who watched as kids were bullied for having crowded teeth and severe malocclusions, so this issue is close to my heart. By accepting Arkansas Medicaid in my practice, I am able to provide quality care to children with severe orthodontic issues, whose parents couldn't afford it on their own. I truly believe that providing excellent orthodontic care and results benefits both the physical and mental wellbeing of children, which positively impacts our state and community as a whole.

Reduced reimbursement would limit my ability to continue to provide care to the Medicaid population in Northeast Arkansas. I am passionate about helping those in need, but I also have to be able to pay my overhead. As I'm sure you're aware, overhead costs are at an all-time high. A fee reduction would force me to limit (or possibly discontinue) the amount of Medicaid cases that I am able to accept each month, and access to medically necessary orthodontic care would likely decline for vulnerable children in my community if rates are decreased.

In conclusion, I strongly urge the Division of Medical Services to maintain or increase orthodontic Medicaid reimbursement rates. Arkansas currently reimburses orthodontic care at one of the lowest rates in the region, threatening access to care for children with severe malocclusions and special needs.

Response: Please see DHS's response to #3 above.

Michael Ashcraft D.D.S., M.S., P.A.

Ashcraft Orthodontics, PLLC

Comment: Please accept this letter as my public statement to be added to the record in agreement with the statements submitted at today's public hearing by the ASDA representative Bill Tarpley (presented letters from both the ASDA and the AAO at zoom meeting 10/25/25), Dr. Kirt Simmons, and Dr. Brittany Stroope regarding the proposed DECREASE in orthodontic limits. I would like to be on record as AGAINST THE PROPOSED DECREASE to the reimbursement limits for orthodontic treatment.

As stated in the above named statements, decreasing these reimbursement limits will be a determinant to the children of the state of Arkansas who depend on the AR Department of Human Services to facilitate and provide funding for their orthodontic care.

Response: Please see DHS's response to #3 above.

**Mark Dake, DDS, MSD, Orthodontist, Westrock Orthodontic
on behalf of Arkansas Orthodontic Providers**

Comment: On behalf of Arkansas Orthodontic Providers and the children and families we serve, I write to express deep concern regarding the proposed reduction in Medicaid reimbursement for orthodontic treatment. Orthodontic care is a medically necessary component of children's oral health and overall well-being, and the proposed fee changes would significantly curtail access—particularly in rural and underserved communities.

The importance of orthodontic care for children's health and the broader Medicaid program

Orthodontic treatment addresses malocclusion that, if left untreated, contributes to increased risk of caries, periodontal disease, abnormal tooth wear, and challenges maintaining oral hygiene—issues that drive higher downstream costs to public programs over time. For the medically necessary cases that are covered under the state's Medicaid program, these cases contain severe crowding, severe spacing or severe cross bite that if left untreated will lead to deeper oral and maxillofacial issues and deeper costs for the state's Medicaid program.

Moreover, orthodontic visits often function as a gateway to identify and refer broader dental needs, bringing children and families into the preventive and restorative care continuum rather than the emergency room. Malocclusion is often a more visible indicator of a dental issue that often can be an entry point for them to find a dental home. When an orthodontist completes an examination, they are also required to establish a dental home with a general or pediatric dentist to prevent further more serious dental issues. Evidence shows that consistent preventive dental care dramatically lowers total costs for Medicaid populations and reduces high-cost, avoidable utilization.

For example, Medicaid enrollees with five consecutive years of preventive dental care had 43% lower total dental costs than those with no preventive care; enrollees without preventive care were 8x more likely to visit an emergency department for a non-traumatic dental condition, 7x more likely to need oral surgery, and 6x more likely to receive an opioid prescription for dental pain. 1,2

Why orthodontics is economically different from other dental procedures

Orthodontics operates on a 2–3 year clinical pathway with dozens of visits, active appliance management, and substantial up-front hard costs (brackets, wires, aligners/appliances), followed by chair time for adjustments and monitoring. By contrast, most common dental procedures (e.g., fillings, extractions) are episodic and often concluded in one or two visits. Any fee schedule must therefore reflect not just the initial placement but the entire longitudinal episode of care—labor, materials, emergency breakage, biologic variability in tooth movement, and retention. Setting reimbursement without this longitudinal lens effectively underprices the care actually delivered and creates a structural mismatch between payment and the real cost of maintaining

outcomes across years. There is minimal economic margin on an orthodontic case at the rates the state has paid for the last decade. This margin has been squeezed by the rising cost of labor and supplies. The new proposed rates will put orthodontists in the position of having to take a loss for each medically necessary orthodontic case they take on. This will prevent most, if not all, licensed orthodontic providers from providing this care to the most vulnerable population in the state.

Access consequences of the proposed fee reduction

At the proposed rates, many orthodontists—particularly those serving low-volume rural clinics with higher travel and staffing burdens—will be unable to provide Medicaid orthodontic care without operating losses. The predictable result would be provider withdrawal, longer wait times, increased travel distances for families, and more children defaulting to crisis-driven ED visits. Each of the 29 orthodontic practices in Arkansas in the Westrock For example, Medicaid enrollees with five consecutive years of preventive dental care had 43% lower total dental costs than those with no preventive care; enrollees without preventive care were 8× more likely to visit an emergency department for a non-traumatic dental condition, 7× more likely to need oral surgery, and 6× more likely to receive an opioid prescription for dental pain. 1,2

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Each of the 29 orthodontic practices in Arkansas in the Westrock Orthodontics group are in network with the state's Medicaid program. We have doctors traveling hours each day from Little Rock, Jonesboro, Fayetteville and Memphis, TN to every corner of our state to provide access to quality orthodontic care. *(See attached list for the communities we serve.)*

Given Arkansas's commitment to equitable access for children, this would be a step backward—clinically and fiscally—relative to the clear gains associated with preventive and specialty dental access.

Request.

We respectfully urge the Division to reconsider the fee reduction on orthodontic cases and to convene a collaborative workgroup with providers to:

1. Align orthodontic reimbursement with the multi-year nature of treatment and its hard costs; and
2. Preserve access in rural and underserved areas, where provider participation is most fragile.

I appreciate your leadership and would welcome the opportunity to discuss Arkansas orthodontic care, and practical reimbursement alternatives that safeguard children's access while stewarding state resources.

Notes on the citations included

1 Preventive-care impact and specific odds ratios: Okunev et al., Journal of Public Health Dentistry (open-access on NIH/PMC and Wiley).

2 Reductions in dental ED visits with Medicaid adult dental coverage/expansion: Singhal et al., HealthServices Research ; Giannouchos et al., BMC Health Services Research.

Arkansas Communities Served by Westrock Orthodontics

Batesville, Bentonville, Berryville, Blytheville, Bryant, Cabot, Conway, El Dorado, Fayetteville, Forrest City, Fort Smith, Harrison, Highland, Hot Springs, Jonesboro, Little Rock, Mountain Home, North Little Rock, Paragould, Pine Bluff, Russellville, Searcy, Siloam Springs, Springdale, Texarkana, West Helena, West Memphis.

Response: Please see DHS's response to #3 above.

AnnaKate Tatum, DDS

Orthodontist, Westrock Orthodontics

Comment: I write to express deep concern regarding the proposed reduction in Medicaid reimbursement for orthodontic treatment. Orthodontic care is a medically necessary component of children's oral health and overall well-being, and the proposed fee changes would significantly curtail access—particularly in rural and underserved communities like Harrison, AR where I practice.

I would like to respectfully urge the Division to reconsider the fee reduction on orthodontic cases and to convene a collaborative workgroup with providers to:

1. Align orthodontic reimbursement with the multi-year nature of treatment and its hard costs; and
2. Preserve access in rural and underserved areas, where provider participation is most fragile.

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and practical reimbursement alternatives that safeguard children’s access while stewarding state resources.

Response: Please see DHS's response to #3 above.

AnnaKate Tatum, DDS

Orthodontist, Westrock Orthodontics

Comment: My name is Dr. AnnaKate Tatum, and I serve as the only in-network orthodontic provider for Arkansas Medicaid within a 50-mile radius of Harrison, Arkansas. I am writing to share how the proposed fee reductions for Medicaid orthodontic treatment would directly and severely impact the children and families I serve in the Ozarks region of north Arkansas.

Harrison and surrounding communities already face significant access barriers

Families in this region travel long distances for specialty dental and medical services, and many rely on our Harrison clinic as their only accessible source for medically necessary orthodontic care. My team and I routinely see children who come from Boone, Newton, Marion, and Searcy Counties — some traveling more than an hour each way — because there are no other Medicaid orthodontic providers available to them. For these families, our clinic represents not only access to orthodontic care, but also a point of connection to the larger oral health system.

The proposed fee schedule would make continued participation impossible

The proposed reimbursement rates would make it financially unviable to continue providing orthodontic care for Medicaid patients. Orthodontic treatment spans two to three years and involves ongoing visits, supplies, and professional time. The proposed fees fall well below the costs necessary to sustain that level of care. If these rates are implemented, our clinic — like many others across the state — would be forced to withdraw from the Medicaid network.

The practical result would be that children in Harrison and the surrounding Ozarks counties would have no local access to orthodontic care. Families would have to travel to Little Rock, Springdale, or Jonesboro for treatment, adding several hours of driving each way for the 2-3 years of treatment and creating additional financial and logistical burdens.

The loss of access will create real harm for children and families

The children we treat are not seeking cosmetic care — they have legitimate, medically necessary orthodontic needs that affect their ability to chew, speak, and maintain good oral hygiene. Without access to timely orthodontic care, these children are at higher risk of developing cavities, gum disease, jaw pain, and tooth loss. For many families in this region, those health consequences would go untreated due to cost and distance. Beyond the clinical impact, there are also emotional and developmental costs. Orthodontic treatment often boosts children’s confidence and quality of life during formative years — something that should not be reserved only for those who can afford private insurance or pay out of pocket.

A plea to preserve rural access to care

Arkansas already struggles to recruit and retain orthodontic specialists, particularly in rural areas like the Ozarks. The proposed fee reductions would make that challenge far worse, undermining the very access that Medicaid was designed to ensure. I have dedicated my career to serving this community, and I want to continue doing so — but I cannot do that sustainably under the proposed reimbursement levels.

I urge the Department to reconsider these proposed reductions and to engage with providers in rural regions to understand the real-world effects on access to care. The children and families of north Arkansas deserve the same opportunities for oral health and healthy development as those in larger urban centers. Thank you for your consideration, and for your ongoing commitment to improving the health of Arkansas’s children.

Response: Please see DHS's response to #3 above.

**Bryan Hiller, DDS, MS, President of Orthodontics
Rock Dental Brands**

Comment: As the President of Orthodontics for Rock Dental Arkansas, PLLC, I am writing to express our grave concern regarding the proposed reductions to Medicaid orthodontic reimbursement rates. Rock Dental Arkansas is the largest provider of Medicaid orthodontic care in the state, employing 11 orthodontists who serve children in 29 Arkansas communities. We are deeply committed to providing equitable access to quality care for families across the state—but these proposed fee changes would make that mission financially unsustainable.

1. The proposed fee schedule would make care for Medicaid patients nonviable

Orthodontic treatment requires a multi-year commitment, specialized materials, and consistent follow-up care. The proposed rates fall well below the level necessary to cover even the basic costs of providing treatment. If enacted, these rates would force most orthodontists—including those within Rock Dental Arkansas—to withdraw from participation in the Arkansas Medicaid program. This would result in an immediate and dramatic reduction in access to care for thousands of children who depend on Medicaid for medically necessary orthodontic services.

2. The loss of access will disproportionately harm children across the state

The orthodontic care covered by the state’s Medicaid program is not simply a cosmetic pursuit. By definition, the state only covers orthodontic treatment deemed medically necessary due to skeletal issues that impact chewing, speech, and long-term oral & maxillofacial health. Should providers be forced to leave the network, the already-limited system will be overwhelmed. Families would face significant barriers to care, as the limited specialty orthodontic capacity at Arkansas Children’s Hospital in Little Rock and Springdale would likely become the only remaining option for many Medicaid patients.

This would create severe backlogs and require families from rural corners of the state—such as the Delta, the Ozarks, and southern Arkansas—to travel hundreds of miles for treatment. The resulting travel time, costs, and missed school and work would further exacerbate disparities for families already facing economic challenges.

3. Rock Dental Arkansas serves communities where no other orthodontic option exists

Our 11 orthodontists dedicate substantial time each week traveling to Batesville, Blytheville, El Dorado, Forrest City, Harrison, Highland, Pine Bluff, Russellville, Texarkana, and West Memphis, among many others. In most of these communities, Rock Dental Arkansas is the only available orthodontic provider accepting Medicaid patients. Losing these services would leave large geographic areas of the state without access to medically necessary orthodontic care altogether.

4. The proposed reductions will worsen an existing workforce shortage

Arkansas already ranks among the lowest states in orthodontists per capita, and it is increasingly difficult to recruit and retain orthodontists willing to practice in smaller and rural communities. Reducing reimbursement to levels below viability will make these efforts virtually impossible. The long-term effect will be fewer providers, fewer treatment options, and wider gaps in access—particularly for vulnerable and low-income children who need these services most.

5. A call for collaboration and sustainability

We understand and share the Department’s responsibility to steward public funds responsibly. However, these proposed reductions will not achieve meaningful savings—they will instead shift costs elsewhere in the system, increase travel burdens, and widen inequities in oral health access. We respectfully urge the Division to pause implementation of the proposed fee schedule and engage with provider organizations, including Rock Dental Arkansas, to develop a reimbursement model that maintains access to care while ensuring fiscal responsibility.

Rock Dental Arkansas stands ready to work in partnership with the Department to find solutions that protect access for Arkansas children and sustain the network of providers who care for them.

Thank you for your time, leadership, and commitment to the health and well-being of Arkansas families.

Response: Please see DHS's response to #3 above.

Kristin Clark

Clark Orthodontics

Comment: I’m reaching out regarding the proposed reduction in orthodontic reimbursement rates. As a provider committed to delivering outstanding quality care, I am deeply concerned about the impact such changes would have—not only on our practice, but also on the patients we serve.

We already provide care under significantly reduced benefit levels, yet we continue to uphold the highest standards in treatment. However, in a time when the cost of living and operating a healthcare practice is steadily increasing, it is increasingly difficult to justify further reductions in reimbursement.

It’s difficult to reconcile the expectation of reduced benefits with the economic reality we all face. A further decrease would make it unfeasible for us to continue participating as an ARkids provider.

We value our relationship with your organization and hope to find a mutually sustainable path forward that ensures continued access to quality orthodontic care for the many children needing our service in the State of Arkansas.

Response: Please see DHS's response to #3 above.

Dr. Alexander Kita

Kita Orthodontics

Comment: My name is Dr. Alexander Kita and I am an orthodontic specialist in North Little Rock and I am an ARKids provider. Recently, the Arkansas orthodontic community was informed by your department that the reimbursement fees will be decreased for the orthodontic CDT codes (D8070, D8080, D8090).

Realizing that costs are increasing for simple procedures in a dental office; those same costs are also increasing in an orthodontic office. There are budgetary concerns made throughout these decisions but the orthodontic community feels these were not taken into consideration when the decision to reduce the reimbursement fees was looked at.

Orthodontic treatment is not just a simple procedure on the same day and move on. It can take upwards of two years to align the teeth and allow them to function together. This functionality, allows a patient to seamlessly go through life without any pathology in their teeth or jaws (provided they brush and floss as prescribed). Studies show that there is at least a 25-40% increase in dental disease with crooked teeth and malocclusions. That includes periodontal disease, carious lesions and temporo-mandibular joint dysfunction.

As I am sure the committee is aware, in order to have Arkansas Medicaid (ARKids) pay for these procedures, there is a point qualification system. In order to qualify for orthodontic treatment, the malocclusion has to be quite severe. The greater the severity of the malocclusion, the harder and longer it takes to treat the patient. The longer it takes to treat the patient, the greater the cost. In addition, many of these patients fail to appear for their appointments which extends their treatment time. They also repeatedly come in with broken appliances which is an added increase in cost.

The overhead costs involved with an orthodontic office can be upwards of 65-80%. The average cost of orthodontic treatment in the state of Arkansas is \$6000 - \$6500. That means the cost to the orthodontic office is \$3900- \$4225 on the low end and \$4800 - \$5200 on the high end. The current fee structure already stretches these costs very thin as can be seen. By reducing these fees, we are taking a loss of a minimum of \$1000.

Contrary to popular belief, orthodontists are not self made millionaires and can not absorb this loss. They are every day people that are treating every person that walks into their practice with respect, equity, compassion and altruism. The selfless acts performed in this impoverished community is frequently unnoticed by many.

If this reimbursement schedule remains as it does, it will leave me and my colleagues no choice but to discontinue treating this patient population. A population that needs it the most. By not treating these

patients, it will set them on a path toward more dental problems and pathologies. That would cost more than if the cost was afforded in the beginning with orthodontic treatment and reimbursing the treating orthodontists at an appropriate rate.

Response: Please see DHS's response to #3 above.

Dr. Natalia Hodge, DDS, MS

Hodge Orthodontics

Comment: As an orthodontist and long-time Medicaid provider, I am writing to express my concern regarding the proposed decrease in Medicaid reimbursement for orthodontic treatment under the Arkansas Department of Human Services' (DHS) plan implementing Act 1025.

I have served as a Medicaid provider for over ten years. During that time, the cost of doing business—staffing, materials, technology, rent, and insurance—has risen significantly. Yet, Medicaid reimbursement for orthodontic treatment has remained unchanged for over a decade. Despite this, I have continued to treat Medicaid patients because I strongly believe that every child, regardless of financial circumstance, deserves access to quality orthodontic care.

The intent of Act 1025 is to *increase* reimbursement rates for dental services. However, DHS's current proposal would *decrease* orthodontic reimbursement. This reduction not only contradicts the spirit of the legislation but would make it financially impossible for many providers—including myself—to continue offering orthodontic treatment under Medicaid.

If this proposed decrease takes effect, I will no longer be able to participate as a Medicaid provider. The proposed rates do not cover the actual cost of providing orthodontic care. Continuing under those conditions would be unsustainable and would jeopardize the ability of many practices to remain open to Medicaid patients. The result would be fewer providers and diminished access to care for the very children this program is designed to help.

I respectfully urge you to reconsider this proposal and ensure that orthodontic reimbursement rates reflect fair and reasonable compensation. Protecting access to orthodontic care for Medicaid patients is essential to maintaining equity and ensuring that all Arkansas children can receive the treatment they need for their long-term oral health and confidence.

Response: Please see DHS's response to #3 above.

Dr. Brittany Stroope, Board Certified Orthodontic Specialist

Comment: I am writing to express my strong opposition to any proposal or policy consideration that would reduce orthodontic Medicaid reimbursement rates in the State of Arkansas. While the current rule revisions under Act 1025 of 2025 appropriately focus on increasing access for oral surgery, pediatric, and special needs dental services, any decrease to orthodontic reimbursement rates would

have significant and detrimental effects on patient access, quality of care, and long-term oral health outcomes for Arkansas's most vulnerable children.

1. Arkansas's Current Orthodontic Fee Schedule was set over 20 years ago

Arkansas orthodontic Medicaid reimbursement rates currently fall well below national averages for comprehensive care. Many orthodontic offices already provide care at or below cost when serving Medicaid patients. A further reduction in fees would make participation financially unsustainable for most providers, forcing many to withdraw from the program. The current fee was set over 20 years ago; with the increases in cost of living, inflation, staff wages, and current operating costs of an orthodontic practice, further reducing this fee will result in my office removing itself from the current provider network.

2. Access to Care Would Be Severely Limited

Reducing fees would directly lead to a decline in the number of orthodontists able to accept Medicaid. This would increase travel distances and waiting times for families, particularly in rural areas where provider shortages are already acute. I currently receive patient inquiries from patients living on average 1.5-2 hours from my office location. I receive an average of 5 Medicaid new patient exam requests a day. I currently have over a 6 month wait for a new patient exam due to lower provider participation in my area.

Many children from low-income or special needs households would lose access entirely to medically necessary orthodontic treatment for issues such as crossbites, impacted teeth, or severe malocclusions that affect chewing, speech, and self-esteem.

3. Orthodontic Care Is Medically Necessary for Many EPSDT Patients

Under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provision, children are entitled to care necessary to correct or ameliorate physical and developmental issues. Orthodontic treatment for severe malocclusions is not cosmetic—it restores proper function, prevents long-term dental and skeletal complications, and supports nutrition and speech development. Lowering reimbursement undermines the intent of EPSDT by making necessary treatment inaccessible.

4. Reduced Fees Would Disproportionately Harm Children with Special Needs

Children with developmental delays, autism spectrum disorder, Down syndrome, or craniofacial differences often require more time, skill, and specialized equipment to complete orthodontic treatment safely. These cases demand longer chair time, additional staff training, and behavioral management techniques. If reimbursement is reduced, the financial feasibility of serving these children diminishes, effectively limiting access for those who need orthodontic intervention most.

5. Decreased Reimbursement Will Increase Long-Term Healthcare Costs

Untreated orthodontic problems often result in premature tooth loss, speech impediments, difficulty eating, and an increased need for restorative and surgical dental procedures later in life. Ensuring access to orthodontic care now reduces the need for higher-cost dental and medical interventions later, saving the Medicaid program money over time.

6. Supporting Provider Participation Is Critical to System Sustainability

Orthodontists want to continue serving Arkansas's Medicaid population, but participation must remain viable. Lowering the rate will severely reduce the participating Orthodontic Specialists who will accept patients. I currently know of 5 orthodontic practices that plan on leaving the provider network if the fee is reduced, leaving densely populated areas of the state (Northwest Arkansas and Little Rock Metro) with minimal provider options.

Conclusion

Reducing orthodontic Medicaid fees would harm children, reduce access, and undermine the goals of Act 1025 to improve oral health for Arkansas's most vulnerable populations. I respectfully urge the Division to maintain or increase orthodontic Medicaid reimbursement rates to ensure that every child in Arkansas has access to essential orthodontic care.

Thank you for your consideration of this critical issue and for your continued commitment to improving the oral health of Arkansas families.

Response: Please see DHS's response to #3 above.

Trevor Hawkins, Attorney, Laurence J. Howe DDS, Dr Jana Barfield, Clint Koen DDS MDS, Hannah M. Buso DDS, Nick Dollar DDS, Dr. Jay Fergus, Jason Havard DDS, Kenton A Ross DMD, Miranda M Childs Bebee DDS, Tracy Schroeffer, Dr Kristopher Liggett, John Isbell DDS, T K McAlister DDS, Lauren Martin DDS, Dr. Chad Jensen DMD, Catherine Akridge DDS, Alan Ainley, Emily K. Cheek DDS, Zachary Dixon D.D.S., and Nicolet Smith

Comment: Our firm offers the following comments for consideration in connection with the proposed Arkansas Medicaid dental reimbursement changes implementing Act 1025 of 2025 ("Act 1025" or the "Act"). For decades, our practice has focused on health law and regulatory compliance, representing a broad range of medical and dental providers throughout Arkansas and advocating for policies that promote equitable access to quality healthcare.

We appreciate the Department's efforts to implement Act 1025 by expanding dental coverage and increasing annual benefit limits for adults with special needs. That said, we believe that three specific, clarifying amendments should be made to the proposed rule change. The following three proposed amendments would advance the stated purpose of Act 1025 while ensuring that its implementation strengthens access to care for Medicaid beneficiaries and remaining fully consistent with state and federal law, including the access requirements of 42 U.S.C. § 1396a(a)(30)(A):

1. The Department should use ICD-10-CM diagnosis codes to identify adults with special needs qualifying individuals to receive the enhanced dental benefits.

DHS's clarification of eligibility based on seven qualifying conditions is a critical step in ensuring appropriate access to dental services for Arkansans with developmental and chronic disabilities. However, further clarification is needed to promote uniform, verifiable, and efficient claims processing.

We respectfully suggest that DHS formally allow (and encourage) providers to report qualifying ICD-10-CM diagnosis codes (“ICD-10 Codes”) directly on the dental claim form when submitting claims for services rendered under the new “adults with special needs” benefit category. For reference, the following are the corresponding ICD-10 Codes for the seven enumerated diagnoses leading to eligibility for “adults with special needs” services using this system:

Qualifying Condition	ICD-10 Codes	Description
Cerebral Palsy	G80.0 – G80.9	Spastic quadriplegic, diplegic, hemiplegic, ataxic, and other forms of cerebral palsy
Epilepsy	G40.0 – G40.9	Epilepsy and recurrent seizures (specify type and status)
Spina Bifida	Q05.0 – Q05.9	Spina bifida with or without hydrocephalus
Down Syndrome	Q90.0 – Q90.9	Trisomy 21, translocation, or mosaicism
Autism Spectrum Disorder	F84.0 – F84.9	Autism, Asperger’s, and other pervasive developmental disorders
Intellectual Disability	F70 – F79	Mild, moderate, severe, profound, or unspecified intellectual disability
Comparable Developmental or Adaptive Impairment	F80 – F89	Communication, developmental, and unspecified disorders producing similar functional impairment

Utilizing these already-established ICD-10 Codes to identify “adults with special needs” eligible for such services would:

1. Provide a consistent, objective indicator of eligibility tied to the physician’s diagnosis;
2. Reduce administrative delays and post-payment audit requests for verification of documentation;
3. Allow DHS to electronically validate and track utilization data across qualifying conditions; and
4. Align Arkansas’s Medicaid documentation standards with those already used for medical and behavioral health claims, which rely on ICD-10 Codes for diagnostic confirmation.

DHS could issue a simple claim-submission directive, instructing dental providers to enter the applicable ICD-10 Code in Box 34 (or its electronic equivalent) of the ADA Dental Claim Form when billing for individuals qualifying as an adult with special needs. The system could then flag these codes to automatically apply the \$1,000 annual benefit limit and the enhanced reimbursement rate set at sixty percent (60%) of the fiftieth percentile national fee schedule. This approach would ensure uniform identification of qualifying beneficiaries while minimizing both provider and state worker burden by reducing unnecessary back-and-forth requests for verification.

2. The Department should clarify that all licensed dentists are entitled to enhanced rates for oral surgery services (oral and maxillofacial surgeons' services), including anesthesia. CDT codes D9222, D9223 and D9248 should be covered for both adults and children.

The Department should clarify that the enhanced reimbursement authorized by Ark. Code Ann. § 20-77-154(a)(1) applies equally to *all* licensed dentists when they provide oral surgery services (oral and maxillofacial surgeons' services), including anesthesia for adults—rather than limiting eligibility for the increased rates to oral and maxillofacial surgeons performing those same services.

Act 1025's plain language supports this interpretation. The Act separately requires DHS to “increase reimbursement rates for (A) oral and maxillofacial surgeons’ dental services, including anesthesia; (B) Pediatric dental services, including anesthesia” *and*, as an entirely distinct category, “(C) dental services for adults with special needs.” Ark. Code Ann. § 20-77- 154(a)(1) (2025). The Act on its face does not limit increased reimbursement to any specific provider for “dental services for adults with special needs,” and thus plain language of the Act supports *all* licensed dentists performing oral surgery services, including anesthesia, to receive the increased rates.

Act 1025's legislative purpose also favors this interpretation. Act 1025 aims to improve access and raise reimbursement for critical dental care. General dentists routinely provide oral surgery services as part of their regular care for patients. They also often serve as the primary dental providers for adults with special needs in community settings. Excluding them from eligibility for the enhanced rate would create a bifurcated rate structure that discourages participation by general dentists, thereby limiting where beneficiaries may access such services. This frustrates the access-promoting purposes of the Act.

Moreover, the alternative interpretation to exclude all other licensed dentists from eligibility for the increased rate would conflict with federal Medicaid law. According to a 2024 survey by KFF, there are only 39 oral and maxillofacial surgeons in Arkansas.¹ Per 42 U.S.C. § 1396a(a)(30)(A) (“30(A)”), DHS must “provide such methods and procedures relating to ... the payment for[] care and services ... as may be necessary ... to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” Restricting enhanced rates for extractions to oral surgeons would:

1. Require DHS to maintain two different reimbursement levels for identical CDT-coded procedures (D7000-D7999), the oral and maxillofacial surgeons’ services (oral surgery services) and pay substantially different rates for the same services based solely on provider specialty; and
2. Create significant geographic gaps in service availability since most Arkansas counties have few or no oral surgeons.

Such a bifurcated system would neither be efficient nor economical, would not lead to quality care for patients on Medicaid, and would not be sufficient to enlist sufficient providers to ensure care availability for such beneficiaries at least to the degree available to the general population in the more rural geographic areas—in violation of 30(a).

In sum, to fulfill both the terms and intent of Act 1025, comply with federal law, and protect patient access, DHS should confirm that all licensed dentists qualify for the enhanced NDAS-based rate when

performing extraction services for adults with special needs. Specifically, DHS should expressly state in the final rule, State Plan Amendment, and Dental Provider Manual that:

“The enhanced reimbursement rates established under Ark. Code Ann. § 20-77-154(a)(1)(C) apply to all licensed dentists when providing oral surgery services, including anesthesia to children and adults.”

This clarification aligns with the plain language and intent of Act 1025, federal access-to-care obligations, and the Department’s duty to implement the statute “consistent with efficiency, economy, and quality of care.”

3. The Department should preserve orthodontic reimbursement rates. There is no language in Act 1025 to change the orthodontic reimbursement rates (CDT Codes D8000-D8999).

While Act 1025 was enacted to *increase* reimbursement and improve access for dental care, application under the proposed rule of the sixty percent (60%) of the fiftieth percentile NDAS benchmark would result in significant *decreases* to orthodontic care rates. Such reductions would defeat the Act’s purpose and jeopardize access to orthodontic care for Arkansas Medicaid beneficiaries. We believe that that this proposed change in reimbursement rates conflict with both the terms and intent of the Act as well as federal law, and should be reversed to preserve orthodontic reimbursement rates.

Applying the sixty percent (60%) of the fiftieth percentile NDAS benchmark rate to orthodontic codes would fail to capture the unique bundled and episodic nature of orthodontic care. NDAS “per-procedure” values do not reflect global orthodontic case costs. Using that benchmark on these services creates a false comparison to single-visit procedures and leads to artificially low rates. This would produce a net reduction of twenty to thirty percent (20-30%) in reimbursement for the affected CDT codes.

This would frustrate the purpose of Act 1025, which requires the Arkansas Medicaid Program to “increase reimbursement rates for” several categories of dental services. Ark. Code Ann. § 20-77-154(a)(1) (2025). Simply stated, those categories are oral surgery services (CDT Codes D7000-D7999), including anesthesia (CDT Codes 9222, D9223, and D9248) for adults and children; pediatric dental services, including anesthesia; and dental services for adults with special needs. Act 1025, in accordance with (a)(1)(C), also increased the yearly maximum from \$500 to \$1,000 for adult special needs patients.

Although some orthodontic services may be read to fall within these categories, the statute requires that such rates be “increase[d].” Thus, Act 1025 must be read to exclude orthodontia services from application of the sixty percent (60%) of the fiftieth percentile of national rates benchmark, which would *decrease* those rates—or else the Act would contradict itself. The clear legislative intent is to expand, not diminish, reimbursement for complex treatment types requiring long-term professional management. A rate-setting methodology that lowers orthodontic reimbursement would run counter to that legislative intent by decreasing rates and, therefore, access to services.

Moreover, utilizing such methodology would violate both the efficiency and access prongs of 42 U.S.C. § 1396a(a)(30)(A). Orthodontic services involves extended treatment plans of typically eighteen (18) to thirty-six (36) months, multiple visits, and significant overhead. A downward adjustment in the rates for codes D8070-D8090 and related maintenance codes would make orthodontic participation in Arkansas Medicaid economically unsustainable. Further cuts would predictably cause orthodontic providers to

withdraw from Medicaid participation, exacerbating already low orthodontic provider participation, further causing insufficient orthodontic care availability for Medicaid beneficiaries. This would reduce access and delay care for children and adults who most need interceptive or corrective treatment, increasing disparities among low-income and special-needs populations.

Orthodontic services are essential, long-duration treatments that cannot absorb a rate reduction without severely limiting access. The proposed NDAS methodology unintentionally penalizes these services, contradicting the intent of Act 1025 to *increase* reimbursement rates and improve care access. DHS should therefore exclude orthodontic codes from the NDAS rate recalculation and maintain current reimbursement rates for these services. Specifically, DHS should amend the proposed rule and State Plan Amendment to state:

“Orthodontic service codes (D8010-D8999) shall retain their current reimbursement levels pending further review. Application of the sixty percent (60%) of the 50th-percentile NDAS methodology shall not result in a decrease in reimbursement for these codes.”

This approach ensures consistency with Act 1025’s mandate to increase dental reimbursements overall, compliance with 30(A), continued access to orthodontic care for Medicaid beneficiaries, and stability for providers managing complex orthodontic cases.

Conclusion

We applaud the efforts of the legislature to enact Act 1025 and of DHS to implement it. If implemented with care, Act 1025 stands to make accepting Arkansas Medicaid beneficiaries more financially feasible for dental providers and thereby increase access to critical dental services. However, we caution that the three proposed amendments detailed above should be made to clarify important points and preserve that fundamental purpose of Act 1025 and to comply with federal law.

CITATION:

¹ <https://www.kff.org/state-health-policy-data/state-indicator/dentists-by-specialtyfield/?currentTimeframe=0&selectedDistributions=oral-and-maxillofacialsurgery&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last accessed October 30, 2025).

Response: Please see above responses to #1-#3, above.

Amy Parker

Comment: I disagree with the reducing the benefits for future kids that will need braces. The parents that have kids on n Arkids is because they can't afford insurance. The kids that need braces won't get them bc the parents can't afford them. Please don't reduce this benefit for future kids that might need them.

Response: Please see DHS's response to #3 above.

Jamie Wiggs

Comment: I STRONGLY DISAGREE with reducing this benefit. Oral health is not something you should skimp out on, especially for children. What is the point of paying Medicaid taxes from my paychecks if it does not benefit my child's health!

Response: Please see DHS's response to #3 above.

Michael Stephen Harrison, Jr. DDS, MS

Hot Springs Endodontics

Comment: I'm a dentist who is a Medicaid provider. I support the position of the ASDA regarding Act 1025, specifically the following:

1. ICD-10 codes need to be used to identify adult special needs patients on claim forms
2. The increase in oral surgery fees, including sedation goes to all licensed dentists for adult and child patients
3. Orthodontic fees should remain unchanged as there was no language in the bill addressing orthodontic fees.

Please move forward with the act that was passed through the legislature and signed by the governor.

Response: Please see the responses to #1-#3 above.

Karina Franco

Comment: Good morning I would like to ask that you please don't reduce this benefit. It's already really difficult to find a orthodontist that takes ARKids and the scoring to get braces is really high. The previous plan was better as if it wasn't for that service/plan one if my kids would of not gotten the help he needed at that time. Now my 7 year old daughter needs this benefit more than ever to help fix her dental problems.

Response: Please see the response to #3, above.

Kelly-Gwynne Fergus, DDS, MDS

Comment: I support the children of Arkansas. I currently accept AR Medicaid patients for orthodontic treatment, but I do this not for the financial benefit BECAUSE THERE IS CURRENTLY NO FINANCIAL BENEFIT in doing so. I do this as a community service to the children in my area. That is the only reason!

But as a Licensed Specialist of Orthodontics in the state of Arkansas I WILL NO LONGER ACCEPT AR MEDICAID ORTHODONTIC PATIENTS if the current fees are reduced. The quality of care will suffer if fees are reduced as most of my specialty colleagues will also stop accepting these patients as the costs would outweigh the reimbursement.

I support the children of Arkansas. Therefore I support the position of the ASDA in regard to Act 1025 and everything stated in the letter sent from Mitchell Blackstock Lawfirm.

I recommend:

1. ICD-10 codes need to be used to identify adult special needs patients on claim forms
2. The increase in oral surgery fees, including sedation goes to all licensed dentists for adult and child patients
3. Orthodontic fees should remain unchanged as there was no language in the bill addressing orthodontic fees.

Response: Please see responses to #1-#3, above.

Matt McDonough

Comment: I wanted to express support for Act 1025 that was passed by the Arkansas legislature. It will only expand access to care for our most vulnerable Arkansans (especially children). Please approve as it was written.

I should clarify that I support the version of the bill that was passed without any changes made to it.

Response: Please see responses to #1-#3, above.

Laurence J. Howe, DDS

Secretary/Treasurer Arkansas State Dental Association, Fellow of Pierre Fauchard Academy, Fellow International College of Dentists - Deputy Regent Arkansas Chapter, Fellow American College of Dentists

Comment: In my capacity as an officer of the Arkansas State Dental Association, I support the ASDA position as outlined in the letter from the Mitchell Blackman Law Firm.

1. ICD-10 codes need to be used to identify adult special needs patients on claim forms

2. The increase in oral surgery fees, including sedation goes to all licensed dentists for adult and child patients
3. Orthodontic fees should remain unchanged as there was no language in the bill addressing orthodontic fees.

Response: Please see responses to #1-#3, above.

Dr. April Buffington Masengale

Comment: I am writing in support of the position of the ASDA (Arkansas State Dental Association) in regard to act 1025.

Response: Please see responses to #1-#3, above.

Clint Koen DDS, MDS

Comment: I agree with and support the position of the ASDA on Act 1025. Please read the letter from the Mitchell Blackstock Firm. I think it explains important points about this matter. Thanks for your help in implementing these new rates to provide care for our patients.

Response: Please see responses to #1-#3, above.

Hannah M. Buso, DDS

Comment: I am contacting you to inform you of my support of the position of the ASDA in regard to Act 1025 as stated in the letter from the Mitchell Blackstock Firm.

1. ICD-10 codes need to be used to identify adult special needs patients on claim forms
2. The increase in oral surgery fees, including sedation goes to all licensed dentists for adult and child patients
3. Orthodontic fees should remain unchanged as there was no language in the bill addressing orthodontic fees.

I ask that you seriously consider these important points that will allow us as dentists to continue providing care to these patients.

Response: Please see responses to #1-#3, above.

Nick Dollar DDS

Prairie Grove Dental Center

Comment: I, Nick Dollar DDS, support the position of the ASDA in regard to Act 1025. I also support the letter from the Mitchell Blackstock Firm.

Response: Please see responses to #1-#3, above.

John Pardo, DDS

Comment: As a practicing dentist in Arkansas I fully support Act 1025 and am in support of ASDAs efforts to improve Medicaid for special needs patients

Response: Please see responses to #1-#3, above.

Elizabeth Hook

Comment: I am greatly displeased to learn that ARkids will be cutting orthodontic coverage. While my own child is far too young for braces, there are thousands of children across the state who will have NO access to orthodontic care! Imagine how tough it is for parents to explain to their child that the state doesn't think they're important enough to get much needed care! This is tragic, and I implore you to consider the children and preserve their access to care!

Response: Please see the response to #3, above.

John Scott, DDS MSD

Conway & North Little Rock Pediatric Dental Groups

Comment: Hello, I wanted to state that I appreciate DHS's efforts to implement these changes in a reasonable timeline. I also support ASDA's stance regarding ICD codes, oral surgery fees for all practitioners, and orthodontic fees.

Health insurance rates have gone up 20-30% for 2026. It is almost unaffordable for many of our staff members. Increasing their salaries comes directly from implementing this increase.

Response: Please see responses to #1-#3, above.

Dr. Jay Fergus, Fergus Spades Dental Care

Comment: I support the children of Arkansas. The quality of orthodontic care for the children of Arkansas will suffer if Medicaid orthodontic fees are reduced as most orthodontic specialist will stop accepting these patients as the costs would outweigh the reimbursement.

I support the children of Arkansas. Therefore I support the position of the ASDA in regard to Act 1025 and everything stated in the letter sent from Mitchell Blackstock Law firm.

I recommend:

1. ICD-10 codes need to be used to identify adult special needs patients on claim forms
2. The increase in oral surgery fees, including sedation goes to all licensed dentists for adult and child patients
3. Orthodontic fees should remain unchanged as there was no language in the bill addressing orthodontic fees.

Response: Please see responses to #1-#3, above.

Jason Havard, DDS President, Arkansas Society of Pediatric Dentists

Comment: I am writing in support of the Arkansas State Dental Association's position on Act 1025 which is outlined in the letter to DHS from the Mitchell Blackstock Firm.

Response: Please see responses to #1-#3, above.

Stefanie Meek, DDS, Pediatric Dentist Conway and North Little Rock Pediatric Dental Group

Comment: As a pediatric dentist serving families in Central Arkansas, I am writing to express my strong support for a Medicaid fee increase for dental providers. More than fifty percent of the patients I treat are covered by Medicaid, and these families depend on access to quality oral health care. However, with the continued rise in the costs of dental supplies, staff wages, and overall business expenses driven by inflation, it has become increasingly difficult to sustain the level of care these patients deserve under the current reimbursement structure. A fee increase is vital to ensuring that small business practices like mine can continue to provide care to this vulnerable population.

Additionally, I wish to express my support for the Arkansas State Dental Association's letter regarding Act 1025. Specifically, I am in favor of the following provisions:

1. ICD-10 codes should be used to identify adult special needs patients on claim forms.
2. The increase in oral surgery fees, including sedation, should apply to all licensed dentists providing services for both adult and child patients.

3. Orthodontic fees should remain unchanged, as there was no language in Act 1025 addressing those fees.

Thank you for your attention to these important issues and for your continued efforts to support Arkansas dental providers and the patients we serve. I appreciate your consideration and advocacy in helping sustain access to essential oral health care for Medicaid recipients across our state.

Response: Please see responses to #1-#3, above.

Kenton A Ross, DMD, president, Arkansas State Dental Association

Comment: DHS, I support the position of the ASDA in regard to Act 1025. Please see the letter from the Mitchell Blackstock Firm [\(Click here to read the letter.\)](#)

1. ICD-10 codes need to be used to identify adult special needs patients on claim forms
2. The increase in oral surgery fees, including sedation goes to all licensed dentists for adult and child patients
3. Orthodontic fees should remain unchanged as there was no language in the bill addressing orthodontic fees.

Thank you for honoring the wording and intent of ACT 1025 to prevent further collapse of the vital network of Medicaid dental providers.

Response: Please see responses to #1-#3, above.

Robert R Carlisle DDS

Comment: The Arkansas State Dental Association has taken a position supporting Act 1025, of which I also support. General dentists perform a majority of extractions for the patients with Medicaid coverage. We need to be reimbursed properly , and if not , many will discontinue being Medicaid providers as expected . Other treatment modalities are performed other than extractions . If Act 1025 fails, those other procedures will be unavailable also . This would create a situation where Arkansans that need help , will find it more difficult to find a provider willing to treat them , even though there would be a case where the office takes a loss on that case . Not a good situation at all.

I support the ASDA position.

Response: Please see responses to #1-#3, above.

Tracy Schroepfer

Congo Dental

Comment: I support the position of the ASDA in regard to Act 1025, in reference to the letter from the Mitchell Blackstock Firm. Please consider:

1. ICD-10 codes need to be used to identify adult special needs patients on claim forms
2. The increase in oral surgery fees, including sedation goes to all licensed dentists for adult and child patients
3. Orthodontic fees should remain unchanged as there was no language in the bill addressing orthodontic fees.

Response: Please see responses to #1-#3, above.

Dr Kristopher Liggett, Fayetteville, AR

Comment: I support the position of the ASDA in regard to Act 1025, and refer to the letter from the Mitchell Blackstock Firm

Response: Please see responses to #1-#3, above.

Dr Matt Bridwell, Kanis Dental, Little Rock, AR

Comment: Please make the increased medicaid reimbursement rates apply to all providers, not just oral surgeons, for adults and children. General dentists do the vast majority of the care for this population, and low Medicaid reimbursement is the #1 reason most providers decline.

Response: Please see the response to #1, above.

Dr. Jessica Sliger, DDS

Board-Certified Pediatric Dentist / Hospitalist, Arkansas Children's Hospital & Arkansas Children's Northwest / Faculty, Lyon College, Owner, Bright Pediatric Dentistry, Associate, The Smile Shoppe

Comment: I am writing to express deep concern regarding the proposed Medicaid fee adjustments that appear to exclude licensed pediatric dentists who provide oral surgery and sedation services to children and adults with special needs in Arkansas.

As a board-certified pediatric dentist, hospitalist at Arkansas Children’s Hospital and Arkansas Children’s Northwest, and faculty member at Lyon College, I serve patients who travel from all over the state to receive care under general anesthesia. Many of these patients—children and adults alike—depend on specialized, hospital-based dental care that only a handful of providers in Arkansas can deliver safely and consistently.

It is disheartening to learn that fee increases may apply only to oral surgeons. Pediatric dentists are specialists too, and we play a critical role in managing the state’s most medically and behaviorally complex dental patients. Without fair reimbursement for oral surgery and sedation services, specialists like myself—especially those running start-up practices—will face unsustainable financial pressures. This could ultimately force us to leave Medicaid networks, further limiting access to care for vulnerable children and adults with special needs.

If the issue is one of cost, I urge DHS to consider a targeted fee adjustment specifically for pediatric dental specialists rather than a broad or exclusive model. Pediatric dentists are essential to the health and safety of Arkansas’s children and special-needs adults. We are not only providing vital clinical care but also supporting hospitals and training the next generation of providers.

Please ensure that pediatric dentists remain included in these critical Medicaid fee discussions. The future of access to safe, specialized dental care for Arkansas’s most vulnerable patients depends on it.

Response: Please see responses to #1-#4, above.

Herman E. Hurd, D.D.S.

Comment: Regarding the proposed changes to the Medicaid dental reimbursement rates, I support the position of the ASDA concerning Act 1025. I agree with the letter from the Mitchell Blackstock law firm regarding the implementation of the Act. Thank you for your consideration of my input.

Response: Please see responses to #1-#3, above.

Kaila Mooney, RDH

Comment:

1. ICD-10 codes need to be used to identify adult special needs patients on claim forms
2. The increase in oral surgery fees, including sedation goes to all licensed dentists for adult and child patients Copy 1 and 2 in to your letter and ask them to uphold the fee increases for pediatric dentists and general dentists.

Please consider including pediatric and general dentists into the increased fee schedule. The kids and special needs adults of Arkansas need this. Dentists cannot afford to treat Medicaid patients with the current fee schedule. It is simply not sustainable.

Response: Please see responses to #1-#4, above.

Karen Ricker, DDS

Comment: I am a board certified pediatric dentist in Fayetteville, Arkansas.

I support the position of the ASDA in regard to Act 1025.

1. ICD-10 codes need to be used to identify adult special needs patients on claim forms
2. The increase in oral surgery fees, including sedation goes to all licensed dentists for adult and child patients
3. Orthodontic fees should remain unchanged as there was no language in the bill addressing orthodontic fees.

This is of utmost importance, and I along with all my colleagues appreciate you support in this matter.

Response: Please see responses to #1-#4, above.

Amanda Hankins, DDS

Comment: I'm reaching out in support of the position of the ASDA in regard to Act 1025. We are losing providers for children on medicaid. It has become an access to care issue in my area. We are asking for the following considerations:

1. ICD-10 codes need to be used to identify adult special needs patients on claim forms
2. The increase in oral surgery fees, including sedation goes to all licensed dentists for adult and child patients
3. Orthodontic fees should remain unchanged as there was no language in the bill addressing orthodontic fees.

Response: Please see responses to #1-#3, above.

Riana Thomas

Comment: I support the position of the ASDA (Arkansas State Dental Association) in regard to Act 1025.

1. ICD-10 codes need to be used to identify adult special needs patients on claim forms
2. The increase in oral surgery fees, including sedation goes to all licensed dentists for adult and child patients. Pediatric dentists are a specialty and shouldn't be excluded from the increase given only to oral surgeons.
3. Orthodontic fees should remain unchanged as there was no language in the bill addressing orthodontic fees.

Response: Please see responses to #1-#4, above.

Heather Hurshman

Comment: To whom it may concern, I support the position of the ASDA (Arkansas State Dental Association) in regard to Act 1025. Dont cut anything that supports the health and well being of CHILDREN! Arkansas as a whole as claimed to be PROLIFE and cutting funding to ANYTHING THAT SUPPORTS A CHILDS WELL BEING IS NOT PROLIFE! Shame on those who support such cuts!

Please note :

1. ICD-10 codes need to be used to identify adult special needs patients on claim forms
2. The increase in oral surgery fees, including sedation goes to all licensed dentists for adult and child patients. Pediatric dentists are a specialty and shouldn't be excluded from the increase given only to oral surgeons.
3. Orthodontic fees should remain unchanged as there was no language in the bill addressing orthodontic fees.

Response: Please see responses to #1-#4, above.

dinhelgudinna@gmail.com

Comment: I support the position of the ASDA (Arkansas State Dental Association) in regards to 1025!! I an an Arkansas constituent and I am many others i know have reached out about this. HEAR US!!

1. ICD-10 codes need to be used to identify adult special needs patients on claim forms
2. The increase in oral surgery fees, including sedation goes to all licensed dentists for adult and child patients. Pediatric dentists are a specialty and shouldn't be excluded from the increase given only to oral surgeons.
3. Orthodontic fees should remain unchanged as there was no language in the bill addressing orthodontic fees.

Response: Please see responses to #1-#4, above.

Elizabeth Brown

Mom of children & adults with significant needs

Executive Director of Resilience & Learning Center

Comment: I am writing to express my support for the position of the Arkansas State Dental Association (ASDA) regarding the implementation of Act 1025.

I appreciate the efforts being made to improve access to dental care for Arkansans and would like to highlight several key points that I believe are important for equitable and effective application of this act:

1. ICD-10 Codes for Adult Special Needs Patients:
2. ICD-10 codes should be utilized to identify adult special needs patients on claim forms. This will ensure accurate reporting, appropriate reimbursement, and proper recognition of the additional care and accommodations required for these individuals.

3. Oral Surgery Fee Increases:

The increase in oral surgery fees, including those for sedation, should apply to all licensed dentists providing these services for both adult and pediatric patients. Pediatric dentists are a recognized specialty within the dental profession and should not be excluded from fee increases that are extended only to oral surgeons.

4. Orthodontic Fees:

Orthodontic fees should remain unchanged, as there was no language in Act 1025 that addressed or authorized modifications to these fees.

I appreciate your attention to these matters and your continued commitment to fair and comprehensive implementation of Act 1025. Thank you for considering these points in alignment with the ASDA's recommendations.

Response: Please see responses to #1-#4, above.

Dr. Emily Fourmy

Comment: I am emailing in support the position of the ASDA in regard to Act 1025, and agree with the letter from the Mitchell Blackstock Firm. The three issues that I would like to see changed are below:

1. ICD-10 codes need to be used to identify adult special needs patients on claim forms
2. The increase in oral surgery fees, including sedation goes to all licensed dentists for adult and child patients
3. Orthodontic fees should remain unchanged as there was no language in the bill addressing orthodontic fees.

Response: Please see responses to #1-#3, above.

Cassie Ross, Special needs mother to a child with a disability

Comment: I am writing to you in support of the ASDA's position in regards to Act 1025.

I strongly disagree with reducing the orthodontic benefit for children on medicaid. Orthodontic fees should remain unchanged as there was no language in the bill addressing orthodontic feeds.

The increase in oral surgery fees, including sedation, goes to all licensed dentists for adult and child patients. Pediatric dentists are a speciality and should be excluded from the increase given only to oral surgeons.

Furthermore, ICD-10 codes need to be used to identify adult special needs patients on claim forms.

Response: Please see responses to #1-#4, above.

Miranda M Childs Bebee, DDS

Comment: I am a practicing dentist in AR and I support the support the position of the ASDA in regard to Act 1025. As stated in the letter from the Mitchell Blackstock Firm I would urge DHS to act in accordance to the ACT 1025. Failing to do so may result in more and more providers not treating the patients that Medicaid serves.

Response: Please see responses to #1-#3, above.

Lamont Parsons DDS

Comment: I support the ASDA position on Act 1025.

Response: Please see responses to #1-#3, above.

John Isbell, DDS

Comment: My name is Dr. John Isbell. I am a dentist in Mountain View, AR. My practice is an active Medicaid provider, seeing many of the children in our county who are enrolled in Medicaid.

Our practice firmly supports the Arkansas State Dental Association's position in regards to Act 1025. Please refer to the letter you have received from the Mitchell Blackstock Firm.

1. ICD-10 codes need to be used to identify adult special needs patients on claim forms.
2. The increase in oral surgery fees, including sedation, goes to all licensed dentists for adult and child patients.
3. Orthodontic fees should remain unchanged, as there was no language in bill addressing orthodontic fees.

Act 1025 stands to make Arkansas Medicaid more financially feasible for many dental offices. This would, hopefully, bring more practices back to accepting Medicaid patients, who desperately need dental care. It might also prevent practices across our state on the verge of considering dropping Medicaid, including our practice, from doing so.

Response: Please see responses to #1-#3, above.

William P. Tompkins DDS

Pediatric Dental Associates and Orthodontics

Comment: I am writing this email to inform you that I am in full agreement with Act 1025. I have been a pediatric dentist in Arkansas since 2004 and remember the fee increase in 2007. This was the last fee increase we received. Since 2007 overhead costs have increased over 100% and employee costs have increased around 70%. Our office is a large provider to the Medicaid population and without this increase it will be very difficult to justify continuing to serve them in a business sense. Please do the right thing and pass this Act to fairly compensate the dental providers for Medicaid patients in the state of Arkansas. Thank you for your time.

Response: Please see responses to #1-#3, above.

Tim Lawrence DDS, PA

Mitchell Blackstock PLLC

Comment: I have been a medicaid provider for 30 years this December. We have had 1 increase in this time to the most vulnerable population in our state. Please do what is right for the kids. We, as providers have been doing our treatment as a love for these children. Please do the same.

Response: Please see responses to #1-#3, above.

John H. Puckett DDS, Paragould, AR

Comment: Please consider my support for Act 1025 regarding Medicaid reimbursement. I have read and completely agree with the legal request from the Blackstone law Firm. I have practiced dentistry for just

over 23 years. Most of that has been in rural Arkansas. I primarily see children under 18, with the only exception being adults with special needs.

I see thousands of patients every year through a very active community involvement model. Prevention is our primary goal, but severe dental needs are still prevalent and desperately need continuous attention. I am a comprehensive provider. We do everything from initial lap visits on toddlers and preschool checks, to full mouth rehabilitation under general anesthesia in a hospital setting. I have operated on the same fees for all these years. Due to rising costs of everything related to dentistry, I subsequently make 30-40% less on take home profit than I did pre-covid. No working person can sustain that for long. My office is a critical piece in the dental puzzle in NEA. I can't do it much longer though. I'm having to make hard financial decisions at the office and at home. This should not be, at this point in my career. This also makes it virtually impossible to foresee anyone being able to do anything related to true rural community care in other undeserved parts of the state.

Please work hard and fast to resolve these issues.

Response: Please see responses to #1-#3, above.

T K McAlister, DDS

Comment: I support the position of the ASDA in regard to Act 1025. Refer to the letter from the Mitchell Blackstone Firm.

Response: Please see responses to #1-#3, above.

Karen Ricker, DDS

Comment: I am a practicing dentist in NW Arkansas and I strongly support the proposed increases to Arkansas Medicaid dental fees. Updating the fee schedule is essential to maintain patient access, cover evidence-based preventive and restorative care, and keep practices able to serve Medicaid patients—particularly children, seniors, and individuals with special healthcare needs.

Reasonable, modernized fees will help:

- Sustain participation among providers across urban and rural communities
- Reduce wait times and travel burdens for families
- Prioritize prevention and early intervention, lowering long-term costs

Thank you for moving this forward to improve access to oral healthcare in Arkansas.

Response: Thank you for your comment.

Ron Hubbard

Comment: I am writing in support of the ASDA's position on implementation of Act 1025. I believe our attorney's letter clearly states the intent of the Act . I have been seeing Medicaid patients for 51 years, children and adults, with no plans tp retire anytime...

Response: Please see responses to #1-#3, above.

Valerie Wilcoxson, resident of Rogers, Arkansas

Comment: I disagree with reducing this benefit!!!!

Response: Please see response to #3, above.

Jackson B. Lowery DDS, Owner/Dentist Seark Smiles Family Dentistry, Monticello, AR

Comment: I am writing in support of the Arkansas State Dental Association (ASDA) in regards to Act 1025. Please refer to the letter submitted by the Mitchell Blackstock Firm that:

- 1) ICD-1o codes need to be used to identify adults special needs patients on claim forms.
- 2) The increase in oral surgery fees, including sedation goes to all licensed dentists for adult and child patients.
- 3) Orthodontic fees should remain unchanged as there was no language in the bill addressing orthodontic fees.

Response: Please see responses to #1-#3, above.

Nickole Shelton, COTA/L
Ray of Sunshine Pediatric Therapy

Comment: Most families if on Medicaid can't afford the extremely high cost of braces and kids don't deserve to be in pain or embarrassment because their families are doing the best they can. Medicaid should cover ortho for kiddos in AR and I'd love to see that happen for my own children and many others. I am currently paying for invisilign for my son due to not medically necessary through his Medicaid and it's a huge struggle to keep up with the \$13,000 I owe them.

Response: Please see response to #3, above. Additionally, Arkansas Medicaid does currently cover orthodontics for children under 21 years of age in ARKIDS based on criteria determining oral health medical need.

Jerry Sanders, DDS

Pediatric Dental Associates and Orthodontics

Comment: I am a practicing dentist in Arkansas and I strongly support the proposed increases to Arkansas Medicaid dental fees. Updating the fee schedule is essential to maintain patient access, cover evidence-based preventive and restorative care, and keep practices able to serve Medicaid patients—particularly children, seniors, and individuals with special healthcare needs.

Reasonable, modernized fees will help:

- Sustain participation among providers across urban and rural communities
- Reduce wait times and travel burdens for families
- Prioritize prevention and early intervention, lowering long-term costs

Thank you for moving this forward to improve access to oral healthcare in Arkansas.

Response: Thank you for the comment.

Bill Dill DDS

Comment: I support the ASDA's position on act 1025

Response: Please see responses to #1-#3, above.

Katie G. Gibson, DDS, MS, Orthodontist

Westrock Orthodontics

Comment: My name is Katie Gibson, and I am an orthodontist who has been practicing in Central Arkansas for the past 7 years. I was born and raised in Northeast Arkansas and know the burden that reduced access to care places on both small towns and urban areas in this state.

I strongly urge the Division of Medical Services to **maintain or increase** orthodontic Medicaid reimbursement rates. Reduced reimbursement rates will pose a direct threat to access to care for children with severe malocclusions all across the state of Arkansas. Reimbursement rates are already quite low, and a further reduction will make it financially unsustainable for practices to continue to provide orthodontic care to patients in need.

Orthodontic treatment spans 2 to 3 years with continued costs for supplies and office visits throughout that time. The proposed fee reduction is well below the cost to provide care, and as a result, many practices will be forced to withdraw from participating in the state's Medicaid program. Orthodontic

treatment, while sometimes cosmetic in nature, is often also medically necessary for proper function and long-term oral health for a lifetime. The Medicaid program only covers care that is necessary.

Please consider maintaining or increasing the orthodontic Medicaid reimbursement rates so that the most vulnerable children in our state do not suffer.

Response: Please see response to #3, above.

Barbara Haire

Smile Shop Pediatric Dentistry

Comment: I want it to be recorded that I support the position of the ASDA in regard to Act 1025,

1. ICD-10 codes need to be used to identify adult special needs patients on claim forms
2. The increase in oral surgery fees, including sedation goes to all licensed dentists for adult and child patients

Thank you for your attention to this important matter to safeguard the Medicaid Dental providers in our great state.”

Response: Please see response to #1 and #2, above.

Stephanie Riley

Comment: I want it to be recorded that I support the position of the ASDA in regard to Act 1025,

1. ICD-10 codes need to be used to identify adult special needs patients on claim forms
2. The increase in oral surgery fees, including sedation goes to all licensed dentists for adult and child patients

Thank you for your attention to this important matter to safeguard the Medicaid Dental providers in our great state.

Response: Please see response to #1 and #2, above.

Paige Gancarczyk

Comment: I'm requesting that it be recorded that I support the position of the ASDA regarding Act 1025:

1. ICD-10 codes need to be used to identify adult special needs patients on claim forms
2. The increase in oral surgery fees, including sedation goes to all licensed dentists for adult and child patients

Thank you for your attention to this important matter to safeguard the Medicaid dental providers in our great state.

Response: Please see response to #1 and #2, above.

Emily Coon

Comment: I want it to be recorded that I support the position of the ASDA in regard to Act 1025,

1. ICD-10 codes need to be used to identify adult special needs patients on claim forms
2. The increase in oral surgery fees, including sedation goes to all licensed dentists for adult and child patients

Thank you for your attention to this important matter to safeguard the Medicaid Dental providers in our great state.

Response: Please see response to #1 and #2, above.

Charles A. Vondran Jr., DDS, MDS

Comment: I strongly disagree with any reduction in Medicaid reimbursement for orthodontic services. The fee now is already less than the cost to provide service.

I feel that any reduction in fees will only push ortho providers from offering treatment.

Response: Please see response to #3, above.

Wanda I. Claro, DDS, MS, Dual Specialist in Orthodontics and Pediatric Dentistry

Comment: I am an orthodontist who has been a dental specialty claims consultant for Medicaid. There are a limited number of orthodontists in the state that are willing and able to see patients through DHS. In order to qualify for orthodontic services through Medicaid a minimum specific score must be demonstrated. This score is determined by the severity of a patient's needs and is sufficiently high. This means that the patients that are approved are not simple, slam dunk cases. Orthodontic treatment is not only for esthetics. There are health issues involved when a patient has severe crookedness in that they are not able to chew properly, cleaning the teeth becomes more difficult with resultant increased cavity risk/rate and gum disease. Some bad bites can cause abrasion of the teeth and destruction of the gum and bones - also making chewing difficult. This in turn prevents adequate nutrition causing general health concerns. There is a greater risk for trauma (breaking) to the front teeth when they are excessively protrusive (stick out), which is an automatic qualifier for treatment. In addition jaw joint issues due to these kinds of bad bites can again cause chewing issues.

Other health issues can create bad bites and severe crowding - like cleft lip and palate. other head and neck birth defects, respiratory illnesses and accidents that prevent normal development of the face, teeth and jaws, not to mention psychological benefits gained. The severity of the patients that score high enough to allow orthodontic treatment also requires more time in treatment than typical cases.

The severity and time factors alone mean minimal to no reimbursement to the practitioner, after overhead is factored in. Many orthodontists even take losses when they treat medicaid patients. I and many orthodontists have seen medicaid patients as give-back to our community as we have seen the tremendous benefits created to better not only the function and esthetics, but the self esteem and the lives of these patients. We do this even with minimal reimbursement or losses are generated. We are also tax payers that contribute to these services and would like to see our tax money provide these necessary services.

Now, the reimbursement for all orthodontic services covered through medicaid have been reduced 25%. This will cause multiple orthodontists to be forced to stop seeing future medicaid patients. I, along with my fellow Arkansas orthodontists, seriously agree with reducing this life altering benefit for the young Arkansans who truly need this service. Please reconsider the decrease and consider re-establishing fees that justify being able to treat these worthy patients.

Response: Please see response to #3, above.

Tracy Schroepfer
Congo Dental Studio

Comment: I support the position of the ASDA in regard to Act 1025, in reference to the letter from the Mitchell Blackstock Firm. Please consider:

1. ICD-10 codes need to be used to identify adult special needs patients on claim forms
2. The increase in oral surgery fees, including sedation goes to all licensed dentists for adult and child patients
3. Orthodontic fees should remain unchanged as there was no language in the bill addressing orthodontic fees.

Response: Please see response to #1-#3, above.

Matt McDonough

Comment: My name is Matt McDonough. I wanted to express support for Act 1025 that was passed by the Arkansas legislature. It will only expand access to care for our most vulnerable Arkansans (especially children).

Response: Thank you for the comment.

T. Stotts Isbell, DDS

Past-President ASDA, Chair ASDA Medicaid Advisory Committee, Immediate Past-Chair ADA Council of Communications, Alternate Delegate representing AR to the ADA House of Delegates, Fellow American College of Dentists, Fellow International College of Dentists, Fellow Pierre Fauchard Academy

_Comment: My name is Dr. T. Stotts Isbell. I am a dentist in Mountain View, AR. Our practice is an active Medicaid provider, seeing many of the children in our county who are enrolled in Medicaid.

Our practice firmly supports the Arkansas State Dental Association’s position in regards to Act 1025.

Please refer to the letter you have received from the Mitchell Blackstock Firm.

1. ICD-10 codes need to be used to identify adult special needs patients on claim forms.
2. The increase in oral surgery fees, including sedation, goes to all licensed dentists for adult and child patients.
3. 3.Orthodontic fees should remain unchanged, as there was no language in bill addressing orthodontic fees.

Act 1025 stands to make Arkansas Medicaid more financially feasible for many dental offices. This would, hopefully, bring more practices back to accepting Medicaid patients, who desperately need dental care. It might also prevent practices across our state on the verge of considering dropping Medicaid, including our practice, from doing so.

Response: Please see response to #1-#3, above.

Michelle Potter, Office Manager / Super Smiles Dentistry

Comment: I’m writing as the Office Manager of Super Smiles Dentistry in Harrison. We are a high-volume Medicaid pediatric practice in a rural area, and we’re one of the very few offices here that still accepts Medicaid. We do this because our community depends on it, many of our families would have no practical way to access timely dental care otherwise.

Our supply, equipment, staffing, and compliance costs have risen dramatically, while Medicaid dental fees have not increased. That gap is getting harder to absorb without reducing access or services, neither of which our community can afford. For that reason, I respectfully support the Arkansas State Dental Association’s position on Act 1025 and ask DHS to incorporate the following clarifications in the final rule:

1. Use ICD-10-CM diagnosis codes on dental claims to identify adults with special needs. This will create a clear, auditable, and efficient path for eligibility and claims processing.
2. Apply the enhanced oral surgery reimbursement, including anesthesia (CDT D9222, D9223, D9248)—to all licensed dentists for adult and child patients. General dentists are often the only realistic access point for these services in rural areas; aligning rates with the procedure (not the specialty) helps ensure access.
3. Preserve current orthodontic reimbursement levels. Act 1025 did not direct a reduction to orthodontic codes, and a decrease would predictably reduce provider participation and access for Medicaid beneficiaries.

These clarifications align with the intent of Act 1025 to improve access, and they are essential for practices like ours to remain sustainable while continuing to serve Arkansas Medicaid families.

Thank you for your time and consideration, and for your work on a policy that truly impacts children and families across rural Arkansas.

Response: Please see responses to #1-#4, above.

Sean Sebourn DDS, MSD

Leap Kids Pediatric Dentistry

Comment: I am a practicing pediatric dentist in Little Rock, Conway, Cabot, Fort Smith and Bentonville, Arkansas, and I write in full support of the Arkansas State Dental Association’s position regarding Act 1025 (formerly SB347) and the accompanying letter from Mitchell Blackstock.

To keep the implementation faithful to the statute and to protect access to necessary care, I respectfully request DHS adopt the following:

1. ICD-10 identification for adult special needs patients. Require ICD-10 codes on claim forms to clearly identify adult special needs patients so their care is appropriately recognized and processed.
2. Oral surgery fee increases (including sedation) applied broadly. Ensure the increase in oral surgery fees—including necessary sedation—applies to all licensed dentists treating adult and child patients, consistent with Act 1025.
3. Orthodontic fees remain unchanged. The bill does not address orthodontic reimbursement; therefore, orthodontic fees should not be reduced or altered as part of this rulemaking. These steps will better align policy with the intent of Act 1025, support access for vulnerable patients (including those with special needs), and provide clarity and fairness in reimbursement.

Thank you for your consideration and for your service to Arkansas patients. *Attachment:* Mitchell Blackstock letter referenced by ASDA.

Response: Please see responses to #1-#4, above.

Deanna Shannon

Comment: I am writing to express my support for the Arkansas State Dental Association’s (ASDA) position regarding the implementation of Act 1025, which was enacted following the passage of SB347 and signed into law by Governor Sanders earlier this year.

The current proposed changes to the Medicaid dental reimbursement rates do not align with the intent of Act 1025. I urge DHS to adopt ASDA’s recommendation to utilize already-established ICD-10 codes to identify adults with special needs who are eligible for dental services. This approach would:

Provide a consistent, objective indicator of eligibility tied to a physician’s diagnosis;

Reduce administrative delays and post-payment audit requests for documentation verification;

Enable DHS to electronically validate and track utilization data across qualifying conditions; and

Align Arkansas’s Medicaid documentation standards with those used for medical and behavioral health claims.

This simple, effective solution would ensure compliance with Act 1025 and improve access to care for a vulnerable population.

Response: Please see response to #2, above.

Blanca Gibbs, Office Manager
Clark Orthodontics

Comment: I am writing to express our concern regarding the proposed reduction in Medicaid reimbursement rates. In a time when costs are consistently rising, it makes no sense to not increase reimbursement rates let alone, reduce them!

If these reductions go into effect, we will unfortunately no longer be able to participate as an in-network Medicaid/ARKids provider. This is not a decision we take lightly, but maintaining financial viability is essential to continuing to provide quality care to our patients.

We strongly urge you to reconsider this decision and to explore adjustments that reflect the real costs of providing care today.

Response: Please see response to #3, above.

Lauren Martin, DDS
Leap Kids

Comment: I am a practicing dentist in Pine Bluff, Arkansas, and I write in full support of the Arkansas State Dental Association’s position regarding Act 1025 (formerly SB347) and the accompanying letter from Mitchell Blackstock.

To keep the implementation faithful to the statute and to protect access to necessary care, I respectfully request DHS adopt the following:

1. ICD-10 identification for adult special needs patients. Require ICD-10 codes on claim forms to clearly identify adult special needs patients so their care is appropriately recognized and processed.
2. Oral surgery fee increases (including sedation) applied broadly. Ensure the increase in oral surgery fees—including necessary sedation—applies to all licensed dentists treating adult and child patients, consistent with Act 1025.
3. Orthodontic fees remain unchanged. The bill does not address orthodontic reimbursement; therefore, orthodontic fees should not be reduced or altered as part of this rulemaking. These steps will better align policy with the intent of Act 1025, support access for vulnerable patients (including those with special needs), and provide clarity and fairness in reimbursement.

These steps will better align policy with the intent of Act 1025, support access for vulnerable patients (including those with special needs), and provide clarity and fairness in reimbursement.

Response: Please see responses to #1-#3, above.

R. Martin Baumgardner, Jr., DDS
Colonel, United States Air Force Reserve, Dental Corps, Retired,
Clements Family Dentistry

Comment: Come on, folks. Our office (Clements Family Dentistry) is the only one in our county that will accept adult Medicaid patients. I (71 years of age, a 30+ year veteran-and veteran of a foreign war) am the only provider of oral surgical services to adult Medicaid patients in Union County. I have been a licensed dentist in Arkansas since 1979. You have the audacity to suggest that you will not pay our office for surgical care which I have been providing all these years (for a fee which is barely a pittance). If you don’t do the right thing, then from now on we will give patients your number and you can take care of them. Being diplomatic all these years has not been productive. When was the last time you received a cost of living adjustment? It’s time for you to do the right thing and apply the Golden Rule.

Response: Please see response to #1, above.

Aisha Henry, Westrock Orthodontics

Comment: Please consider these concerns! I am a practicing dentist in West Memphis, Forest City, Blytheville, and Helena, Arkansas, and I write in full support of the Arkansas State Dental Association's position regarding Act 1025 (formerly SB347) and the accompanying letter from Mitchell Blackstock.

To keep the implementation faithful to the statute and to protect access to necessary care, I respectfully request DHS adopt the following:

1. ICD-10 identification for adult special needs patients.
Require ICD-10 codes on claim forms to clearly identify adult special needs patients so their care is appropriately recognized and processed.
2. Oral surgery fee increases (including sedation) applied broadly. Ensure the increase in oral surgery fees—including necessary sedation—applies to all licensed dentists treating adult and child patients, consistent with Act 1025.
3. Orthodontic fees remain unchanged. The bill does not address orthodontic reimbursement; therefore, orthodontic fees should not be reduced or altered as part of this rulemaking

These steps will better align policy with the intent of Act 1025, support access for vulnerable patients (including those with special needs), and provide clarity and fairness in reimbursement.

Thank you for your consideration and for your service to Arkansas patients.

Attachment: Mitchell Blackstock letter referenced by ASDA.

Response: Please see responses to #1-#3, above.

Larry & Kendra Pliler

A special needs mother, educator, and humanitarian.

Comment: I support the position of the ASDA (Arkansas State Dental Association) in regard to Act 1025.

1. ICD-10 codes need to be used to identify adult special needs patients on claim forms
2. The increase in oral surgery fees, including sedation goes to all licensed dentists for adult and child patients. Pediatric dentists are a specialty and shouldn't be excluded from the increase given only to oral surgeons.
3. Orthodontic fees should remain unchanged as there was no language in the bill addressing orthodontic fees.

Response: Please see responses to #1-#4, above.

Dr. Chad Jensen, DMD, owner, Super Smiles Dentistry

Comment: We are one of the largest Medicaid dental providers in our region, serving thousands of Medicaid recipients across North Arkansas. Many of our patients, especially children and adults with special healthcare needs, depend entirely on Medicaid for access to essential dental and orthodontic care.

I am writing to express my strong support for the Arkansas State Dental Association's (ASDA) position regarding the implementation of Act 1025 and to urge the Department to adopt the recommendations outlined in the Mitchell Blackstock letter dated October 31, 2025, which can be found here: <https://rgsfb6sab.cc.rs6.net/tn.jsp?....>

Specifically, I urge DHS to:

1. Adopt the use of ICD-10 codes to identify adult special needs patients on claim forms to ensure accurate, efficient, and uniform processing.
2. Clarify that all licensed dentists are eligible for the enhanced oral surgery reimbursement rates, including anesthesia services for both adults and children, not just oral and maxillofacial surgeons.
3. Preserve current orthodontic reimbursement rates, as Act 1025 contains no language authorizing a reduction in orthodontic fees. Any decrease would severely limit access to orthodontic care for Medicaid beneficiaries.

As both a general and orthodontic provider, I can state unequivocally that if orthodontic reimbursements are reduced, we will be unable to continue offering orthodontic services to Medicaid patients. This would have a devastating effect on access to care for families throughout rural Arkansas.

The intent of Act 1025 was clear, to expand access and improve reimbursement to strengthen provider participation and care availability. The above clarifications are essential to realizing that intent and ensuring compliance with federal access-to-care standards.

Response: Please see responses to #1-#4, above.

Nancy Ha, DDS, MS

Westrock Orthodontics

Comment: Please include the attached letter for my comments in regards to Act 1025. As the local orthodontist, I care for many medicaid recipients and can attest to the positive impact of Medicaid coverage of orthodontic treatment on the Fort Smith and surrounding community. Thank you for your kind consideration as you make decisions that will affect the dental care for the Medicaid population of Arkansas.

I am a practicing dentist in Fort Smith, Arkansas, and I write in full support of the Arkansas State Dental Association's position regarding Act 1025 (formerly SB347) and the accompanying letter from Mitchell Blackstock. To keep the implementation faithful to the statute and to protect access to necessary care, I respectfully request DHS adopt the following:

1. ICD-10 identification for adult special needs patients.
Require ICD-10 codes on claim forms to clearly identify adult special needs patients so their care is appropriately recognized and processed.
2. Oral surgery fee increases (including sedation) applied broadly. Ensure the increase in oral surgery fees—including necessary sedation—applies to all licensed dentists treating adult and child patients, consistent with Act 1025.
3. Orthodontic fees remain unchanged. The bill does not address orthodontic reimbursement; therefore, orthodontic fees should not be reduced or altered as part of this rulemaking

The bill does not address orthodontic reimbursement; therefore, orthodontic fees should not be reduced or altered as part of this rulemaking. These steps will better align policy with the intent of Act 1025, support access for vulnerable patients (including those with special needs), and provide clarity and fairness in reimbursement.

Response: Please see responses to #1-#3, above.

Catherine Akridge, DDS

Northwest Arkansas

Comment: As a practicing dentist in Northwest Arkansas, I want to express my strong support for the proposed increases to Arkansas Medicaid dental fees. Approximately 40–45% of my patients are Medicaid recipients, and while I remain deeply committed to serving this population, the current reimbursement rates make it increasingly difficult to continue doing so.

Far too often, I am forced to deny care because the cost to provide treatment exceeds what Medicaid reimburses. What breaks my heart most are the cases involving special needs adult patients who require sedation for even basic dental services. These are among the most vulnerable individuals in our communities—people who cannot care for themselves and rely entirely on others for their oral and overall health.

Providing safe and effective dental treatment for these patients requires additional time, staffing, and resources. Yet Medicaid rarely covers sedation services, leaving patients and families in impossible situations. At present, Arkansas effectively relies on pro bono work to meet the essential dental needs of its most vulnerable citizens. This is neither sustainable nor equitable, and it leaves families struggling to find care that, in some cases, is life-saving.

Updating the Medicaid dental fee schedule is a crucial step toward restoring access to care, supporting providers who want to serve, and ensuring that every Arkansan—regardless of disability or financial situation—can receive the dental care they need and deserve.

My specific support is for the letter you received from Mitchell Blackstock Firm.

Response: Please see responses to #1-#3, above. Additionally, thank you for the comment related to sedation services. A separate piece of legislation, Act 568 was passed to address this need and we are currently working on a rule to implement that Act.

Jacob Sutton, DDS

Comment: As a medicaid dental provider in Arkansas, I strongly support the position of the Arkansas State Dental Association in regards to Act 1025. The following are critical points that need to be corrected so that Arkansans on medicaid can have the access to dental care that they need.

1. ICD-10 codes need to be used to identify adult special needs patients on claim forms
2. The increase in oral surgery fees, including sedation goes to all licensed dentists for adult and child patients
3. Orthodontic fees should remain unchanged as there was no language in the bill addressing orthodontic fees.

Response: Please see responses to #1-#3, above.

Dr. Stephen Taylor

Comment: I support the position of the ASDA on act 1025. If it cost more to provide the service than we get reimbursed we will no longer be able to treat Medicaid patients.

Response: Please see responses to #1-#3, above.

Alan Ainley

Dental Association

Comment: Position regarding Act 1025. I would refer you to the letter from the Mitchell Blackstock Firm regarding considerations that need to be immediately addressed. Your prompt attention to this matter is greatly appreciated and affects the health of multitudes of Arkansans.

Response: Please see responses to #1-#3, above.

John Cauldwell, DDS

My Village Pediatric dentistry

Comment: I am a practicing dentist in Arkansas and I strongly support the proposed increases to Arkansas Medicaid dental fees. Updating the fee schedule is essential to maintain patient access, cover evidence-based preventive and restorative care, and keep practices able to serve Medicaid patients—particularly children, seniors, and individuals with special healthcare needs.

Reasonable, modernized fees will help:

- Sustain participation among providers across urban and rural communities
- Reduce wait times and travel burdens for families
- Prioritize prevention and early intervention, lowering long-term costs

Response: Thank you for the comment.

Emily K. Cheek, DDS

Leap Kids Dental on S. Bowman

Comment: I am a practicing dentist in Little Rock, Arkansas, and I write in full support of the Arkansas State Dental Association’s position regarding Act 1025 (formerly SB347) and the accompanying letter from Mitchell Blackstock.

To keep the implementation faithful to the statute and to protect access to necessary care, I respectfully request DHS adopt the following:

1. ICD-10 identification for adult special needs patients.
Require ICD-10 codes on claim forms to clearly identify adult special needs patients so their care is appropriately recognized and processed.
2. Oral surgery fee increases (including sedation) applied broadly. Ensure the increase in oral surgery fees—including necessary sedation—applies to all licensed dentists treating adult and child patients, consistent with Act 1025.
3. Orthodontic fees remain unchanged. The bill does not address orthodontic reimbursement; therefore, orthodontic fees should not be reduced or altered as part of this rulemaking

These steps will better align policy with the intent of Act 1025, support access for vulnerable patients (including those with special needs), and provide clarity and fairness in reimbursement.

Response: Please see responses to #1-#3, above.

Zachary Dixon, D.D.S.

Comment: I support the position of the ASDA in regard to Act 1025, in reference to the letter from the Mitchell Blackstock Firm.

Response: Please see responses to #1-#3, above.

Nicolet Smith
Leap Kids Dental

Comment: I am a practicing dentist in Cabot, Arkansas, and I write in full support of the Arkansas State Dental Association's position regarding Act 1025 (formerly SB347) and the accompanying letter from Mitchell Blackstock.

To keep the implementation faithful to the statute and to protect access to necessary care, I respectfully request DHS adopt the following:

1. ICD-10 identification for adult special needs patients. Require ICD-10 codes on claim forms to clearly identify adult special needs patients so their care is appropriately recognized and processed.
2. Oral surgery fee increases (including sedation) applied broadly. Ensure the increase in oral surgery fees—including necessary sedation—applies to all licensed dentists treating adult and child patients, consistent with Act 1025.
3. Orthodontic fees remain unchanged. The bill does not address orthodontic reimbursement; therefore, orthodontic fees should not be reduced or altered as part of this rulemaking.

These steps will better align policy with the intent of Act 1025, support access for vulnerable patients (including those with special needs), and provide clarity and fairness in reimbursement.

Response: Please see responses to #1-#3, above.

Jeanie Sallings

Comment: Good morning. I just wanted to let you know I support the position of the ASDA (Arkansas State Dental Association) in regard to Act 1025.

I am in support of:

1. ICD-10 codes need to be used to identify adult special needs patients on claim forms
2. The increase in oral surgery fees, including sedation goes to all licensed dentists for adult and child patients. Pediatric dentists are a specialty and shouldn't be excluded from the increase given only to oral surgeons.
3. Orthodontic fees should remain unchanged as there was no language in the bill addressing orthodontic fees.

Response: Please see responses to #1-#4, above.

Dr. David Wardlaw

Comment: I am an orthodontist with offices in Little Rock and Conway. I have been a Medicaid provider for eight years. I was motivated to become a provider because of the obvious need for competent orthodontic care for financially challenged children in our state. It has been my experience that the current orthodontic reimbursement does not come close to covering the expenses of treating these patients. I suspect that every orthodontic provider experiences the same thing. These cases can be complex and treatment often goes well beyond estimated time for various reasons. Many providers have made the decision to not participate because of the negative economic impact it has on their practices. To consider reducing the orthodontic reimbursement below current levels will have a devastating impact on those that are continuing to provide care, despite the negative financial impact on their practices. Many will decide to discontinue their participation. I fear that the children of our state will be the most negatively impacted. I would request that the decision to reduce or maintain fees at the current level be reviewed and a reasonable increase be implemented.

Response: Please see response to #3, above.

Bryan B. King
State Senator, District 28

Comment: I am writing regarding the proposed Arkansas Medicaid dental reimbursement changes to implement Act 1025 of 2025. It is crucial that these changes are executed thoughtfully to uphold the intent of the Act, which aims to make it more financially viable for dental health-care providers to serve Arkansas Medicaid beneficiaries, thereby increasing access to essential dental services.

A concerned dentist, who is one of my constituents and a Medicaid dental provider in Harrison serving our rural region, has raised three concerns with the proposed rule changes. Specifically, OHS is being asked to use ICD-10-CM diagnosis codes to identify adults with special needs, which would qualify individuals to receive the enhanced dental benefits; clarify that all licensed dentists are entitled to enhanced rates for oral surgery services (oral and maxillofacial surgeons' services); and preserve orthodontic reimbursement rates.

Arkansas already struggles to provide dental care in rural areas, and any proposed rule changes should consider the impact on all those who may be affected. Thank you for your time and attention to this matter. If I can be of further assistance, please do not hesitate to contact me.

Response: Please see responses to #1-#3, above.

Bryan B. King
State Senator, District 28

Comment: I am writing regarding the proposed Arkansas Medicaid dental reimbursement changes to implement Act 1025 of 2025. It is crucial that these changes are executed thoughtfully to uphold

the intent of the Act, which aims to make it more financially viable for dental health-care providers to serve Arkansas Medicaid beneficiaries, thereby increasing access to essential dental services.

The only Medicaid orthodontic provider in Harrison, which serves our rural region, has raised concerns about the proposed reimbursement rates for orthodontics. Arkansas already struggles to provide orthodontic specialists in rural areas, and the proposed fee reductions could exacerbate this challenge.

Thank you for your time and attention to this matter. I respectfully ask that you give every consideration to all those affected by any changes. If I can be of further assistance, please do not hesitate to contact me.

Response: Please see response to #3, above. Orthodontic rates will not be decreased.

Billy Tarpley

Public hearing held remotely 10/15/25 @ 9:30 AM CST

Comment: I have sent a copy of this letter and a copy of a letter from the Arkansas Association Orthodontics. I've emailed that to Elizabeth, Nell, Chawnte I believe, just a little while ago. For purposes for the record, if you don't mind, I am just going to read this letter which is very short, but it will at least get in the record. The letter reads,

"Dear Ms. Pitman, After reviewing the proposed rules provided by your agency, the Arkansas State Dental Association (ASDA) offers the following recommendations and requests: 1. ASDA disagrees with DHS's interpretation of the language in Act 1025 relating to "oral and maxillofacial surgeons' dental services", but we understand how that misinterpretation occurred. To that end, we recommend that D7140 (simple extraction) and D7210 (surgical extraction) be made payable to all licensed dentists as well as oral and maxillofacial surgeons. These are routine tooth extraction codes used by all dentists and should not be designated to oral surgeons alone. 2. Regarding the identification of special needs patients, ASDA recommends that DHS allows dentists to make that designation with ICD-10 diagnoses codes placed in Box 34 of the ADA claim form. This designation makes it clear that the patient is "high complexity" using a standardized diagnosis code. 3. As there is no reference to changing the fees for orthodontic procedures, and the stated purpose of the Act is to increase reimbursement rates for certain dental services in the subtitle, the ASDA supports the position of the Arkansas Association of Orthodontists to leave orthodontic fees unchanged.

Respectfully submitted, Kenton Ross DMD, President of ASDA and Billy Tarpley, Executive Director."

With a copy of this letter going to The Honorable Sarah. H. Sanders.

And I would add to that letter, there is also a company letter made available it is addressed to Elizabeth Pittman from Dr. Nicole Powell. Dr. Powell is President Arkansas Association Orthodontics. So, both letters have been submitted via email. So, I hope that is suitable and I hope I spoke clearly.

Response: Please see responses to #1-#3, above.

Kirt Simmons

Public hearing held remotely 10/15/25 @ 9:30 AM CST

Comment: I was the craniofacial orthodontist that started the program at Arkansas Children Hospital almost 30 years ago. I just wanted to convey my concern for the lower rate increases and the effect they will have on those services offered at Arkansas Children Hospital. The fees were already low; they are still below the 50th percentile of national fees even if they remain unchanged. So, it is not like the current fees are above the 50th percentile, they're still below 50th percentile and I would also like add as reviewer for Medicaid orthodontics cases in the state of Arkansas that many orthodontic services these codes are provided not only by orthodontics in the state of Arkansas but also by many pediatric and general dental providers in our small rural communities. So, the lowering of these fees significantly, as in these proposed rates, I would expect to have a large impact on our fragile population as well as those few dental providers that are currently willing to accept the current few. And so, I would like to and my endorsement to at least maintain current orthodontic rates as they are. Thank you, sir.

Response: Please see response to #3, above.

Terry Fiddler

Public hearing held remotely 10/15/25 @ 9:30 AM CST

Comment: Thank you very much. I have three statements that I would like to make and questions. These come from oral surgeon groups and some of the periodontic groups concerning codes. Do we need to get prior authorization before performing a procedure? If so, what is the protocol for submitting prior authorizations? And if there is no prior authorization is required what is the protocol for submitting claims. And finally, I would make a statement that since this will be reimbursable retroactive, how to you determined how the retroactive amounts are being paid to the particular specialist either pedo or oral surgeries, and will that be a, needing to be sent for the difference to DHS or would DHS already recognize the difference and forward that payment to the particular dental office. Thank you very much for that consideration.

Response: Thank you for the comment. Based on guidance from CMS we have separated the provision increasing reimbursement rates from the provision increasing the annual service limit. The annual service limit provision will be introduced in a separate rule. For the reimbursement rate increases, there will be no prior authorizations required, unless it is temporarily necessary to implement the policy by

the effective date. The Medicaid billing system will be configured to identify beneficiaries that trigger the higher reimbursement rate.

We will provide billing guidance through Official Notices and other documents. Additionally, we will continue to provide billing support through our Provider Support Contractor, who can be reached at 877-650-2362.

Dr. Stroope

Public hearing held remotely 10/15/25 @ 9:30 AM CST

Comment: I'm speaking to express my strong opposition, I'm an orthodontist in Springdale, to any proposal or policy consideration that will reduce orthodontic Medicaid reimbursement rates. While I agree with the increase and fees for restorative surgery, pediatric and special needs dental services are needed. I think it is going to have detrimental effect on the kids and the access to care of those who are needing orthodontic treatment. Many of us already provide this care at a below cost or at minimal kind a profit to serve these Medicaid patients. A further reduction in these fees will make this program unstable and our participation will dwindle as providers. Most providers in the state will withdraw from the program that are licensed orthodontists. This treatment is more involved than a normal routine dental service. The average case fee ranges between 5,000 to 10,000 dollars in the country for private practice orthodontics not a corporate setting. If you reduce the Medicaid rates this would make the practices joining it below sustainability, and few practices can afford to treat these kids. We carry higher fixed overhead costs than a lot of offices with brackets, wires, lab fees and staffing. We see these kids twice or sometimes once a month, every two months, for two or three years. Over the past three years our expenses have ballooned over 25 percent and in a low reimbursement environment we cannot absorb to take these without jeopardizing our own financial viability. Given that only severe cases qualify for orthodontics under the ARKids population, this population pool is a very complex orthodontic case to treat. Lowering the reimbursement makes these cases too risky for the providers to take on. This will reduce the number of kids being seen. In other states that have cut orthodontic benefits, the provider participants have declined measurably leaving these kids without access. From a fiscal perspective timely orthodontic intervention reduces the need for more expensive restoration and surgical care later. This will mitigate long-term Medicaid expenditures. A short-sided rate cut now will yield higher costs downstream for the Medicaid program. These kids will need complex oral surgery for impacted teeth, restorative procedures from caries caused by teeth not in the proper alignment so the children cannot brush. They'll have TMJ disorders, air way issues. Studies show that every dollar spent on medically necessary orthodontics care can reduce the Medicaid program \$3 to \$5 dollars in the future. Untreated orthodontics problems can cause tooth loss, speech impediments, difficulty eating, medical problems like sleep apnea. So, we must ensure as a state that this orthodontic care is available to these kids. Reducing fees will decline the number of participating providers in the Little Rock area, the Northwest Arkansas area, and all the rural areas like Dr. Simmons mentioned. This especially will cause our vulnerable populations of special needs kids, kids with autism and down syndrome, to require extra staff, extra chair time, more behavior management. So, orthodontists may choose not to treat these cases because they simply cannot do it in their office.

So, in conclusion we feel most orthodontists that are in the provider program that the reduction in fees will not be viable for us to continue with the program. And I do not foresee, personally, myself, that I will be able to stay as a provider in the Springdale area, which I am the only provider of ARKids orthodontics, private practice orthodontics, in the city of Springdale. I don't know if I will be able to stay as a provider if these changes do lower. Thank you.

Response: Please see response to #3, above.



ARKANSAS
DEPARTMENT OF
**HUMAN
SERVICES**

Office of Policy and Rules

P.O. Box 1437, Slot S295, Little Rock, AR 72203-1437

P: 501.320.6383 F: 501.404.4619

October 2, 2025

Mrs. Rebecca Miller-Rice
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
#1 Capitol, 5th Floor
Little Rock, AR 72201

Dear Mrs. Rebecca Miller-Rice:

Re: Dental Rates and Annual Limit Increase

Please arrange for this rule to be reviewed by the ALC-Administrative Rules Subcommittee. If you have any questions or need additional information, please contact me at 501-320-6383 or by emailing Mac.E.Golden@dhs.arkansas.gov.

Sincerely,

Mac Golden

Mac Golden
Attorney III
Office of Policy and Rules

Attachments

**QUESTIONNAIRE FOR FILING PROPOSED RULES WITH
THE ARKANSAS LEGISLATIVE COUNCIL**

DEPARTMENT _____
 BOARD/COMMISSION _____
 BOARD/COMMISSION DIRECTOR _____
 CONTACT PERSON _____
 ADDRESS _____
 PHONE NO. _____ EMAIL _____
 NAME OF PRESENTER(S) AT SUBCOMMITTEE MEETING _____
 PRESENTER EMAIL(S) _____

INSTRUCTIONS

In order to file a proposed rule for legislative review and approval, please submit this Legislative Questionnaire and Financial Impact Statement, and attach (1) a summary of the rule, describing what the rule does, the rule changes being proposed, and the reason for those changes; (2) both a markup and clean copy of the rule; and (3) all documents required by the Questionnaire.

If the rule is being filed for permanent promulgation, please email these items to the attention of Rebecca Miller-Rice, miller-ricer@blr.arkansas.gov, for submission to the Administrative Rules Subcommittee.

If the rule is being filed for emergency promulgation, please email these items to the attention of Director Marty Garrity, garritym@blr.arkansas.gov, for submission to the Executive Subcommittee.

Please answer each question completely using layman terms.

1. What is the official title of this rule?

2. What is the subject of the proposed rule? _____
3. Is this rule being filed under the emergency provisions of the Arkansas Administrative Procedure Act? Yes No

If yes, please attach the statement required by Ark. Code Ann. § 25-15-204(c)(1).

If yes, will this emergency rule be promulgated under the permanent provisions of the Arkansas Administrative Procedure Act? Yes No

4. Is this rule being filed for permanent promulgation? Yes No

If yes, was this rule previously reviewed and approved under the emergency provisions of the Arkansas Administrative Procedure Act? Yes No

If yes, what was the effective date of the emergency rule? _____

On what date does the emergency rule expire? _____

5. Is this rule required to comply with a *federal* statute, rule, or regulation? Yes No

If yes, please provide the federal statute, rule, and/or regulation citation.

6. Is this rule required to comply with a *state* statute or rule? Yes No

If yes, please provide the state statute and/or rule citation.

7. Are two (2) rules being repealed in accord with Executive Order 23-02? Yes No

If yes, please list the rules being repealed.

If no, please explain.

8. Is this a new rule? Yes No

Does this repeal an existing rule? Yes No

If yes, the proposed repeal should be designated by strikethrough. If it is being replaced with a new rule, please attach both the proposed rule to be repealed and the replacement rule.

Is this an amendment to an existing rule? Yes No

If yes, all changes should be indicated by strikethrough and underline. In addition, please be sure to label the markup copy clearly as the markup.

9. What is the state law that grants the agency its rulemaking authority for the proposed rule, outside of the Arkansas Administrative Procedure Act? Please provide the specific Arkansas Code citation(s), including subsection(s).

10. Is the proposed rule the result of any recent legislation by the Arkansas General Assembly?
Yes No

If yes, please provide the year of the act(s) and act number(s).

11. What is the reason for this proposed rule? Why is it necessary?

12. Please provide the web address by which the proposed rule can be accessed by the public as provided in Ark. Code Ann. § 25-19-108(b)(1).

13. Will a public hearing be held on this proposed rule? Yes No

If yes, please complete the following:

Date: _____

Time: _____

Place: _____

Please be sure to advise Bureau Staff if this information changes for any reason.

14. On what date does the public comment period expire for the permanent promulgation of the rule? Please provide the specific date. _____

15. What is the proposed effective date for this rule? _____

16. Please attach (1) a copy of the notice required under Ark. Code Ann. § 25-15-204(a)(1) and (2) proof of the publication of that notice.

17. Please attach proof of filing the rule with the Secretary of State, as required by Ark. Code Ann. § 25-15-204(e)(1)(A).

18. Please give the names of persons, groups, or organizations that you anticipate will comment on these rules. Please also provide their position (for or against), if known.

19. Is the rule expected to be controversial? Yes No

If yes, please explain.

NOTICE OF RULE MAKING

The Department of Human Services (DHS) announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§20-76-201, 20 77-107, and 25-10-129. This rule implements Act 1025 of 2025 (the Act).

The Act requires, beginning September 1, 2025, an increase of Medicaid reimbursement rates for oral and maxillofacial surgeons' dental services and anesthesia, pediatric dental services and anesthesia, and dental services for adults with special needs. The rates shall be set to sixty percent of the fiftieth percentile for national fees as determined by the annual National Dental Advisory Service Comprehensive Fee Report adjusted for the state. The Act also requires an increase to the annual reimbursement limit for dental services for adults with special needs from \$500 to \$1000. To comply with the Act, the Division of Medical Services revises the Medicaid Dental Provider manual to reflect the required increases and add a definition of adults with special needs. DMS will submit a corresponding Medicaid State Plan Amendment to the Centers of Medicare & Medicaid Services requesting approval to be effective September 1, 2025. The estimated financial impact for the current fiscal year is \$25,427,968.00 and for the next fiscal year \$33,903,957.00. The expected promulgation date for the rule is January 1, 2026.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Policy and Rules, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. This notice also shall be posted at the local office of the Division of County Operations (DCO) of DHS in every county in the state. You may also access and download the proposed rule at ar.gov/dhs-proposed-rules.

Public comments can be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than November 1, 2025. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

A public hearing will be held by remote access through Zoom. Public comments may be submitted at the hearing. The details for attending the Zoom hearing appear at ar.gov/dhszoom.

If you need this material in a different format, such as large print, contact the Office of Policy and Rules at 501-320-6428. The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. **4502292178**

Elizabeth Pitman, Director
Division of Medical Services

Kate Chagnon

From: Legal Ads <legalads@arkansasonline.com>
Sent: Wednesday, October 1, 2025 11:39 AM
To: Kate Chagnon
Subject: Re: Full Run Ad (Rule 309)

[EXTERNAL SENDER]

Thanks, Kate. Notice is scheduled for Fri 10/3, Sat 10/4, and Sun 10/5.

Gregg Sterne, Legal Advertising
Arkansas Democrat-Gazette
legalads@arkansasonline.com

From: "Kate Chagnon" <Kate.Chagnon@dhs.arkansas.gov>
To: "legalads" <legalads@arkansasonline.com>
Cc: "Mac Golden" <Mac.E.Golden@dhs.arkansas.gov>, "Jack Tiner" <jack.tiner@dhs.arkansas.gov>, "Lakeya Gipson" <Lakeya.Gipson@dhs.arkansas.gov>, "Elaine Stafford" <elaine.stafford@dhs.arkansas.gov>
Sent: Wednesday, October 1, 2025 9:18:49 AM
Subject: Full Run Ad (Rule 309)

Hello,

Please reply to this email using REPLY-ALL.

Please run the attached public notice in the *Arkansas Democrat-Gazette* on **Friday 10/3/25, Saturday 10/4/25, and Sunday 10/5/25.**

I am aware that the print version will only be provided to all counties on Sundays.

Invoice to: **AR Dept of Human Services
OPR, ATTN: Lakeya Gipson
P.O. Box 1437, Slot S295
Little Rock, AR 72203-8068**

(Lakeya.Gipson@dhs.arkansas.gov)

Please reply-all to this message with a confirmation.

Sincerely,



Kate Chagnon

From: Kate Chagnon
Sent: Thursday, October 2, 2025 12:29 PM
To: register@sos.arkansas.gov
Cc: Jack Tiner; Mac Golden; Lakeya Gipson; JAMIE EWING
Subject: DHS/DMS - Proposed Filing - Dental Rates and Annual Limit Increase (Rule 309)
Attachments: Arkansas Register-Proposed Filing_Dental Rates and Annual Limit Increase_R309.pdf

Hello,

Attached please find a Proposed Filing for Dental Rates and Annual Limit Increase (Rule 309).

The public notice will run on Friday 10/3/25, Saturday 10/4/25, and Sunday 10/5/25.

The public comment period ends Saturday, 11/1/25.

Please reply with a confirmation.

Sincerely,



Kate Chagnon
Rules & Regulations Coordinator
Arkansas Department of Human Services
Office of Policy and Rules

P: 501.371.1316
kate.chagnon@dhs.arkansas.gov

humanservices.arkansas.gov

Privacy Notice: This email may contain confidential information protected by state/federal laws. If you are not the intended recipient, please let the sender know, and delete the message/attachment(s) from your system.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT _____
BOARD/COMMISSION _____
PERSON COMPLETING THIS STATEMENT _____
TELEPHONE NO. _____ **EMAIL** _____

To comply with Ark. Code Ann. § 25-15-204(e), please complete the Financial Impact Statement and email it with the questionnaire, summary, markup and clean copy of the rule, and other documents. Please attach additional pages, if necessary.

TITLE OF THIS RULE _____

1. Does this proposed, amended, or repealed rule have a financial impact?
Yes No

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule?
Yes No

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes No

If no, please explain:

(a) how the additional benefits of the more costly rule justify its additional cost;

(b) the reason for adoption of the more costly rule;

(c) whether the reason for adoption of the more costly rule is based on the interests of public health, safety, or welfare, and if so, how; and

(d) whether the reason for adoption of the more costly rule is within the scope of the agency's statutory authority, and if so, how.

4. If the purpose of this rule is to implement a *federal* rule or regulation, please state the following:
 - (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year

General Revenue _____
Federal Funds _____
Cash Funds _____
Special Revenue _____
Other (Identify) _____

Total _____

Next Fiscal Year

General Revenue _____
Federal Funds _____
Cash Funds _____
Special Revenue _____
Other (Identify) _____

Total _____

(b) What is the additional cost of the state rule?

Current Fiscal Year

General Revenue _____
Federal Funds _____
Cash Funds _____
Special Revenue _____
Other (Identify) _____

Total _____

Next Fiscal Year

General Revenue _____
Federal Funds _____
Cash Funds _____
Special Revenue _____
Other (Identify) _____

Total _____

5. What is the total estimated cost by fiscal year to any private individual, private entity, or private business subject to the proposed, amended, or repealed rule? Please identify those subject to the rule, and explain how they are affected.

Current Fiscal Year

\$ _____

Next Fiscal Year

\$ _____

6. What is the total estimated cost by fiscal year to a state, county, or municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year

\$ _____

Next Fiscal Year

\$ _____

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars (\$100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes No

If yes, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

- (1) a statement of the rule's basis and purpose;
- (2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;
- (3) a description of the factual evidence that:
 - (a) justifies the agency's need for the proposed rule; and
 - (b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;
- (4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;
- (5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;
- (6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and
- (7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
 - (a) the rule is achieving the statutory objectives;
 - (b) the benefits of the rule continue to justify its costs; and
 - (c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

FINANCIAL IMPACT STATEMENT ADDENDUM

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars (\$100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes No

If yes, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose; **Act 1025 of 2025 requires the Division of Medical Services (DMS) to increase Medicaid reimbursement rates for oral and maxillofacial surgeons' dental services and anesthesia, pediatric dental services and anesthesia, and dental services for adults with special needs.**

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute; **Comply with Act 1025 of 2025.**

(3) a description of the factual evidence that:

(a) justifies the agency's need for the proposed rule; and

(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs; **The rule mirrors the requirements of Act 1025 of 2025.**

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule; **Not applicable.**

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule; **Not applicable.**

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and **Existing limits and rates were considered too low by the provider community.**

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

(a) the rule is achieving the statutory objectives;

(b) the benefits of the rule continue to justify its costs; and

(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives. **The Agency monitors State and Federal rules and policies for opportunities to reduce and control costs.**

Statement of Necessity and Rule Summary Dental Rates Increase

Statement of Necessity

Act 1025 of 2025 requires the Division of Medical Services (DMS) to increase Medicaid reimbursement rates for oral and maxillofacial surgeons' dental services and anesthesia, pediatric dental services and anesthesia, and dental services for adults with special needs. These increases begin September 1, 2025.

Summary of Changes

Pursuant to Act 1025, DMS revises the Medicaid Dental Provider manual to reflect the rate increases. DMS also submits a corresponding Medicaid State Plan Amendment reflecting the changes.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

September 1, 2025

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of
Conditions Found (Continued)

(17)(a) Dental Services, continued:

Beginning on or after September 1, 2025, reimbursement rates for oral and maxillofacial surgeons' dental services, including anesthesia; and pediatric dental services, including anesthesia; and dental services for adults with special needs, including anesthesia; and excluding orthodontic services, are set to sixty (60) percent of the fiftieth percentile for national fees as determined by the 2025 edition of the National Dental Advisory Service (NDAS) Comprehensive Fee Report adjusted for Arkansas. To derive Arkansas's adjustment factor of 0.8145, the State identified and averaged the zip code multipliers for Arkansas as published in the NDAS to reflect differences in the median rates for ZIP codes representing geographic areas within the state.

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~~The adjustment will be redetermined annually, when the NDAS rate publication is reviewed and rates will be adjusted accordingly.~~

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

September 1, 2025

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

September 1, 2025

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: September 1, ~~2010~~2025

9. Clinic Services (Continued)

(5) End-Stage Renal Disease (ESRD) Facility Services

Reimbursement is made at the lower of: (a) the provider's actual charge for the service or (b) the allowable fee from the State's ESRD fee schedule based on reasonable charge.

The Medicaid maximum is based on the 50th percentile of the Arkansas Medicare facility rates in effect March 1, 1988. Rates will be reviewed annually.

After discussion with CMS, it was determined that the Arkansas Medicare 75th percentile is considered the norm for Arkansas Medicare reimbursement. Since the State reimburses at Arkansas Medicare's 50th percentile, the reimbursement rates will not exceed Arkansas Medicare on the aggregate.

Effective for claims with dates of service on or after July 1, 1992, the Title XIX maximum rates were decreased by 20%.

Effective for dates of service on and after October 1, 2004, the Arkansas Medicaid Program covers training in peritoneal self-dialysis for beneficiaries with end-stage renal disease.

Reimbursement for peritoneal self-dialysis and training has been established as follows.

The Arkansas Medicaid maximum allowable daily fee for training in continuous ambulatory peritoneal dialysis (CAPD) equals the maximum allowable daily fee (\$130) for a hemodialysis treatment plus \$12.00 per day. This is the same methodology used by Medicare to calculate their CAPD training reimbursement rate.

The Arkansas Medicaid maximum allowable daily fee for training in continuous cycling peritoneal dialysis (CCPD) equals the maximum allowable daily fee (\$130) for a hemodialysis treatment plus \$20.00 per day. This is the same methodology used by Medicare to calculate their CCPD training reimbursement rate.

~~10. Dental Services~~

~~Refer to Attachment 4.19-B, Item 4.b.(18).~~

~~The agency's rates were set as of November 21, 2007 and are effective for services on or after that date. All rates are published on the agency's website (www.medicaid.state.ar.us). Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of dental services. Reimbursement rate maximums are calculated at 95% of the 2007 Delta Dental Plan of Arkansas Inc.'s Premier rates. Upon CMS approval, the reimbursement rates calculated under this method will be submitted to the United States District Court for the Eastern District of Arkansas (case of Arkansas Medical Society v. Reynolds) for its approval.~~

~~**Dentures—Based on contract price established through competitive bidding.**~~

~~Medicaid dental rates will be adjusted as follows. The Division of Medical Services and the Arkansas State Dental Association shall meet on two year cycles beginning January 1, 2007, to evaluate the dental rates considering the factors set out in 42 U.S.C. Section 1396a(a)(30)(A) and shall review Delta Dental's then current Premier rates, identify rate adjustment to be made, and agree on the implementation methodology and date.~~

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: September 1, 2025

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

September 1, 2025

10. Dental Services

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OTHER TYPES OF CARE

September 1, 2025

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: September 1, ~~2010~~, 2025

12. Prescribed drugs, dentures, prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

b. Dentures

Refer to Attachment 4.19-B, Item 10.

Based on contract price established through competitive bidding.

c. Prosthetic Devices

- (1) Eye Prostheses - Refer to Attachment 4.19-B, Item 4.b.(13).
- (2) Hearing Aids - Refer to Attachment 4.19-B, Item 4.b.(12).
- (3) Ear Molds - Refer to Attachment 4.19-B, Item 4.b.(14).
- (4) Pacemakers and Internal Surgical Prostheses - Reimbursed at 80% of invoice price.
- (5) Hyperalimentation - Reimbursement according to the lower of the amount billed or the Title XIX maximum charge allowed.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: September 1, 2025

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Table of Contents

State/Territory Name: Arkansas

State Plan Amendment (SPA) AR-25-0009

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
230 South Dearborn
Chicago, Illinois 60604



Financial Management Group

May 20, 2026

Janet Mann
Director of Health and Medicaid Director
Arkansas Department of Human Services
112 West 8th Street, Slot S401
Little Rock, AR 72201-4608

RE: TN AR-25-0009

Dear Director Mann:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Arkansas state plan amendment (SPA) to Attachment 4.19-B AR-25-0009, which was submitted to CMS on September 30, 2025. This plan amendment revises reimbursement for certain dental services, including oral and maxillofacial surgery, pediatric dental services, and services for adults with special needs.

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of September 1, 2025. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Robert Bromwell at (410)-786-5914 or via email at Robert.Bromwell@cms.hhs.gov.

Sincerely,

Todd McMillion

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER

2 5 — 0 0 0 9

2. STATE

Arkansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

September 1, 2025

5. TYPE OF PLAN MATERIAL (*Check One*)

NEW STATE PLAN

AMENDMENT TO BE CONSIDERED AS NEW PLAN

AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION

1905(a)(10) and 42 CFR 440.1

7. FEDERAL BUDGET IMPACT

a. FFY 2025 \$ \$2,383,734

b. FFY 2026 \$ \$27,897,165

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19-B, Page 1p1
Attachment 4.19-B, Page 1pp1
Attachment 4.19-B, Page 3b
Attachment 4.19-B, Page 3b(0.5)
Attachment 4.19-B, Page 4b

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (*If Applicable*)

NEW
NEW
Attachment 4.19-B, Page 3b (TN 10-0010)
NEW
Attachment 4.19-B, Page 4b (TN 10-0010)

10. SUBJECT OF AMENDMENT

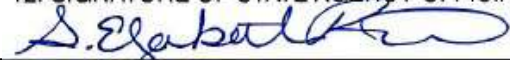
Dental Rates and Annual Limit Increase

11. GOVERNOR'S REVIEW (*Check One*)

- GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL



13. TYPED NAME

Elizabeth Pitman

14. TITLE

Director, Division of Medical Services

15. DATE SUBMITTED

09/30/2025

16. RETURN TO

Office of Rules Promulgation
PO Box 1437, Slot S295
Little Rock, AR 72203-1437

Attn: Mac Golden

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

9/30/25

18. DATE APPROVED

May 20, 2026

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL

9/1/25

20. SIGNATURE OF REGIONAL OFFICIAL



21. TYPED NAME

Todd McMillion

22. TITLE

DRR, Director

23. REMARKS

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

September 1, 2025

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Medicaid Rate for CDT Code X = (Arkansas Adjustment Factor, updated for the year) x 0.60 x (Most current published NDAS-Reported National 50th Percentile Fee for CDT Code X)

Rates for the agency's dental fee schedule were set as of September 1, 2025, and are effective for services provided on or after that date. The fee schedule is based on sixty (60) percent of the fiftieth percentile of national fees from the National Dental Advisory Service (NDAS) Comprehensive Fee Report, adjusted for Arkansas, as described above. The State has in place a public process, which complies with the requirements of Section 1902(a)(30)(A) of the Social Security Act.

The agency's fee schedule is available to providers and the public and is published on the Medicaid agency's website at: <https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/fee-schedules/>

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: September 1, 2025

9. Clinic Services (Continued)

(5) End-Stage Renal Disease (ESRD) Facility Services

Reimbursement is made at the lower of: (a) the provider's actual charge for the service or (b) the allowable fee from the State's ESRD fee schedule based on reasonable charge.

The Medicaid maximum is based on the 50th percentile of the Arkansas Medicare facility rates in effect March 1, 1988. Rates will be reviewed annually.

After discussion with CMS, it was determined that the Arkansas Medicare 75th percentile is considered the norm for Arkansas Medicare reimbursement. Since the State reimburses at Arkansas Medicare's 50th percentile, the reimbursement rates will not exceed Arkansas Medicare on the aggregate.

Effective for claims with dates of service on or after July 1, 1992, the Title XIX maximum rates were decreased by 20%.

Effective for dates of service on and after October 1, 2004, the Arkansas Medicaid Program covers training in peritoneal self-dialysis for beneficiaries with end-stage renal disease.

Reimbursement for peritoneal self-dialysis and training has been established as follows.

The Arkansas Medicaid maximum allowable daily fee for training in continuous ambulatory peritoneal dialysis (CAPD) equals the maximum allowable daily fee (\$130) for a hemodialysis treatment plus \$12.00 per day. This is the same methodology used by Medicare to calculate their CAPD training reimbursement rate.

The Arkansas Medicaid maximum allowable daily fee for training in continuous cycling peritoneal dialysis (CCPD) equals the maximum allowable daily fee (\$130) for a hemodialysis treatment plus \$20.00 per day. This is the same methodology used by Medicare to calculate their CCPD training reimbursement rate.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

September 1, 2025

10. Dental Services

Refer to Attachment 4.19-B, Item 4.b. (17a).

The agency's rates were set as of November 21, 2007 and are effective for services on or after that date. All rates are published on the agency's website at: <https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/fee-schedules/>

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of dental services. Reimbursement rate maximums are calculated at 95% of the 2007 Delta Dental Plan of Arkansas Inc.'s Premier rates. Upon CMS approval, the reimbursement rates calculated under this method will be submitted to the United States District Court for the Eastern District of Arkansas (case of Arkansas Medical Society v. Reynolds) for its approval.

Beginning on or after September 1, 2025, reimbursement rates for oral and maxillofacial surgeons' dental services, including anesthesia; pediatric dental services, including anesthesia; and dental services for adults with special needs, including anesthesia; and excluding orthodontic services, are set to sixty percent (60%) of the fiftieth percentile for national fees as determined by the annual National Dental Advisory Service Comprehensive Fee Report adjusted for Arkansas. To derive Arkansas's adjustment factor of 0.8145, the State identified and averaged the zip code multipliers for Arkansas as published in the NDAS to reflect differences in the median rates for ZIP codes representing geographic areas within the state.

The rates were calculated per CDT service code:

Medicaid Rate for CDT Code X = (Arkansas Adjustment Factor, currently 0.8145) x 0.60 x (NDAS-Reported National 50th Percentile Fee for CDT Code X), as evidenced by:

Medicaid Rate for D0120 = 0.8145 x 0.60 x \$72 = \$35.19

The State compared the new rates for affected services side-by-side to the existing fee schedule rates.

The State will review and update rates annually by using the most recent NDAS Comprehensive Fee Report and an updated Arkansas Adjustment factor according to the methodology established on September 1, 2025:

Medicaid Rate for CDT Code X = (Arkansas Adjustment Factor, updated for the year) x 0.60 x (Most current published NDAS-Reported National 50th Percentile Fee for CDT Code X)

Rates for the agency's dental fee schedule were set as of September 1, 2025, and are effective for services provided on or after that date. The fee schedule is based on sixty (60) percent of the fiftieth percentile of national fees from the National Dental Advisory Service (NDAS) Comprehensive Fee Report, adjusted for Arkansas, as described above. The State has in place a public process, which complies with the requirements of Section 1902(a)(30)(A) of the Social Security Act.

The agency's fee schedule is available to providers and the public and is published on the Medicaid agency's website at: <https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/fee-schedules/>

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: September 1, 2025

12. Prescribed drugs, dentures, prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)
- b. Dentures
- Based on contract price established through competitive bidding.
- c. Prosthetic Devices
- (1) Eye Prostheses - Refer to Attachment 4.19-B, Item 4.b.(13).
 - (2) Hearing Aids - Refer to Attachment 4.19-B, Item 4.b.(12).
 - (3) Ear Molds - Refer to Attachment 4.19-B, Item 4.b.(14).
 - (4) Pacemakers and Internal Surgical Prostheses - Reimbursed at 80% of invoice price.
 - (5) Hyperalimentation - Reimbursement according to the lower of the amount billed or the Title XIX maximum charge allowed.