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January 7, 2026

Janet Mann, Secretary
Arkansas Department of Human Services
112 West 8th Street, Slot S401
Little Rock, AR 72201
Janet.Mann@dhs.arkansas.gov

RE: Act 1025 of 2025 – Request for Reconsideration of DHS's Decision Not to Adopt Implementing Rules

Dear Secretary Mann:

The Arkansas State Dental Association submits this letter in response to the Arkansas Department of Human Services' December 16, 2025 correspondence to the Administrative Rules Subcommittee of the Arkansas Legislative Council stating that DHS does not intend to adopt rules implementing Act 1025 of 2025. We respectfully request that DHS reconsider that determination.

Act 1025 represents a deliberate legislative response to long-standing access problems in Arkansas's Medicaid dental program. Inadequate reimbursement has materially limited provider participation, which in turn restricts beneficiary access to care. The rate and benefit changes enacted by Act 1025 are vital to reversing those trends. While we recognize the constraints imposed by federal Medicaid law, the record to date does not support the conclusion that Act 1025 is unimplementable. Rather, it demonstrates that DHS selected a single implementation pathway that CMS found incomplete despite the existence of other lawful options expressly contemplated by the Act. This letter sets forth the legal and factual basis for reconsideration, demonstrating that Act 1025 remains implementable under federal Medicaid law through multiple available pathways.

I. Statutory Framework and DHS's Duty to Implement Act 1025

Act 1025 directs DHS to make two separate changes to the Arkansas Medicaid dental program:

1. Increase reimbursement rates for specified dental services using a defined methodology; and
2. Increase the annual reimbursement cap applicable to dental services for adults with special needs.

The Act further directs DHS to apply for "any federal waiver, Medicaid state plan amendment, or other authorization necessary" to implement these changes. This language is significant. It reflects legislative recognition that federal approval might require flexibility and that different components of the Act may require different federal mechanisms.

Nothing in Act 1025 conditions the implementation of one change on the success of the other. Nor does the Act restrict DHS to a single federal approval vehicle. DHS therefore retains discretion as to *how* to implement the Act, but not whether to pursue implementation altogether. To effectuate the legislature's intent and secure the most prompt federal approval, DHS should pursue implementation of each component of Act 1025 independently where necessary.

II. DHS's Implementation Efforts to Date

DHS initially proceeded appropriately by initiating rulemaking under the Arkansas Administrative Procedure Act ("AAPA") and circulating an Interested Persons Packet addressing both the rate increases and the reimbursement cap changes. DHS then submitted a consolidated State Plan Amendment to the Centers for Medicare & Medicaid Services under the title AR-25-0009 seeking approval of both components in the same form published in the Interested Person's Packet. As of the date of this letter, it does not appear that DHS has responded to comments submitted on the proposed changes as required under the AAPA.

On December 15, 2025, CMS responded with a formal request for additional information and clarification (attached as **Attachment A**). Shortly thereafter, DHS notified the Administrative Rules Subcommittee that it would no longer pursue rulemaking for Act 1025, asserting that the

Act, as written, conflicts with federal Medicaid requirements such that CMS would not approve rules drafted in compliance with the Act.

III. CMS's December 15, 2025 Letter Does Not Bar Implementation of Act 1025

CMS's December 15th correspondence does not conclude that Act 1025 is incompatible with federal law. To the contrary, CMS's comments reflect routine SPA review concerns and identify specific compliance issues with the proposal as submitted that may be remedied by DHS.

With respect to reimbursement rates, CMS's questions arise under Section 1902(a)(30)(A) of the Social Security Act and its implementing regulations, which require that payment rates be consistent with efficiency, economy, quality of care, and sufficient provider participation. *See* 42 U.S.C. § 1396a(a)(30)(A); 42 C.F.R. § 447.204. CMS requested additional justification for the proposed methodology, including evidence related to access, utilization, and the basis for the selected benchmark.

With respect to reimbursement caps, CMS raised concerns under the comparability requirement at 42 U.S.C. § 1396a(a)(10)(B) and 42 C.F.R. § 440.240, noting that diagnosis-based benefit limits within the State Plan may result in similarly situated beneficiaries receiving different amounts of services. CMS further noted that benefit limits must comply with the "amount, duration, and scope" requirements of 42 C.F.R. § 440.230.

Critically, CMS did not state that the underlying policy goals were impermissible. Instead, CMS expressly referenced alternative approaches, including medical-necessity-based benefit structures and waiver authority, as potential paths to compliance. Taken together, the CMS letter supports the conclusion that sufficient and lawful pathways exist to obtain federal approval of the Act's changes, if pursued through appropriate mechanisms.

IV. The Two Components of Act 1025 Raise Distinct Federal Considerations

The two directives enacted in Act 1025 operate in fundamentally different regulatory domains under federal Medicaid law. Increases to provider reimbursement rates are evaluated through rate-setting and access standards focused on sufficiency and participation, while changes to benefit caps implicate comparability and benefit-design requirements governing the scope of

covered services. These frameworks are not interchangeable and do not require joint consideration. Treating the Act's provisions as a single, inseparable package can appear to conflate distinct federal review standards and unnecessarily narrow the range of lawful implementation options available to the agency.

Reimbursement rates are evaluated primarily under Section 1902(a)(30)(A) and related guidance, which focus on access, sufficiency, and actuarial soundness. Reimbursement caps, by contrast, implicate comparability and benefit design rules under Sections 1902(a)(10)(B) and 440.230–440.240 of the federal regulations.

Nothing in federal Medicaid law requires these issues to be resolved through a single SPA submission. Treating the two components as inseparable is not required by statute and, respectfully, resulted in DHS abandoning viable implementation options.

V. Lawful Implementation of the Reimbursement Rate Increases Through a SPA

The rate-setting framework adopted by Act 1025 is well within the scope of SPA-based implementation. CMS has long recognized that states may use a variety of benchmarks, including national or regional fee data, so long as the methodology is clearly described and supported. *See* 42 C.F.R. § 447.252(b); CMS State Medicaid Manual § 6000 et seq.

CMS's concerns regarding the use of 60% of the fiftieth percentile of national dental fees relate to evidentiary support, not authority. Those concerns can be addressed through additional documentation, including:

- actuarial analysis explaining the selected percentile and percentage;
- comparisons to current Arkansas Medicaid rates and surrounding states;
- provider participation data demonstrating improved access; and
- Arkansas-specific adjustments to national benchmarks.

Nothing in CMS's correspondence suggests that these rate increases are barred from approval under a revised or supplemented SPA.

VI. Lawful Implementation of the Reimbursement Cap Changes

The reimbursement cap changes present a different analysis, but they are likewise implementable.

A. Medical-Necessity-Based State Plan Structure

Act 1025 does not require that the higher reimbursement cap be applied categorically or without regard to medical necessity. DHS retains discretion to structure the benefit so that services above a base cap are available when medically necessary for individuals whose conditions require additional or more complex dental care.

CMS has repeatedly recognized that benefit limits may be exceeded when medically necessary, consistent with 42 C.F.R. § 440.230(d). Structuring the cap increase in this manner would address CMS's comparability concerns while remaining faithful to the legislature's intent.

B. Waiver Authority

Alternatively, and *more directly*, diagnosis-based benefit enhancements are a traditional use of waiver authority under Section 1115 of the Social Security Act. CMS itself referenced waiver options in its December 15th letter. A narrowly tailored waiver would permit the differentiated cap contemplated by Act 1025 without running afoul of comparability requirements, while allowing DHS to evaluate access and fiscal impacts over time.

The General Assembly expressly required DHS in Act 1025 to pursue waiver authority for this purpose if necessary to implement the Act. Declining to do so effectively renders that statutory directive meaningless.

VII. Legislative Intent and Administrative Responsibility

While DHS is not required to promulgate rules that violate federal law, it likewise may not nullify an enacted statute by declining to pursue available and lawful implementation pathways. Arkansas courts have long recognized that agencies must harmonize state law with federal requirements where reasonably possible and may not defeat legislative intent through administrative inaction.

Here, CMS has identified discrete compliance concerns with the proposal as submitted, not an inherent conflict with federal law. Act 1025 expressly anticipated that federal approval might require flexibility and required DHS to pursue alternative mechanisms, including separate State Plan amendments or waiver authority, as necessary to give effect to the legislature's directives. Where lawful pathways remain available, DHS's obligation is not satisfied by identifying obstacles, but by engaging those pathways in good faith. Declining to do so risks converting routine federal review questions into a de facto nullification of duly enacted state law.

VIII. Request for Reconsideration

For these reasons, the Arkansas State Dental Association respectfully requests that DHS reconsider its decision not to adopt rules implementing Act 1025. Specifically, we urge DHS to:

- treat the reimbursement rate and reimbursement cap provisions as legally distinct;
- continue to pursue SPA approval for the reimbursement rate increases with appropriate supporting analysis; and
- pursue either a medical-necessity-based State Plan revision or waiver authority to implement the reimbursement cap changes.

The improvements enacted by Act 1025 are essential to increasing provider participation and ensuring meaningful access to dental care for Medicaid beneficiaries across Arkansas. We stand ready to assist DHS and the General Assembly in identifying and supporting a compliant path forward.

Thank you for your consideration and for your continued service to the people of Arkansas.

Sincerely,

Trevor Hawkins
Counsel for ASDA

CC: Senator Tyler Dees and
Representative Matthew J. Shepard
Co-Chairs of the Arkansas Legislative Council –
Administrative Rules Subcommittee

C/O: Rebeecca Miller-Rice
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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
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Medicaid and CHIP Operations Group

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

December 15, 2025

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: State Plan Amendment (SPA) AR-25-0009 Request for Additional Information

Dear Director Mann:

The Centers for Medicare & Medicaid Services (CMS) has completed our review of the proposed amendment submitted under transmittal number (TN) AR-25-0009. This state plan amendment has a requested effective date of September 1, 2025, and proposes to amend coverage to the Dental Services benefit at 1905(a)(10) of the Social Security Act (the Act).

Section 1902(a)(4) of the Social Security Act (the Act) requires that states have a state plan for medical assistance that meets certain federal requirements that set out a framework for the state program. Implementing regulations at 42 CFR § 430.10 provides that, "the State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program." CMS notes that services must be provided in "*sufficient in amount, duration, and scope to reasonably achieve its purpose*" in accordance with 42 C.F.R. § 440.230(b).

Further, section 1902(a)(10)(B) of the Act specifies that "A State plan for medical assistance must…provide…that the medical assistance made available to any individual described in subparagraph (A)- (i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and (ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A).

Before we can continue processing this amendment, we need additional or clarifying information.

Attachment A

Coverage Questions - Attachment 3.1-A page 4c and Attachment 3.1-B page 4d:

1. The state has submitted AR-25-0009 increasing limits on Dental Services to a subset of individuals over 21 to align with state-specific legislation. The state proposes to add language to Attachment 3.1-A page 4c and Attachment 3.1-B page 4d as follows:
   "There is an annual benefit limit of $500 for Dental Services for adults without special needs. Beginning on September 1, 2025, the annual benefit limit for Dental Services for adults with special needs is one thousand dollars ($1,000). Adults with special needs are individuals age 21 and over with a chronic disability as established by the primary care provider or other licensed physician's diagnosis that Is attributable to a diagnosis of one of the following:
   - *Cerebral Palsy;*
   - *Epilepsy;*
   - *Spina bifida;*
   - *Down syndrome;*
   - *Autism spectrum disorder;*
   - *Intellectual disability; as established by a full-scale standard intelligence score of 70 or below, measured by a standard test designed for individual administration that is administered by a qualified professional; or*
   - *Any other condition that results in impairment of general intellectual or adaptive behavior similar to an individual qualifying under paragraph (6);*
   - *Originates before the person attains the age of twenty-two (22);*
   - *Has continued or can be expected to continue indefinitely; and*
   - *Constitutes a substantial impairment to the person's ability to function without appropriate support services, such as daily living and social supports, medical services, job training or employment services."*

   We understand the intent of changes on the coverage page is to allow for a higher limit within the benefit, however, as written, the new proposed language does not align with the Medicaid policy for comparability of Medicaid State Plan services described in statute, regulation, and other policy guidance as this describes different benefit limits for individuals on the basis of diagnosis and not medical necessity.

   CMS provides the following options to update Dental Services in the state plan:
   a. The state can consider removing the newly proposed language from the submission and considering a policy update to instead include soft limits (no hard cap) of $500 for adults over 21 and updating the language accordingly to allow the state to approve higher limits for all individuals covered under the state plan when determined to be medically necessary.
   b. The state can consider scoping which services the state would like to provide within the Dental Services benefit. The scope of an optional benefit can either parse out the specific services that are covered, regardless of underlying diagnosis, when medically necessary (such as cleaning, filling cavities, behavioral management,

services with accompanying sedation etc.) OR can parse out the overall purposes, regardless of underlying diagnosis (such as protecting natural teeth, preventing gum disease, or addressing oral pain,). Service(s) cannot be limited to individuals with a specific diagnosis but could be defined in a way so its purpose will address needs of those individuals.

Additionally, the state may consider other options under waiver authority as previously communicated through technical assistance.

2. The services described on this page include hard/capped limits that cannot be exceeded based on medical necessity. This page was last updated in 2010, and CMS does not have a record of a sufficiency analysis for this benefit. The state indicated on the 15-day call that a sufficiency analysis was recently conducted for the Dental Services benefit. To demonstrate that services are provided in "sufficient in amount, duration, and scope to reasonably achieve its purpose" in accordance with 42 C.F.R. § 440.230(b), please provide a sufficiency analysis. Please see the 2010 Sufficiency ARA Memo for more information.

3. Additionally, at the bottom of the page, the state has language which addresses the Dentures benefit. The Dental Services benefit is authorized under 1905(a)(10) of the Act. Dentures are a separate optional benefit under 1905(a)(12) of the Act (item 12.b in Arkansas's state plan) and this language should be removed from the Dental Services benefit page and updated in 12.b. Please note, a sufficiency analysis should be provided for the Dentures benefit as well should these pages be added to the submission and include hard limitations.

   When incorporating this language into item 12.b. CMS also requests an update to the denture limit to simply describe any limitation on amount duration or scope. E.g. simply indicate that services require prior authorization for medical necessity and clarify there is a lifetime limit of one set of dentures (one full or combination of one upper and one lower). The state plan coverage page should not include additional eligibility or provider enrollment information, and this language should be removed from the state plan coverage pages as it does not relate to coverage. Please refer to previous technical assistance for more detail.

Reimbursement Questions

Section 1902(a)(30)(A) stipulates that payments must be consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers so that care and services are available under the plan to the same extent available to the general population.

1. Please explain how the State determined that setting reimbursement at 60% of the 50th percentile of the National Dental Advisory Service (NDAS) Comprehensive Fee Report

provides rates that are consistent with efficiency, economy, and quality of care under §1902(a)(30)(A).

a. What analysis supports that this level of reimbursement is sufficient to ensure provider participation and access?
b. Did the State consider other percentiles or percentages (e.g., 70% of the 50th percentile or 60% of the 60th percentile)?
c. Please provide a side-by-side comparison of the rates that are affected by this SPA.

Consistent with regulations at 42 C.F.R. § 447.252(b), the State Plan methodology must specify comprehensively the methods and standards used by the agency to set payment rates. The State plan methodology must be comprehensive enough to determine the required level of payment and the FFP to allow interested parties to understand the rate setting process and the items and services that are paid through these rates. Claims for federal matching funds cannot be based upon estimates or projections. The reimbursement methodology must be based upon actual historical utilization and actual trend factors.

2. The SPA states that rates are "adjusted for Arkansas."

a. Please describe the adjustment factors and provide an example calculation.
b. How does the adjustment ensure that rates reflect Arkansas' cost and provider market conditions?
c. Please include the methodology or index that Arkansas will use to adjust rates and include when the rates will be adjusted in the State Plan language.

Standard Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

   (i) a complete list of the names of entities transferring or certifying funds;
   (ii) the operational nature of the entity (state, county, city, other);
   (iii) the total amounts transferred or certified by each entity;
   (iv) clarify whether the certifying or transferring entity has general taxing authority: and,
   (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

Attachment A

We are requesting this additional/clarifying information under provisions of section 1915(f) of the Social Security Act (added by PL 97-35). This has the effect of stopping the 90-day clock for CMS to take action on the material, which would have expired on December 29, 2025. A new 90-day clock will not begin until we receive your response to this request.

In accordance with our guidelines to all State Medicaid directors dated January 2, 2001, and subsequently reiterated in the August 16, 2018 Center for Medicaid and CHIP Services Informational Bulletin, if a response to a formal request for additional information from CMS is not received from the state within 90 days of issuance, CMS will initiate disapproval of the SPA or waiver action. In addition, because this amendment was submitted after January 2, 2001 and is effective after January 1, 2001, please be advised that we will defer federal financial participation (FFP) for state payments made in accordance with this amendment until it is approved. Upon approval, FFP will be available for the period beginning with the effective date through the date of approval.

We ask that you respond to this RAI via the OneMAC portal at http://onemac.cms.gov.

If you have any questions, please contact Lee Herko at 570-230-4048 or via email lee.herko@cms.hhs.gov.

Sincerely,

WENDY E. HILL PETRAS -S

Digitally signed by WENDY E. HILL PETRAS -S
Date: 2025.12.15 13:53:57 -08'00'

Wendy E. Hill Petras, Acting Director
Division of Program Operations

Attachment A