ARKANSAS REGISTER

Proposed Rule Cover Sheet

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Name of Department Department of Human Services

Agency or Division Name Division of Medical Services

Other Subdivision or Department, If Applicable N/A

Previous Agency Name, If Applicable N/A

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Name of Rule Dental Rates and Annual Limit Increase

Newspaper Name Arkansas Democrat Gazette

Date of Publishing October 3, 2025

Final Date for Public Comment November 1, 2025

Location and Time of Public Meeting 10/15/25 @ 9:30 a.m.--Zoom: https://us02web.zoom.us/j/84615976880

10. Dental Services

Refer to Attachment 3.1-A, Item 4.b. (16) for information regarding dental services for EPSDT eligible children under age 21.

Dental services are available for Medicaid beneficiaries aged twenty-one (21) and over, but most are benefit limited. Specific benefit limits and prior authorization requirements for beneficiaries aged twenty-one (21) and over are detailed in the Dental Provider Manual.

There is an annual benefit limit of $500 for dental services for adults without special needs. Beginning on September 1, 2025, the annual reimbursement cap 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:

(a) Is attributable to a diagnosis of one of the following:
   1. Cerebral Palsy;
   2. Epilepsy;
   3. Spina bifida;
   4. Down syndrome;
   5. Autism spectrum disorder;
   6. 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
   7. Any other condition that results in impairment of general intellectual or adaptive behavior similar to an individual qualifying under paragraph (6);

(b) Originates before the person attains the age of twenty-two (22);

(c) Has continued or can be expected to continue indefinitely; and

(d) 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.

Extractions **and fees paid to the dental lab for the manufacture of dentures** are excluded from the annual limit.

All dentures, whether full or partial, must be provided by the one dental lab under contract with the Arkansas Medicaid Program to manufacture dentures. For adults, there is lifetime limit of one set of dentures. This policy applies to both:

- **Medicaid eligible beneficiaries aged twenty-one (21) and over and**
- **Medicaid eligible beneficiaries under age twenty-one (21) whose eligibility is based on a "pregnant woman aid category" AND whose Medicaid ID number ends in the 100 series (100 through 199).**

Mark-Up

10. Dental Services

Refer to Attachment 3.1-B, Item 4.b. (16) for information regarding dental services for EPSDT eligible children under age twenty-one (21).

Dental services are available for Medicaid beneficiaries aged twenty-one (21) and over, but most are benefit limited. Specific benefit limits and prior authorization requirements for beneficiaries aged twenty-one (21) and over are detailed in the Dental Provider Manual.

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:

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   7. Any other condition that results in impairment of general intellectual or adaptive behavior similar to an individual qualifying under paragraph (6);

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All dentures, whether full or partial, must be provided by the one dental lab under contract with the Arkansas Medicaid Program to manufacture dentures. For adults, there is lifetime limit of one set of dentures. This policy applies to both:

- **Medicaid eligible beneficiaries aged twenty-one (21) and over and**
- **Medicaid eligible beneficiaries under age twenty-one (21) whose eligibility is based on a "pregnant woman aid category" AND whose Medicaid ID number ends in the 100 series (100 through 199).**

~~Refer to Attachment 3.1-B, Item 4.b. (16) for information regarding dental services for EPSDT eligible children under age 21.~~

Mark-Up

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 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, 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.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.- All rates are published on the agency's website.

Mark-Up

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

(17) Dental Services (Continued)

(b) Oral Surgeons (Continued)

Beginning on September 1, 2025, reimbursement rates for oral and maxillofacial surgeons' dental services, including anesthesia, 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.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. All rates are published on the agency's website.

Mark-Up

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.~~

Mark-Up

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 (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.

Beginning 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, 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.

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:

(a) Is attributable to a diagnosis of one of the following:
1. Cerebral Palsy;
2. Epilepsy;
3. Spina bifida;
4. Down syndrome;
5. Autism spectrum disorder;
6. 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
7. Any other condition that results in impairment of general intellectual or adaptive behavior similar to an individual qualifying under paragraph (6);

(b) Originates before the person attains the age of twenty-two (22);

(c) Has continued or can be expected to continue indefinitely; and

~~(a)~~(d) 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.

Dentures - Based on contract price established through competitive bidding.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. All rates are published on the agency's website.

Mark-Up

TOC not required

201.500 Dentist Role in the Child Health Services (EPSDT) Program

~~1-15-11~~9-1-25

The Child Health Services (EPSDT) Program is a federally mandated child health component of Medicaid. It is designed to bring comprehensive healthcare to individuals eligible for medical assistance from birth up to their 21st birthday. The purpose of this program is to detect and treat health problems in the early stages and to provide preventive healthcare, including necessary immunizations. Child Health Services (EPSDT) combines case management and support services with screening, diagnostic and treatment services delivered on a periodic basis.

A. Early and periodic screening and diagnosis and treatment (EPSDT) is a healthcare program designed for (1) health evaluations as soon after birth as possible, (2) repeated at regular recommended times, (3) to detect physical or developmental health problems and (4) healthcare, treatment and other measures to correct or improve any defects and chronic conditions discovered.

1. Screening

   The Arkansas Medicaid Program recommends for **all** eligible EPSDT beneficiaries under 21 years of age, regularly scheduled examinations and evaluations of their general physical and mental health, growth, development and nutritional status.

   These screenings must include, but are not limited to:

   a. Comprehensive health and developmental history.
   b. Comprehensive unclothed physical examination.
   c. Appropriate vision testing.
   d. Appropriate hearing testing.
   e. Appropriate laboratory tests.
   f. Dental screening services furnished by direct referral to a dentist for children within 6 months after the first eruption of the first primary tooth, but no later than 12 months (per the American Academy of Pediatrics).

   Screening services must be provided in accordance with reasonable standards of medical and dental practice; as soon as possible in a child's life; and at intervals established for screening by medical, dental, visual and other healthcare experts.

   An age appropriate screening may be performed when a child is being evaluated or treated for an acute or chronic condition and billed as an EPSDT screening. See the EPSDT manual for information regarding EPSDT screenings.

2. Diagnosis

   Diagnosis is the determination of the nature or cause of physical or mental disease or abnormality through the combined use of health, history, physical, developmental and psychological examination, laboratory tests and X-rays.

3. Treatment

   Treatment means physician, hearing, visual services or dental services and any other type of medical care and services recognized under state law to prevent or correct disease and abnormalities detected by screening or by diagnostic procedures.

   Physicians and other health professionals who perform a Child Health Services (EPSDT) screening may diagnose and treat health problems discovered during the screening or may refer the child to other appropriate sources for treatment. If immunization is recommended at the time of screening, immunization(s) **must** be provided at that time, **or a direct referral given**.

Mark-Up

If a condition is diagnosed through a Child Health Services (EPSDT) screen that requires treatment services not normally covered under the Arkansas Medicaid Program, those treatment services will also be considered for reimbursement if the service is medically necessary and permitted under federal Medicaid regulations.

B. Child Health Services (EPSDT) providers are encouraged to refer to the EPSDT provider manual for additional information. Information can be obtained by going to the ~~Arkansas Medicaid~~**DMS website to view provider manuals.**~~at **https://medicaid.mmis.arkansas.gov/** and by checking on provider information.~~

Dentists interested in becoming a Child Health Services (EPSDT) provider may contact the central Child Health Services Office. **View or print Child Health Services contact information.**

201.600 Dentist Role in the Pharmacy Program

~~3-14-15~~9-1-25

Medicaid covers prescription drugs in accordance with policies and regulations set forth in this section and pursuant to orders (prescriptions) from authorized prescribers. The Arkansas Medicaid Program complies with the Medicaid Prudent Pharmaceutical Purchasing Program (MPPPP) that was enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990. **This law requires Medicaid to limit coverage to drugs manufactured by pharmaceutical companies that have signed rebate agreements.** Except for drugs in the categories excluded from coverage, Arkansas Medicaid covers all drug products manufactured by companies with listed labeler codes.

PRESCRIPTION DRUG INFORMATION

If you have prescription drug prior authorization concerns, please call the Prescription Drug PA Help Desk. **View or print Prescription Drug PA contact information.**

Prescribers may also refer to the **Pharmacy vendor website** ~~at **https://arkansas.magellanrx.com/provider/documents/**~~ to obtain the latest information regarding prescription drug coverage.

212.000 Summary of Coverage

~~2-1-22~~9-1-25

The Dental Program covers an array of common dental procedures for individuals of all ages. However, there are specific limitations for coverage for individuals age 21 and over.

~~Effective for dates of service on and after July 1, 2009, d~~Dental procedures ~~will be~~are covered for Medicaid eligible adult beneficiaries (age 21 and over). However, there is a benefit limit for covered services of $500.00 per state fiscal year (July 1 through June 30) for adult beneficiaries ~~age 21 and over~~without special needs. Beginning September 1, 2025, adults with special needs may receive dental services up to $1,000 per state fiscal year. 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:

(a) Is attributable to a diagnosis of one of the following:

1. Cerebral Palsy;
2. Epilepsy;
3. Spina bifida;
4. Down syndrome;
5. Autism spectrum disorder;

Mark-Up

6. 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

7. Any other condition that results in impairment of general intellectual or adaptive behavior similar to an individual qualifying under paragraph (6);

(b) Originates before the person attains the age of twenty-two (22);

(c) Has continued or can be expected to continue indefinitely; and

(d) 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.

To receive the higher benefit limit, the dentist must submit documentation establishing the PCP or physician diagnosis of a qualifying special need. The higher benefit limit will be administered as an extension of benefits for the individual with special needs.

~~A.~~

Extractions and complete and partial dentures are excluded from the ~~$500.00~~ benefit limit for adults.

Medicaid dental procedure codes are listed in **Section 262.100** for beneficiaries under age 21. Procedure codes for individuals age 21 and over are listed in **Section 262.200**. Each section lists the procedure codes covered, prior authorization requirements and the necessity of submitting X-rays with the treatment plan. **Section 262.200** also lists the procedure codes that are benefit limited.

214.100 Tobacco Cessation Products and Counseling Services

~~2-1-22~~9-1-25

Tobacco cessation products either prescribed or initiated through statewide pharmacist protocol are available without prior authorization (PA) to eligible Medicaid beneficiaries. Additional information can be found on the **DHS Contracted Pharmacy Vendor website** or in the **Prescription Drug Program Prior Authorization Criteria**.

Counseling services and benefits are defined below:

A. Prescribers must review the Public Health Service (PHS) guideline-based checklist with the patient.

B. The prescriber must retain the counseling checklist and file in the patient records for auditing. **View or print the checklist**.

C. Counseling procedures do not count against the twelve (12) visits per state fiscal year (SFY), but they are limited to no more than two (2) 15-minute units and two (2) 30-minute units for a maximum allowable of four (4) units per SFY.

D. For beneficiaries age twenty-one (21) and over, counseling procedures will count against the applicable ~~$500 adult dental~~ benefit limit. If the beneficiary is under the age of eighteen (18), and the parent/legal guardian smokes, he or she can be counseled as well, and the visit billed under that minor's beneficiary Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent/legal guardian session will count towards the four (4) counseling sessions limit described in section C above.

E. Beneficiaries who are pregnant are allowed up to four (4) 93-day courses of treatment per calendar year.

Mark Up

NOTE: The course of treatment is defined as three consecutive months.

F. If the beneficiary is in need of intensive tobacco cessation services, the provider may refer the beneficiary to an intensive tobacco cessation program: **View or print the Arkansas Be Well Referral Form**.

G. Additional prescription benefits will be allowed per month for tobacco cessation products and will not be counted against the monthly prescription benefit limit. Tobacco cessation products are not subject to co-pay.

H. Tobacco counseling for the control and prevention of oral disease must be billed when the provider counsels and refers the beneficiary to an intensive tobacco cessation program.

I. Behavior management by report must be billed when tobacco counseling for the control and prevention of oral disease has been provided to the beneficiary.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

J. Refer to **Section 262.100** and **262.200** for procedure codes and billing instructions.

236.000 Prescription Prior Authorization

~~3-14-15~~9-1-25

Prescription drugs are available for reimbursement under the Arkansas Medicaid Program pursuant to an order from an authorized prescriber. Certain prescription drugs may require prior authorization.

The dental provider must request prior authorization before prescribing a prescription drug to an eligible Medicaid beneficiary.

Dental providers must refer to the **Pharmacy vendor website** ~~at https://arkansas.magellanrx.com/provider/documents/~~ for information relative to:

A. Prescription drugs requiring prior authorization

B. Drugs subject to specific prescribing requirements

C. Criteria for drugs requiring prior authorization

241.010 Fee Schedules

~~12-1-12~~9-1-25

Arkansas Medicaid provides **fee schedules on the ~~Arkansas Medicaid~~DMS website**. ~~The fee schedule link is located at **https://medicaid.mmis.arkansas.gov/** under the provider manual section.~~ The fees represent the fee-for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.

Procedure codes and/or fee schedules do not guarantee payment, coverage or amount allowed. Information may be changed or updated at any time to correct a discrepancy and/or error. Arkansas Medicaid always reimburses the lesser of the amount billed or the Medicaid maximum.

262.200 ADA Procedure Codes Payable to Medically Eligible Beneficiaries Age 21 and Older

~~2-1-22~~9-1-25

Mark-Up

The following list shows the procedure code, procedure code description, whether or not prior authorization is required, whether an X-ray should be submitted with a treatment plan and if there is a benefit limit on a procedure.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

The column titled **Benefit Limit** indicates the benefit limit, if any, and how the limit is to be applied. When the column indicates **"Yes, $500~~.00~~/$1,000",** then that item, when used in combination with other items listed, cannot exceed the $500~~/.00~~$1,000 Medicaid maximum allowable reimbursement limit for the state fiscal year (July 1 through June 30). **Other limitations** are also shown in the column (i.e.: **1 per lifetime**). If **"No"** is shown, the item is not benefit limited.

NOTE: The use of the symbol, ⁂, along with text in parentheses, indicates the Arkansas Medicaid description of the product.

Dental Screening (See Section 215.000)
Radiographs (See Sections 216.000 – 216.300)
Tests and Laboratory
Dental Prophylaxis (See Section 217.100)
Topical Fluoride Treatment (Office Procedure) (See Section 217.100)
Restorations (See Sections 219.000 – 219.200)
Amalgam Restorations (including polishing) (See Section 219.100)
Composite Resin Restorations (See Section 219.200)
Crowns – Single Restoration Only (See Section 220.000)
Surgical Services (including usual postoperative services)
Repairs to Complete and Partial Dentures (See Section 223.000)
Fixed Prosthodontic Services (See Section 224.000)
Oral Surgery (See Section 225.000)
Simple Extractions (includes local anesthesia and routine postoperative care) (See Section 225.100)
Surgical Extractions (includes local anesthesia and routine postoperative care) (See Section 225.200)
Other Surgical Procedures
Osteoplasty for Prognathism, Micrognathism or Apertognathism
Unclassified Treatment
Smoking Cessation

Mark-Up

Statement of Necessity and Rule Summary
Dental Rates and Annual Limit 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. The Act also requires an increase to the annual reimbursement limit for 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 along with the increase to the annual reimbursement limit for services provided to adults with special needs. The annual reimbursement limit increases from five hundred dollars ($500) to one thousand dollars ($1000). The annual reimbursement limit for dental services for adults without special needs remains set at five hundred dollars ($500). A definition of adults with special needs is added to the manual. DMS also submits a corresponding Medicaid State Plan Amendment reflecting the changes.

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