GEHA Policies & Procedures
Connection Dental Network
State Specific Policies & Procedures - State of Arkansas

The below policies and procedures are in addition to the contractual requirements and the GEHA Policies & Procedures for the CONNECTION Dental Network. In the event the below terms conflict with the contractual requirements or the GEHA Policies & Procedures for the CONNECTION Dental Network, the terms below shall supersede.

Appeal and Grievance Procedures
Please see Network Appeals/Grievances Policies and Procedures.

Terminations Procedures
Insurers are required to develop procedures to provide for continuity of care for beneficiaries. Ark. Code Ann. §23-99-408(a). The procedures must at least ensure that a newly enrolled beneficiary can continue to seek treatment from a nonparticipating provider for a "current episode of an acute condition" until the current episode of treatment ends, or for a period of 90 days. Ark. Code Ann. §23-99-408(a)(1). An "acute condition" is defined as "a medical condition, illness, or disease having a short and relatively severe course." Ark. Code Ann. §23-99-403(1). Beneficiaries receiving treatment from a participating provider who has been terminated are entitled to the same coverage: 90 days for an acute condition or until the current episode of treatment is completed, whichever comes first. Ark. Code Ann. §23-99-408(a)(2). These procedures must also explain to a beneficiary how he or she can seek continued coverage. Ark. Code Ann. §23-99-408(a)(3).

Health insurers are required to establish mechanisms to ensure timely processing of request for participation or renewal by providers and in making decisions that affect participation status. These mechanisms are required to include provisions for the provider to receive a written statement of reasons for the insurer's denial of a request for initial participation or renewal.
Ark. Code Ann. § 23-99-411

Dispute Resolution Process
Please see Network Appeals/Grievances.

Network Participation Procedures
No contracting agent shall sell, lease, assign, convey, or otherwise grant access to the contracting agent's panel of contracted health care providers or the contracting agent's contracted reimbursement rates to another entity unless authorized in an agreement between the contracting agent and the provider. At least annually and upon written request of a contracted provider, a contracting agent shall disclose in writing or electronically to its providers all payors and other entities to which the contracting agent has sold, leased, assigned, conveyed, or otherwise granted access to the contracting agent's panel of contracted health care providers and the contracting agent's reimbursement rates.
A.C.A. § 23-63-113

(a) A health care insurer shall not, directly or indirectly:
  (1) (A) Impose a monetary advantage or penalty under a health benefit plan that would affect a beneficiary's choice among those health care providers who participate in the health benefit plan according to the terms offered.

(B) "Monetary advantage or penalty" includes:
(i) A higher copayment;
(ii) A reduction in reimbursement for services; or
(iii) Promotion of one (1) health care provider over another by these methods;
(2) Impose upon a beneficiary of health care services under a health benefit plan any copayment, fee, or condition that is not equally imposed upon all beneficiaries in the same benefit category, class, or copayment level under that health benefit plan when the beneficiary is receiving services from a participating health care provider pursuant to that health benefit plan; or
(3) Prohibit or limit a health care provider that is qualified under § 23-99-203(d) and is willing to accept the health benefit plan's operating terms and conditions, schedule of fees, covered expenses, and utilization regulations and quality standards, from the opportunity to participate in that plan.

(b) Nothing in this subchapter shall prevent a health benefit plan from instituting measures designed to maintain quality and to control costs, including, but not limited to, the utilization of a gatekeeper system, as long as such measures are imposed equally on all providers in the same class.

Ark. Code Ann. §23-99-204

(a) The state's any willing provider laws shall not be construed:
(1) To require all physicians or a percentage of physicians in the state or a locale to participate in the provision of services for a health maintenance organization; or
(2) To take away the authority of health maintenance organizations that provide coverage of physician services to set the terms and conditions for participation by physicians, though health maintenance organizations shall apply the terms and conditions in a nondiscriminatory manner.

(b) (1) The state's any willing provider laws shall apply to:
(A) All health insurers, regardless of whether they are providing insurance, including prepaid coverage, or administering or contracting to provide provider networks; and
(B) All multiple-employer welfare arrangements and multiple-employer trusts.
(2) This subsection shall apply only to the extent permitted by ERISA, the federal Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001 et seq.

(c) (1) The state's any willing provider laws shall be construed to include within their provider definitions all those providers of the same class or classes who are:
(A) Practicing or operating within a border city in an adjoining state; and
(B) Licensed or authorized to practice or operate by the adjoining state, regardless of whether the provider is licensed or otherwise authorized to operate in Arkansas.
(2) As used in this section, "border city" means a city in a state adjoining Arkansas which adjoins the Arkansas state line and is not separated from an Arkansas city only by a navigable river.

(d) (1) As clarification, nothing in the state's any willing provider laws shall be construed to cover or regulate health care provider networks offered by noninsurers.
(2) If an employer sponsoring a self-insured health benefit plan contracts directly with providers or contracts for a health care provider network through a noninsurer, then the any willing provider law does not apply.
(3) If a health insurer subcontracts with a noninsurer whose health care network does not meet the requirements of the any willing provider law, then the noninsurer may create a separate health care provider network that meets the requirements of the any willing provider law.
(4) If the noninsurer chooses not to create the separate health care provider network, then the responsibility for compliance with the any willing provider law is the obligation of the health insurer to the extent permitted by ERISA, the federal Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001 et seq.

Ark. Code Ann. §23-99-801

Quality of Care Procedures
Insurers issuing or delivering managed care plans must establish mechanisms by which providers can provide input into the insurer's medical policies, utilization review criteria and procedures, quality and credentialing criteria, and medical management procedures.
Ark. Code Ann. §23-99-412

Claims Procedures
A subscriber identification card shall state, in a clear and legible manner, the network applicable to provider claims arising under the subscriber identification card. A provider network's contractual discounts or other alternative rates of payments shall be enforceable and binding on all parties only with respect to the network identified.
A.C.A. § 23-63-113

The U.S. Office of Personnel Management (OPM) has contracting authority for both the Federal Employees Dental and Vision Insurance Program (FEDVIP) and the Federal Employees Health Benefits (FEHB) plans. GEHA is contracted with the OPM for both its Connection Dental Federal FEDVIP plan and GEHA Health FEHB plans.
5 U.S.C.A. § 8902

The terms of GEHA's contracts with the OPM which relate to the nature, provision, or extent of coverage or benefits (including payment with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relate to health insurance or plans.
5 U.S.C.A. §8902(m)(1)

The GEHA Health plan, like other FEHB medical plans, offers limited dental coverage to its members and, by law, the FEHB plans are the first Payor (before FEDVIP plans) for dental coverage provided to FEDVIP Covered Enrollees.
5 U.S.C.A. § 8954(e)

To ensure consistency in the coordination of benefits among the FEDVIP carriers, the OPM has amended its contract with GEHA to state that when treating a FEDVIP Covered Enrollee, the Plan Allowance (which, for Connection Dental Federal is defined as the amount we allow for a specific procedure) is the maximum amount that may be charged to a FEDVIP Covered Enrollee. Neither GEHA nor any FEDVIP Covered Enrollee shall be held responsible or liable for any amounts greater than the FEDVIP allowable amount for services rendered by a Participating Provider to a FEDVIP Covered Enrollee. FEDVIP Covered Enrollees cannot be billed the difference between FEDVIP Plan Allowance and the first Payor's allowance, when the first Payor's allowance is greater than the FEDVIP allowable amount. Thus, FEDVIP Covered Enrollees will only be responsible for payment of the balance of the FEDVIP Plan Allowance minus all payments made by the first Payor and GEHA. FEDVIP Covered Enrollees and GEHA will not be responsible for increased out-of-pocket costs when Covered Enrollees utilize the services of a Connection Dental Participating Provider that also participates in another Payor's PPO network. This is applicable to GEHA Connection Dental Federal and the GEHA Health Plan.
FEDVIP Technical Guidance, Amendment 0005

Provider-Patient Relationship
Under Arkansas law, an insurer or preferred provider organization cannot impose a monetary advantage or a penalty under a health benefit plan that would affect a beneficiary's choice of providers who participate in the plan. A "monetary advantage or penalty" includes: (1) a higher copayment; (2) a reduction in reimbursement for services; or (3) promotion of one provider over another by these methods.
Ark. Code Ann. §23-99-204.

Insurers may not prohibit, restrict or penalize providers for disclosing any health care information that the provider deems appropriate regarding the nature of treatment, risks, or alternatives thereto, the availability of alternate therapies, consultations, or tests, the decision of utilization reviewers or similar persons to authorize or deny services, the process that is used to authorize or deny health care services or benefits, or information on financial incentives and structures used by the insurer.
Ark. Code Ann. §23-99-407

Required Content in Contract
All parties for contracts between an insurer and a preferred provider agree that the insured individual or covered member will have no obligation to make payment for any medical service rendered by the provider that is determined not to be medically necessary; provided, however, that charges for medically necessary services received by the insured which are not covered by the minimum basic benefit policy shall be considered the responsibility of the insured. ("Medically necessary" is not defined within the statute.)
Ark. Code Ann. §23-98-109

These policies and procedures are subject to change without notification as permitted by law. Any changes in state and/or federal laws that are applicable to the GEHA Participating Provider Agreements or the CONNECTION Dental Network are hereby incorporated into these policies and procedures.

Please note: Government Employees Health Association, Inc.'s Federal Employee Health Benefits Plans are not subject to state law. GEHA owns and operates the CONNECTION Dental Network, which is a non-risk bearing PPO network. The above policies and procedures may or may not be applicable to the CONNECTION Dental Network, depending on whether the network is included within the state-specific definitions that are applicable to state laws, rules and regulations.

GEHA Covered Persons are participants in the Federal Employees Health Benefits Program, and benefit matters for such participants shall be resolved by the United States Office of Personnel Management ("OPM") in accordance with the disputed claims procedures in the Federal Employees Health Benefits Act and the regulations of the OPM.

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