POLICY AND PROCEDURE

POLICY NAME: Network Quality Standards	**POLICY ID: AR.NTWK.113**
BUSINESS UNIT: Network	**FUNCTIONAL AREA: Network**
EFFECTIVE DATE: 11/16/26	**PRODUCT(S): AR Ambetter, QualChoice, and ARTC**
REVIEWED/REVISED DATE: 11/2/26	
REGULATOR MOST RECENT APPROVAL DATE(S):	

POLICY STATEMENT:
Policy is created to outline quality standards, quality programs and initiatives and oversight that providers must follow and/or participate in as an in-network provider.

PURPOSE:
To provide quality standards and participation requirements in quality initiatives and oversight for in-network providers.

SCOPE: This policy applies to In-network providers participating in Marketplace (on and off exchange), Medicaid, and non-marketplace commercial offered by QCA Health Plan, Inc., QualChoice Life and Health Insurance, Inc. Celtic Insurance Company d/b/a Arkansas Health and Wellness Insurance Company; and Arkansas Total Care, Inc. (collectively "Plan").

DEFINITIONS:

POLICY:
All in-network providers are required to participate in Plan quality initiatives and oversight activities as outlined in applicable contractual requirements and Plan communications. These initiatives and oversight activities may include, but are not limited to:

- Programs related to care management, which includes the Members Empowered to Succeed (METS) Program, and the Partnership in Care program,
- Quality of Care (QOC) reviews,
- Risk adjustment activities, and
- Special Investigations Unit (SIU) requests.

Participation includes timely response to Plan requests, completion of required documentation, and engagement in identified quality initiatives/programs identified in this policy, the provider manual, or Plan communications. activities as applicable to the provider's scope of services.

Providers whose level of participation does not demonstrate engagement in required quality initiatives will be subject to additional review by the Plan's Network Quality Review Committee and may be determined non-compliant with network quality standards and terminated from the network.

While telehealth services are permitted, providers of all specialties, including medical/surgical and behavioral health providers, are expected to maintain the capability to provide in-person services when clinically appropriate and to support continuity of care. Providers whose service delivery model relies exclusively on telehealth, without the ability to provide in-person services when clinically indicated, may be referred to the Network Quality Review Committee for review. Provider types whose services are not customarily delivered in person are excluded from this standard, and any such exclusion will be determined using the same criteria for medical/surgical and behavioral health providers. Providers not following Arkansas telehealth laws (Ark. Code Ann. § 17-80-401 through § 17-80-407) are subject to termination from the network.

Providers are expected to support continuity of care and appropriate transitions between levels of care based on member need. This includes ensuring that members have access to clinically appropriate lower levels of care following higher-intensity services.
Providers whose service delivery model does not support appropriate transitions of care or results in gaps in follow-up services will be subject to additional review and may be determined non-compliant with network quality standards.

Examples of non-compliance may include, but are not limited to, failure to coordinate appropriate discharge planning, lack of referral pathways to lower levels of care, or patterns of maintaining members in higher levels of care without clinical justification

All providers must meet certification requirements as applicable. In addition, all Arkansas Total Care providers must follow and comply with all Arkansas Medicaid certification requirements on an ongoing basis, as applicable. These requirements include but are not limited to maltreatment checks, background checks, staffing ratios, facility requirements, and if applicable a childcare license. Additionally, CES Waiver and CSSP providers who offer Supportive Living must follow all standards outlined in the CES Agency Standards, including, but are not limited to the transition of care and unable to serve standards outlined. Failure to do so could result in corrective action or network termination.
It is the responsibility of the provider to monitor these quality standards and participate in the Plan's quality initiatives as stipulated in this policy.

If a provider is terminated for not meeting these quality standards, not participating in quality initiatives or not complying with SIU investigations, the provider will not be allowed to rejoin the network for a minimum of 24 months.

PROCEDURE:
These requirements will be monitored by the Plan on an ongoing basis. The Plan's Network Quality Review Committee (NQRC), a cross-functional workgroup including representatives from Population Health & Clinical Operations, Behavioral Health, Care Management, Compliance, and Provider Network Management, will meet at least biannually to review provider performance against network quality standards. The committee will

- Review claims that may indicate that a provider is not compliant with this policy, or not compliant with state laws including but not limited to:
    - Providers of any specialty, medical/surgical or behavioral health, that submitted only telehealth claims over a 6-month period based on adjudicated claims data;
    - CSSP/OBH providers delivering Therapeutic Community Level 1 or other facility-based HCBS services must provide, or maintain documented referral and coordination arrangements for, clinically appropriate lower levels of care, including Therapeutic Community Level 2 and less intensive HCBS (e.g., Adult Life Skills, Rehabilitative Day Services, Peer Support for adults; Behavioral Assistance, Child and Youth Support Services for child/youth), consistent with applicable Arkansas Medicaid certification requirements. Providers with no claims for lower levels of care over a 6-month period may be reviewed to confirm that appropriate step-down and referral pathways exist. The absence of such claims alone does not constitute non-compliance.
    - Facility-based medical/surgical providers of post-acute or intermediate levels of care (e.g., skilled nursing, inpatient rehabilitation, long-term acute care) with patterns of extended stays and no documented discharge or referral to lower levels of care over a 6-month period;
- Review referrals from Quality, SIU, or PHCO for providers with concerns including but not limited to:
    - Failure to respond to Plan requests for additional information, either consistently, or depending on severity from a referral from Quality, SIU or PHCO.
    - Failure to support appropriate transition of care, either consistently through quality-of-care concern reviews or depending on severity, from a care management referral

Thresholds may be adjusted based on clinical appropriateness and program requirements. Any adjustment will be documented, including its basis, and applied using comparable criteria for medical/surgical and behavioral health providers.

If the provider fails to meet the requirements in this policy, the provider may be terminated from the network for cause with a 90-day notice. The notice will include the identified deficiencies, applicable policy and/or contractual requirements; immediate termination may occur when required due to member safety, fraud, or regulatory mandate. Providers will be unable to rejoin the network for a period of 24 months.

Before terminating a provider under this policy, the Committee will consider the impact on member access and network adequacy for the affected service type.

REFERENCES: NA

ATTACHMENTS: NA

ROLES & RESPONSIBILITIES: It is the responsibility of the Network Quality Review Committee to review the data and make determinations.

REGULATORY REPORTING REQUIREMENTS: None

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
New Policy Document	Policy Created	7/1/2026
Revision	Clarified telehealth and CSSP language	11/2/2026

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.