

POLICY AND PROCEDURE

POLICY NAME: Network Quality Standards	POLICY ID: AR.NTWK.113
BUSINESS UNIT: Network	FUNCTIONAL AREA: Network
EFFECTIVE DATE: 11/1/26	PRODUCT(S): AR Ambetter, QualChoice, and ARTC
REVIEWED/REVISED DATE:	
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
- 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 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 predominantly on telehealth without a meaningful in-state physical presence or the ability to provide in-person services will be determined non-compliant with network quality standards and terminated from the network. Providers providing 80% or more services via telehealth will be reviewed for possible termination from the network.

Prior to joining the network, facility-based providers must provide a program description inclusive of the services they will be offering, how services will be delivered and who will be delivering each service. This program description should also include step-down services offered. This program description will be reviewed by a representative of the Plan’s Network Quality Review Committee. The Plan representative will follow up with the provider if there are clarifications needed related to the program description.

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 need for provider termination, including but not limited to:
 - Providers with more than 80% of all claims provided as telehealth over a 6-month period based on adjudicated claims data;
 - CSSP/OBH providers delivering Therapeutic Community Level 1 must offer at a minimum Level 2. CSSP/OBH providers with TC Level 1 claims and no TC level 2 claims over a 6-month period.
 - CSSP/OBH providers providing facility-based HCBS services with no claims for less intensive HCBS over a 6-month period. For example, a Therapeutic Community program must provide less intensive HCBS for the adult population, examples include Adult Life Skills, Rehabilitative Day Services, Peer Support, etc. Similarly, a Residential Community Reintegration program must offer less intensive HCBS for the child/youth population, examples include Behavioral Assistance, Child and Youth Support Services, Family Support Partners, etc.
- 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.

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.

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
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REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
New Policy Document	Policy Created	7/1/2026

POLICY AND PROCEDURE APPROVAL

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