HMO
Provider Network Adequacy Standards

STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services

March 2025

I. Definitions

A. **Dental Service Area:** Dental service areas consist of Milwaukee, Waukesha, Racine, Kenosha, Ozaukee, and Washington counties.
B. **DHS (The Department):** Wisconsin Department of Health Services
C. **Distance Standard:** Distance to provider based on the most direct route
D. **Drive Time:** Time to provider based on driving distance
E. **HMO:** Health Maintenance Organization
F. **Inpatient/Outpatient Hospital:** A non-specialized hospital or hospital specializing in Pediatrics as a non-specialized hospital. In all other instances a non-specialized hospital is one which is not exclusive to a single category of service or specialty including, but not limited to, behavioral health, cardiology, or orthopedics.
G. **OB/GYN:** Obstetrician/Gynecologist. Member population consists of females aged 12 and above.
H. **PCP:** Primary Care Provider
I. **Provider-to-Enrollee Ratio:** The ratio is determined by the count of providers within time/distance standards of the service area (County) as the numerator. A count of members within the service area (County) is the denominator. The Department expects 90% of the members within the service area meet time/distance standards.
J. **Rural:** Any county that is not considered urban under the definition below
K. **Service Area:** The geographic service area within which potential members must reside in order to enroll in and remain enrolled in an HMO. To be eligible to enroll in an HMO, a potential member must be a resident of the county (or one of the counties) in the HMO's assigned service area.
L. **Urban:** Brown, Dane, Eau Claire, Fond du Lac, Kenosha, La Crosse, Marathon, Milwaukee, Outagamie, Ozaukee, Racine, Rock, Sheboygan, St. Croix, Walworth, Washington, Waukesha, and Winnebago Counties based on similar population density characteristics
M. **Urgent Care:** Services provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services are often but not always those that if not fulfilled could result in an emergency room visit or inpatient admission.

II. Purpose

This document describes the standards for HMO provider network adequacy for BadgerCare Plus HMO and Medicaid SSI HMO.

III. Programs affected

X	BadgerCare Plus HMO
X	Medicaid SSI HMO

IV. Policy

This policy is created to comply with 42 C.F.R. §§ 438.68, 438.206, and 438.207. The policy describes the requirements for HMO provider network adequacy standards created by DHS for BadgerCare Plus HMO and Medicaid SSI HMO. The DHS-HMO contract requires HMOs to comply with these standards.

V. Provider network adequacy standards

A. Access standards

Table - 1								
Provider Type	**Provider Specialty Code - Description**	**Population**	**Program**	**Counties**	**Drive Time (min)**	**Distance (mls)**	**Provider-to-Enrollee Ratio -**	**Wait Time**
Dental	271 – General Dentistry Practitioner 289 – Dental Hygienist	Adult	BC+ & SSI	Urban	45	30	1:1600	Routine: < 90 Days Emergent: < 24 Hrs
				Rural	90	75	1:1900	
	271 – General Dentistry Practitioner 274 – Pediatric Dentist 289 – Dental Hygienist	Pediatric		Urban	45	30	1:1600	
				Rural	90	75	1:1900	
Mental Health & Substance Use Providers	112 – Licensed Psychologist (PhD) 117 – Psychiatric Nurse 120 – Licensed Psychotherapist 121 – Licensed Psychotherapist with SAC 122 – Alcohol & Other Drug Abuse Counselor 123 – Certified Psychotherapist with SAC 124 – Certified Psychotherapist 126 – Qualified Treatment Trainee (QTT) 339 – Psychiatry 532 – Registered Alcohol & Drug Counselor 740 – Mental Health	*Adult & Pediatric	BC+ & SSI	Urban	45	30	1:900 Psychiatrist and Psychologist	10 Business Days from Request
				Rural	75	60	1:1100 Psychiatrist and Psychologist	

Table - 1								
Provider Type	**Provider Specialty Code - Description**	**Population**	**Program**	**Counties**	**Drive Time (min)**	**Distance (mls)**	**Provider-to-Enrollee Ratio -**	**Wait Time**
OB/GYN	095 – Nurse Practitioner/Nurse Midwife 212 – Nurse Midwife 316 – Family Practice 318 – General Practice 328 – OB/Gynecologists 350 – Licensed Midwife	Adult & Pediatric (ages 12-17)	BC+ & SSI	Urban	15	10	1:100	15 Business Days from Request
				Rural	45	30	1:120	
PCP	092 – Certified Family Nurse Practitioners 093 – Other Nurse Practitioners 100 – Physician Assistants 316 – Family Practice 318 – General Practice 322 – Internal Medicine	Adult	BC+ & SSI	Urban	15	10	1:100	15 Business Days from Request
				Rural	40	30	1:120	
	090 – Certified Pediatric Nurse Practitioners 092 – Certified Family Nurse Practitioners 093 – Other Nurse Practitioners 100 – Physician Assistants 316 – Family Practice 318 – General Practice 322 – Internal Medicine 345 – Pediatricians 080 – Federally Qualified Health Center (HealthCheck related) 734 – Screener (HealthCheck) 735 – Screener/Case Management (HealthCheck)	Pediatric	BC+ & SSI	Urban	15	10	1:100	15 Business Days from Request
				Rural	40	30	1:120	

Table - 1								
Provider Type	**Provider Specialty Code - Description**	**Population**	**Program**	**Counties**	**Drive Time (min)**	**Distance (mls)**	**Provider-to-Enrollee Ratio -**	**Wait Time**
Hospital	010 – Inpatient/Outpatient Hospital	All Members	BC+ & SSI	Urban	45	30		
				Rural	75	60		

*Adult & Pediatric = Separate age population and provider category among adult and pediatric population

B. Availability standards

1. Medically necessary contracted services must be available 24 hours a day, 7 days a week.
2. HMOs must ensure that network providers offer hours of operation that are no less than hours of operation offered to commercial members or Medicaid fee-for-service members.
3. HMO must incorporate urgent care access and availability analysis to determine potential over utilization of emergency room visits and inpatient admissions. Within wait time analysis, include the HMO's network capacity to non-emergency services 24 hours a day 7 days a week and whether a lack of capacity causes unnecessary levels of care utilization.

C. Development of the standards

As required under 42 CFR §438.68, the following factors were considered when developing the HMO provider network adequacy standards:

a. HMO enrollment per county and service area
b. The expected utilization of services
c. The number and types of network providers of network providers needed to furnish contracted services
d. The number of providers in the county accepting new members
e. The population density of the county (urban or rural)
f. The geographic location of network providers and members, considering distance, travel time, and means of transportation used by members

g. The ability of network provides to communicate with limited English proficient members in their preferred language and ensure physical access and reasonable accommodations for members with disabilities
h. The availability of triage lines, telehealth, and other evolving technologies. Technology is considered secondary to the physical provider location requirements.

D. HMO provider network oversight

1. The HMO notifies DHS and submits documentation regarding network providers when:
   a. The HMO enters the initial contract with DHS,
   b. annually, or
   c. a significant change in benefit programs, geographic service area, member enrollment, new member population, or composition of or payments to the provider network occur.

2. DHS conducts an annual network adequacy analysis confirming the HMO's network adequately supports the access, availability, and capacity standards described in this document and the DHS-HMO contract. DHS also considers additional metrics and data sources to determine network adequacy, including member grievances and appeals, out-of-network reports, Consumer Assessment of Healthcare Providers and Systems surveys, and the DHS's external quality review organization. The Department expects HMOs meet both drive and distance standards to be compliant. The network adequacy analysis will result in either approval, conditional, or exception status by services area county.

   a. Approval status is granted when the DHS's review and the HMO service area is within standards.
   b. Conditional status is granted when DHS determines network conditions are such that the HMO may continue providing services in an area under but must remediate the specific deficiencies. Conditional terms may require the HMO to produce a corrective action plan, lead to decertification, enrollment suspension and/or other action in the interest of the members. While under conditional status the HMO must provide DHS member impact assessments and remedies to improve standards.
   c. Exception status may be granted during the annual review and upon expansion requests where limited services preclude the HMO from meeting adequacy standards only if the following conditions are met:
      i. Reason for limited services is outside the control of either or both DHS and HMO.
      ii. The HMO provides documentation and justification for adequate network despite deficiencies.
      iii. The HMO monitors and provides periodic member access impact assessments.

   DHS will use this information to determine exception status or take alternative action.

VI. Revision history

Date	Rev. No.	Change
02/24/2025	2	Updated Table 1 wait time standards; removed Urgent Care from Table 1 and updated header information; updated definitions around dental service areas; updated OBGYN populations; changed definition for provider to enrollee ratio.
09/01/2023	1	Original P&P