Today's Network Adequacy Requirements

Source	Citation	Applies to	Enacted / last updated	Enforced by
Health Care Quality Act	P.L.1997, c.192 (N.J.S.A. 26:2S-1 et seq.)	All carriers offering managed care plans	Enacted 1997	DOBI
Network adequacy rule (commercial)	N.J.A.C. 11:24A-4.10	Insurers offering managed care plans	Adopted 2000 (R.2000 d.183) Last amended 2011 Readopted unchanged Dec. 2024 (to 2031)	DOBI
HMO access standards	N.J.A.C. 11:24-6.2 and 6.3	All licensed HMOs, including Medicaid MCOs	Same time/distance and appointment standards as 11:24A-4.10	DOBI
NJ FamilyCare MCO contract	Art. 4.8 Provider Network, pp. 131–158 §4.8.8 network standards, pp. 144–153 §5.12 appointment availability, pp. 29–30	Medicaid managed care organizations	Current version Jan. 2026; amended periodically	DMAHS
Pediatric Medicaid network adequacy law	P.L.2021, c.276 (N.J.S.A. 30:4D-7ff, -7gg)	Medicaid MCOs, enrollees under 21	Signed Nov. 8, 2021 Effective Feb. 1, 2022	DMAHS
Federal overlay	42 CFR Part 438 (Medicaid managed care) No Surprises Act directory rules	Medicaid MCOs; commercial plans	2024 Access Rule: wait-time standards 2028; secret shopper surveys 2029. Directory rules 2022	CMS, through DMAHS and DOBI

Why revisit now

Today's standards count where a provider is listed, not whether they are seeing patients there, accepting new ones, or available by telehealth. Most were built for a 2000-era HMO market. Gaps push people out of network, delay care, and send them to the ED, which raises costs for everyone.

Considering adverse selection

Standards must be strong enough to deliver care and achievable enough that waivers aren't routine. Otherwise the plan with the stronger network attracts the most complex patients and their higher claims, while others avoid costly providers, and families absorb the delay, stress, and cost as conditions advance.

Same State, Different Standards: Medicaid vs. Commercial

Standard	Medicaid MCO (contract + P.L.2021, c.276)	Commercial insurers (DOBI, N.J.A.C. 11:24A-4.10)
Primary care time/distance	✓ 2 PCPs within 5 mi/10 min urban; 10 mi/15 min non-urban (90%)	✓ 2 PCPs within 10 mi or 30 min (90% of the enrolled population)
Pediatric primary care	✓ 5 mi/10 min urban; 10 mi/15 min non-urban; every child within 30 min	✗ No child-specific standard
Pediatric subspecialists	✓ 14 specialties: 15 mi/30 min urban, 40 mi/60 min non-urban; 24 must be in network	✗ Only “tertiary pediatric services” within 45 mi/60 min
Child psychiatry, oncology, developmental-behavioral peds	✓ 10 mi/20 min urban; 30 mi/45 min non-urban	✗ Not named
Adult specialists	✓ 13 specialties: 15 mi/30 min urban, 40 mi/60 min non-urban	✓ 45 mi or 1 hr (90% of members within each county svc area)
Hospitals and institutional services	✓ Acute hospital within 15 mi/30 min	✓ Acute hospital 20 mi/30 min; tertiary and inpatient psych 45 mi/60 min
Dental network	✓ 2 dentists, same distance as PCPs; pediatric dentists as primary care dentists (§4.8.9)	✗ Not in 11:24A-4.10 (dental sold separately)
Wait times: primary care	✓ Urgent 24 hrs; acute 72 hrs; routine 28 days	✓ Urgent 24 hrs; routine 2 weeks; physical 4 months
Wait times: specialists, behavioral health, prenatal	✓ Specialist routine 4 wks; BH routine 10 days; prenatal by trimester	✗ No state standard
Telehealth counts toward adequacy	◐ Telehealth-only providers don’t count; in-person + telehealth do (§4.8.3)	✗ Not addressed in N.J.A.C. 11:24A-4.10
Waiver / exception path	✓ DMAHS specialty waivers; MCO must negotiate out-of-network care	◐ Facility mileage relief; member-initiated in-network exception
Public reporting of gaps	◐ Waivers and out-of-network contracts reported to DMAHS; public on request	✗ None

✓ required ◐ partial ✗ not required.

Directory Rules: What Must Be Listed and How Fast

	DOBI Commercial insurers and HMO licensure	DMAHS NJ FamilyCare MCOs	CMS Federal
Citation	DOBI provider network rules (N.J.A.C. 11:24C-4.5, 4.6; 2013) Out-of-Network Consumer Protection Act (P.L.2018, c.32)	NJ FamilyCare MCO contract §4.8.4 (Jan. 2026); must meet or exceed the federal Medicaid rules (see CMS)	Medicaid: federal managed care rule (42 CFR 438.10) and Consolidated Appropriations Act, 2023 §5123 (2025) Commercial: No Surprises Act §116 (provider directories), effective 2022
What must be listed	Name, gender, office locations, phone, credentials, specialty, accepting new patients, practice limitations, languages; in-network hospital outpatient facilities; search by specialty and area	Name, degree, group; board certification; specialty; address, phone, office hours per site; accepting new patients per site; ages served; hospital affiliations; disability accommodations by type; telehealth; transportation; languages incl. ASL. Behavioral health listed by service; dentists by child age; separate doula directory; 5–25 mile radius search	Medicaid: name and group, address, phone, website, specialty, accepting new patients, languages (incl. ASL), accessibility, telehealth; searchable Commercial: name, address, specialty, phone, digital contact
Update timeline	Website within 20 days of a provider joining or leaving, a hospital affiliation change, or a confirmed error. Print copy mailed within 5 business days	Web directory updated at least every 7 days; machine-readable data feed (API) within 30 days; doula directory quarterly; free paper copy on request	Medicaid: online within 30 days; paper monthly (quarterly if mobile-enabled) Commercial: within 2 business days of a provider update
Verification	Confirm providers with no claims in 12 months; removal after 30 days with no reply. Answer accuracy disputes within 15 days	Members must have an online way to report errors. State contract monitoring and external quality reviews (IPRO); secret shopper checks of directory accuracy from 2029	Medicaid: no set verification cycle Commercial: verify every 90 days; remove providers who can't be verified
If the listing is wrong	No directory-specific member remedy	General contract sanctions and liquidated damages (§7.15, §7.16), none tied to directory errors; no member-specific remedy	Commercial: member pays in-network cost-sharing if they relied on the directory; plan answers network-status questions within 1 business day

Who Is Enforcing What Today?

	DOBI Commercial insurers and HMO licensure	DMAHS NJ FamilyCare MCOs	CMS Federal
Oversight	Fully insured commercial plans; HMO licenses (not self-funded employer plans)	Medicaid MCOs through the contract and P.L.2021, c.276	Medicaid managed care (42 CFR 438); No Surprises Act directory rules
How networks are checked	Network filings at licensure and plan approval	Provider network files and GeoAccess analysis (§4.8.3, §4.8.12); annual pediatric compliance certification	Reviews state network standards and assurances
Audits and monitoring	Market conduct examinations; consumer complaints; Quest Analytics reports; Pending requirement for independent audits never implemented.	Contract monitoring; appointment monitoring (§5.13); EQRO quality reviews (IPRO) and HEDIS measures; claims review can flag providers who never bill	2024 rule requires independent secret shopper surveys of wait times and directory accuracy
Penalties and remedies	Fines and corrective action plans	Liquidated damages and sanctions (§7.15, §7.16.9); waiver conditions	Enforced through the state
What members can see	Complaint process; network findings rarely visible	Waiver and out-of-network contract data, on request	State must post wait-time standards and survey results

For discussion

Which checks work, which don't, and which can run regularly across both markets? What remedies help members? Could quality measures like HEDIS serve basis for carrots and sticks?

New: CMS proposed rule (Oct. 16, 2026)

Medicare Advantage only: verify directories every 90 days, report and post accuracy scores. Members who rely on a wrong listing pay in-network cost-sharing.