Public Comments to the Medical Assistance Advisory Council (MAAC)

Written comments submitted after the April 22, 2026 MAAC meeting

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New Jersey Future

My Name is Deandrah Cameron, Policy Manager at New Jersey Future. We believe every New Jerseyan deserves to live in a prosperous, fair economy, thriving communities, and healthy neighborhoods. We promote policies that promote access to clean drinking water Statewide.

New Jersey Future played a pivotal role in crafting the comprehensive New Jersey lead service line replacement statute (P.L. 2021, c. 183), enacted in 2021[1], and is proud that our work, along with that of our partners, demonstrates our collective leadership in long-term solutions on this public health issue. Although New Jersey is at the halfway point of its 10-year goal to replace lead service lines by 2031, we are not halfway done, and some families remain exposed to lead in their drinking water.

While New Jersey's Medicaid program, administered through the NJ FamilyCare Comprehensive Demonstration under Section 1115 of the Social Security Act (approved March 30, 2023, and effective through June 30, 2028)[2], provides essential reactive measures for lead poisoning, it falls short in preventive interventions that could avert exposure at its source. NJ FamilyCare covers blood lead screenings and medical management after a child has been exposed. The state could improve by offering environmental interventions, such as water filters, to prevent exposure and poisoning[3].

Families are being exposed today! In Essex County alone, where over 100,000 residents rely on Medicaid and 55% of all residents are renters[4], over 51% of the housing stock predates 1960[5] While Lead service line replacements are ongoing, many NJ FamilyCare enrollees remain vulnerable in the interim. These families are disproportionately renters in older housing who lack the authority or funds to replace pipes or purchase high-quality filtration. For infants, drinking water can account for up to 60% of lead exposure, and there is no safe level.

Lead poisoning in NJ disproportionately impacts children living in predominantly Black, Brown, and low-income communities. Among the largest municipalities in NJ with the highest percentage of children under 6 with elevated blood lead levels are Trenton, Irvington, East Orange, and Plainfield. These towns all contain majority Black and Brown populations, and the percentage of persons in poverty in these towns ranges from 17.1 to 24.7 percent, well above the state percentage of 9.7 percent[6].

NEW JERSEY HUMAN SERVICES

Top 10 Large Municipalities Ranked by Highest Percentage of Children Younger Than Six Years of Age with an EBLL in SFY 2024

Municipality (County)	% Children < 6 Years with an EBLL
Trenton City (Mercer)	5.1%
Irvington Township (Essex)	4.1%
East Orange City (Essex)	3.1%
South Brunswick Township (Middlesex)	2.9%
Atlantic City (Atlantic)	2.5% (tie with Plainfield City)
Plainfield City (Union)	2.5% (tie with Atlantic City)
Newark City (Essex)	2.4% (tie with Edison Township)
Edison Township (Middlesex)	2.4% (tie with Newark City)
Parsippany-Troy Hills Township (Morris)	2.2% (tie with Jersey City)
Jersey City (Hudson)	2.2% (tie with Parsippany-Troy Hills Township)

Total Children = 2020 U.S. Census for Children 0-6 Years of Age
Percent EBLL = (Total EBLL / Total Screened) * 100

[7]

By including coverage for filters under the 1115 waiver, we can empower providers to offer solutions to high-risk households, including those with pregnant persons, G-tube-fed individuals, documented kidney disease, and cardiovascular disease.

In Cook County, Illinois, the Medicaid-managed CountyCare program successfully distributed filters to thousands of at-risk families[8]. The program demonstrates that this is both operationally feasible and fiscally responsible. Integrating water filtration into Medicaid is a low-cost intervention that will save the state billions in long-term health and educational costs. We must ensure that for New Jersey's most vulnerable children, prevention, not just treatment, is at the center of care.

Thank you for the opportunity to speak on this important matter.

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[1] AN ACT concerning the replacement of lead service lines and supplementing Title 58 of the Revised Statutes https://pub.njleg.gov/bills/2020/PL21/183_.PDF

[2] DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services 7500 Security Boulevard, Mail Stop S2-25-26Baltimore, Maryland 21244-1850 State Demonstrations Group https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nj-familycare-comp-demo-appvl-tech-crctns-atcmnt-r.pdf

[3] Potential Lead Exposure Mapping (PLEM) in New Jersey https://experience.arcgis.com/experience/bc82aa1d39d54e5d944d701cf7e8450d

[4] Essex County, New Jersey https://data.census.gov/profile/Essex_County,_New_Jersey?g=050XX00US34013#housing

[5] American Community Survey B25034Year Structure Built https://dat

[6] HDPulse: An Ecosystem of Minority Health and Health Disparities Resources. National Institute on Minority Health and Health Disparities. Created 1/24/2025. Available from https://hdpulse.nimhd.nih.gova.census.gov/table?q=B25034:+Year+Structure+Built+essex+county+new+jersey

[7] CHILDHOOD LEAD EXPOSURE IN NEW JERSEY ANNUAL REPORT STATE FISCAL YEAR 2024(July 1, 2023 –June 30, https://www.nj.gov/health/childhood-lead/documents/childhood-lead-2024-annual-report.pdf

[8] Proactive Filter Program for Medicaid Families Cook County, IL https://www.protectkidsfromlead.com/case-studies/cook-county-il

Maiysha Ware

NJ Association for the Treatment of Opioid Dependence

On behalf of NJATOD membership, we write to respectfully highlight significant operational risks associated with the planned transition of substance use disorder laboratory services into managed care. We appreciate the State's efforts to support continuity of care, provider onboarding, and timely payment during behavioral health integration.

At the same time, our review indicates that laboratory services in the opioid treatment program setting are deeply embedded in clinical workflow, patient safety, documentation integrity, and regulatory compliance. For that reason, this change should not be treated as a routine payer conversion.

NJATOD recently gathered provider feedback from opioid treatment programs regarding current laboratory arrangements. The survey included 16 responses from member agencies, several of which operate multiple locations, representing roughly 60 percent of the membership sample. The findings suggest that most OTPs have workable relationships with their current specialty laboratories, but that stability is often supported by highly tailored workflows that may not be easily replicated under a broad managed care laboratory model. Nine respondents reported a direct interface with the OTP EHR or EMR, while seven still rely on a separate portal. Only three reported that staff can place orders directly in the EHR or EMR; ten reported that orders must be entered separately, and the remaining responses reflected other manual or lab-assisted processes.

The survey also confirms that OTPs depend on more than a basic testing vendor. Providers reported relying heavily on daily specimen pickup, on-site collection support, integrated bloodwork and urine drug screening, customized reporting, troubleshooting support, and access to toxicology consultation. These are not convenience features; they are operational requirements in the OTP environment. Providers further reported that turnaround time is clinically important, with most describing approximately twenty-four hours for screening results and twenty-four to forty-eight hours for definitive testing.

Additional provider input reinforces the same theme. OTPs typically engage specialty SUD laboratories because those laboratories understand OTP workflow, can often interface with the OTP's EHR, support compliant documentation, troubleshoot reporting issues, and tailor reports to clinical use. Daily specimen pickup, flexible scheduling, collector support, integrated services through one vendor, and access to toxicology expertise are especially valuable. By

contrast, large general laboratory arrangements that require patients to travel elsewhere for collection, do not provide collectors, offer slower turnaround, or require staff to manually place orders and retrieve results from separate systems are generally much less workable in OTP operations.

Recent updates shared by DMAHS during February 2026 Behavioral Health Integration Consumer Advocate Forum further reinforce the need for a careful and operationally grounded transition approach. DMAHS reported that Phase 1 remains active, Phase 2 is now targeted for 2027, and Phase 3 remains to be determined. The State also advised that transition planning continues to prioritize continuity of care, provider onboarding, and timely payment, while Phase 1 flexibilities are ending on an MCO-by-MCO basis. Prior authorization remains in place, Aetna has already initiated medical necessity reviews, and out-of-network providers continue to be supported during transition with a gradual expectation of movement toward in-network care.

Stakeholder feedback summarized by DMAHS also identified broader system concerns directly relevant to laboratory carve-in planning. Participants highlighted persistent navigation challenges, lagging enrollment and awareness related to behavioral health care management, and the continuing importance of social supports such as housing, food, transportation, outreach, and strong community partnerships. These findings underscore that implementation success cannot be measured by contracting status alone. The transition must be structured in a way that is understandable to providers and patients, minimizes administrative friction, and does not create new barriers to timely, clinically necessary testing.

Key finding: The principal risk is not whether laboratory services exist, but whether contracted laboratories can meet OTP workflow, documentation, turnaround, and collection requirements without forcing providers into manual workarounds or disrupting care.

Requested Actions Before Transition

- Publish DMAHS network standards for SUD laboratory services that explicitly address OTP operational adequacy, including interface capability, order-entry workflow, daily specimen pickup, specimen collection support, turnaround expectations, reporting quality, and technical support.
- Establish a uniform statewide operating framework across all MCOs for covered codes, billing rules, reimbursement expectations, prior authorization requirements, denial correction pathways, and escalation contacts for laboratory services.
- Maintain transition protections until operational readiness is demonstrated in practice, not merely until contracts are signed. Out-of-network reimbursement protections should remain in place until MCO networks can actually support OTP workflow without disruption.
- Define minimum turnaround standards for both screening and definitive testing and require corrective action when contracted laboratories cannot meet them.
- Require advance testing and validation with ordering providers, laboratories, EHR vendors where applicable, and MCOs before any transition protections are lifted.
- Create a dedicated rapid-response escalation structure for laboratory access, billing, claims, and workflow issues during implementation.

- Provide written assurance that medically necessary laboratory services will not be delayed, denied, or operationally interrupted during the transition period.
- Commit to ongoing quarterly stakeholder communication, including regular implementation updates, training notices, and structured opportunities for providers, laboratories, advocates, and membership organizations to raise issues before and after go-live.

We strongly support the State's goal of strengthening behavioral health integration and improving care coordination. However, the SUD laboratory carve-in should proceed only when the operational realities of OTP care have been fully reflected in readiness standards, network expectations, and implementation protections.

Thank you for your consideration and for your continued partnership in supporting access to high-quality SUD treatment services in New Jersey. We welcome continued dialogue with State leadership and NJ FamilyCare staff as this transition planning moves forward.

Sincerely,

Maiysha Ware

NJATOD President