

NEW JERSEY REGISTER

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MOST RECENT UPDATE TO NEW JERSEY ADMINISTRATIVE CODE: SEPTEMBER 21, 1992

See the Register Index for Subsequent Rulemaking Activity.

NEXT UPDATE: SUPPLEMENT OCTOBER 19, 1992

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On occasion, a proposing agency may extend the 30-day comment period to accommodate public hearings or to elicit greater public response to a proposed new rule or amendment. An extended comment deadline will be noted in the heading of a proposal or appear in a subsequent notice in the Register.

At the close of the period for comments, the proposing agency may thereafter adopt a proposal, without change, or with changes not in violation of the rulemaking procedures at N.J.A.C. 1:30-4.3. The adoption becomes effective upon publication in the Register of a notice of adoption, unless otherwise indicated in the adoption notice. Promulgation in the New Jersey Register establishes a new or amended rule as an official part of the New Jersey Administrative Code.

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NEW JERSEY REGISTER

The official publication containing notices of proposed rules and rules adopted by State agencies pursuant to the New Jersey Constitution, Art. V, Sec. IV, Para. 6 and the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. Issued monthly since September 1969, and twice-monthly since November 1981.

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NEW JERSEY REGISTER, MONDAY, NOVEMBER 16, 1992

EXECUTIVE ORDERS

(a)

OFFICE OF THE GOVERNOR

Governor Jim Florio

Executive Order No. 66(1992)

Creation of Chief of Economic Recovery

Issued: October 19, 1992.

Effective: October 19, 1992.

Expiration: October 19, 1993.

WHEREAS, the greatest challenge facing American government today is its ability to secure economic prosperity for all citizens; and

WHEREAS, every American has a right to a job that rewards hard work with security, good wages, dignity, and self-respect; and

WHEREAS, the vitality of families depends upon the availability of jobs that offer them the means to purchase a home, to send children to college, to pay for medical bills, and to care for family members who are aged or sick; and

WHEREAS, the economic means to enjoy a full and abundant life has been the heart of the American dream for over two centuries; and

WHEREAS, today New Jersey and the nation are currently experiencing a recession which has caused unemployment levels in our State to rise as high as nearly 10%, well above the national average—a jobs drought that is totally unacceptable; and

WHEREAS, every public official, of whatever political affiliation, bears a solemn responsibility to address this problem in a spirit of cooperation and with the higher interests of our citizens in mind; and

WHEREAS, the pain caused by workers idled by the economy to our society and its people demands attention without regard to partisan political advantage or posturing; and

WHEREAS, the Legislative and Executive Branches must work together to prepare and implement creative and innovative solutions to solve a problem that is not a Republican problem or a Democratic problem but a New Jersey problem; and

WHEREAS, Senate President Donald T. DiFrancesco and Speaker of the General Assembly Garabed "Chuck" Haytaian have joined with me in a spirit of openness and cooperation to attack this State's most serious economic problems—through the means of this Order and through legislation—so that together we can make a difference in the lives of each and every citizen of New Jersey; and

WHEREAS, government must seize upon this sense of cooperation and unity, and take every possible step in the coming year to infuse our economy with new jobs, and to provide our citizens with a renewed sense of hope; and

WHEREAS, government must provide aggressive leadership in attacking this recession through economic strategies that recognize the central importance of the private sector; and

WHEREAS, it is the responsibility of the State and local governments to work cooperatively with our private sector to create economic growth, development, and real permanent jobs by cultivating creative partnerships between the private and public sectors in order to ensure that new businesses and emerging industries take root and prosper in this State; and

WHEREAS, New Jersey has adopted a variety of programs which are designed to promote economic growth through the investment of capital in infrastructure improvements; the provision of capital for new businesses and high technology industries; for the building of structures and other facilities designed to increase opportunities for employment in manufacturing, industrial, commercial, recreational, retail and service enterprises in the State; the making available of financial assistance to encourage new and varied enterprises to locate in the State and to assist existing enterprises to remain and to expand in the State thereby improving employment opportunities for our citizens; the provision of financial and other assistance to encourage the construction of an appropriate balance of housing, industrial and commercial facilities; and the provision of funding for cultural and historical projects and programs; and by reducing the size of State government; and

WHEREAS, New Jersey has invested billions of dollars assuring the presence of a well educated, well trained, and highly skilled labor force within our borders, including substantial investments in public education, higher education, and job training programs; and

WHEREAS, New Jersey has made strategic investments in our future by harnessing the enormous potential of the bond market with new capital programs through the joint efforts of the Executive Branch and the Legislature, enacting such bills as the Economic Recovery Fund Act, under which the New Venture Capital Fund, the Export Loan Program, and the Pooled Loan Program were created; and

WHEREAS, the New Jersey Legislature and I have taken other important steps toward creating jobs in the State, such as lifting the cap on the Transportation Trust Fund, enacting the Permit Extension Act and the New Skills Partnership Act; and

WHEREAS, notwithstanding its substantial recent efforts to promote economic growth and prosperity for our citizens, New Jersey still lingers in the throes of a recession which has produced high unemployment within this State, thus adversely affecting the economy of the State and the prosperity, safety, health, and general welfare of its citizens and their standard of living; and

WHEREAS, it is therefore necessary to take further actions to provide for the revival of the State's economy and the creation of jobs in the immediate future to provide our citizens with immediate relief from the pain of unemployment; and

WHEREAS, beyond the substantial resources it has already committed to combating the effects of the recession in this State and the promotion of economic growth and employment opportunities here, the State has only limited additional resources which can be dedicated to addressing the problems of this recession; and

WHEREAS, there is an urgent need for the State to do more now to encourage and promote immediate economic growth and reduce unemployment; and

WHEREAS, the action set forth in this Order is one more step of the many others the Legislature and I have taken, and which we will take in the months ahead, toward moving New Jersey's economy forward; and

WHEREAS, in addition to the principal departments and agencies of State government, a number of State authorities have been given substantial responsibility for the carrying out of New Jersey economic development programs which provide an enormous potential for investing millions of dollars in projects across this State that will boost our economy and provide thousands of jobs to our hard-working citizens; and

WHEREAS, New Jersey's authorities—such as the South Jersey Transportation Authority, the Hackensack Meadowlands Development Commission in the North, and the Casino Reinvestment Development Authority, the New Jersey Sports and Exposition Authority, and the Economic Development Authority all operating statewide—act independently to invest millions of dollars in capital revenues in different parts of the State; and

WHEREAS, the State must better manage, coordinate, prioritize, direct, and target its existing resources in order to accomplish the goals of energizing our economy and creating jobs; and

WHEREAS, in order to stimulate our economy immediately, New Jersey should provide active and vigorous leadership to its authorities to ensure speedier investment and a more coordinated strategy for action to harness the collective financial power of these authorities; and

WHEREAS, in order to maximize the effectiveness of our existing resources, the Senate President, the Speaker and I have concluded that it is necessary for there to exist better management and control over these authorities to the end that they work together in a coordinated fashion to create more employment opportunities for this State's citizens in the immediate future; and

WHEREAS, it is also necessary that the principal departments of State government and their divisions and agencies, in carrying out their respective responsibilities under law, all coordinate their efforts and their activities with those of the authorities in order to ensure the accomplishment of this goal; and

WHEREAS, it is only by uniting our vast energies and resources in this State that we have a chance to restore the rising tide of opportunity that is the heart of the American promise and hope of the middle class; and

WHEREAS, New Jersey should use every resource at its disposal to attack an unemployment problem that is simply unacceptable.

NOW, THEREFORE, I, JAMES J. FLORIO, Governor of the State of New Jersey, together with Senate President Donald T. DiFrancesco

and Speaker of the General Assembly Garabed "Chuck" Haytaian, by virtue of the authority vested in me by the Constitution and laws of the State of New Jersey, do hereby ORDER and DIRECT as follows:

1. For purposes of this Order authorities are defined as follows: the Atlantic City Convention Center Authority, the Casino Reinvestment Development Authority, the Delaware River and Bay Authority, the Delaware River Port Authority, the Development Authority for Small Business Minorities and Woman's Enterprise, the Economic Development Authority, the Educational Facilities Authority, the New Jersey Expressway Authority, the Hackensack Meadowlands Development Commission, the Health Care Facilities Financing Authority, the New Jersey Highway Authority, the Housing and Mortgage Finance Agency, the New Jersey Transit Corporation, the Passaic Valley Sewerage Commission, the Port Authority of New York and New Jersey, the South Jersey Port Corporation, the South Jersey Transportation Authority, the Sports and Exposition Authority, the State Agriculture Development Committee, the New Jersey State Building Authority, the New Jersey Transportation Trust Fund Authority, the New Jersey Turnpike Authority, the Urban Development Corporation, the New Jersey Wastewater Treatment Trust, the New Jersey Water Supply Authority, and the Waterfront Commission of New York Harbor.

2. There is hereby created the position of Chief of Economic Recovery (hereinafter sometimes the "Chief"), who shall be empowered to act on my behalf to direct a comprehensive and aggressive effort involving every part of State government to stimulate New Jersey's economy, to promote economic growth, and to provide jobs to the citizens of this State. The Chief's primary responsibility shall be to direct, control, prioritize, and coordinate the work of the State authorities to the extent permitted by law. The Chief shall have cabinet status, shall be appointed by me in consultation with the Senate President and the Assembly Speaker, and shall serve at my pleasure during the duration of this Order.

3. The Chief of Economic Recovery shall be responsible for identifying all programs currently pending in any State authority, department or agency which would promote economic growth or create jobs, and shall take every necessary and proper action to ensure the immediate implementation of such programs. In order to assist the Chief, the authorities (or the departments or agencies if so directed), in such format as determined by the Chief, shall forthwith identify all programs and projects currently pending before them, which have the potential to promote economic growth and create jobs in the immediate future and shall provide a listing of all such programs and projects. The Chief shall examine all such projects, and prioritize them in the order of their potential to immediately create jobs and promote economic growth. The authorities shall cooperate fully with the Chief in this evaluative process and shall take every necessary and proper action to ensure the immediate implementation of the programs and projects which are determined by the Chief to be priority projects or programs. The authorities shall provide the Chief with any other such information requested by him. This process of evaluation and prioritization of projects and programs shall be a continuing process. The Chief shall meet periodically with the authorities to evaluate and prioritize new programs or projects, or review existing priorities as circumstances warrant.

4. The Chief shall regularly meet with all departments and agencies having responsibility for any economic development project of an authority, and shall expedite the resolution of any impediments to the immediate implementation of such projects. All departments and agencies are ordered to cooperate fully with the Chief in this respect.

5. The Chief is directed to identify unencumbered funds and other resources of the authorities (or departments or agencies) and to make recommendations as to how these resources can be pooled to further the purposes of this Order and to expedite the investment of such resources for appropriate purposes.

6. The Chief is authorized to provide assistance to private businesses and local and county government bodies in resolving matters that may prevent or delay speedy implementation of economic projects. The Chief shall also be responsible for forming partnerships with private investors and entrepreneurs for the purpose of providing the private sector with all appropriate assistance in promoting investment in New Jersey.

7. All authorities which by law are required to submit their minutes, resolutions, or actions to me for my approval or veto, shall henceforth simultaneously submit such minutes, resolutions, or actions to the Chief. The authorities shall fully cooperate with the Chief in his review of such items and shall promptly furnish him with any and all information which he may request in connection with his review thereof.

8. The Chief of Economic Recovery shall report and advise the Senate President, the Assembly Speaker and me in the exercise of my authority to approve or veto the minutes, resolutions or actions of the authorities so as to further the purposes of this Order.

9. I hereby direct all State departments, agencies and authorities to provide the Chief of Economic Recovery with the fullest measure of cooperation in implementing this Order, and to make available to the Chief any and all resources as may be necessary in discharging the Chief's responsibilities. The Chief is empowered to draw upon the resources and personnel in the existing State departments, agencies, and authorities.

10. The Chief of Economic Recovery shall have access to all information within the possession of any department, agency or authority concerning economic development projects. This Order shall constitute his authorization to receive all such information, without the necessity of any further writing or directive from me.

11. The Chief of Economic Recovery shall report to the Senate President, the Assembly Speaker and me on a weekly basis, or more frequently as the need arises, to advise us on the progress achieved in carrying out this Order.

12. This Order shall take effect immediately and shall remain in effect for one year.

(a)

OFFICE OF THE GOVERNOR
Governor Jim Florio
Executive Order No. 67(1992)
Establishment of New Jersey 2000 Advisory
Committee

Issued: October 16, 1992.

Effective: October 16, 1992.

Expiration: Indefinite.

WHEREAS, it is critical to initiate changes in our education system to assure that all New Jersey students are prepared for the next century; and

WHEREAS, in 1990 the President of the United States and the Governors of all fifty States endorsed six national education goals for the year 2000; and

WHEREAS, New Jersey added a seventh goal—expanding parental involvement in the schools; and

WHEREAS, the second annual report card issued by the New Jersey Department of Education assessing the State's progress toward meeting these goals has shown some advances but a need for further improvements; and

WHEREAS, it is imperative to have local communities involved in, and committed to, strategies for reaching these goals; and

WHEREAS, it is important to recognize the efforts of local communities by granting a State designation of New Jersey 2000 to communities who develop a plan to attain the seven educational goals; and

WHEREAS, a State advisory panel can assist in promoting Statewide education reform in New Jersey by advising the Governor on which communities to recommend for New Jersey 2000 designation and advising the Governor, the Legislature, and the Department of Education on issues regarding school reform in New Jersey;

NOW THEREFORE, I, JAMES J. FLORIO, Governor of the State of New Jersey, by virtue of the authority vested in me by the Constitution and by the Statutes of this State, do hereby ORDER and DIRECT:

1. There is hereby established the Governor's New Jersey 2000 Advisory Committee which shall be composed of not more than 30 individuals, appointed by the Governor, who shall be representative of a broad cross-section of the citizens of New Jersey, including, but not limited to, education organizations, local school districts, the higher education community, business and civic leaders, parents and students. Two co-chairs of the Committee shall be designated by the Governor from among the Committee members.

2. It shall be the charge and duty of the New Jersey 2000 Advisory Committee to:

(a) Advise the Governor on which communities to recommend for New Jersey 2000 designation, based on a review of their plans according to the criteria specified below;

(b) Promote the concept of New Jersey 2000 and encourage communities to meet the criteria;

(c) Review the criteria for designation and make recommendations for any changes to that criteria;

(d) Advise the Governor, the Legislature and the Department of Education on how to best promote desired school reforms;

(e) Encourage an active dialogue at the State and local level about school reform in general, including the recommendations of the Quality Education Commission;

(f) Advise the Department of Education on the allocation of any federal funds that may be provided for the support of this initiative; and

(g) Advise the Department of Education on the development of the annual State report on our progress toward the national goals.

3. The Committee shall review plans for New Jersey 2000 designation to see if the plans meet the following criteria:

A. Adoption of Goals

(1) The plan must identify who will be involved in the effort and show that those participating represent a sufficiently broad segment of the community including educators, parents, students, business and government leaders, social agencies, and others; and

(2) The plan must contain documentation of formal action by participants to adopt New Jersey 2000 goals and pledge support thereof.

B. Development of Strategy

(1) The plan must identify participants in implementation of strategy to attain the goals adopted by the community.

(2) The plan must contain documentation that participants assisted in developing the strategy; and

(3) The plan must include a strategy which meets the following conditions:

- (i) identify planned activities in a concise and logical sequence;
- (ii) identify who is responsible for conducting activities
- (iii) include a timeline for the completion of planned activities; and
- (iv) describe resources committed to completion of activities.

C. Development of Progress Report

(1) The plan must contain a format/outline which will be used to report progress toward accomplishing the seven goals and the various program initiatives identified in the community's strategy;

(2) The plan must identify who is responsible for preparation and distribution of the progress report; and

(3) The plan must describe how and when the progress report will be distributed.

D. Plan and Support School Reform

The community's strategy must include the following:

(1) Activities designed to accomplish each of the seven New Jersey 2000 goals; and

(2) Efforts directed toward accomplishment of one or more of the following school reform measures:

- Curriculum framework and standards;
- Preschool education;
- Integrated social services for students in K-12;
- Programs to ensure successful student outcomes for inner city students and those who are socially, economically, and emotionally disadvantaged;
- School-based management;
- Teacher in-service programs to increase teacher knowledge and skills in the areas of student learning and cognition, curriculum and assessment, and the influences of diversity in culture, communication, and learning style on teaching and learning;
- Changes in the school schedule to provide more time and greater flexibility for new and existing programs; and
- Integration of technology resources into educational programs;

4. The Committee is authorized to call upon any department, office, division or agency of the State to supply such data, reports and other information as it deems necessary and appropriate to discharge its responsibilities under this Order. Each department, office, division, or agency of the State is authorized and directed, to the extent not inconsistent with law, to cooperate with the Committee and to furnish it with such information and assistance as is necessary to accomplish the purpose of this Order.

5. Until such time as the members of the Committee are appointed, the Commissioner of Education shall review plans submitted for New Jersey 2000 designation based on the criteria set forth above and advise the Governor on which communities should receive that designation.

6. This Order shall take effect immediately.

RULE PROPOSALS

EDUCATION

(a)

STATE BOARD OF EDUCATION

Physical Education and Athletics Personnel and Procedures

Proposed Amendment: N.J.A.C. 6:29-3.4

Authorized By: State Board of Education; John Ellis, Secretary, State Board of Education and Commissioner, Department of Education.

Authority: N.J.S.A. 18A:1-1, 4-10, 4-15, 28-7, 35-5, 36-19 and 40-4,

Proposal Number: PRN 1992-493.

Submit written comments by December 16, 1992 to:
Edward Richardson, Acting Rules Analyst
N.J. Department of Education
225 West State Street, CN 500
Trenton, New Jersey 08625-0500

The agency proposal follows:

Summary

Pursuant to the provisions of Executive Order No. 66(1978), N.J.A.C. 6:29, Health, Safety and Physical Education, was reviewed and revised; subsequently amendments to these rules were adopted by the State Board of Education on February 7, 1990.

N.J.A.C. 6:29-3.4(d), which was adopted at that time, requires each student trying out for a place on a school athletic squad or team to have a medical examination by a physician licensed to practice medicine no more than 60 days prior to the first practice session. However, the required examination may not be given before the first day of the school year as defined in N.J.S.A. 18A:36-1. Many students are seen annually by their physician for a physical examination which cannot be used to meet the requirement because of the limited time during which a physical examination may take place. Therefore, the 60 day rule places an additional burden upon the parents and the physician. A health history update completed by the parent or legal guardian is already required and sufficient for participation on a subsequent athletic squad or team during the school year. The Department is now proposing the following amendments:

N.J.A.C. 6:29-3.4(d) will be amended to expand the time for a physical examination for any candidate for a place on a school athletic squad or team to 365 days prior to the first practice session. New language stipulates the minimum information to be included in the health history update which must be completed prior to a student's participation on an athletic squad or team during the remainder of the year covered by the physical examination when the examination was completed more than 60 days prior to the first practice session.

N.J.A.C. 6:29-3.4(e)ix requires the assessment of the heart with attention to the presence of murmurs, noting rhythm and rate before and after exercise. Based upon recommendations from the Committee on School Health and Sports Medicine of the New Jersey Chapter of the American Academy of Pediatrics, assessment of cardiac abnormalities is not enhanced by minimal or short term exercise. Thus, the assessment required before and after exercise has been removed as it is considered unnecessary.

Social Impact

The social impact of the proposed amendment will be positive. Students who are physically fit and who have received an annual physical will not be required to undergo an additional examination to take part in interscholastic athletic competition.

Economic Impact

No additional costs to school districts will be incurred with the possibility of a savings of funds in some districts being present. There may be a decrease in the number of sports physical examinations completed by the school medical inspector, resulting in a potential cost saving to school districts.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required because the proposed amendment does not impose reporting, recordkeeping or other compliance requirements on small businesses as defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The amendment impacts solely upon New Jersey school districts and on schools operated by the New Jersey Department of Education.

Full text of the proposal follows (additions indicated in boldface thus; deletions indicated in brackets [thus]):

6:29-3.4 Athletics procedures

(a)-(c) (No change.)

(d) Each candidate for a place on a school athletic squad or team shall be given a medical examination by the medical inspector or designated team doctor [no more than 60] **within 365 days** prior to the first practice session [or in] **with examinations being made available throughout the school year consistent with the district's athletic schedule.** In lieu thereof, the medical inspector may accept the report of such an examination by a physician licensed to practice medicine.

[1. Any examination which shall be used to determine the fitness of a pupil to participate in athletics shall not be given before the first day of the school year, as defined in N.J.S.A. 18A:36-1, for which such fitness is being determined.

2. Each candidate must undergo one medical examination in each school year.

3. To participate on a subsequent athletic squad or team, a health history update shall be completed by the parent or legal guardian in accordance with district policy.]

1. To participate on an athletic squad or team, each candidate whose medical examination was completed more than 60 days prior to the first practice session shall provide a health history update of medical problems experienced since the last medical examination, which shall be completed by the parent or legal guardian. The health history update shall include, but not be limited to, the following information:

i. Hospitalizations/operations;

ii. Illnesses;

iii. Injuries;

iv. Care administered by a physician; and

v. Medications.

[4.]2. (No change in text.)

(e) A medical examination to determine the fitness of a pupil to participate in athletics shall include, as minimum, no less than the following:

1. (No change.)

2. A physical examination which shall include, as a minimum, no less than the following:

i.-viii. (No change.)

ix. Assessment of the heart with attention to the presence of murmurs, noting rhythm and rate [before and after exercise];

x.-xv. (No change.)

(f)-(i) (No change.)

HEALTH

(a)

OFFICE OF HEALTH POLICY AND RESEARCH

Notice of Draft State Health Plan

Diabetes, Cancer, Surgery and Renal Dialysis Services, Mental Health, Occupational and Environmental Health, Injuries and Emergency Care, Communicable Disease Control, AIDS, and Preventive and Primary Care

Take notice that the Department of Health is hereby releasing two preliminary draft chapters of the State Health Plan, prepared pursuant to P.L. 1991, c.187. The State Health Planning Board welcomes public input regarding the content of these chapters. The two chapters are AIDS and preventive and primary care.

The release of these chapters follows the November 2, 1992 publication in the New Jersey Register of the other seven chapters of the current phase of the State Health Plan: diabetes, cancer, surgery and renal dialysis services, mental health, occupational and environmental health, injuries and emergency care, and communicable disease control.

The purpose of this notice is to assure widespread dissemination of the draft chapters. Due to budget cuts, the Department of Health is unable to incur the expense of mailing the draft chapters to interested individuals. Consequently, the Department intends to use this notice as a means of making the documents available to the public. No formal action on the chapters is proposed.

Beginning on November 17, 1992, the State Health Planning Board will hold a series of six hearings (one in each Local Advisory Board region) to obtain public testimony which it will consider in revising and preparing the final versions of each chapter. Interested parties are invited to testify on any or all of the chapters at the hearings, which are scheduled for the following dates:

November 17, 1992	LAB VI
November 19, 1992	LAB I
December 1, 1992	LAB IV
December 3, 1992	LAB II
December 15, 1992	LAB V
December 17, 1992	LAB III

For information about the times and locations of the hearing, please contact Margaret Payne at the address below. Individuals should sign up before the hearing at which they wish to present their testimony by contacting Margaret Payne as follows:

Margaret Payne
Office of Boards and Councils
New Jersey Department of Health
CN 360
Trenton, N.J. 08625
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Written testimony may also be submitted, and should be sent to Ms. Payne by December 18, 1992. More specific information about the hearings and presentation of testimony was published in the New Jersey Register on November 2, as a separate notice. (See 24 N.J.R. 3789(a).)

When finalized as elements of the State Health Plan, all of the chapters will be used as advisory documents by the State Health Planning Board and the Commissioner of the Department of Health, as a guide to implementing public health policy, formulating planning rules, and in making decisions regarding Certificates of Need.

Each chapter has been prepared by Department of Health staff, in consultation with experts in the relevant fields, and with other departments and agencies of the New Jersey State government. The Department of Health and the State Health Planning Board have recognized that there may be short-comings or gaps in each chapter. Specific areas of concern must be identified and addressed before the chapters can be finalized. That is the purpose for which general public input and participation is solicited. As presented, the drafts represent a preliminary effort to establish the direction that health policy development should take in this State in the coming years.

The State Health Plan drafts for AIDS and preventive and primary care follow:

I. EXECUTIVE SUMMARY

AIDS is caused by two viruses, HIV-1 and 2. HIV-1, which causes the majority of cases, has been isolated from a variety of body fluids, and can be transmitted by sexual contact between men, women, and men and women. It can also be transmitted from infected mothers to infants, gestationally or at childbirth. In New Jersey, however, the main means of transmission is through the sharing of contaminated needles and syringes by injection-drug users (IDUs).

The AIDS epidemic is actually an epidemic of HIV infection, and full-blown AIDS is the last stage of the disease process. The virus disables and finally destroys the immune system, leaving individuals infected open to a number of otherwise rare cancers and opportunistic infections. Nearly all HIV-infected individuals will develop AIDS if they live long enough; the mean latency period of HIV is 10 years.

AIDS can strike anyone, but the most characteristic New Jerseyan with HIV/AIDS is a poor, minority, inner-city IDU. A relatively recent and alarming trend is the increase in infection through heterosexual contact, which accounted for 14 percent of reported cases in the first six months of 1992.

The economic cost of the epidemic to New Jersey has been considerable, and will grow steadily in the 1990s. Direct costs include care and treatment and support services; indirect costs include loss of wages and future earnings.

Estimates of the cost of care vary. The first attempt to calculate the comprehensive lifetime cost of treating a person with HIV/AIDS resulted in an estimate of about \$85,000. New Jersey's Early Intervention Program (EIP) up-front costs are much lower, but because the Health Department's stated policy is to test all sexually active New Jerseyans for HIV, and because early intervention has the potential to lengthen the lives of people with HIV/AIDS, costs will be considerable over time. The state must therefore expand its capacity to care for HIV/AIDS patients and find a more effective way to finance that care.

This is particularly essential because, in comparison with other patients, people with HIV/AIDS are young and poor, and many lack private insurance; many are also ineligible for Medicaid. With the fate of the Health Care Trust Fund uncertain, it seems clear that the State must develop a new financing mechanism for the care of medically indigent individuals.

However the HIV/AIDS effort is funded in the future, it is vital that costs be contained. Among the ways this can be accomplished are: reducing the cost of acute inpatient care, developing better and more available levels and modalities of care, strengthening prevention education efforts, and developing ways to relieve pressures on insurers and providers.

New Jersey's goal is to develop a broadly defined continuum of HIV/AIDS care that encompasses prevention education, counseling and testing, care and treatment, and support services. In the long run, this will rationalize care delivery and contain costs—goals not only for the AIDS epidemic specifically, but of the State Health Plan generally.

The heart of New Jersey's care and treatment effort is the Early Intervention Program (EIP). It was the first statewide program to implement the 1989 federal recommendations on early intervention and drug prophylaxis. Its goal is to substitute cost-effective outpatient care in multidisciplinary clinics for inpatient hospital care, and to link clients to needed services by case management. There are now seven designated EIP sites, with more than 5,000 clients.

Because persons with HIV/AIDS have such great and varying needs, there is no doubt that effective case management is vital to the State's fight against AIDS. In some areas of the state, there is a shortage of case managers, in others overlapping occurs. Efforts should be made to even this out, and to provide uniform standards for all case managers.

Additionally, because this chapter recommends that all acute care hospitals should provide AIDS outpatient care, each hospital should have an HIV/AIDS case manager on staff.

Most people with HIV/AIDS are found in "special" and well-defined at-risk populations, which include substance abusers, incarcerated persons, women, children, and gay and lesbian individuals. Each group must be addressed differently; however, in planning prevention education programs and other HIV/AIDS-related programs and strategies, it is critical to keep in mind that the disease can strike anyone, and that all New Jerseyans must be knowledgeable enough to avoid risky behaviors.

In all matters relating to HIV/AIDS in New Jersey, it should be remembered that two-thirds of New Jerseyans with HIV/AIDS are members of minority groups, and that attention must be paid to their unique cultural, linguistic, and other characteristics and needs.

II. INTRODUCTION

The national death toll from the AIDS epidemic is a hundred times greater than that of any flood, hurricane, or earthquake that has struck the United States in this century. AIDS kills an average of nearly 100 New Jerseyans every month. It is selective, disproportionately impacting the state's disadvantaged populations—minorities, substance abusers, and the poor—and placing severe strain on an already overburdened social services system. And it increasingly threatens entire families; although the HIV infection rate has leveled for some at-risk populations, cases are growing alarmingly among New Jersey's women of childbearing age.

Although the nation's—and New Jersey's—response to the AIDS epidemic has been substantial, it has also been insufficient. The federal Ryan White legislation is underfunded; nevertheless, it has channeled desperately needed resources to New Jersey's HIV Care Consortia and to two of its hardest-hit cities, Newark and Jersey City. New Jersey has pioneered in the development of HIV/AIDS case management and in an early intervention program that, given sufficient resources, could make AIDS a chronic disease and change the face of the epidemic.

In 1990, Governor Jim Florio asked the State Commissioner of Health to prepare a comprehensive state plan to combat AIDS in New Jersey. Many—but, significantly, not all—of its more than 40 recommendations have been implemented, including the formulation of a broader counseling and testing policy, and the creation of HIV/AIDS Resource Centers and an Office of Women and AIDS within the Division of AIDS Prevention and Control of the State Department of Health.

Despite these efforts, serious problems persist all along the state's continuum of HIV/AIDS-related programs and services. Although some of New Jersey's at-risk populations have received and responded to the Health Department's AIDS-awareness messages, others have not; we have not, for example, succeeded in even loosening the knot that binds AIDS and substance abuse.

Barriers to accessing care persist. The innovative Early Intervention Program (formerly TAP) is oversubscribed, with waiting lists of six to eight weeks at some sites. Medicaid reimbursement rates for HIV/AIDS care are wholly inadequate, providing just one of several reasons why some New Jersey physicians, dentists, and other health care professionals are reluctant to treat the stricken. While virtually all New Jersey hospitals can and do deliver first-rate HIV/AIDS inpatient care, too few of them are equally able and willing to provide ongoing outpatient care after discharge. Sub-acute care alternatives for people with HIV/AIDS are sorely lacking. Finally, there are shortages of nearly all of the many ancillary services they need—legal assistance, buddies and other volunteers, dental care, substance abuse treatment and, perhaps most acutely, adequate housing.

This chapter represents no great departure from the State's past efforts to confront AIDS. We are either doing the right things—or at least know what the right things to do are.

Accordingly, this chapter's 18 recommendations are intended to further increase our knowledge of the epidemic; to promote HIV/AIDS awareness in both the general public and at-risk groups; to widen the availability of counseling and testing; to remove the remaining barriers to the access of appropriate and timely care and treatment; to target special populations for HIV/AIDS-related services; and, perhaps most crucially, to more adequately finance those services.

III. RECOMMENDATIONS

GENERAL

1. The State should, through expanded surveillance activities, seroprevalency testing, research, and data collection and analysis, promote the continuing acquisition of knowledge about the New Jersey HIV/AIDS epidemic. These activities should include a comprehensive data analysis of the Early Intervention Program and a statewide care and treatment and service need-assessment survey sufficiently detailed to serve as a guide for the future allocation of human and financial resources.

PREVENTION EDUCATION

2. The State, in partnership with the private sector, should structure and implement a multifaceted and multimedia HIV/AIDS public awareness and education campaign. This campaign should address the general public, in order to build support for safe behavior and personal risk reduction, but should also include components specifically targeted to high-risk populations. Particular care will be taken to ensure that the campaign's messages address the

linguistic, cultural and other special characteristics and needs of minority communities.

3. As more HIV incidence data become available, the State should add HIV profiles to the State's ongoing community health profiles, and use them to tailor community-based HIV/AIDS prevention activities for maximum cost-effectiveness and impact in both high and low-incidence areas of New Jersey.
4. The State should take all possible action to persuade New Jersey school systems to include an HIV/AIDS prevention education component in family life and other similar programs at all grade levels. This program should be developed jointly by the Department of Health and the Department of Education to ensure accuracy, consistency, and age-appropriateness. Serious consideration should be given to the development of a condom-distribution program such as those in New York City, Los Angeles, and Philadelphia, as one part of a comprehensive program that presents all sexual-behavior options, including abstinence.
5. As a matter of public health, the State should make condoms available to incarcerated persons in all State-operated correctional facilities, as part of a broadly based effort to prevent the infection of inmates.
6. The State should take all possible action to impede the transmission of HIV among injection-drug users, including the initiation of a needle-exchange demonstration project. Such an initiative will require clear objectives and a receptive environment, and have the support of local government and health officials, and the community. This project should be one of a number of measures, including expanded outreach and education, targeted to this population.
7. The State should coordinate the tuberculosis-related efforts of the Division of AIDS Prevention and Control and the Division of Epidemiology, Environmental and Occupational Health Services of the Department of Health. All training of TB program staff and outreach workers should include information about HIV/AIDS risk assessment, counseling and testing, and confidentiality issues. Cultural and linguistic sensitivity training should be included.

COUNSELING AND TESTING

8. The State should aggressively promote HIV counseling and testing in a greater variety of health care settings, including hospitals and ambulatory care facilities, as a standard component of their service delivery. It should also increase the availability of HIV counseling and testing to community-based agencies which incorporate intensive outreach interventions (for example, mobile health vans) to improve access to HIV/AIDS services for at-risk populations. This expansion is particularly necessary because it is now the stated policy of the Department of Health to recommend testing for all sexually active New Jerseyans. All counseling should be culturally and linguistically appropriate, and all testing should require informed written consent.

CARE AND TREATMENT

9. The State should take action to increase the capacity of the New Jersey health care system to treat persons with HIV/AIDS. This should include any necessary measure, including licensure suspension and the refusal to approve certificates of need, to ensure that every acute-care hospital in the State has the capacity to treat HIV/AIDS patients on both an in- and outpatient basis—and does so when necessary. The State should also designate several hospitals as HIV/AIDS tertiary care centers to serve as anchors to the system by treating particularly difficult and/or severe cases.
10. The State should seek an increased Medicaid reimbursement rate for both inpatient and outpatient HIV/AIDS care. This should include higher rates for physicians and dentists providing care in their private offices or outpatient clinics.
11. In place of the Health Care Trust Fund, the State should develop a public financing mechanism to cover HIV/AIDS care and treatment for those who are not Medicaid-eligible or covered by private insurance.
12. The State should take all necessary action to place persons with HIV/AIDS in skilled nursing facilities and other long-term care alternatives that are equipped to care for young patients. Reimbursement should be based on severity of illness.
13. As a part of a broader program to expand the availability of drug treatment services for New Jerseyans the State should establish and/or expand treatment programs for women with HIV/AIDS and

their children. Such programs should provide primary, prenatal, post-partum and medical day care for women, and developmental day care for their children.

14. The State should encourage primary care physicians—especially pediatricians—to treat “routine” cases of HIV infection in children, in accordance with the recently developed protocol. Pediatricians should make contact with the Pediatric HIV Network as quickly as possible, and the most seriously ill children should be referred to them for treatment.
15. The State should respond to the growth of the HIV/AIDS epidemic and the concomitant need for additional health care and social services professionals by encouraging the formation of a cadre of trained professionals specializing in HIV/AIDS care and service delivery at all levels. Measures could include publicly funded or subsidized training programs for nurses, nurses’ aides, nutritionists, and social workers; alternative practice models; practice fellowships; and the enhancement of the HIV/AIDS components of residency and post-doctoral programs. The recruitment and training of minority health care professionals, including case managers, should be particularly encouraged.
16. The State should seek additional sources of funding for the AIDS Drug Distribution Program, including public-private partnerships with pharmaceutical firms.

SUPPORT SERVICES

17. The State should require all State-funded health care inpatient and outpatient facilities treating HIV/AIDS patients to provide case management, according to uniform standards set by the Department of Health.
18. The State should establish an interdepartmental working group, chaired by the assistant commissioner of the Division of AIDS Prevention and Control and meeting bimonthly, to coordinate efforts that facilitate the provision of support services for people with HIV/AIDS, such as housing, which do not fall directly and/or exclusively under the purview of the Department of Health.

IV. CURRENT STATUS, TRENDS AND ANALYSIS

The Human Immunodeficiency Virus and AIDS

The clinical disease called AIDS is caused by two viruses, known as human immunodeficiency virus types 1 and 2 (HIV-1 and -2). These viruses invade the cells in the body—especially the “helper” lymphocytes of the immune system. Most cases of AIDS in the world—including the Americas—are caused by HIV-1 (hereafter, HIV), which was also the first to be discovered.

HIV has been isolated from a variety of body fluids, including blood, semen, vaginal secretions, milk, urine, cerebrospinal fluid, tears and saliva. However, studies indicate that only contact with blood, semen and vaginal secretions, and a nursing mother’s milk, can transmit the virus.

HIV has been shown to be transmitted sexually by contact between men, from men to women, and from women to men. Between men, it appears that unprotected receptive anal intercourse with an infected partner is more likely to infect one with HIV than is insertive anal intercourse or any type of oral-genital contact. Among women living in the United States, the main means of contracting HIV infection are sexual contact with male injecting drug users (IDUs) or bisexual male partners, and injecting drug use. In the United States (and in New Jersey) IDUs are the main source of heterosexual transmission. IDUs acquire HIV through the sharing of blood-contaminated paraphernalia (needles and syringes). HIV infection can be transmitted vertically from infected mothers to their infants during gestation and at childbirth.

Since 1981, when homosexual men in California and New York began to develop unusual cancers and severe infections, we have come to recognize AIDS and HIV infection as a new fact of life. At a time in history when most infectious diseases have been conquered or controlled in developed nations, we now have to struggle with an organism that destroys the human immune system, and a disease that is almost 100 percent fatal and difficult—though not possible—to treat.

It is important to remember that the AIDS epidemic is actually an epidemic of HIV infection. AIDS itself usually represents the final stages of a lethal infection that began years earlier. Typically, after becoming infected, a mononucleosis-like infection (fever, chills, rash) occurs in one to three months and causes the production of antibodies which are reflected in a positive HIV blood test. Unlike other human infectious viruses, HIV is able to remain permanently infectious within several types

of immune system cells, making the infected individual a lifelong risk to others. The virus’ ability to disable and eventually destroy the immune system leaves the infected individual vulnerable to otherwise rare cancers (Kaposi’s sarcoma and non-Hodgkin’s lymphoma) and bacterial, viral, fungal, and parasitic infections.

Infections which take advantage of the weakened immune system are called opportunistic infections. They include parasites like *Pneumocystis carinii* and toxoplasma; bacteria like tuberculosis and salmonella; viruses like herpes simplex and cytomegalovirus; and fungi like candida and cryptococcus. Infection of the brain results in dementia and encephalitis, while infection of the gastrointestinal tract causes ulcers of the mouth and esophagus, chronic diarrhea, and weight loss. HIV infection in women and children differs somewhat in the specific symptoms and diseases encountered, but the pattern of immune destruction, recurrent infections, weight loss, dementia—and death—is the same.

After infection, the mean incubation (latency) period before symptoms of full-blown AIDS appear is ten years. It is now generally assumed that more than 90 percent of all HIV-infected individuals who survive long enough will develop AIDS or clinically severe HIV infection.

Because the immune systems of people with HIV/AIDS are badly compromised, there is no typical course of illness. The infections are frequently life threatening and difficult to treat. Typically, people with HIV/AIDS suffer periods of severe illness alternating with periods of relatively good health. Thus, there is a need for health care and support services at a variety of levels, from acute hospital care with efficient discharge planning to community-based care and services. Care may include stays in sub-acute, long-term, and residential facilities, at home and in hospices. How well these facilities and services are integrated and made accessible is the crux of this epidemic and the heart of this chapter.

Epidemiology

New Jersey has been hit very hard by the HIV/AIDS epidemic. Its cumulative total of 13,572 reported AIDS cases (as of June 30, 1992) places it fifth among all states. It is estimated that 30,000 to 50,000 New Jerseyans are infected with HIV, 4,000 of whom are living persons with AIDS. New Jersey’s epidemiological profile is different from most other states however. For example:

- The leading HIV transmission category in New Jersey is injecting drug use, at 54 percent of total adult and adolescent AIDS cases; IDUs constitute only 23 percent nationally. Fully 60 percent of the State’s women with AIDS are or were IDUs, and 33 percent more had sexual contact with an HIV-infected man, or one at high risk of infection.
- The epidemic has hit New Jersey’s minorities with particular force. Cases among African-Americans and Hispanics account for two-thirds of the state’s total, compared to 46 percent nationally. More than three in four (78 percent) New Jersey women with AIDS are African-American or Hispanic, as are four in five (81 percent) of its pediatric cases.
- Almost three percent of New Jersey’s AIDS cases are children—the second-highest percentage in the U.S. The State has 10 percent of the nation’s pediatric cases.
- The proportion of AIDS cases among New Jersey women is double that found nationally.

An Epidemic of the Disadvantaged. One conclusion that must be drawn from this profile is that New Jersey’s primary reservoir of HIV-infected individuals and people with AIDS consists of poor, minority, inner-city, present or former IDUs and their families. In New Jersey, more than almost anywhere else in the United States, the epidemic is battering the economically and socially disadvantaged. This has important consequences for policy making.

The Growth of Heterosexual AIDS. There is also a relatively recent and alarming trend in the incidence of both HIV infection and AIDS in the state. Between the beginning of the epidemic and the end of 1987, heterosexual-contact AIDS cases accounted for just seven (7) percent of New Jersey’s total; since then, they have grown to 13 percent. Analysis of preliminary data from the Division of AIDS Prevention and Control’s new HIV reporting system indicates that 14 percent of all reports of HIV infection received during the first six months of 1992 also resulted from heterosexual contact. Heterosexual-contact cases of HIV infection is the fastest-growing category in the state.

This disturbing trend, along with an estimate that one percent of the sexually active New Jersey population is now HIV infected, led the

Health Department to recommend in November 1991 that every sexually active New Jerseyan be tested for the virus.

Geographic Distribution. There are HIV-infected individuals living in every city and county of the State, but by far the majority of cases are reported in the northeastern cities of Newark, East Orange, Jersey City,

Paterson, and Elizabeth. Newark and Jersey City are two of the 16 U.S. cities designated as recipients of Federal Ryan White Title I funds for HIV/AIDS care and treatment. This is in large measure due to the high concentration of IDUs in these urban areas. The table below lists AIDS cases **only** for the 15 top AIDS cities in New Jersey, with annual incidence and cumulative case counts.

City	1988 Cases	Per 100K	1989 Cases	Per 100K	1990 Cases	Per 100K	Cumulative Cases Per 100K	
Newark	422	153.3	498	180.9	441	160.2	2538	922.2
East Orange	94	127.8	113	153.6	116	157.7	655	890.5
Atlantic City	28	73.7	68	179.0	75	197.4	226	595.0
Jersey City	195	85.3	231	101.1	186	81.4	1319	577.1
Orange	29	96.9	29	96.9	28	93.6	172	574.8
Irvington	49	80.3	47	77.0	50	81.9	294	481.8
Hoboken	23	68.9	20	59.9	22	65.9	160	479.1
Paterson	87	61.7	112	79.5	97	68.8	634	450.0
New Brunswick	25	59.9	42	100.7	22	52.7	166	398.0
Plainfield	22	47.2	34	73.0	24	51.5	181	388.7
Elizabeth	50	45.5	62	56.4	62	56.4	361	328.2
Union City	25	43.1	20	34.5	29	50.0	167	287.9
Passaic	33	56.9	23	39.6	36	62.0	155	267.1
Trenton	28	31.6	32	36.1	32	36.1	179	201.9
Camden	22	25.1	30	34.3	30	34.3	144	164.6

The table below shows the incidence of AIDS (only) by LAB for year of diagnosis. Complete data for 1991 is not yet available.

LAB	1988 Cases	Per 100K	1989 Cases	Per 100K	1990 Cases	Per 100K	Cumulative Cases Per 100K	
Region I	187	17.1	211	19.2	204	18.6	1220	111.2
Region II	400	29.0	435	31.6	397	28.8	2698	195.7
Region III	769	60.5	887	69.7	821	64.5	4880	383.6
Region IV	190	14.1	219	16.3	188	14.0	1140	84.7
Region V	91	6.8	148	11.1	126	9.5	680	51.1
Region VI	170	13.0	304	23.3	308	23.6	1239	95.0

Region I: Morris Passaic, Sussex, and Warren Counties
 Region II: Bergen and Hudson
 Region III: Essex and Union
 Region IV: Hunterdon, Mercer, Middlesex, and Somerset
 Region V: Burlington, Camden, Cumberland, Gloucester, and Salem
 Region VI: Atlantic, Cape May, Monmouth, and Ocean

A Growing Epidemic. The HIV/AIDS epidemic in New Jersey is not abating. Because of the long latency period of HIV, and the effects of drug prophylaxis and treatment, we are assured of an increasing number of living new AIDS cases, even as the rate of HIV infection slows. When the new CDC case definition for AIDS takes effect, we can expect an increase of 50 to 75 percent in the number of individuals who are diagnosed as having AIDS.

There are several means of projecting the estimated number of AIDS cases over the next couple of years. The Centers for Disease Control, using back-calculation and extrapolation, estimates that there will be 58,000 to 68,000 new cases nationally in 1992, and an additional 61,000 to 72,000 in 1993. Adding these new cases to the present national total of just over 200,000 cases at the end of 1991 yields an estimated 320,000 to 340,000 cumulative U.S. AIDS cases by the end of 1993.

Department of Health epidemiologists, using similar methods for New Jersey data, predicted a cumulative total of 13,000 to 15,300 cases diagnosed by the end of 1991. Adjusted for reporting delays, they believe about 13,600 cases have actually been diagnosed, slightly more than the lower estimate. The number of reported cases has **doubled** since April 1989. With the expected change in the AIDS case definition, the number of infected persons meeting the criteria is expected to increase 50 to 70 percent during the first year, with smaller increases in subsequent years.

Dr. June E. Osborn, chairperson of the National Commission on AIDS, recently wrote: "Numerically, the HIV epidemic in the decade of the 1990s will be far worse than what we have seen so far, and it will touch us all."

The Social and Economic Impact of AIDS in New Jersey

The social and economic "cost" of this epidemic, in which more Americans have already died than were killed in the Korean and Vietnam

Wars combined, is in many ways immeasurable. One need only listen to the accounts of the HIV-infected and people with AIDS to realize the social and economic trauma it has caused them, and their families. And its cost to society as a whole is more than the sum of these individual parts. Nevertheless, there are some statistical benchmarks which can be applied to HIV infection and AIDS that help to assess the magnitude of the epidemic's cumulative social and economic impact.

Social Impact. HIV infection and AIDS most often strikes New Jerseyans in the prime of life. In 1988, they were the eighth-leading cause of death in the State (and fifteenth nationwide), but they were the **leading** cause for African-American men aged 25-44 and women aged 15-44, and the second-leading cause of death for white men 25 to 44. By 1990, they had risen to be the overall leading cause for New Jerseyans in that age group.

The fact that most New Jersey women with HIV/AIDS are of child-bearing age has had—and will increasingly have—grave consequences. Seroprevalence studies of New Jersey newborns between 1988 and 1991 consistently indicated that about one infant in 200 is born to an HIV-infected mother, or about 600 a year. If 30 percent of them develop HIV infection, the state will have 180 newly infected infants a year in the 1990s.

Analyses of patterns of cause-specific death rates, which have traditionally been used to assess the relative importance of various causes of death on the population, are heavily weighted toward the elderly and do not reflect the impact of deaths from HIV infection and AIDS or other diseases that often cause premature death.

More useful is another measurement, called Years of Potential Life Lost (YPLL). YPLL, a measure of premature death, is the sum of the years of life not lived to a defined upper-age limit (in this case, 65)

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by those who died before reaching that age. In 1989, HIV infection and AIDS ranked fourth as causes of premature death in New Jersey, with a total of 43,267 YPLL.

But as we have seen, AIDS is a burgeoning epidemic. During 1990 alone, the incidence of HIV/AIDS rose by more than two percent and vaulted into second place behind cancer as a cause of premature death. That year, more than **80 percent** of the YPLL from HIV/AIDS occurred among individuals aged 25-44. Moreover, HIV infection and AIDS were the leading causes of premature death in New Jersey's African-American population in 1990, with an increase of nearly eight percent in one year.

Economic Impact. There are a number of ways to assess the economic cost and impact of the HIV/AIDS epidemic. Most of the studies done to date are based upon relatively small numbers of HIV/AIDS patients, and more data is needed. Nevertheless, all the studies point to one unalterable fact: the cost of this epidemic, however it is calculated, is already considerable, and it will grow steadily over the next decade.

The economic impact of the epidemic embraces both direct and indirect costs. Direct costs include personal medical care (hospital stays, physician costs, inpatient and outpatient services, drugs, ancillary services, nursing and home health care, respite and hospice services) as well as nonpersonal direct expenditures such as biomedical research, health education campaigns, blood screening and testing, and support services.

Indirect costs include the loss of wages as a result of illness and disability and the loss of future earnings as a result of premature death. The loss of future productivity will be substantial because, as was discussed above, HIV infection primarily strikes young adults.

● **The Cost of Care**

Estimates of the cost of care of people with HIV/AIDS also vary widely. As Fred J. Hellinger of the U.S. Department of Health and Human Services points out in the fall, 1991 issue of *Inquiry*—the first article to attempt a forecast of all individuals with HIV—it is particularly difficult to estimate the number of HIV-infected individuals receiving care. Since the advent of widespread drug prophylaxis and other changes in treatment, estimating costs has become even more problematic.

Using CDC data, along with that from several states (including New Jersey), and making a number of conservative assumptions on the number of hospital stays per year, survival time, and the cost of drugs, Hellinger estimates the annual cost of treating a person with AIDS at \$32,000, of which \$24,000 is for inpatient care and \$8,000 is for other services. In New Jersey, 12 HIV-related diagnosis-related groups (DRGs) were devised and implemented to reimburse hospitals for inpatient care. In 1989, 86 hospitals counted 6,148 admissions, and an average cost per admission of just over \$12,000, for a total inpatient care cost of over \$75 million. (See table following summarizing the New Jersey AIDS funding).

Using these estimates in combination with current and projected incidence data yields the following annual total U.S. costs of medical care for the HIV/AIDS epidemic:

- 1991—\$5.8 billion
- 1992— 7.2 billion
- 1993— 8.7 billion
- 1994—10.4 billion

These estimates represent an average yearly increase in the cost of care of about 21 percent, and are higher than most previous attempts to assess the epidemic's care costs. This is due to projected longer survival times and the increased use of costly medications.

In a sense, advances in treatment and drug prophylaxis are the victims of their own success, since they have the potential to keep people with HIV/AIDS alive longer to absorb more resources. The ultimate goal of early intervention is to render HIV disease a chronic condition rather than a terminal one.

Using data from a 1989 study by Arno, *et al.* in the *Journal of the American Medical Association*, and from several other states, Hellinger estimates the average annual cost of outpatient care for HIV-infected persons without AIDS at \$5,150. For New Jersey, however, there is a somewhat different picture. The Early Intervention Program (EIP) is based on several premises—one being that it may be possible to reduce the cost of care by getting newly seropositive individuals into treatment before their immune systems are severely compromised. Hellinger cites early EIP data indicating annual costs (without drugs: see below) of less than \$2,000.

It should be noted, however, that at most one-fifth of New Jersey's estimated 40,000 infected persons are currently receiving treatment. The stated purpose of the Health Department's HIV testing policy is to identify as many more of them as possible, and to get them into treatment as quickly as possible. If that were to occur, however, access to care would be a very serious problem, since there are already three- to six-week waiting lists at every EIP site.

It is therefore incumbent upon the State to expand its capacity to treat people with HIV disease. This cannot be done by fine-tuning the present system, but only by increasing capacity and finding a more effective means of financing care. These issues are discussed later in the chapter.

● **The Early Intervention Program (EIP)**

In 1990, New Jersey implemented the Early Intervention Program (formerly known as TAP), which was discussed briefly above. It is now the heart of New Jersey's HIV/AIDS effort. Early EIP data indicated that its clients made an average of four to six clinic visits a year, at an average cost per visit of \$212 (exclusive of drugs) for an annual cost of outpatient care of less than \$2,000. Drugs such as AZT and aerosolized pentamidine could boost annual per-patient costs as much as \$4,000; nevertheless, this cost compares to an average bill for one acute care hospital stay for PCP of \$14,000 to \$19,000.

There are some problems with this approach. Providers are reimbursed less well for outpatient care than for inpatient visits. A proportion of the costs of early-intervention care are for drugs; again, inadequate reimbursement is a problem. Additionally, EIP aims at the creation of a true continuum of care, and many of the social services it provides are also inadequately reimbursed, if they are reimbursed at all. Finally, because one of the chief aims of early intervention is a humane one—to enable people with HIV/AIDS to live better and, if possible, longer—care must be provided over a longer period of time, and this increases costs. This is particularly true when patients are asymptomatic, and thus ineligible for many entitlement programs. A program like EIP therefore poses funding challenges for the State. The Early Intervention Program will be discussed in more detail later in this chapter.

● **Who Will Pay?**

As we have seen, this epidemic is exacting, and will continue to exact, a high social and economic cost from American government and society.

The following table summarizes New Jersey AIDS funding (in 1,000's of dollars) beginning in 1987. Amounts for 1991 and 1992 are estimates.

HEALTH

PROPOSALS

	Health	Edu.	Cor.	DYFS	Medicaid	Total
State	\$4,500	\$0	\$1,309	\$0	\$0	\$5,809
Private	\$700	\$0	\$0	\$0	\$0	\$700
Federal	\$700	\$0	\$0	\$0	\$0	\$700
Total, 1987:	\$5,900	\$0	\$1,309	\$0	\$0	\$7,209
State	\$14,283	\$0	\$3,971	\$0	\$3,622	\$20,876
Private	\$1,100	\$0	\$0	\$0	\$0	\$1,100
Federal	\$5,400	\$114	\$0	\$0	\$2,510	\$8,024
Total, 1988:	\$20,783	\$114	\$3,971	\$0	\$5,132	\$30,000
State	\$18,683	\$0	\$4,707	\$1,228	\$6,857	\$37,175
Private	\$1,100	\$0	\$0	\$0	\$0	\$1,100
Federal	\$11,800	\$357	\$0	\$600	\$6,564	\$19,321
Total, 1989:	\$31,583	\$357	\$4,707	\$1,828	\$13,421	\$51,896
State	\$16,071	\$0	\$5,097	\$1,228	\$11,977	\$34,373
Private	\$1,100	\$0	\$0	\$0	\$0	\$1,100
Federal	\$12,900	\$241	\$0	\$1,500	\$11,466	\$26,107
Total, 1990:	\$30,071	\$241	\$5,097	\$2,728	\$23,443	\$61,580
State	\$15,242	\$0	\$5,546	\$1,228	\$19,648	\$41,664
Private	\$1,000	\$0	\$0	\$0	\$0	\$1,000
Federal	\$14,387	\$480	\$0	\$2,160	\$18,810	\$35,837
Total, 1991:	\$30,629	\$480	\$5,546	\$3,388	\$38,458	\$78,501
State	\$16,447	\$0	\$11,982	\$1,440	\$27,517	\$57,386
Private	\$0	\$0	\$0	\$0	\$0	\$0
Federal	\$13,281	\$680	\$0	\$2,560	\$26,343	\$42,864
Total, 1992:	\$29,728	\$680	\$11,982	\$4,000	\$53,860	\$100,250

But the actual cost of direct medical care for AIDS is not inordinate. In a 1987 article in *Public Health Reports*, Scitovsky and Rice estimated that in 1991 AIDS care would represent just 1.4 percent of national medical care costs. This relatively small percentage is absorbable—but only if costs can be distributed equitably across all payers and providers. Nationally, however, this is not the case. Access to care is not universal, and the lack of health insurance is a growing problem.

This is also true in New Jersey, where a high percentage of people with HIV/AIDS are indigent. Until now, access to care has been generally maintained, but the burden on public payers and on the Health Care Trust Fund has been considerable. This issue will become even more urgent with the expiration of the Trust Fund at the end of November 1992.

Admissions data from New Jersey acute-care hospitals indicates that in comparison with other patients, people with HIV/AIDS are young, poor, much more likely to be on Medicaid, and much less likely to have their own health insurance. Additionally, fully **84 percent** of all children with AIDS admitted in 1989 were on Medicaid. With the fate of the Trust Fund uncertain, **it is critical that the state develop an alternative funding mechanism for HIV/AIDS care for those who have no insurance and are ineligible for Medicaid.**

In a time of governmental fiscal restraint and cuts in entitlement programs, it is becoming increasingly vital to contain the cost of HIV/AIDS care and to determine which providers are most heavily impacted, so that available funds can be channeled to them.

In theory, the redistribution of HIV/AIDS costs to take some of the burden off overstretched public payers ought not to be an insurmountable task. Private payers claim that HIV/AIDS is a major concern, and many of their policies contain clauses that limit their losses. But studies have shown that AIDS is well down the list of those illnesses that absorb claim dollars (16th among commercial insurers; 14th among Blue Cross/Blue Shield plans).

Nevertheless, all payers are likely to resist plans that increase their share of AIDS coverage. It is therefore essential that policy makers try to contain costs by doing the following:

- Reducing acute, inpatient care;
- Developing alternative levels of care: subacute, skilled nursing, hospice, home, etc.;
- Developing targeted programs or subsidies to relieve pressures on particular insurers and/or providers; and
- Strengthening prevention education to slow the epidemic's growth.

V. THE EXISTING HEALTH DELIVERY SYSTEM: BUILDING A CONTINUUM OF CARE

New Jersey's efforts to build and maintain a broadly defined continuum of care, encompassing not only medical care and treatment at all levels, but also prevention education, counseling and testing, and support services, is an attempt to provide for the varied needs of people with HIV/AIDS. It is also an integral part of a broader effort, embodied in this State Health Plan, to rationalize the delivery of health care and to contain its spiraling costs.

The Early Intervention Program, aspects of which are described above, also aims at the creation of a continuum of care that maximizes community-based resources and reduces the need for expensive acute-care inpatient services. Although the EIP sites link clients with some ancillary services, the main emphasis is on outpatient medical care and treatment. Because of the complex and cross-cutting character of this epidemic, however, an even more broadly defined continuum of care is essential—and is presented below.

Prevention Education

Many discussions of "continuum of care" for people with HIV/AIDS omit consideration of the role of prevention education. As noted earlier, this plan uses the broadest possible definition of the continuum concept, including in it not only HIV counseling and testing (see below), but prevention education as well.

The reason for this is clear. Although much progress has been made in the development of HIV/AIDS-related drugs, those developed so far are only prophylactic and therapeutic, and do not cure the disease. Moreover, most researchers believe that we are some years away from an effective vaccine. Prevention education therefore remains our best weapon for altering the course of the epidemic.

Good prevention education programs work. Early in the epidemic the gay community responded to educational campaigns, and began increasingly to practice "safer" sex. Many of New Jersey's other high-risk populations—drug users and adolescents, for example—are and will probably continue to be more difficult to reach, but the effort must—and is—being made by the state through professional training programs and the carefully targeted prevention education campaigns called for in last year's State Plan for HIV/AIDS.

Because some, but not all, of the recommendations of the state plan have been implemented, **this chapter also recommends a multifaceted, multimedia HIV/AIDS public awareness and education campaign to build public support for safe behavior and risk reduction. This program should have universal appeal and application, but should also contain components which are targeted to specific populations. The unique**

cultural and linguistic characteristics unique to the state's minority communities should receive particular attention. In this time of limited resources, the State should seek a partnership with New Jersey business and industry to aid in mounting this campaign.

• **Professional Training.** The goal of professional training is to reduce the incidence of HIV infection and AIDS by increasing the knowledge and skills of health and human services providers so that they may better deliver HIV-related services, prevent the transmission of HIV in the medical/dental setting, and deal wisely and compassionately with clients, patients, and co-workers. Again, professionals should be sensitized to the unique characteristics and needs of the state's minority populations.

FY 92 money in the amount of \$613,094 was awarded directly to professional associations and institutions of higher education to provide job training and instruction in "universal precautions" to health care professionals—physicians, nurses, other hospital staffers, home health care providers, drug treatment counselors and medical staffs, corrections nurses and counselors, mental health professionals, and social workers. Training and educational sessions were held in every county of the state and reached over 2,500 health care professionals in the first half of SFY 92.

Additionally, *AIDSLINE*, a monthly newsletter containing a calendar of relevant training opportunities and the latest developments in HIV/AIDS treatment is mailed to over 4,700 health care professionals a month. Training is also offered by AIDS division staff to other agencies which provide prevention education, health care, and social services to people with HIV/AIDS or those at high risk of infection.

This epidemic will demand increasingly extensive health resources, which are already spread too thin by shortages of trained personnel and by the continuing reluctance of some to provide care to people with HIV/AIDS. Effective training of health care workers at all levels is the best way to deal with these problems. Nevertheless, shortages abound. If the growing health care (and social service) needs of New Jerseyans with HIV/AIDS are to be met in the years ahead a **marked expansion of both the health care provider pool and its associated capacity to deliver effective, appropriate HIV/AIDS-related services will be necessary.** These professionals will require discipline-specific educational resources which are designed to develop skills ensuring effective HIV/AIDS-related care.

• **Public Information Activities.** New Jersey's public information activities provide all New Jerseyans with accurate information on HIV transmission and prevention. Those at risk are encouraged to change risky behaviors, to be tested for HIV, and if found to be infected, to seek early-intervention treatment. A variety of communication strategies are employed both for the general public and for targeted campaigns. These include the New Jersey AIDS Hotline (which handled nearly 20,000 calls in 1991); printed materials (more than 1,200,000 pieces in '91); billboards; bus posters; promotional items; and **HIV/AIDS Update**, the AIDS division's newsletter.

New Jersey public information activities are coordinated with the National AIDS Information and Education Program—the Center for Disease Control's component responsible for the "America Responds to AIDS" campaign. This campaign's materials can be adapted to specific locations, increasing the likelihood of obtaining media air time and placements.

• **Prevention Education for Targeted Populations.** New Jersey's HIV/AIDS epidemic is a selective one. Although HIV infection and AIDS can—and do—strike anyone, they have impacted with particular force on several populations: minorities, drug users, gays, adolescents and, increasingly, women and children. The state has targeted each of these high-risk groups with programs and material tailored to their specific situation and needs. Recent and current initiatives include:

- Production of **Protecting Our Future: A Manual for Responding to HIV/AIDS on New Jersey College Campuses**, a handbook to guide college administrators in implementing HIV prevention and education programs at their institutions;
- Training Hispanic teens for PACO, a community-based organization in Jersey City, to be "buddies" for young people with HIV/AIDS in their community, and to educate other teens;
- Substance abuse and AIDS training for Department of Education trainers, or directly for teachers; and
- Grants with the Essex and Camden chapters of the American Red Cross to provide outreach education to minority communities.

Two other initiatives should be mentioned. **Health Education/Risk Reduction** programs and services are efforts to reach high-risk individuals with behavioral risk-reduction messages. To deliver them, the state funds four HIV Prevention Consortia, representing a total of 30 agencies. The consortia's services are designed to complement existing programs such as HIV counseling and testing, referral, and partner notification.

The **Minority Initiative** aims at preventing or reducing high-risk behavior among members of minority groups through street and community outreach and intervention, and prevention education campaigns. It currently funds 12 community-based organizations, chosen on a competitive basis, which serve primarily racial/ethnic minority populations. Their services include prevention education and referral to IDUs (and their sexual partners) and to HIV-infected women and women at high risk of infection.

• **Experiential Speakers Bureau.** In response to a recommendation of the state plan for HIV/AIDS, and with the assistance of the Hyacinth Foundation, the Experiential Speakers Bureau was created, and began to function, in late 1991. The bureau now has a membership of 135 speakers; about two-thirds are persons with HIV/AIDS, and the remainder are family members, caregivers, and friends. In the first six months of 1992, speakers gave 130 educational presentations to adults and children all over the state. Their purpose is to dispel many of the myths still surrounding HIV/AIDS, and to increase public sensitivity to the issues confronted by persons with HIV/AIDS and their families and friends. In short, it aims to introduce knowledge, care, and concern into an area of health education heretofore dominated by fear.

• **Demographics and HIV Prevention Programming.** Until recently, only AIDS cases were reported, and incidence data reflected HIV infection that might have occurred years earlier. With the advent of HIV case reporting, more timely incidence data will eventually be available for quite localized and/or specifically targeted populations. Under the former system, for example, very few adolescents appeared in the AIDS data base, since, although they were infected in their teens, they often did not develop AIDS until they were well into their twenties.

With this detailed and population-specific HIV incidence data, HIV profiles could be added to the state's ongoing community health profiles. These would be very helpful in targeting both high- and low-incidence areas with tailored prevention messages. Funding for prevention education could be allocated much more precisely.

It is often difficult to assess the impact of prevention education programs on the public's knowledge, attitudes and behavior. Nevertheless, we know that these programs can be effective, and we need more of them. The recent report of the National Commission on AIDS called for a comprehensive national HIV-prevention program. In its absence, the initiative continues to lie with the states. New Jersey must continue and, if possible, increase its efforts in this critical component of the continuum of HIV/AIDS care.

• **HIV/AIDS and New Jersey Schools.** New Jersey school systems enjoy "home rule," and HIV/AIDS prevention education varies from system to system. It is **imperative** that children receive consistent, comprehensive and age-appropriate information about this epidemic and how it could touch their lives. The Departments of Health and Education should develop such a curriculum, and school systems should be strongly encouraged to use it. It should include discussion of the full range of "safer" sex alternatives, including abstinence. After close consultation with local school boards, school officials, and community members, consideration should be given to making condoms available to students.

HIV Counseling and Testing

As described above, the most effective strategy for reducing and controlling the spread of HIV infection is through prevention strategies which promote and reinforce the behaviors which reduce the risk of exposure and transmission. A critical component in the Health Department's prevention effort is the provision of counseling and testing services. Counseling and testing encourage at-risk individuals to identify risky behaviors, and inform them of their HIV status. Significantly, counseling and testing programs can also facilitate access to early treatment intervention services for infected individuals.

The Department of Health is committed to maintaining and expanding a network of geographically accessible HIV counseling and testing programs in a variety of health care settings. The Department encourages widespread HIV testing because of the availability of therapeutic interventions which can prevent or delay some manifestations of HIV

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disease, and to provide an opportunity for more effective education and counseling. In fact, in November 1991 the Health Department recommended that every sexually active New Jerseyan be tested for HIV. There are a number of special populations for which widespread screening would be particularly desirable; for example, pregnant women, since surveys continue to show that 0.5 percent of them are seropositive.

HIV counseling and testing services are available in a total of 181 health care settings in New Jersey. In addition to the twenty (20) free-standing voluntary counseling and testing sites, testing is also available at:

- 34 Sexually Transmitted Disease Clinics,
- 55 Drug Treatment Centers,
- 30 Tuberculosis Clinics,
- 23 Family Planning Clinics,
- 18 Pre-natal Programs, and
- 4 Local Health Departments.

In light of the Health Department's ambitious testing policy, expansion of counseling and testing to an even greater number and variety of settings—especially ambulatory care facilities—is strongly recommended.

To that end, the Division of AIDS Prevention and Control should expand the availability of HIV counseling and testing to a number of strategically located, community-based agencies that have a greater capability to provide intensive outreach to populations at risk for HIV infection. Funding should be directed to those agencies which can access minority women, female sex workers, female partners of injection-drug users, high-risk youth and pregnant teenagers. Particular attention should be given to those agencies, such as Checkmate Inc. in Monmouth County, which have the capability to provide mobile HIV counseling and testing services, in order to maximize the delivery of needed services to those at greatest risk for HIV infection.

During the period January 1 through December 31, 1991, the HIV counseling and testing network tested a total of 63,183 individuals, with 3,215, or five percent, testing positive. This was a 46 percent increase over the 43,352 people testing during calendar year 1990. Sixty (60) percent of those who were tested returned to receive their test results, along with critical risk reduction, health education, and behavior-changing messages for reducing the risk of exposure to and transmission of HIV.

The **Notification Assistance Program (NAP)** provides trained HIV counselors to locate confidentially tested HIV-positive clients who fail to return for their test results. In so doing, exposed or infected individuals are referred for early care and treatment.

During the period January 1 through December 31, 1991, NAP received 972 referrals from various counseling and testing programs. Of this total, 442 were HIV positive, and 530 were "contacts" (sexual or needle-sharing partners) of HIV-positive individuals. Seven NAP field investigators located 607, or 62 percent, of these individuals, and delivered services to 600 (99 percent) patients.

Care and Treatment

The **Early Intervention Program (EIP)**. As was mentioned earlier, the heart of New Jersey's care and treatment program for people with HIV/AIDS is the Early Intervention Program (EIP), formerly known as TAP.

Until relatively recently, infection with HIV was tantamount to a death sentence — in many cases a rather imminent one. Researchers and public health officials have estimated that without drug therapy a large majority of the HIV-infected will die within two years of meeting the AIDS diagnostic criteria. But we now know that with the widespread HIV counseling and testing recommended by the Department of Health in November 1991, early medical intervention, and preventive (prophylactic) drug therapy at the proper time in the course of infection, some HIV-infected individuals can live better—and sometimes longer—lives.

When the Centers for Disease Control and the National Institutes of Health reported in 1989 on the efficacy of drug prophylaxis in delaying the onset and mitigating the symptoms of HIV disease, the implication was that it could increasingly be dealt with as a treatable chronic disease.

New Jersey responded quickly to take advantage of this opportunity by grafting expanded counseling and testing and early intervention to its existing managed care system by creating the Early Intervention Program. The EIP was the first statewide, state-funded program to implement the 1989 federal recommendations on early intervention and prophylaxis. Because it can extend and improve the quality of life for

many individuals with HIV/AIDS, EIP is a compassionate program; because it substitutes outpatient care in multidisciplinary clinics for acute inpatient care in hospitals, it is a cost-effective program; because it not only provides medical treatment, but also links people with HIV/AIDS to other needed services through case management, it is a comprehensive program.

EIP presents both a great opportunity and a knotty problem. The opportunity, of course, lies in its capacity to treat individuals before they are acutely ill—or even when they are asymptomatic—and slow the course of the disease. The problem is that, in point of fact, most New Jersey EIP clients are not asymptomatic; in many cases, they are quite ill. **Moreover, despite a recent increase in physician hours, there is still a six- to eight-week back-up at EIP sites.** Informal triage is performed on site, however, so the sickest patients are usually seen fairly quickly.

Even if the Department of Health's recommendation that all sexually active New Jerseyans be tested for HIV is only a "direction of intention," rather than a realistic goal, the demand for services at EIP clinics and elsewhere will grow steadily through the 1990s. There is a responsibility incumbent on the state to coordinate and maximize all available resources, **but it is unrealistic to think that providing early intervention services for even a somewhat greater portion of the state's estimated 40,000 HIV-infected individuals can be done without an expansion of the program. Accordingly, all New Jersey hospitals should have the capacity to treat HIV/AIDS patients on an outpatient, as well as inpatient basis.**

There are presently seven (7) designated Early Intervention Program sites, enrolling more than 5,000 clients. The original five, up and running in 1990, were St. Michael's Medical Center, UMDNJ Stratford/Camden, Jersey City Medical Center, Raritan Bay Medical Center, and St. Joseph's Hospital and Medical Center. Two additional sites—Elizabeth General Medical Center and Atlantic City Medical Center—began operations in April 1992.

The following table indicates active EIP patient census, and utilization (average visits per month), by site for the original five sites. The SFY 92 utilization levels are projected from December 1991 on. The two new sites are expected to add a total of about 150 active clients in their first year of operation.

SITE	CENSUS	FY 91 VISITS/MONTH	FY 92 AVG VISITS/MONTH
Raritan Bay	292	133	157
St. Michael's	1735	285	634
St. Joseph's	950	246	306
Jersey City MC	1231	195	255
UMDNJ	600	92	134
TOTAL	4808	951	1486

Among these nearly 5,000 current EIP clients, males outnumber females by more than two to one. The following three tables profile the EIP population by referral source, transmission risk, and race/ethnicity:

REFERRAL SOURCE (%)

Counseling/Testing Site:	21%
Private Physician:	19%
Drug Treatment Center:	9%
Hospital Inpatient:	11%
Community Clinic:	6%
Community-based Organization:	4%
Prison/Jail:	12%
Other/Self:	18%

TRANSMISSION RISK (%)

Gay/Bisexual Contact:	11%
Injecting Drug Use:	56%
Gay/Bisex. Contact and IDU:	1%
Heterosexual Contact:	18%
Blood Products:	2%
Other/Unknown:	12%

RACE/ETHNICITY (%)

White:	26%
Black:	44%
Hispanic:	28%

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Interested Persons see Inside Front Cover

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The AIDS Drug Distribution Program (ADDP). Prophylactic drug therapy is the crucial component of early intervention. Unfortunately, there is no vaccine to prevent HIV infection, and no "magic bullet" to cure it. But there are several drugs—and the number is growing—that can often stave off or mitigate the symptoms of HIV-related infections and help to avert costly hospitalizations. For example, Zidovudine (AZT) slows the virus' ability to reproduce itself, and often delays the onset of the infections and malignancies of full-blown AIDS. Anti-infective drugs such as Bactrim help to control infections such as Pneumocystis pneumonia.

Since 1987, Federal funds have been channeled to the states to help people pay for FDA-approved drugs such as AZT and Bactrim. The Division of AIDS Prevention and Control created the AIDS Drug Distribution Program (ADDP) to disburse funds for the purchase of these medications.

Under ADDP, Federal funds are allocated to the AIDS Division, which subcontracts out the administrative operation of the program to Medicaid. There are several eligibility requirements: an individual may not be eligible to receive benefits from other third-party sources, including Medicaid. If he or she is single, annual income may not exceed \$30,000.

Between 1987 and December 1, 1991, ADDP served a total of nearly 2,900 clients, and processed over 32,500 claims (prescriptions). There are currently about 1,600 active beneficiaries. In the most recent month for which data were available (November 1991), they filed 1,186 claims totalling \$181,486—an average of \$153 per claim. In FY 91, ADDP processed about 10,000 claims, but there were no state dollars to supplement \$2.2 million in Ryan White and HRSA funds.

Given a growing epidemic, the development of new and effective drugs, an increased life span for people with HIV/AIDS, and no expansion in Medicaid, it is safe to say that increasing amounts of state funding will be necessary to meet the demand in the foreseeable future. **Accordingly, this chapter strongly recommends that an additional source of stable funding be found for ADDP.**

Case Management/Support Services. The efficacy of the EIP concept hinges as much on case management as it does on drug prophylaxis. In fact, EIP was the product of a merger of a new treatment philosophy—early intervention/drug prophylaxis—with an already existing system of managed care for people with HIV/AIDS that had been developed in New Jersey in the early years of the epidemic with the assistance of the Robert Wood Johnson Foundation.

The concept of case management actually antedates the HIV/AIDS epidemic, but no disease or complex of diseases had ever before made it so indispensable or tested it so severely. People with HIV/AIDS are in extraordinary need of assistance with problems associated with work, home life, medical care, legal issues, finances, nutrition, and housing. Many of these services are in very short supply (See "Unmet Needs"). Moreover, people with HIV/AIDS are subject to so many changes in health status that planning can be very difficult.

One of the chief advantages of EIP is that its clients' medical care is far better integrated with the other services they need than is often the case. Working together with care and other service providers, the case manager develops a comprehensive plan for each client; screens the client; and may make arrangements for him/her to be seen at a hospital or private provider's office rather than the EIP clinic, when appropriate.

The program refers clients to a multiplicity of providers and agencies including:

- Drug treatment programs;
- The County Board of Social Services;
- Specialty clinics (OB/GYN, STD, dermatology, etc.);
- Long-term care facilities;
- Local hospitals and private providers;
- Social Security and Municipal Welfare; and
- A wide variety of community-based organizations, many of which are members of the Ryan White Title I and Title II consortia.

Unfortunately, each EIP center's referral network is an informal one, and so is the communication between EIP and the entities to which its clients are referred. Therefore, most data are inadequate or incomplete. When all policymakers have to go on is anecdotal data, it is every difficult to make an accurate assessment of unmet needs, or to prioritize remedial action. **Better data collection on EIP referrals is clearly necessary, and is recommended in this chapter.**

Many AIDS-related organizations and advocates assert that more case management is needed throughout the system. The problem may be less

one of numbers and more one of coordination of existing case managers, however. For a further discussion of this issue, see the section entitled "Unmet Needs."

AIDS and Acute Care Hospitals. As mentioned earlier in this chapter, the geographic selectivity of this epidemic has worked to concentrate the overwhelming majority of people with HIV/AIDS in certain areas of the state (primarily in the northeast), and the major share of inpatient HIV/AIDS care to a relatively small number of hospitals located in those areas. The following table shows the number and percentage of 1991 hospital admissions for HIV/AIDS, by county.

COUNTY	1991 ADMISSIONS FOR HIV/AIDS	PERCENTAGE OF TOTAL HIV/AIDS ADMISSIONS
Atlantic	180	2.4%
Bergen	324	4.3
Burlington	46	0.6
Camden	314	4.2
Cape May	3	0.0
Cumberland	28	0.4
Essex	2739	36.5
Gloucester	5	0.1
Hudson	841	11.2
Hunterdon	22	0.3
Mercer	508	6.8
Middlesex	522	6.9
Monmouth	530	7.1
Morris	188	2.5
Ocean	75	1.0
Passaic	593	7.9
Salem	0	0.0
Somerset	28	0.4
Sussex	17	0.2
Union	543	7.2
Warren	7	0.1
TOTAL	7513	100.0%

Note that nearly 48 percent of total admissions occurred in Essex and Hudson Counties alone, with Passaic (7.9 percent), Union (7.2 percent), and Monmouth (7.1 percent) their closest rivals.

It is no coincidence that the state's EIP sites are located primarily in those counties, and that their hospitals provide inpatient care for large numbers of HIV/AIDS patients. Nevertheless, at present there seems to be little if any evidence that there is any significant AIDS patient "dumping" on the inpatient side. If they observe universal precautions, virtually all New Jersey hospitals are equipped to treat—and should treat—most acute care episodes of people with HIV/AIDS. **Should any evidence be found that a hospital is evading, by one means or another, the inpatient treatment of HIV/AIDS patients, state sanctions, including licensure suspension and the denial of certificate of need applications, should be applied.**

As we have seen, the AIDS epidemic is growing, but it does not appear that the bed capacity of the state's hospital system will be overtaxed. Department of Health projections indicate that the increase in daily bed requirements for HIV/AIDS patients will be just 60 beds (from a total of 346 in 1992) by 1995.

The following table indicates projected acute-care hospital bed requirements for people with HIV/AIDS through 1995. It indicates estimated admissions, average length of stay (ALOS), bed-days and bed requirements, based on estimated live HIV/AIDS patients 1989-1995.

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<u>Est. Living Year</u>	<u>HIV/PWAs(1)</u>	<u>Adms.(2)</u>	<u>Av'g LOS (3)</u>	<u>Total Bed Days</u>	<u>Daily Beds Required</u>
1989	6897	6148	17.7	108528	297
1990	7586	6792	16.8	113698	312
1991	8448	7505	16.0	119895	328
1992	9483	8331	15.2	126429	346
1993	10690	9248	14.4	133319	365
1994	12069	10265	13.7	140585	385
1995	13793	11394	13.0	148247	406

Total admissions, ALOS, and total bed days for 1989 are from Department of Health Center for Health Statistics, and are based on UB-82 data.

- (1) Estimated cases based on estimates on working paper on living HIV/AIDS patients and the assumption, based on HRET data, that they represent 58% of these needing inpatient care.
- (2) Based on estimated 11% annual increase.
- (3) Based on estimated 5% decrease in ALOS per year.

Given the existing excess capacity of many New Jersey hospitals, the system should be able to absorb the increase.

Most New Jersey hospitals, therefore, are theoretically capable of treating the acute care episodes of most HIV/AIDS patients. The most severely ill, however, should and could be referred to several hospitals with the most experience in, and resources for treating these cases. This chapter will recommend the designation of several hospitals as "HIV/AIDS tertiary care centers," some of which will undoubtedly be the present EIP-affiliated facilities.

The most severe inequities in AIDS hospital treatment, then, are not on the inpatient side. However, there is considerable anecdotal evidence that upon discharging HIV/AIDS patients, many hospitals are referring them to the nearest EIP site for all subsequent outpatient care, as well as for case management services. This is placing a very heavy burden on the EIP clinics and the hospitals with which they are affiliated. There are considerable back-ups there, and many of the less ill patients must wait weeks for treatment. This runs counter to the original concept of early intervention, and the situation can only worsen as more and more HIV-infected persons come forward to be treated.

Accordingly, the State should expand considerably the EIP program specifically and the State's hospital system's capacity to provide HIV/AIDS outpatient care generally. In calling for a State AIDS plan in October 1990, Governor Florio termed AIDS a "community disease," which should be dealt with at the community level. In keeping with this conception, it is essential not only to expand existing EIP sites or add new ones, but also to strongly encourage all the State's community hospitals to treat not only the acute episodes of persons with HIV/AIDS from the surrounding area, but to provide their outpatient care as well.

Facilities providing this care should also have case managers who can effectively link their patients with the support services they need. This will accomplish two ends: first, the system's capacity to treat people with HIV/AIDS will expand as the number of individuals needing care grows; second, the maldistribution of AIDS cases which presently threatens to overburden a small number of facilities, while not eliminated, should be lessened.

Financing Issues. This chapter has focused primarily on hospital-based services. At the request of the Department of Health, the Codman Research Group has provided the following data on all 1989 and 1990 New Jersey hospital admissions with an HIV/AIDS-related DRG. Note that charges for HIV/AIDS care increased by over 25 percent in just one year.

	1989	1990	% Change
Total admitted	6,148	6,868	+ 11.7
Patient days	108,528	117,704	+ 9.4
Charges	75.256 mil	94.291 mil	+ 25.3
LOS	17.7	17.3	-(2.25%)
Cost/admission	12.2	13.7	+ 12.3%
Cost/day	.69	.79	+ 14.5%

Any recommendations for the future financing of all HIV/AIDS care, inside and outside of hospitals must include two patient groups—those who are Medicaid-eligible and those until now covered by the Health Care Trust Fund.

An analysis of the payer mix of the inpatient admissions listed above indicates that Medicaid is the source of payment for over 35 percent of those admitted. Those who identify themselves as "self-pay" or cite

"local public assistance" as a source of payment comprise another 26.2 percent. Medicare pays for just three percent of admissions, while those having private insurance coverage declined from 30 percent in 1989 to 27.1 percent in 1990. The Health Care Trust Fund has been financing the care of at least half of those designated as "self-pay."

The state's EIP program is nothing more nor less than enhanced outpatient clinic services and case management based at seven acute-care facilities across the state. The location of EIP sites at hospitals responded to the need to ensure a nucleus of appropriate medical services which would be accessible particularly to those persons with HIV/AIDS without a regular source of primary care and health insurance coverage.

A review of the payer mix of EIP clients yields data similar to that for hospital inpatients with HIV/AIDS. Medicaid patients and those usually identified as "self-pay" and "local public assistance" comprise over **two-thirds** of all program participants. Again, the care of approximately half of the self-pay group has been financed in the past through the Health Care Trust Fund.

In an all-payer system Medicaid theoretically pays the total cost of care for eligible patients. However, in the future, Medicaid reimbursement for inpatient acute care is likely to fall short of this level. Consequently, those hospitals that serve the most Medicaid-eligible patients will incur greater losses, and may be placed in a difficult financial position.

The much-needed expansion of EIP recommended in this chapter will also depend upon an adequate Medicaid reimbursement rate for outpatient care. **In an attempt to make facilities providing inpatient and outpatient HIV/AIDS care whole, it is recommended that the State seek an increase in both the inpatient and outpatient rate for HIV/AIDS care.** (Federal regulations may not permit an increase for a specific diagnosis, but they will allow increased reimbursement for those hospitals and other facilities that provide comprehensive outpatient services or that are designated as specialty care facilities which meet certain conditions. In effect, this will reimburse these institutions for the increased resources and staffing needed to provide both inpatient and outpatient care.)

Although there are other factors involved, an increased reimbursement rate for HIV/AIDS outpatient care **that encompasses that delivered by private physicians in their offices** may also persuade more of them to treat these patients. Such an increase is therefore recommended.

Fundamental insurance reform will almost certainly be a central part of New Jersey's response to the current health care "crisis." This reform—which may include such features as open enrollment and a ban on exclusions for pre-existing conditions—will help some New Jerseyans with HIV/AIDS. Certainly it will help reduce the current level of discrimination against persons with HIV/AIDS in this area. However, one ought not hope for too much from these initiatives, given the socioeconomic status of the majority of New Jersey's persons with HIV/AIDS, for whom any kind of insurance is probably out of the question.

Therefore, the expansion (and perhaps even the continuation) of EIP (and the entire New Jersey AIDS effort) depends to a considerable extent upon the existence of a source of payment for those who are truly medically indigent. The Health Care Trust Fund is about to expire, and current discussions are focusing on extending health coverage to those who are employed but not insured. An expansion of employer-based insurance will not cover much of the population seeking HIV/AIDS care from the New Jersey health care system. **Accordingly, this chapter recommends a publically-subsidized insurance mechanism providing basic coverage for the medically indigent, administered by**

Medicaid, that will optimize federal reimbursement as these individuals become eligible for the Medicaid program.

Sub-Acute Care. Many people with HIV/AIDS who are not in need of hospital acute care nevertheless need some form of institutional care. Not only is this care often more appropriate, it is also usually less expensive. There is a serious shortage of the various forms of sub-acute institutional care for people with HIV/AIDS in New Jersey, and problems of access persist, despite the clear advantages inherent in treating these patients in these settings. One result of these access problems is that many persons with HIV/AIDS who are no longer acutely ill must remain in the hospital—at considerable cost—because there is no other available facility to which they can be properly discharged.

One modality of sub-acute institutional care is the so-called “step-down” unit, which is located in the acute care hospital itself. Such a unit, called the Intensive Therapeutic Care Unit for Persons with AIDS, is being established at the Jersey City Medical Center. Ready for occupancy in 1993, the unit will have 18 beds and provide medical and nursing care, medication, physical, occupational and activities therapy, and psychosocial and case management for those patients who no longer require acute care, but are not yet ready to return to the community. The unit will deliver a 30-day course of treatment at a per diem cost of about \$370.

The first skilled nursing facility to admit substantial numbers of AIDS patients was Wanaque, in 1989. This initiative has been largely successful, and the AIDS unit there remains at nearly full occupancy. Few other nursing homes have come forward to admit AIDS patients, however. Some facilities argue that they do not have the necessary expertise or equipment; others that AIDS patients are too young and wouldn't “fit in”; others that they have no vacancies. On the other hand, some also say that they would admit AIDS patients at the enhanced reimbursement rate Wanaque received. This is now a moot point, because Wanaque no longer receives a special reimbursement rate but is reimbursed according to the severity of illness of its patients.

It is clear that **the State should take action to place persons with HIV/AIDS in skilled nursing facilities and other long-term care alternative settings that are equipped to care for young patients. As is now the case with Wanaque, reimbursement should be based on severity of illness.**

There also continues to be a clear need for additional hospice care.

Ryan White Title II, Resource Centers, and the HIV Care Consortia. In November of 1990, President Bush signed HR 5257, appropriating funds for the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990. This legislation has three titles. Title I appropriates funds for emergency assistance to cities and localities disproportionately affected by the HIV/AIDS epidemic. In New Jersey, the city of Newark and Hudson County both received Title I awards.

Title II provides financial assistance based on a formula to states, to enable them to improve the quality, availability, and organization of health care and support services for individuals and families with HIV/AIDS.

Title III provides direct financial assistance to individual projects for the provision of early intervention services to individuals and families with HIV/AIDS. In New Jersey, a total of five (5) projects received funding under Title III.

Six networks of local service providers covering 11 counties, called HIV Care Consortia, were established in 1991 and funded by Title II of the Ryan White CARE Act.

The consortia, which respond to the need for coordination identified in the state HIV/AIDS plan, were successful respondents to an RFA issued by the Health Department in May 1991. They are:

- Coalition on AIDS in Passaic County
- Middlesex County Health Department
- AIDS Coalition of South Jersey
- Shore Area Health Education Center
- Bergen County AIDS Coalition
- Union County AIDS Coalition

These consortia are required to:

- Support and/or facilitate the organization of **systems of care** for individuals and families with HIV disease through the development of a public/private partnership of essential providers and community-based organizations;
- Identify gaps in service needs and develop a comprehensive **continuum of services** to meet those needs;

- Promote coordination and integration of community resources;
- Ensure continuity of services through effective **case management**; and
- Provide cost-effective alternatives to hospitalizations.

The Consortia are currently providing core services, linked through case management, to about 2,000 persons with HIV/AIDS. By the terms of the Ryan White legislation, 50 percent of Title II funds must be used for treatment and outreach services. Title II also funds the AIDS Drug Distribution Program and a limited amount of home health care.

HIV/AIDS Resources Centers like the ones called for in the State Plan for HIV/AIDS are incorporated in five of the consortia. They help to plan and coordinate the delivery of services, on a regional basis, and also aid in designing and implementing the public awareness and prevention education programs which **must** undergird any effective AIDS strategy. They constitute “one-stop shops” where people with HIV/AIDS can be directed to all existing medical and social services.

The consortia vary in size depending on the extent of the geographic area to be covered, the number of individuals with HIV disease in that area, and the needs of the various subgroups and special populations it contains. Consortia contract with service providers—who all sign a letter of agreement—for specific services or activities, in compliance with applicable state regulations.

Because the best way to coordinate and deliver HIV/AIDS services is at the community level, the state is transferring implementation and monitoring responsibilities to local entities. For example, some health service grants that have been state-controlled in the past are now being turned over to local, community-based organizations for administration and oversight.

During FY 1992 this initiative included letters of agreement with home care agencies in the eleven (11) counties managed by the consortia, several hospital- and community-based management projects, and other AIDS service organizations. In most cases these projects are already lead or member agencies in the consortia in which they are subsumed.

In the consortia-selection process, preference was given to established organizations with experience in program management. Some guidance in this area and others has come from the AIDS division of the State Department of Health. This, combined with the fact that some Title II programs—especially the AIDS Drug Distribution Program (ADDP)—are “user-friendly” facilitated consortia activities during the first year of federal funding, enabling them to avoid some of the organization and management problems that have been experienced by Newark and Jersey City, the recipients of Title I funds.

Ryan White Title I: Newark and Jersey City/Hudson County. Newark and Jersey City, among the hardest-hit cities in the United States, were the recipients, respectively, of \$4.1 million and \$1.6 million of Ryan White Title I Year 01 funds. The Title I program in Newark is administered by the HIV Planning Council of Newark, East Orange and Irvington, New Jersey (hereafter referred to as the Newark Council), a consortium of 26 organizations providing care and treatment and social services to people with HIV/AIDS. The Hudson County AIDS Consortium is composed of 38 member organizations. A representative of the Division of AIDS of the State Department of Health sits on each body, and has one vote.

For the five years preceding Ryan White, some HIV/AIDS-related services in Newark and Jersey City were provided by the AIDS Health Services Program. The purpose of this program, largely funded by the Robert Wood Johnson Foundation and HRSA, was to develop an integrated network of community-based health and social services for persons with AIDS and HIV disease in Newark and Jersey City. The focus of this program, a precursor of the Ryan White Title I consortia, was case management. Over its five-year life, almost 3,500 persons were entered into case management; when the program ended in 1991 there were more than 2,500 in the system. Comprehensive data for this program can be found in the table on page 47.

The Department of Health played a coordinating role in the program, issuing grants to member organizations, monitoring subsequent program management, and providing back-up technical assistance and troubleshooting when needed.

A profile of those served by this program is instructive:

- 60 percent were African Americans, 13 percent Hispanics, and 27 percent were whites.
- 72 percent were males, 28 percent females (8 percent were children under age 8).

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- 55 percent of the adults with known risk factors were IDUs.
- Just 18 percent were employed full- or part-time.
- Only 15 percent had private insurance coverage, 61 percent had public coverage, and more than 24 percent had none at all.

Clearly, serving this largely minority, socioeconomically disadvantaged, and often drug-abusing population will pose considerable problems for the Title I consortia.

The program's final report noted that, although case loads were high and an expansion of case management services was still needed, individuals most in need of service coordination were usually afforded the referrals, medical and social interventions and follow-up they needed to maintain themselves outside the acute-care setting.

Significantly, a largely successful effort was made to coordinate this case management with community-based case management provided by Medicaid through the AIDS Community Care Alternatives Program (ACCAP). At the end of 1991, ACCAP was case-managing 685 persons with HIV/AIDS. Significantly, 90 percent of ACCAP's clients said their case managers made it easier for them to obtain needed services. The table below, part of a report on ACCAP case management prepared by Dr. Stephen Crystal for the Institute for Health, Health Care Policy, and Aging Research of Rutgers, summarizes utilization by ACCAP clients, by percent of enrollees using services.

—Pharmaceutical:	94%
—MD:	79%
—Hospital Inpat:	57%
—Hospital Outpat:	69%
—Home Health Agency:	58%
—Medical Equip:	64%
—Transportation:	40%
—Private RN:	20%
—Dental:	18%

Crystal theorizes that the low percentage of dental claims filed may be a result of the great difficulty people with HIV/AIDS are having in obtaining dental care. The same may be true of transportation, which is a major problem for many PWAs.

The major concern during the final year of the AIDS Health Services Program was that there be a smooth transition to Ryan White funding in both Newark and Jersey City. This apparently occurred, and there were few, if any, significant breaks in services. This was in part due to the fact that RWJ and HRSA were able to front the programs' costs until the Title I consortia could take over.

That both the Newark Council and the Hudson County AIDS Consortium had some difficult times during Year 01 of Ryan White funding is not too surprising. The consortia are a mix of large and small, experienced and inexperienced organizations. Some of them lack grant-writing and program-management experience. Inevitably, there has been some interagency competition for scarce dollars, and some frustration in both organizations over the fact that Title I funds can be spent only on treatment-related activities, when many member organizations have considerably more experience in prevention programs.

Of the two Title I consortia, Hudson County was somewhat more effective in getting the federal dollars to organizations and programs during Year 01. It was aided by the fact that a large number of its member organizations were already up and running with HRSA funds, which were simply folded into Ryan White. The Newark Council's first year was a bit more problematical than Hudson County's. This was in some measure due to a lack of coordination, infrastructure, and experience in grant writing and program management on the part of its member organizations. Members also experienced difficulty in obtaining the necessary insurance—including "hold harmless" clauses—from the City of Newark. Newark was therefore able to draw down only a small portion of its more than \$4 million in Year 01 funding.

Neither Newark nor Hudson County has conducted a comprehensive needs assessment study. Newark has one, but it is cursory, rating services only by their relative importance. Hudson County is preparing a survey for 1992 through 1996, but it will not be ready before the end of this year. One positive development is that a client-level reporting data system will eventually be coming on line. This system will track individual clients through the system, and should provide harder data on referrals, utilization of services, etc. The system will present some problems of confidentiality that will need resolving.

There is, however, reasonably good utilization data for these two hard-hit areas compiled by the AIDS Health Services Program in 1990. It

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is unlikely that it will have changed radically since then. Much of it will be presented in the "Unmet Needs" section of this chapter. The areas of greatest unmet need are in sub-acute, out-of-hospital care, housing, and substance abuse treatment.

Special Populations

HIV/AIDS is a selective disease, and the overwhelming majority of cases are found in specific at-risk populations. The following is a description of the epidemic as it affects several of these groups, and an assessment of what is being done—or should be done—to meet their needs.

As stated at the outset of this chapter, the "most characteristic" New Jerseyan with HIV/AIDS is a poor, minority, inner-city IDU. In fact, fully two thirds of them are either African American or Hispanic; minorities, therefore, are disproportionately represented in some of the special populations discussed below. This assertion should not be read as in any way judgmental; nevertheless, it is of critical importance to remember that minority communities have unique and specific characteristics and needs that must be taken into account when designing any HIV/AIDS strategy or initiative.

Substance Abusers. The New Jersey HIV/AIDS epidemic is unique in the nation because nearly 60 percent of its cumulative AIDS cases are related to injecting drug use (IDU). Fully 35 to 45 percent of the IDUs in Newark, Jersey City, Paterson and New Brunswick are believed to be HIV infected. All epidemiological evidence indicates that in New Jersey IDUs are the risk group requiring the most intensive attention and resource allocation.

Poverty, discrimination and homelessness make IDUs one of the most difficult populations to reach. Most IDUs are heterosexual males and sexually active; their sexual partners, nearly all of whom are women of childbearing age, are also at high risk. Most of the children with AIDS in New Jersey become infected, directly or indirectly, through a drug-using parent.

In New Jersey, effective drug treatment is synonymous with HIV/AIDS prevention. Moreover, the total cost of drug treatment is significantly less than the cost of AIDS care. Outpatient methadone treatment, for example, costs between \$2,200 and \$3,000 a year. Residential treatment—which ranges in cost from \$14,000 to \$20,000 annually—is much less than the diagnosis-to-death costs of treating a person with HIV/AIDS.

Nevertheless, the quality and quantity of drug treatment available in urban areas of the State is inadequate to meet current needs—and HIV/AIDS related services within existing programs are inadequate as well. There are not enough funds or treatment slots; consequently, there are waiting lists and barriers to access. Five-year utilization data for the AIDS Health Services Program in Newark and Jersey City are instructive. Less than 50 percent of people with HIV/AIDS needing these services received them; substance abuse treatment ranked 8th out of 34 services in degree of unmet need. (See table at end of chapter.) **Expanded HIV/AIDS-related services for substance abusers are needed as part of a more general need to increase the state's capacity to identify, assess and treat substance abusers.** There is a particularly urgent need for programs targeted to women which provide primary, prenatal, post-partum, and medical day care, as well as developmental day care for their children.

In September 1991, the Office for Treatment Improvement of the federal Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) announced that New Jersey was the recipient of a \$27.8 million award for a three-year drug treatment project to be located on a campus-like facility in Secaucus. The project will also provide primary medical care facilities to its clients, including HIV counseling and testing and early-intervention therapy to those who are infected. The Campus Treatment Demonstration Project will increase New Jersey's drug treatment beds by nearly 40 percent.

Because it has been demonstrated that HIV-infected substance-abusing individuals do best in residential care programs with controlled environments, the project is significant for New Jersey's HIV/AIDS effort. Clients who test positive will not only receive early-intervention care and drug prophylaxis; they will also be linked to outside HIV-related programs and services by a medical social worker assigned to the project. When the three-year grant has expired, it is hoped that the State will be able to maintain all or most of the project's 360 beds.

The great majority—approximately 80 percent—of the State's drug abusers, however, are not in jail or in treatment. Rather, they are in—if not always of—the community. There is a serious need for creative outreach programs to reach this population. Although skepticism about the possibility of effecting behavioral change in this population continues,

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there are now reputable studies that show that if IDUs are approached with respect and appropriate harm reduction models—including condom distribution, instruction on how to clean needles, and needle exchange programs—are applied, considerable behavioral change in this population can be achieved.

To cite one example, data compiled from the Needle Exchange Program of the New Haven Health Department has demonstrated a drop in HIV transmission among program participants. The program has also apparently served as a "bridge to treatment"; during its early months a quarter of participants expressed interest in drug treatment, and 15 percent actually entered treatment. Although no research protocol has as yet been designed to assess the program's effect on illicit drug use, there are no indications that it has increased.

The report of the Governor's Advisory Council on AIDS recommends a needle exchange demonstration project—as does this chapter.

Incarcerated Persons. A significant percentage of inmates in State correctional facilities are HIV infected, or have AIDS. This fact, exacerbated by the strong link of HIV disease to substance abuse, seriously impacts inmates, as well as their families and communities.

There have been about 600 confirmed cases of AIDS among inmates of the State correctional system since 1982. There are now about 80 inmates with AIDS and about 700 more who are known to be HIV-infected. The true number is probably higher. A CDC-sponsored serosurvey of individuals entering the system in 1991 yielded a seropositivity rate of 9 percent for males. The rate for females was considerably higher—13 to 14 percent.

Until recently, inmates with AIDS have been segregated from the general prison population, either in a special medical unit or at St. Francis Medical Center in Trenton. Several inmates brought suit against the Department of Corrections in early 1992, and a settlement led to the dismantling of the special medical unit and the return of ambulatory inmates with AIDS to the general prison population.

The 1991 State Plan for HIV/AIDS recommended the development by the Departments of Health and Corrections of a standardized and coordinated HIV/AIDS educational program for all inmates, and voluntary confidential testing on demand (including pre- and post-test counseling). These materials and this testing are now available, and there is at least one counselor in each institution. **As a matter of public health, the State should also make condoms available to all inmates of the State correctional system, as just one part of this broadly based effort to prevent infection.**

AIDS and Tuberculosis. In the last several years there has been a resurgence in the incidence of tuberculosis (TB) in some New Jersey populations. The HIV-infected are among those most at risk for TB, because of their crippled immune systems. They become ill more quickly than those with uncompromised immune systems. The several strains of multiple-drug-resistant-TB (MDR-TB) can be rapidly fatal to people with HIV/AIDS.

This dual-epidemic phenomenon has several implications. TB prophylaxis and treatment regimens for people with HIV/AIDS should be managed differently, especially if they live in settings, such as homeless shelters, with significant numbers of persons with TB. TB program staffs should be informed about HIV risk assessment, counseling and testing, and confidentiality issues; and HIV counseling and testing should be an integral component of TB treatment. Ideally, the best place to treat TB in persons with HIV/AIDS is in the setting where they receive treatment for HIV disease.

Women. In New Jersey, more than in much of the rest of the United States, women comprise a significant number of cases of AIDS and HIV infection. Fully 23 percent of New Jersey's AIDS cases and as many as 9,000 of its cases of HIV infection are women. Until recently, far too little attention was paid to the impact of HIV/AIDS on women, and little was done to understand and treat the various aspects of HIV-complicated disease—especially gynecological conditions—which appear to be unique to women. Through most of the history of this epidemic, the Centers for Disease Control case definition of AIDS did not include many of these female-specific symptoms and diseases.

This situation is beginning to change, albeit too slowly. The 1991 State Plan for HIV/AIDS called for the creation, within the Division of AIDS Prevention and Control, of an Office of Women and AIDS. This was accomplished in April 1991. This office focused its attention first on coordinating and strengthening the AIDS Division's activities pertaining

to women, and on influencing program planning to ensure that an equitable amount of resources is allocated to them.

The Office of Women and AIDS considers HIV/AIDS awareness and prevention among its most important concerns, and immediately focused its attention on redirecting resources to target women. To raise public awareness about women and AIDS, a full-scale women's prevention campaign began in April 1992. As part of this initiative, the Office of Women and AIDS produced an informational flyer for distribution to about 65,000 sites statewide. The flyer is unusual, in that its content is designed to cross ethnic/racial groups and socioeconomic levels to address prevention of HIV infection in what is now the largest women's at-risk population—those engaging in heterosexual relations.

The Office of Women and AIDS also is using its women's initiative grant funds to aggressively target special populations of women for HIV/AIDS prevention efforts. Two small grants were awarded for local community prevention efforts—one to minority women in Atlantic County, and the second to minority women participating in the WIC program in Plainfield.

In an effort to increase knowledge about aspects of HIV/AIDS specific to women, the office worked with the Division of Epidemiology on a UMDNJ-based study investigating the natural history of HIV disease in women, with particular attention to the gathering of new information on the frequency of gynecological problems in a population of New Jersey HIV-infected women.

HIV-infected women also need early access to routine health care. For many women, early signs of infection are manifested as gynecological conditions which may go undetected without appropriate intervention and follow-up. Efforts must be made to ensure the availability of appropriate care and treatment. A FY 93 RFA for about \$150,000 in grant funds which will link HIV-infected women to treatment was distributed. The Office of Women and AIDS monitors the availability of treatment through ongoing communication with the seven EIP sites, and by identifying and removing barriers to care and treatment for women. The office will also assist the Division of Civil Rights in coordinating HIV-based discrimination complaints filed by women.

The Office of Women and AIDS and advocacy and community-based organizations such as the New Jersey Women and AIDS Network and the African-American Women United Against AIDS, have done a great deal to address this critical high-risk group, but much remains to be done. (See the section on "Unmet Needs".)

Children. The basic care requirements for HIV-infected children have not changed since the publication of "Generation in Jeopardy," a 1989 report by the New Jersey Pediatric AIDS Advisory Committee. The course of HIV infection in children, whose immune systems have not had an opportunity to develop, is somewhat different than it is among adults. Different treatment regimens are therefore required. Typical illnesses in children include severe and chronic bacteria and lung infections, failure to thrive, encephalopathy, pneumonia, recurrent diarrhea, kidney and heart failure, and central nervous system complications resulting in developmental delays, including mental and motor retardation.

A wide range of health, developmental, and social services may be required, particularly if the quality of life of the child and his or her family is taken into account. These services may include inpatient, outpatient, dental, home and hospice care; nutritional, speech, physical and psychosocial therapy; transportation, advocacy, death and bereavement counseling, day care, recreation, and respite care.

Children with HIV infection present enormous and urgent challenges to health and human services systems in New Jersey. They need continuing medical care which must be fully integrated with a host of other services to meet their families' complex needs.

Typically, a child with AIDS will be cared for at home, visit an HIV treatment center or other medical resource once or twice a month, and require hospitalization two or three times a year, until the final stages of the illness, when the latter may be more frequent and prolonged. A child participating in research protocols will also have more frequent and prolonged contacts with the health care system.

The HIV-infected child's mother is also infected with the virus and/or debilitated by drug abuse. She may be unable to provide the demanding care needed by the child—and other siblings—who may also be infected. If another relative is not available to assist, the child must be placed in a foster home. In New Jersey, adequate foster care slots are not always available and children are at risk of becoming "boarder babies" in hospitals. Although New Jersey has five available group homes

for young children (1 to 6 years of age), these facilities can accept only five children at a time.

Because of the nature of the disease and its profound effect on children and their families, intensive case management services must be provided in order to meet the medical, developmental and psychosocial needs of children and their families. As with other children with special health care needs, availability of adequate ambulatory care and community-based services by children with HIV is expected to reduce hospital occupancy and reduce the cost of health care for this population.

In 1988, Special Child Health Services (SCHS) was awarded a three-year pediatric AIDS demonstration grant by the Bureau of Maternal and Child Health and Resource Development of the Department of Health and Human Services. The major goals of the Pediatric AIDS Demonstration Project were to develop a statewide network of Pediatric HIV Regional Treatment Centers to provide comprehensive, coordinated, family-focused services for children with HIV infection and their families, and a State and national Pediatric HIV Resource Center. With these funds, SCHS established the HIV Treatment Network, with three regional and two affiliate sites throughout the state. In addition, during the second year of the project, the Children's Hospital AIDS Program (CHAP) competed successfully for indeterminate designation as the National Pediatric HIV Resource Center. Funds awarded by MCH were not sufficient to cover the cost for case management within the network agencies and MCH Block Grant funds were allocated for this service.

In 1991, SCHS was approved for another three-year grant period to continue the project implementation and transform the network into a Family Service Network with a focus on family needs as well. Federal funds awarded to New Jersey were considerably less than requested, however, and SCHS has again supplemented the awarded funds with MCH Block Grant funds to pay for the case management services needed for this project.

Seven hundred and fifty-seven (757) high-risk children are currently being served by the Pediatric AIDS Regional Treatment Centers. A breakdown of the population served for the reporting period from November 1, 1991 through January 31, 1992 is as follows:

Patients by age:

<1 month	8
1 month -< year	180
1-4 years	354
5-9 years	139
10-12 years	53
13 years	23

Of the children served, 85 percent were covered by Medicaid, and approximately 8 percent had private insurance. The balance was either self pay, eligible for SCHS sliding fee scale or had other sources for payment. Approximately 64 percent of the children served were African-American, 20 percent Hispanic, and 14 percent were white. While a majority of the children were residents of Essex, Hudson, Union and Passaic counties, children from all of the State's 21 counties were served by the regional centers. This project has created a well-integrated statewide network of services which continues to function at maximum capacity with the currently available funds. Services provided include outreach, screening and testing, medical management, case management, and community education.

Gay and Lesbian Individuals. The first cases of AIDS in the United States were among gay men, and well over half of cumulative AIDS cases have come from the gay population. The epidemiology of AIDS in New Jersey, of course, has been different. New Jersey remains the only state where AIDS cases among IDUs outnumber those in gay or bisexual men, and this fact has shaped New Jersey's response to the epidemic. What is sometimes forgotten, however, is that there are 10 counties in New Jersey where the primary mode of HIV transmission is still unprotected sex between men. These areas of the State—and this at-risk population—should receive more attention when statewide strategies to confront AIDS are devised.

Between 1985 and 1987, the Department of Health provided funds to the New Jersey Lesbian and Gay Coalition for a substantial prevention education campaign. Many believed that gays "got the message" and began practicing safer sex to avoid infection. The reality is that prevention education efforts targeted to the gay/lesbian community have been sporadic at best since 1987, that many younger gay men and lesbian women have **not** gotten the message, and that their current behavior is placing them at risk. Moreover, there is evidence of some "re-

cidivism"—a reversion to risky sexual behavior—among older members of the gay community. There is a need to reassess our prevention education initiatives with these facts in mind, and to ensure that future programs do not omit this population.

Further, there is a significant number of gay men and Lesbian women of color in New Jersey, and their attitudes toward their sexual orientation are often different from those of whites. Many refuse to acknowledge their homosexuality, referring to themselves instead as "men (women) who have sex with other men (women)." The consequence of this is that prevention education campaigns that have been effective among gay and lesbian whites have not been so successful in reaching people of color. Future programs must be free of **any** open or covert insensitivity to race, and materials to which people of color can relate must be designed.

VI. UNMET NEEDS

More than a year after the publication of the State Plan for HIV/AIDS, and despite the infusion of federal funds from the Ryan White CARE Act, there are still yawning gaps in the care continuum and shortages of vital services for people with HIV/AIDS. There is no doubt that the additional federal funding has made a difference, and that services are being provided that were lacking a year ago. But the need is so overwhelming, and the number of New Jerseyans with HIV/AIDS is increasing so rapidly, that only limited ground has been gained. Cathy Cummins, coordinator of the Middlesex County HIV Care Consortium, told *New York Times* in March that "we identified \$2 million worth of program needs and only got a half a million. But we are filling in some obvious service gaps."

Faced with little prospect of increased state funding, the State Plan for HIV/AIDS emphasized the better coordination of existing services, and recommended the establishment of Resource Centers to accomplish it. These centers were incorporated into the six HIV Care Consortia, which began receiving Ryan White Title II funds last year.

In the face of an epidemic that places such complex and cross-cutting demands on New Jersey's health care and social services system, it is undeniable that better coordination was, and is needed. But there is more than a little truth in what Joseph Bordo, president of the New Jersey Chapter of the National Association of Social Workers, had to say in testimony before the 1991 Legislative Appropriations Committee hearings on the Department of Health budget. Bordo said: "Coordination of services, a favorite buzz word, is not relevant in the AIDS world because it assumes that necessary services are in place and just need to be better coordinated." This simply is not the case yet, particularly in the areas of the State hardest hit by the epidemic.

Medical Care and Treatment. Although everything is relative, of all the elements along the care continuum, inpatient medical care and treatment seems to be in the best shape. The State's acute care hospitals have borne the brunt of HIV/AIDS care, even when some other level of care might have been more appropriate. Service-utilization data from the AIDS Health Services Program in Newark and Jersey City between 1986 and 1990 indicates that 92 percent of those needing hospital inpatient services were able to obtain them; of 34 services, this one ranked lowest as an "unmet need.")

There can be no doubt, however, that the great share of this burden has rested on the shoulders of a relatively small number of hospitals in the highest incidence areas of the State. (See table, p. xx) As pointed out earlier, there is little or no evidence of patient "dumping," but some hospitals appear to be referring their discharged patients to other facilities for ongoing HIV/AIDS care and support services.

While hospitals should be fully able to care for people with HIV/AIDS who need acute care, they should **not** be places where others who are less severely ill languish because of a serious and continuing shortage of sub-acute alternative settings. Many hospitals continue to have great difficulty in discharging patients to more appropriate sub-acute settings. The reason for this seems to be a combination of continuing discrimination (no one wants to be the "AIDS hospital"), and money.

Finding sub-acute inpatient care for people with HIV/AIDS is one of the most difficult tasks now facing New Jersey's public health officials. **It is very important that strategies be developed to improve access to subacute care facilities for these patients.**

As time passes, and early intervention and drug therapy become increasingly effective, the illness of more and more people with HIV disease will be manageable on an outpatient basis. As noted, New Jersey was quick to respond to this fact with EIP, which now has more than 5,000 clients.

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The AIDS Health Services Program's 1991 report estimated that about 77 percent of needed outpatient medical services are currently being delivered. Compared to other service gaps and unmet needs in the continuum, this is not too bad. Nevertheless, there are waiting lists for EIP medical services, despite a recent increase in clinic hours and the addition of two new sites. The passage of time will inevitably increase demand, and plans to handle it need to be formulated as soon as possible.

The majority of New Jerseyans with HIV/AIDS are members of minority groups. The barriers for minorities in accessing health care generally in New Jersey are often magnified for those with HIV/AIDS. There is no simple solution to this problem, but it must be addressed. Health care professionals should be sensitive to the special needs of minorities; discrimination should be attacked at its roots; and services should be delivered in a linguistically and culturally appropriate manner.

The AIDS Drug Distribution Program, discussed earlier in this chapter, has been effective in providing AZT and other therapeutic drugs to people with HIV disease. Fully one half of the first year's Ryan White Title II funding went into this program, but as demand grows other stable funding sources for the program must be sought. Indeed, the HIV Planning Council for Newark, East Orange and Irvington requested supplemental Ryan White Title I funds for medication to supplement that supplied from the ADDP.

The benefits of early intervention, both from a fiscal and a humanitarian standpoint, are self-evident. **There can be no greater imperative associated with this epidemic than that effective medication be available to all persons with HIV disease who may benefit from it.**

Health Care Professionals

Management of most asymptomatic HIV-infected individuals is well within the capacity of primary care physicians; to encourage physicians to provide this care was the primary intent of *Identification and Management of Asymptomatic HIV-Infected Persons in New Jersey: A Practical Protocol for New Jersey Clinicians*, prepared in 1990 by the Academy of Medicine for New Jersey and the State Department of Health and mailed to several thousand New Jersey physicians. But the response was not overwhelming.

Inadequate reimbursement for this care is the chief—but not sole—obstacle in the way of more widespread primary HIV/AIDS care and treatment outside the hospital clinic setting. The problem must be addressed—and this chapter recommends that the State seek an increase in the Medicaid reimbursement rates for both in- and outpatient care—but incentives to physicians and other health care professionals willing to treat HIV/AIDS patients also ought to be considered, if a future shortage of such professionals is to be averted. "Burn-out" is a very real danger for health care professionals treating AIDS on a regular basis, and the next "generation" of provider must be educated to meet the growing demand for care. A number of initiatives are possible, including the enhancement of the HIV/AIDS component in residency and post-doctoral programs; subsidized training programs for nurses, nurses' aides, nutritionists, and social workers; and alternative practice models. Efforts should be made to increase the number of minority health care professionals, including case managers, serving minority communities and minority New Jerseyans with HIV/AIDS.

It is clear that some New Jersey dentists have also been reluctant to treat persons with HIV disease. This is a serious problem, since an estimated 70 percent of people with HIV/AIDS experience dental problems associated with the disease. There are several State-funded HIV-dedicated dental clinics, but many patients have to travel long distances to get to them. Dental care is now funded in two of the HIV Care Consortia; this should alleviate access problems somewhat—but not enough.

Support Services

The AIDS epidemic has placed an enormous load on a State health support and social services system that was already overburdened, fragmented, underfunded, and inadequate. The epidemic in New Jersey has been socioeconomically and geographically selective, hitting hardest those in need of help of every kind, in those areas of the state most overextended in trying to provide it. Virtually all sources, including the Ryan White Title I consortia grant applications and Dr. Stephen Crystal's report on ACCAP case management, agree that the greatest unmet needs, and the largest service gaps are here—**outside** the medical care and treatment system, narrowly defined. As the Newark Planning Council recently stated: "The critical social structure systems are overwhelmed or nonexistent [and] the needs are endless."

Housing is one area of desperate need, especially in the inner-city areas of Essex and Hudson County. Needs assessments are imprecise (and we need better ones)—and they vary, but they are all sobering. Cumulative data from the AIDS Health Services Program indicates that only about 40 percent of its Newark and Jersey City clients who needed housing services were able to obtain them in the life of the program. Housing ranked 6th of 34 services in degree of unmet need.

The Newark Planning Council maintained in its Year 02 grant application that 50 percent of its area's symptomatic population lacks "basic order" needs—food and shelter; the AIDS Health Services Program of Newark reports that 55 percent of its clients need housing services; Essex County claims that it has about 550 homeless families; and the Coalition for the Homeless estimates that 30 percent of the homeless population is HIV infected.

Moreover, people with HIV disease are most often the last to be served. There is considerable anecdotal evidence that licensed facilities such as skilled nursing homes, intermediate and residential care facilities, and boarding homes are discriminating against people with HIV/AIDS, but it has proven difficult to obtain details and documentation of specific instances of discrimination. AIDS case managers in the Newark and Jersey City area recently reported that 866 of their clients needed housing services, but that only 46 percent of them had their needs met. The situation is not helped much by the fact that there are fewer than 100 state-supported housing beds for people with HIV/AIDS in New Jersey. Clearly, this is a crisis of the first magnitude.

The link between AIDS and substance abuse was discussed earlier in this chapter; suffice it to say here that in the Newark area at least 40 percent of IDUs are seropositive. There are waiting lists everywhere for drug treatment and only 34 residential drug treatment beds statewide which are reserved for people with HIV/AIDS. As mentioned earlier, substance abuse treatment ranked 8th of 34 needed services in Newark and Jersey City between 1986 and 1990; less than half of those needing services obtained them. The outpatient situation is slightly better: many methadone and drug-free programs have HIV/AIDS components; nevertheless, the demand exceeds the availability. Certainly the Campus Treatment Program in Secaucus is a step in the right direction if its HIV/AIDS component proves its effectiveness. Indeed, service needs are greatest in those areas with the largest numbers of IDUs, since the drug-abusing population is generally sicker and more alienated from the "system" than other people with HIV disease.

In addition to housing/shelter and substance abuse treatment, there are shortages of virtually every other support service needed by persons with HIV/AIDS. Many of these do not fall under the direct purview of the Department of Health. **If the shortages are to be alleviated, interdepartmental action is needed. A new State interdepartmental body should be created—or the present one which deals only with housing issues should be expanded—to facilitate and coordination in dealing with these crosscutting issues and needs.**

Case Management

There are two articles of faith about the best way to deal with this epidemic: that services be coordinated by case management and that they be delivered, whenever possible, by organization based in the community. Case management is the key to an effective continuum of care for an illness that fluctuates in severity in every patient and that places such widely varying demands on the state's health and social services system. In their Year 02 application for Ryan White Title I funds, the Newark Planning Council stated: "An effective case management component improves client compliance, averts hospitalizations, increases access to scarce medical resources by unburdening physicians and other health care and other social services providers from arranging for many necessary services."

New Jersey pioneered in case management for people with HIV/AIDS, but a decade into the epidemic there is apparently still a long way to go before the advantages of the concept are maximized. In fact, Newark made expanded case management its number one priority in its service plan for 1992, and one of its major objectives the "improvement in the overall quality and consistency of case management services." The Hudson County AIDS Consortium also requested supplemental funds for expanded case management services.

In part, the call for more (and more effective) case management is a reflection of the epidemic's growth. Case managers are handling more and more clients; the active case load of the case managers at the Jersey City Medical Center EIP site is over 100. Despite the many calls for expanded case management, however, there are indications that the

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problem may not entirely be a question of numbers—that there are as many instances of case management overlap and duplication as there are shortages. It is clear that uniform standards for case management and, in some areas, better coordination of case managers, are very much needed. Moreover, as more hospitals develop the capacity to treat HIV/AIDS outpatients, they will need case managers on staff.

Community-based Organizations

It is also conventional wisdom that many services for people with HIV/AIDS are most effectively delivered by community-based organizations. In the long run, this will probably prove to be true. Problems are posed in the short run, however, since many of the organizations based in the communities and neighborhoods of high HIV/AIDS incidence lack infrastructure and experience both in applying for grants and administering them when received.

Women

Despite the considerable efforts of the Office of Women and AIDS and other organizations, much more must be done for women with HIV disease, and for those at risk of infection. As in the case with most at-risk populations, there continues to be a basic lack of knowledge about HIV/AIDS among women. This is sometimes due to the inadequacy and shortage of targeted prevention education material and other sources of information, and to a certain reluctance (common in many populations), to acknowledge the extent to which they are at risk of infection. Some women's advocates recommend more precisely targeted programs for special populations of women—IDUs, the sexual partners of IDUs, and prostitutes—who are not only at high risk themselves, but who are particularly likely to transmit HIV to others. Peer programs would be particularly valuable for these populations.

Many health care practitioners are still reluctant to consider HIV infection an important causal factor of gynecological conditions. There have been some attempts on the part of public health professionals and women's advocacy groups to address this situation—and the situation has improved—but it is still unsatisfactory. More must also be done to inform women of available services to which they are entitled.

Because many women are mothers as well, there is a need to facilitate “one-stop shopping” for the health care needs of the entire family. If a woman with HIV/AIDS requires hospitalizations her case manager should make every effort to arrange child care, as some women delay treatment because they fear they may lose their children.

There are far too few substance abuse treatment slots for women with HIV/AIDS—and even fewer for those who are pregnant. In this case as well, women presently fear the loss of their children to the foster care system if they seek treatment. **There is an urgent need for the State to expand the availability of substance abuse treatment for HIV-infected women and their children.**

Children

New Jersey's network of pediatric HIV/AIDS care is a nationally recognized model. Like other programs, however, the program needs additional state funding, particularly to improve access to care of mothers of HIV-infected children. **Because infected children and their parents have a particularly varied list of health care and support service needs, current reimbursement rates—especially Medicaid's—are insufficient, and should be increased to reflect this intensity of care.** This will also assist in finding qualified and willing providers.

Moreover, at the existing Federal funding level, services for children cannot be expanded and the network agencies are unable to adequately meet the increasing number of children needing HIV/AIDS services. This problem, along with the implementation of newly revised regulations requiring mandatory reporting of the HIV infection, will exhaust the available resources for existing and newly identified New Jersey children and their families. There is a need to look for alternative and continuing funding sources to expand these resources.

Some strain to the system would also be alleviated if more pediatricians were comfortable with providing “routine” care to HIV-infected children, while at the same time establishing contact with the network and referring to it the most seriously ill. A DOH-sponsored protocol is now available for pediatric HIV disease treatment. The State should do everything possible to encourage its use by New Jersey physicians.

The creation and utilization of an effective case management system is the best way to help infected children and their families locate, obtain and maintain the needed health services within their communities. A case management component has been established in the Pediatric HIV Network sites but, because MCH/HRSA funds are limited, these services have had to be funded through the MCH Block Grant. Since the Block funds are also limited, the case management resources are **not** adequate to meet the current and projected needs of the pediatric population.

The pediatric HIV treatment network is already overburdened, and expansion of its focus to include more services for families has been very difficult at the existing funding levels. Many agencies are trying to expand services without additional staff but this has been very difficult. This situation, if it continues, will result in inadequate services for children. An effective network of providers is currently in place, but additional resources are needed if it is to meet the ever-growing needs of New Jersey's children and their families.

HIV infection in adolescents presents particularly tough problems for families, care providers, and public health and educational authorities. They are one of the at-risk groups most difficult to reach with prevention education messages that effect behavioral change. Another problem is that adolescents are currently unable to seek HIV counseling, testing and treatment without parental consent.

Moreover, there currently exists no comprehensive, coordinated care and treatment program for adolescents. Infants and children receive services through the Pediatric HIV Network, and adults have an array of detection, treatment and management services available through programs funded by the Division of AIDS. However, even though Special Child Health Services has been charged with the responsibility of expanding all services for children, the limited funding received from the Maternal and Child Health Bureau does not allow network agencies to expand their staff and modify their services sufficiently to meet the unique educational, behavioral and psychosocial needs of adolescents.

The table immediately following shows aggregate HIV/AIDS-related service data as of May 1990 for the AIDS Health Services Program in Newark and Jersey City. While these two cities have been particularly hard-hit by the epidemic—and are therefore particularly needy—the table nevertheless conveys a largely accurate impression of the extent to which the many needs of New Jerseyans with HIV/AIDS were—and for the most part are—best being met—and those which were, and are, largely unmet. It is significant to note that while hospital inpatient needs have been reasonably well provided for, outpatient and inpatient sub-acute needs are not. Other areas of acute concern are housing and substance abuse treatment.

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SERVICES	NEED	UTILIZED	NEED RANK	MET NEED	UNMET NEED RANK
Clinic/OPD	4313	3216	1	.746	23
Hospital Inpt. Svc.	2539	2332	5	.918	34
Private Physician	431	331	17	.768	26
Public Health Clinic	88	54	31	.614	17
Dental	367	262	18	.714	22
Inpatient Hospice	78	9	32	.115	1
Home Care Hospice	60	22	33	.367	5
VNA/Home Nursing Care	1273	808	11	.635	18
Nursing Home Care (ICF)	95	24	30	.253	2
Nursing Home (skilled)	128	36	28	.281	3
Housing	627	259	14	.413	6
Psychiatric Svcs.	319	240	19	.752	25
Psychologist	238	162	20	.681	20
Psychopharmacologist	142	124	26	.873	32
Social Worker	3204	2619	2	.817	31
Pastoral/Clergy	962	845	13	.878	33
Visitation Volunteer	153	120	25	.784	28
Couns. Res. (Self)	2986	2370	4	.794	29
Couns. Res. (Fam./Sig. Other)	1777	1004	7	.565	12
Educational Resources	1375	1059	10	.770	27
Drug Alcohol Treatment	1491	683	8	.458	8
Support Group	2157	734	6	.340	4
Financial Assist.	3059	2065	3	.675	19
Buddy	215	101	22	.470	9
Practice Support Volunteers	195	87	23	.446	7
Home Meal Delivery	39	22	34	.564	11
Foster Care (Children)	123	92	29	.748	24
Transportation Services	984	580	12	.589	14
Relocating Services	132	75	27	.568	13
Community AIDS Agency	577	289	15	.501	10
Legal Assistance	237	142	21	.599	16
Other Children's Services	443	353	16	.797	30
Specific Women's Services	166	117	24	.705	21
Other	1443	859	9	.595	15

Notes:

Data taken from AIDS Health Services Program—Aggregate Service Utilization Report as of 5/3/90

- Need** = services needed
- Utilized** = services utilized
- Need Rank** = services ranked in order from most frequent (=1), to least frequent (=34)
- Met Need** = services needed/services utilized
- Met Need Rank** = a measure of met/unmet need (most unmet need =1, least unmet need =34)

Data for the following 12 months indicate that needs were met at about the same rate, and that unmet-needs rank remained largely the same. What is significant is the increasing demand for services—evidence of how rapidly the epidemic is growing. Reported need levels for 1991 were greater for every service. For example:

- Clinic/OPD: +30%
- VNA/Home Nursing Care +26%
- Housing +38%
- Psychiatric Services +46%
- Drug/Alcohol Treatment +37%
- Transportation +34%

In order for resources to be optimally allocated, it will be essential for the State to acquire more comprehensive and timely data not only on the epidemiology of HIV/AIDS, but also on present and future needs for both care and treatment and support services. While it will continue to be possible to treat without undue strain the acute episodes of people with HIV/AIDS, there can be no doubt that this epidemic will continue to place an immense burden on all other elements of the continuum of care, in the years ahead.

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PREVENTIVE AND PRIMARY CARE**A. EXECUTIVE SUMMARY**

Primary care has risen to the top of the nation's health care agenda in recent years. Its place in the overall system is a concern of public policy-makers and private businesses, physicians and patients, states and private citizens. As a result of this attention, a greater degree of consensus now exists about what primary care really means. Although frequently defined in terms of the providers of certain kinds of services, professionals generally agree that it involves far more. In its broadest sense, primary care encompasses not only treatment and prevention, but also the process through which they are delivered. Primary care must be available in one's community; include attention to the health of the patient's family; and be comprehensive, continuous, and accessible regardless of individuals' ability to pay (Harmon, 1991).

Economics is both the most intractable of barriers to primary and preventive care, and the most in need of correction. The lack of payment for preventive and primary care flaws the health care finance system, as does the widespread fragmentation of payment mechanisms. The situation is exacerbated by financial disincentives to the provision of preventive and primary care, and strong incentives for more specialized and procedure-based care.

To assure the availability of comprehensive primary care for all New Jerseyans, this chapter presents a dual approach that includes both financing and service provision. This is done on the assumption that it would be futile to attempt to change health care organization and delivery without also changing the financial mechanisms that drive it. Major insurance reforms are proposed for the working population, who would be insured through their place of employment, and a new plan, New Jersey SHIELD (State Health Insurance Enrollment and Local Care Delivery), is proposed for the uninsured population. Both would incorporate the following elements:

- Standardization of benefits, emphasizing preventive and primary care;
- Provider payment reform to encourage preventive and primary care service provision;
- Standardized eligibility criteria, with services available to all New Jerseyans, regardless of health status, employment status, place of employment, or previous insurance claims;
- Standardization and automation of claims, billing, and payment for all publicly and privately insured;
- Coordination of care that would provide appropriate access to specialty care for the insured population, and offer, in addition, health care management services for the uninsured population, as well as linguistically and culturally appropriate coordination of care for ethnic/racial minority groups.

The plan presented in this Chapter is built on the existing insurance and public/private delivery system. It restructures the State's financing from a hospital-based system funded in part through the New Jersey Health Care Trust Fund, to a preventive and primary care-oriented system that is more responsive to the individual. When implemented, the recommendations in this chapter can be expected to change in fundamental ways New Jersey's health care service organization and delivery, and the financing of them. The impact of both should be strongly positive, correcting many of the flaws in the existing system.

The greater availability and accessibility of preventive and primary care services will have the following positive social impacts:

- Improved health status for New Jerseyans, particularly those who now lack insurance, or are underinsured, or are members of ethnic/racial minority populations;
- A more efficient allocation of health care services;
- Reduction of administrative burden; and
- A more equitable and nondiscriminatory health care system.

The proposed changes will occur within the framework of the May 27, 1992 federal court decision that invalidated portions of New Jersey's rate-setting system by declaring illegal the allocation of certain costs, such as uncompensated care, to members of self-insured groups. This decision dictates that a new way of paying for uncompensated care must be devised, and it seems appropriate to use the dollars generated by the former New Jersey Health Care Trust Fund to pay for the New Jersey SHIELD Plan.

To illustrate the effect of reallocating Trust Fund dollars, the cost of providing a standard insurance policy through a publicly-funded plan may be compared to the cost of the Trust Fund. Assuming that the approximately \$750 million projected as 1992 expenditures from the Trust Fund would be available for purchase of policies for the publicly-insured, and that a basic primary care oriented policy costs between \$2,000-\$2,400, approximately 341,000 people could be covered. Since the number of uninsured persons in the New Jersey SHIELD Plan would be drastically reduced by the proposed universal coverage of workers through their place of employment, it is possible that no more than 341,000 of the 800,000 now covered through the Trust Fund, would need to be insured through the SHIELD Plan.

There should also be cost savings to the system associated with other recommended changes. The standardization of claims, billing, and payment should reduce administrative costs, and electronic transfer of payment should reduce interest costs. The anticipated decreases in mortality and morbidity should save costs associated with more expensive

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modalities of care, such as hospitals. Use of community rating should reduce the administrative costs associated with calculation of experience rating scales.

One aspect of preventive and primary care requires special highlighting: New Jersey's local health departments. This chapter contains a separate subchapter to describe the local public health delivery system, its problems, and recommendations for change. This subchapter follows at the end of the section on preventive and primary care.

The reader should be aware that this Chapter does not cover specific preventive and primary care interventions. Because the Chapter is part of a larger document, the State Health Plan, many aspects of preventive and primary care are contained in other chapters. The reader is referred to these chapters for in-depth information about specific topics such as maternal and child health, cardiovascular disease, cancer, AIDS, addictions, and so forth.

B. GOALS AND OBJECTIVES

Healthy New Jersey 2000 emphasizes the access problem related to preventive and primary care, and lists objectives by which the State's progress can be measured. The relevant goals are as follows:

1. Decrease the percentage of the population under 65 years of age with no health insurance from 11.7% of the total population, 16.0% of the black population and 25.0% of the Hispanic population to 3.0% of the total population, 3.0% of the black population and 3.0% of the Hispanic population (1989 baseline);
2. Decrease the percentage of the population without health insurance coverage who are under 65 years of age and employed or a spouse or dependent of an employed person from 7.7% to 2.0% (1989 baseline);
3. Increase the percentage of residents who have a source of preventive and primary care from 84.4% of total residents and 84.2% of black residents to 98.0% of total residents and 98.0% of black residents (1986 baseline);
4. Decrease years of potential life lost per 100,000 population under 65 years of age from 5,778.7 to 5,200.0 (1988 baseline);
5. Increase life expectancy at birth for minority babies from 71.8 years to 75.0 years (1988 baseline).

C. PROBLEM IDENTIFICATION**Definition of Primary Care**

Primary care has been defined in various ways. For the purpose of this chapter, the term is used in a comprehensive sense that includes prevention and treatment services provided in a context that fosters continuity of care and provider responsibility for coordinating services. The recognized providers of preventive and primary care are physicians in the specialties of family practice, general practice, general internal medicine, general pediatrics, obstetrics, and gynecology. Also included are nurse practitioners, certified nurse midwives, and physician assistants, as well as general practice dentists.

Comprehensive preventive and primary care encompasses the provision of sick and well care to all age groups in each stage of the lifecycle, from before birth to old age. It includes screening for the early detection of disease or risk factors, immunizations, counseling, diagnosis of health problems, treatment and reassessment for acute or chronic illness, as well as health promotion services. To foster continuity, services should be provided to the individual by a single practitioner or group of practitioners. Referral to specialists and admission to hospitals should be arranged by this provider as they are needed, so that the patient is part of an ongoing, coordinated system of care.

Optimally, preventive and primary care includes several components that make services more accessible to clients. Accessibility is improved when providers offer extended evening, early morning, and weekend hours, and 24-hour on-call coverage with follow-up. For many individuals, particularly those with physical and mental impairment, readily available transportation is needed for travel to the primary practitioner's office or clinic. For others, varied supportive features such as bilingual staff or translators, cultural awareness and sensitivity on the part of health care workers, and child care services may be essential to assure the use of preventive and primary care as needed to remain healthy.

Family-centeredness and community orientation (use of community data in planning or identification of problems) have also been suggested as important practice characteristics related to prevention and primary care (Starfield, 1992). Beyond the clinician's office, other avenues

through which illness prevention and health promotion may be pursued include community development and environmental programs and public health education campaigns.

Preventive and primary services should form the foundation of the health care system. They should constitute the "point of entry" into the system. The extent to which these services are provided effectively has ramifications for secondary and tertiary components of the system; in fact, these higher level components cannot function properly in the absence of a sound preventive and primary care foundation.

Problems in Financing, Organization, and Delivery of Services

In many important ways, the existing care system does not adequately provide the services that people need. Preventive and primary care, both in New Jersey and nationally, has been eclipsed by costly, but not necessarily cost-effective, types of service.

In the context of the present health care system, a broad and comprehensive definition of preventive and primary care immediately suggests that there are at least two fundamental problems. One is the fragmentation of services. The other is the perverse financial incentives that dictate the kind of services provided; perverse because payment often rewards treatment above prevention, sickness care above wellness care, and specialized care above preventive and primary care. These two problems are highly interrelated, and discussion of one in isolation is difficult, so the divisions in the text that follows will not be clearcut.

The Patchwork Organization of Primary Care Services. Nationwide and in New Jersey, there is no widely accepted prototype of a health care system to guide the organization and delivery of services. The result is a pastiche in both the private and public sectors. Elements of the system for primary and preventive care include practitioners in private and group practices, health maintenance organizations, local health departments, Federal Qualified Health Centers, state categorical programs such as Maternal and Child Health prenatal and pediatric clinics, community health agencies, family planning and HIV early intervention and treatment programs, a wide variety of health education and prevention programs, and hospital outpatient departments.

While such diversity can be beneficial in encouraging competition between providers and promoting patient choice, the limitations of a fragmented system are considerable. For example, duplication of services and administrative structures results in increased costs. It is difficult for consumers to ascertain where and how to receive high quality care, when practice protocols and the amount of emphasis given to preventive care vary widely from one practitioner or setting to another. Consequently, some patients receive inappropriate care from inappropriate providers at excessive costs.

Minority Access: In general, minorities encounter more hardships and barriers than others when they seek to enter the health care system. In addition to problems arising from the fragmentation and complexity of the system, minorities are thwarted from receiving needed care due to a maldistribution of health practitioners and services. Even when services are geographically accessible, the lack of cultural awareness and sensitivity among providers is a prevalent problem. There may be language barriers to communication, or an absence of culturally relevant and ethnically appropriate services.

In some treatment settings, discrimination, whether based on socioeconomic status or race/ethnicity will not afford minority populations fair and equitable treatment. The lack of sensitivity in terms of such things as appointment scheduling, caring attitudes, and the availability of linguistically appropriate health education materials will often result in a justified perception that the health care system is unresponsive or even hostile to their needs.

As a result of these formidable obstacles, many individuals tend to seek care only during crisis situations. Underutilization of services may be misconstrued as a justification for reducing or eliminating those services. In this way, rather than addressing the institutional and systemic factors/barriers that discourage minorities from using care, access is further limited.

Health Insurance and Primary Care. Preventive and primary care services in New Jersey and the rest of the nation are driven by reimbursement mechanisms. Health insurance, the means of payment for most services in this country, is offered by more than 1,200 insurance companies with thousands of different coverage plans and benefits. The plethora of choices can be overwhelming, if not incomprehensible. To support this array of options, payers are forced to incur the expenses

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associated with administering and marketing many plans to many different population groups. These expenses are then passed on to consumers.

Many people are precluded from obtaining insurance due to the practice of demographic or experience rating. With demographic rating, the insurance company bases its rates on age, occupation, sex, and geographical location. Information about the health status and claims experience of the population to be insured is also incorporated in experience ratings. The result is that groups or individuals who are more seriously ill and have submitted more claims for health services are charged higher rates by the insurer. In most cases like this, commercial insurers are not willing to write a policy on seriously ill individuals at any cost.

By contrast, community rating, which actuarially determines one rate for everyone in the population without regard to demographic factors, is infrequently used. An exception to this is HMOs, which tend to use community rating by choice. In New Jersey, Blue Cross is the only insurance company that is **required** to use community rating, but this applies only to their individual plans.

Employers find health insurance costs rising faster than general inflation, and are responding by decreasing coverage and/or requiring increased payment by workers. With high unemployment, fewer people

obtain health insurance from their jobs. Those who do may find that coverage is shrinking. Typically, visits to primary care providers are not covered under indemnity plans (the most prevalent type of health insurance), while hospitalizations that may be the result of a lack of preventive care or timely primary care intervention are covered. In 1990, only 34 percent of the nation's private sector employees with insurance had well-baby benefits. Only 28 percent of these employees were covered for immunizations (U.S. Department of Labor, 1990). This means that preventive and primary care for those covered under these insurance plans is generally an out-of-pocket expense.

Ambulatory Care Sensitive Conditions. To assess the impact of barriers to preventive and primary care, researchers have begun studying hospitalizations for conditions that could likely have been avoided or decreased in intensity, had adequate primary care been available and utilized. In 1989, there were approximately 130,000 such hospital admissions; in other words, one out of every eight hospitalizations may have been the result of a failure of New Jersey's primary care system. Hospitalization costs for these conditions, known as Ambulatory Care Sensitive Conditions (ACS), amounted to over 640 million dollars for New Jersey patients in 1989. The distribution of costs by payer was generally parallel to that for all inpatient admissions in the following year:

COST OF ACS ADMISSIONS TO NEW JERSEY HOSPITALS

Payer	Cost of ACS Admissions 1989	Percent of Total Cost	Percent of Total Revenue, All I/P Admissions 1990
Medicaid	\$ 54,730,000	9%	8%
Medicare	302,795,000	47%	46%
Other Federal	41,484,000	6%	1%
Private Insurance	191,228,000	30%	33%
Self-Pay/Charity	5,027,000	8%	12%
Total	\$640,244,000	100%	100%

Source: (C) PANDORA 1991, The Codman Group, Inc.

The \$640 million spent in one year in New Jersey represents hospitalization costs that might have been avoided if a better system of preventive and primary care had been in place. Patients in New Jersey hospitals have a total of \$50 million added to their bills to pay costs of care to uninsured people for conditions that may have been preventable.

As the Table shows, Medicare and private insurance patients incur much larger costs, indicating that lack of primary care coverage is a problem for the insured, as well as the uninsured. The problem may be due to a lack of primary care coverage for those who have insurance, leaving many New Jerseyans underinsured, or without coverage for needed services, many of which could be provided outside hospitals in less expensive settings.

The Uninsured. Nationally, there are an estimated 37 million people without health insurance. The number of uninsured persons in New Jersey has been increasing each year and will soon approach one million. In 1989, New Jersey had nearly 800,000 uninsured persons. Almost twelve percent of those under the age of 65 have no health insurance. Appendix A breaks down the total uninsured population in the State by county. There are also more uninsured persons in New Jersey than there are people who are Medicaid eligible. The latter constituted 7 percent of the population in 1990 or about 567,000 individuals.

A disproportionate percentage of the minority population is uninsured. Even those with coverage often have limited benefits and may be denied access to some services. In New Jersey in 1989, 16 percent of African Americans, and 25 percent of Hispanics under the age of 65 had no health insurance coverage. These percentages for minority uninsured are considerably higher than the comparable percentage for the population as a whole, of 11.7 percent.

Not all uninsured persons are from the lowest income groups. This is a striking change from past years, and it has serious implications for future workers. According to a report on "Health Insurance for the Uninsured in New Jersey" by Dr. Richard Kronick of the University of California, 39% of all uninsured in New Jersey are in a family with income above 300% of the poverty level. About 428,000 uninsured persons, or 55 percent of this State's uninsured population, are full-time workers or dependents of full-time workers. An additional 85,000 or 11 percent worked at least 1,500 hours per year (approximately 75 percent

of full-time employment), or were the dependents of such workers. The majority, or about two-thirds of uninsured persons, therefore represent the working population.

Small businesses, particularly in the retail trade and service industry where many low-wage minority workers are employed, infrequently offer health insurance benefits. Employees in these businesses usually lack the resources to obtain insurance on their own, and many join the ranks of the uninsured who often delay seeking medical attention. These individuals are then forced into crisis-oriented, episodic care provided in more costly settings such as emergency rooms.

In New Jersey, a UMDNJ-Eagleton Poll released on July 20, 1992, indicated that 20 percent of those who had a health-related problem, but did not see a physician, failed to do so because of a lack of health insurance. Compared to New Jerseyans who have health insurance, those without it were five times less likely to have visited a physician, even when they had health problems.

The Supply of Primary Care Providers. At the present time, there is an insufficient supply of primary care medical providers, particularly family practice physicians, in many parts of the State. This situation is largely a function of the higher salaries for specialists who are more generously compensated by third party payers for their procedure-based practices, compared to primary care physicians. For example, the average income of a family or general practitioner was \$102,500 in 1988, while a cardiovascular/thoracic surgeon's average income was \$310,000 (Pope and Schneider, 1992). The reimbursement policies used by insurers to pay physicians serve as a financial disincentive to those who might otherwise choose to be primary care practitioners.

Primary care physicians are subject to a further financial disincentive when they treat Medicaid and uninsured patients. Physicians who accept Medicaid patients receive an unrealistically low rate of reimbursement. In New Jersey, Board-certified and non board-certified practitioners are reimbursed at \$16 and \$14, respectively, for office visits. Although some providers are paid more, such as HealthStart providers who give preventive services to infants, provider fees are low overall, and serve to discourage many providers. For primary care providers in private practice, there are even stronger disincentives for serving uninsured persons who are unable to pay out of pocket. Providers of care to these patients receive no reimbursement at all.

An area of concern for ethnic/racial populations is their under-representation among those who deliver health care services. This is an important issue because health behaviors are often culture-bound, and minority groups represent many cultures, value systems, and perspectives. When there are not enough primary care providers available who can understand and respect the culture of the patient, and offer health interventions that are culturally sensitive and linguistically appropriate, patients' health may suffer.

For some populations, even an adequate supply of practitioners, including ethnically/racially representative physicians, is not sufficient to ensure access to health care. The uninsured and Medicaid populations face access barriers that will be only partially resolved by adequate numbers of providers. Thus, in order to provide access to all New Jerseyans, other initiatives must accompany an increase in the number of preventive and primary care providers.

Problems in Caring for the Poor and Uninsured. While often acting as the family physician for the poor, hospital emergency departments are inappropriate service modalities. Not only is hospital-based care more expensive, but it is often provided by specialists who are unaccustomed to providing preventive and primary care, and who cannot assure the continuity of care that is needed. The principal source of subsidized preventive and primary care for people who do not have insurance is through hospital outpatient departments, with payment from the Health Care Trust Fund.

Programs with federal funding struggle to meet the needs of clients. Federally Qualified Health Centers and school-based youth services programs, for example, have experienced uncertain funding. Many of the numerous Federal and State categorical programs available to underserved populations are seriously hampered by the complexity of widely differing eligibility criteria, program requirements, and target populations, as well as a dearth of available practitioners. Similar problems have also been experienced in the programs for the poor sponsored by local governments.

In view of the aforementioned problems of physician supply and lack of insurance, it is not surprising that, according to the 1986 National Access Survey, 18 percent of respondents, or 43 million Americans, reported having no regular source of health care. The poor are more likely to report having no regular source of care. In 1986, 16.8 percent of nonpoor reported no regular source of care compared to 20.2 percent of the poor. Poor children are more than twice as likely to have no regular source of care as nonpoor children: 15 percent compared to 7 percent of nonpoor children.

The number of ambulatory visits reported by individuals in fair or poor health also differed significantly by income. The poor are much less likely to receive primary care, despite their higher need status. The survey found that "... the nonpoor in fair or poor health had 37 percent more ambulatory visits than did lower income individuals reporting the same health status." (RWJF, 1987).

Poor families and low-income families who move in and out of poverty are at greater risk of impaired health status than more affluent individuals. They do not have sufficient resources to meet their basic needs, nor the ability to cope with unanticipated health problems, nor to invest in their own or their children's future. Many cannot afford adequate nutrition.

A growing number of minorities are disenfranchised from the larger society and "disadvantaged" in terms of personal growth and development opportunities, and eroding health status often results. Consequently, the improvement in overall health status experienced by Americans in the last two decades has not included these groups. *Healthy People 2000* documents health status disparities on the basis of race and ethnicity.

Health Promotion. The importance of healthy habits in maintaining wellness is widely recognized. As a result, many Americans have incorporated active exercise, a low-fat low-sodium diet, moderation in drinking, safe sex practices, and so forth in their lifestyles. Excellent, regular primary care will never take the place of these healthy practices in maintaining wellness.

Unfortunately, there are barriers to health promoting activities, just as there are barriers to preventive and primary care. For this reason, too many people continue to smoke, drink excessively, abuse drugs, gain excess weight, drive recklessly, and fail to exercise. In part, the problem is a lack of knowledge; thus health education remains a high priority, although inadequate funding for health education programs is a constraint. In other cases, information may be available, but it does not get through to those who need it. Peer pressure and other social and cultural

factors play a major part in shaping one's health habits. Consequently, for example, teens may be taught the harmful effects of smoking or youth violence, but if their friends condone, support, and encourage these activities, mere counter-information will be ineffective.

Stress presents another obstacle to maintaining healthy habits. Factors as diverse as poverty, overwork, and divorce may diminish the individual's ability to develop or continue wellness-enhancing behaviors. In many ways, we are confronted with messages that encourage health damaging activities. For example, some poor urban communities have an abundance of billboards advertising cigarettes and alcohol. Effective strategies are lacking for many communities to address the behaviors which are considered modifiable.

In spite of obstacles and problems, examples of successful health promotion programs abound. Many of these are described in other chapters of the State Health Plan. Effective strategies can be achieved through individual counseling, programs in schools, workplaces, and communities, or through legislation. For example, laws prohibiting smoking in public places or requiring the clean-up of toxic waste sites promote health and prevent injury or disease. However, laws that could have extremely beneficial effects on the population's health are frequently controversial if they infringe upon individual freedoms or rights (for example, the assault weapon ban law), appear coercive (for example, laws requiring helmets use for cyclists), or have the effect of penalizing the unfortunate (for example, attempts to impose higher taxes on cigarettes and alcohol, which would take a heavier financial toll on the poor than the wealthy). For these reasons, it is not possible to simply legislate wellness for the public. Nonetheless, laws have an important part to play in creating a salubrious environment, where it becomes easier for people to engage in health-enhancing behaviors and more difficult for them to take up health-damaging activities. Similar outcomes can be achieved on a smaller but no less effective scale in schools and workplaces, by instituting programs and policies and creating an atmosphere which makes it clear that wellness is a priority.

There is ample evidence that the potential of preventive services is not presently being realized. The American College of Physicians and the U.S. Preventive Services Task Force have both identified age- and risk-appropriate services. These services, such as cancer screenings and risk assessments, are not generally offered by health care providers. Lack of intent, lack of staffing, lack of professional training opportunities, and lack of financing are often cited barriers.

Health promotion and disease prevention are potentially far more cost effective than post hoc treatment. Health promotion/disease prevention activities cannot be ignored as a means to attain the best return on scarce resources as well as to provide improved health status for present and future generations.

D. THE EXISTING SYSTEM OF HEALTH CARE

This section of the chapter is organized under three main headings: 1) Primary Care Practitioners, 2) The Insurance/Payment System, and 3) Delivery Systems. There is a substantial amount of overlap between these topics; for example, Medicare and Medicaid are discussed as payment, and yet part of the "Primary Care Practitioner" content covers Medicare reimbursement of physicians. Nonetheless, the aim is to give the reader an understanding of the providers of and payers for primary care, as well as the system of care which is currently available.

Primary Care Practitioners

Physician Supply. Nationally, the physician to population ratio was 234 per 100,000 population in 1989, according to the American Medical Association. New Jersey's 20,342 physicians placed the State ninth in physician to population ratios, with 260 physicians per 100,000 population in 1989. This represents a large increase since 1970, when there were about 146 physicians per 100,000 population. Stated another way, the number of civilians per non-federal physician dropped from 686 persons per physician in 1970 to 384 persons per physician in 1989.

In New Jersey, approximately 37 percent, or 7,485 of New Jersey's physicians, are reported as primary care practitioners (family practice, general practice, internal medicine, pediatrics and obstetrics/gynecology). This is about the same percentage as is reported nationally. The number of primary care specialists actually practicing primary care, however, is lower due to subspecialization among physicians in internal medicine, pediatrics and obstetrics and gynecology. According to data from the 1991 Annual Report of the American Board of Medical Specialties, 64, 17 and 10 percent respectively of persons certified in internal medicine,

pediatrics and obstetrics and gynecology went on to receive a subspecialty certification. As the table below demonstrates, applying these national percentages to New Jersey's physician supply in primary care lowers the percentage of the state's 20,342 physicians in primary care from 37 to 25 percent.

Specialty	#	% Non- subspecialty	Primary Care Supply (in FTEs)
Internal Medicine	3,082	36%	1,110
Pediatrics	1,716	83%	1,424
Obstetrics/Gynecology	1,199	90%	1,079
Family Practice	1,488	*	1,488
Total	7,485		5,101

*Geriatric medicine represents five percent of subspecialty certifications in family practice and is generally considered to be a primary care specialty.

Thus, although New Jersey has substantially more physicians per population than the national average, we have a less favorable ratio of family/general practitioners to population than the nation. There are approximately 5,000 persons per family/general practitioner in New Jersey, compared to 3,500 persons per family/general practitioner in the U.S. While internal medicine, pediatric and obstetric and gynecology ratios are close to or better than national averages, the overall adequacy of primary care specialists practicing preventive and primary care is the issue.

Other industrialized countries, whose GNP for health care is considerably lower than that of the U.S., have substantially larger proportions of primary care practitioners. While a direct relationship cannot be inferred, comparisons are increasingly being made between the percentage of generalist physicians in England, Canada and the United States at 70, 50 and 40 percent respectively and the inverse relationship to the cost of health care in each of the respective countries.

At the present time, there is an insufficient number of primary care providers and, in particular, family practice physicians. The declining interest in primary care residency programs as well as the significant decrease in interest in family practice among students entering medical school (Colwill, 1992) will exacerbate this situation. Inadequate numbers of providers will intensify competition for these practitioners among the privately insured who are seeking primary care, and increase barriers to care for publicly insured persons.

The proportion of minority physicians creates yet another barrier, particularly in the minority community. Some data exist on medical school enrollment and graduation, however, very limited, if any, information is available on the number of African American, Latino, Asian, and American Indian practitioners in the State.

Physician Reimbursement. Physician reimbursement policies used by private payers and Medicare have contributed to some of the higher costs of health care. The main reasons are the inflationary nature of the "customary, prevailing and reasonable" method of reimbursement, as well as differences in payment for procedural and non-procedural services (Whitcomb and Tosteson, 1990).

The "customary, prevailing and reasonable" (CPR) method pays private physicians for each service according to what the physician has customarily charged in the past, and the prevailing charge of other physicians in the area and specialty. The reasonable charge is the lowest of the actual charge, the customary charge, or the prevailing charge. The approach of paying physicians according to the costs in the area has resulted in extreme variations in reimbursement between types of procedures, geographic areas, and specialties. These variations are not always attributable to differences in costs of practice. For example, prior to recent changes in this reimbursement system, board-certified or board-eligible internists received higher Medicare reimbursement than primary care physicians for providing the same service (OTA, 1991). In addition, identical services provided by different physicians could be reimbursed at considerably different rates based on the individual's past charges.

The CPR method has also caused "surgical and technical procedures to become increasingly overvalued relative to visits and consultations. This contributes to marked disparity between the incomes of primary care practitioners and other physicians . . . and may have also contributed to the rapid growth in the provision of surgical and technical procedures compared with visits and consultations." (PPRC, 1992).

Relative Value Fee Schedule Reimbursement. Medicare expenditures for physician services, which escalated at an average annual rate of more

than 13 percent since Medicare was enacted in 1965, provided the impetus for Congress to look at realigning the pattern of payments to physicians to reflect the costs associated with providing a service. The Consolidated Omnibus Reconciliation Act of 1985 (COBRA) created the Physician Payment Review Commission (PPRC) to advise Congress on relative payment and required the Health Care Financing Administration to undertake a relative value study.

The PPRC recommended a set of proposals to address physician reimbursement issues which were enacted by Congress in the Omnibus Budget Reconciliation Act of 1989 (OBRA89). The major elements in the physician payment reform provisions were the Medicare Fee Schedule, limits on the amounts physicians may charge beneficiaries above the approved Medicare fee, and Volume Performance Standards (VPS) to control expenditure growth.

The Medicare Fee Schedule, which include some of the work conducted by Professor William Hsiao and his colleagues at Harvard University to develop a resource based relative value scale, is the basis for physician payment reform. The Medicare Fee Schedule was implemented on January 1, 1992 and is being phased in from 1992 to 1996, to replace the CPR system.

The intent of the relative value fee schedule is to direct reimbursement away from a procedure-based, technologically intensive system to a system that rewards physicians for evaluation and management of patient care activities. The basis of physician payments therefore, shifts from charges to relative values reflecting resource costs. The relative values measure physician time and effort and include practice expenses such as overhead and malpractice.

The effects of the fee schedule will differ across physician specialties. Physicians who primarily provide evaluation and management services, such as preventive and primary care services, can expect considerable increases in total payments under the fee schedule. When weighing physicians' services according to the resources involved in providing them, primary care was found to be undervalued. The Medicare Fee Schedule redresses this imbalance and provides increased reimbursement for primary care physicians. For example, family and general practice physicians are estimated to receive an increase of 39 percent when the fee schedule is fully implemented in 1996.

Payments to specialists providing predominantly evaluation and management services will increase. Specialties providing more procedures (for example, cardiology and gastroenterology) will receive lower payments. Payments to surgical specialties and hospital-based specialties will decrease substantially although some general surgeons will receive increased revenue. The variations are due to the different mix of services provided by physicians, the prior charges relative to peers, and comparisons between local charges and payments adjusted by geographic area factors (PPRC, 1992).

Other elements of the OBRA89 physician payment reform have also been implemented. In 1991, charge limits became effective. By 1993, the Medicare charges will be limited to 115 percent of Medicare fee schedules for physicians not participating in assignment agreements with Medicare. Physicians accepting assignment agree to accept the Medicare Fee schedule payment as payment in full, in exchange for being listed in a directory available to all Medicare beneficiaries, receiving expedited claims processing, and having prevailing charge screens which are five percent higher than those of nonparticipating physicians.

The first Volume Performance Standards (VPS) were set in 1990 in recognition of the fact that restricted Medicare fees resulted in rapid increases in volume of services. To counteract this trend, fee updates are linked to increases or decreases in expenditure growth, so that outlays for physicians grow at a level in line with the gross domestic product.

It is anticipated that the physician payment reform measures will constrain growth in Medicare program expenditures for physician services. Medicare hospital expenditures experienced a significant decline with the implementation of inpatient cost control efforts in the mid-1980s. This decline contrasts significantly with continued increases in national health care expenditures.

Nurse Practitioners and Other Non-Physician Providers. Due to changes in the law, previous constraints to the use of nurse practitioners and physician assistants have been removed. Both are trained to provide primary care and are now eligible for reimbursement. Community-based clinics which are nurse-run can be a vital source of primary care.

Nurse practitioners are able to provide economical primary care. Traditionally, they have provided care in under-served areas. By training, they are attuned to the complex psychosocial issues of vulnerable populations. Their education emphasizes preventive care as well as case

management and care coordination. Nurse practitioners are also skilled at intervening with primary care clients who have chronic care conditions. They may base their practice in a broad range of community settings, including community health centers, schools, and occupational health clinics.

Insurance/Payment Systems

Indemnity Plans. The majority of insured New Jerseyans have indemnity plans. Health insurance coverage in the traditional indemnity plan is principally for costs related to hospitalization and acute care. These policies also entail deductible or copayment responsibilities for the insured party, which, in combination with the hospitalization emphasis, create disincentives for the utilization of preventive and primary care services. Not only are few preventive and primary care services covered, but deductibles or copayments must be made for the few that are covered. Often in the case of the relatively less expensive preventive and primary care services, the amount of the deductible or copayment is almost equal to the cost of the service. Thus the coverage is of little assistance to those who opted to insure because they could not afford to pay for preventive and primary care services in the first place.

In the section on Ambulatory Care Sensitive Conditions, data presented indicate that insured and uninsured populations alike are admitted to hospitals for conditions that appropriate primary care might have prevented. Given the structure of indemnity plans that serves as a disincentive for the utilization of preventive and primary care, the Ambulatory Care Sensitive Condition data are not surprising.

Health Maintenance Organizations and Preferred Provider Organizations. Health Maintenance Organizations (HMOs) are prepaid, organized health care plans. Persons who enroll in HMOs are provided with comprehensive benefits that are financed through prepaid premiums with nominal copayments. Services may be provided through a variety of service delivery systems including staff, group or network-model HMOs. The principal difference between these three models is the organization of the medical staff. For example, in a staff-model HMO, physicians are employees of the HMO, whereas in a network-model HMO, the HMO contracts with several single or multispecialty group practices to provide services.

Independent practice associations (IPAs), preferred provider organizations (PPOs), exclusive provider organizations (EPOs), or point-of-service (POS) plans incorporate system delivery elements of HMOs, but differ with respect to the prepaid capitation financing mechanism. Providers are more frequently reimbursed according to a discounted or negotiated fee-for-service schedule.

A number of definitions exist to differentiate between HMOs and PPOs which are as varied as the multiple types of financing and delivery systems used by the hundreds of HMOs and PPOs. Nonetheless, these systems share common elements that include, among others, the selection of providers, restricted access to certain types of health care such as subspecialists, financial incentives to remain within the system and methodologies to evaluate and encourage changes in the clinical practices of providers.

More important than the differences between HMOs and PPOs is the distinction between these alternative delivery systems and traditional indemnity plans. In the latter, the insurer simply reimburses the insured individual for incurred health expenses and has no direct relationship with the provider of care. Alternative delivery systems, on the other hand, develop a direct link between the insurer and the provider of care in an attempt to better manage the health care provided to the individual. In this process, both the provider and consumer surrender some freedom on choice to the HMO or PPO as a quid pro quo for an improved quality of care and cost containment.

The term managed care is used in a number of contexts to mean many different things. The definitions run the gamut from intensive case management to utilization review, prior authorization and other monitoring techniques. Within this definition, the growth of managed care has been tremendous and is incorporated in virtually every health care plan in the nation. Critics, however, maintain that most managed care is little more than the management of costs and nominal efforts are made to reduce the volume of care or appropriately manage the delivery of health care.

According to a 1990 survey conducted by the Health Insurance Association of America (HIAA), "pure" HMOs have about 20 percent of market share within traditional insurance arrangements. While the growth of HMOs has been relatively flat in recent years, growth since the 1970s has been stronger. In 1970 there were 37 HMOs with about

3 million people enrolled. By the end of 1990, there were 569 HMOs with 36.5 million members. Providing an equivalent figure for PPOs or managed care programs is complicated by the number and variety of definitions for these alternative delivery systems.

In New Jersey, total HMO enrollment in 1991 was 975,926, or approximately 13 percent of the State's population. The largest concentrations of enrollees were in the counties of Burlington, Camden, and Middlesex, each having more than 100,000 enrollees.

A much smaller group of New Jerseyans participates in (PPOs). There are only a few PPOs in the State, and all of them are part of an HMO. All are operated by private insurance companies, and the State has no statutory authority for oversight of PPOs.

Self-Insurance. Perhaps the fastest growing approach to paying for health care is the self-insurance of businesses. Self-insured employers assume health care risks directly, rather than paying premiums to an insurance company. Nationally, self-insured plans paid for 44 percent of all medical bills covered by employers in 1990. Over 80 percent of employers with more than 5,000 workers now fund their own medical care expenditures (Iglert, 1992).

Employers find a number of advantages in self-insuring. Many of these benefits derive from the federal Employee Retirement Insurance Security Act of 1974 (ERISA). A section of this law preempts state laws which relate to employee benefit plans in those cases when businesses self-insure. The result is that self-insured employers do not have to comply with state-mandated health insurance coverage requirements. They are free to structure their health benefits as they choose without the interference of state insurance regulations (Fox and Schaffer, 1989).

Self-insured employers also benefit financially from not having to pay insurance companies' premiums and from not having to pay state taxes on these premiums. Employers only make payments as claims arise, frequently using insurance companies to process them. Thus they avoid paying insurance companies' marketing expenses and their costs for assuming risk for the employer (Iglert, 1992).

It should be noted that, while businesses prefer self-insuring for the reasons cited, self-insurance creates difficult obstacles for state and national health policy-makers. Without the ability to mandate standardized benefits and practices such as community rating, opportunities for addressing problems of the uninsured are limited. For this reason, states such as Massachusetts have attempted to be exempted from ERISA, but they have been unsuccessful to date.

Medicaid. Medicaid is an assistance program for the poor that is jointly funded by the State and Federal governments. In 1990, approximately 567,000 New Jersey residents were Medicaid recipients. Income limits for the Medicaid program vary by age. For pregnant women, and children up to age one, coverage includes those with incomes up to 185% of the federal poverty level (\$17,000 per year with no asset test). Children born after September 30, 1983, are eligible for coverage, up to 100 percent of the poverty level, with no asset test.

According to the Health Care Financing Administration, private practitioners provided about three million physician visits to Medicaid recipients in New Jersey. Total Medicaid reimbursement to physicians for fiscal year 1992 was about \$80 million, or an average of \$20.00 for office visits and related ancillary services. The \$80 million in annual reimbursement to private practitioners represents just under three percent of New Jersey's Medicaid budget.

The number of dental practitioners available to the Medicaid population has been decreasing. Less than 20 percent of active dentists in New Jersey provide care to Medicaid recipients. Of 648,000 Medicaid eligible persons, only about 25 percent receive dental care. The primary reason again is the very low rate of Medicaid reimbursement for dental services. For example, the average Medicaid rate of reimbursement for an extraction is \$15.00; the average charge for the service by dentists is \$60.00. Medicaid reimbursement for dental services is currently \$28 million, representing just under one percent of New Jersey's Medicaid budget.

Garden State Health Plan. The Department of Human Services administers a model public HMO to Medicaid recipients in ten New Jersey counties. Presently there are about 16,000 persons enrolled in the Garden State Health Plan (GSHP) with 179 participating providers. As a result of the Health Care Cost Reduction Act of 1991 which required expansion of managed care services in New Jersey, the Division of Medical Assistance and Health Services has undertaken activities to expand the GSHP for Medicaid-eligible persons. The membership goal is 36,000 members by June 30, 1993.

The Health Care Cost Reduction Act also required the GSHP to provide coverage for employed persons who are not eligible for Medicaid

and do not have health insurance or who cannot afford the health insurance offered by the employer. In addition, small employers who have not provided health insurance would be eligible to purchase coverage through the GSHP. The New Jersey SHIELD Plan which is discussed later in this Chapter will offer yet another option to the Medicaid population.

Medicare. Medicare is the federally-funded entitlement program for the population age 65 and older. Although it includes other small groups, such as those with end stage renal disease, most of those covered are the elderly. Part A pays for health care services, chiefly hospitalization. It is acute-care oriented, with severe gaps in preventive and primary care areas, such as dental and eye care, pharmacy supplies, and flu shots. Part B of Medicare pays for physician visits at predetermined rates. Because these rates are often considerably lower than provider costs, some providers refuse to accept Medicare patients.

Delivery Systems

Federally Qualified Health Centers. The nine Federally Qualified Health Centers in New Jersey and their satellite sites provide comprehensive community-based preventive and primary care services in high-need urban and rural areas. In 1990, FQHCs provided about 300,000 medical and dental encounters. They are federally mandated to provide 24-hour coverage for their patients and FQHC physicians are required to have admitting privileges at local hospitals to provide continuity of care for the high-risk populations served by the centers. Almost 50 percent of FQHC users are uninsured, and 40 percent are covered by Medicaid. Fifty-five percent of users have incomes below 100 percent of poverty level, and 40 percent have incomes between 100 and 200 percent of poverty level. On the average, 55 percent of FQHC users are African-American, 30 percent are Hispanic, and 10 percent are white. Clearly, the FQHCs are major providers of preventive and primary care services to underserved minority groups in the state.

A primary funding source for the FQHCs is federal grant monies provided under the Public Health Service Act. In 1990, the FQHCs received about \$10 million or 50 percent of their total revenue from federal funds, although this percentage varies considerably by site. The purpose of this funding is to subsidize the provision of preventive and primary care services to uninsured persons and to those with limited income and limited insurance to cover the cost of health care.

The FQHCs were generally known as community or migrant health centers prior to the Omnibus Reconciliation Act of 1989 (OBRA 89), which amended the Social Security Act to create a class of entities known as Federally Qualified Health Centers. Currently FQHCs consist of federally funded Section 330 community health centers, Section 329 migrant health centers, and Section 340 health care for the homeless sites, as well as sites which have been designated as "look-alike" sites by the Health Care Financing Administration. There is presently one non-federally funded look-alike FQHC in New Jersey, the Eric B. Chandler Health Center in New Brunswick.

Within the OBRA 89 legislation establishing the FQHCs was the requirement that state Medicaid agencies reimburse FQHCs at 100 percent of their reasonable costs for services provided to Medicaid recipients. The FQHC rate of reimbursement for the centers currently ranges from about \$50 to \$65 per visit. It is projected that the average reimbursement will increase to about \$75. This level of reimbursement represents a considerable increase over previous Medicaid reimbursement, which had been the same as that of private practitioners, or \$16 and \$14 respectively, for board-certified and non-board-certified practitioners. Approximately 40 percent of FQHC Medicaid visits will be reimbursed at the higher rate, increasing current Medicaid reimbursement to FQHCs from \$2 million to about \$6 million annually. It is anticipated that the increase in revenues will enable FQHCs to significantly expand their services.

Preventive and Primary Care Demonstration Projects. Recommendations from the Governor's Commission on Health Care Costs advocated expansion of non-hospital-based delivery systems for preventive and primary care. Legislation passed in June 1991 provided for two demonstration projects to develop alternative primary care delivery sites. The demonstration projects include expanding services and hours of operation at Federally Qualified Health Centers, and developing affiliations between hospitals and community-based primary care sites in the Competitive Initiatives program. Funding for the projects is from a 0.53 percent assessment of hospital revenues for two years.

The State's FQHC expansion project reimburses services provided to additional uninsured clients at a rate equal to 90 percent of the FQHC

Medicaid rate of reimbursement. A portion of the funding for the FQHC project has been allocated to support start-up costs related to increased hours of operation as well as for minor capital and other facility improvements to enable FQHCs to expand capacity. A major advertising campaign is also being undertaken to provide publicity for the centers to attract new users. The program is being evaluated to determine if payment for uninsured clients from the Health Care Cost Reduction funds will enable FQHCs to increase their capacity for serving poor and underserved populations. Since implementation in January, 1992, all centers have expanded hours of operation to at least 60 hours per week including evenings and weekend hours. In the first two quarters, patient volume increased by over 16,000 visits, up 10% over the previous year.

Funds were also allocated to develop partnerships between urban hospitals with high uncompensated care costs and community health centers to provide preventive and primary care in the most appropriate community setting. The overall goal of the CIP is to improve the health status and prevent the inappropriate hospitalization of uninsured persons through the provision of comprehensive community-based preventive and primary care services. Another major program objective is to reduce the use of hospital emergency rooms as a locus for preventive and primary care delivery to inner city and rural populations lacking family physicians.

In 1992, the Competitive Initiatives Program (CIP) supports four partnerships between hospitals and community-based providers which allow for the delivery of coordinated preventive and primary care in community-based settings. Four large demonstration projects have been awarded \$1,300,000 for each of two years of funding. The grant recipients are:

- Jersey City Medical Center (with Jersey City Family Health Center)
- United Hospitals Medinter (with proposed United Community Health Plan)
- Muhlenberg Regional Medical Center (with Plainfield Health Center)
- Cooper Hospital/University Medical Center (with CAMcare Health Corporation)

In the first year of operation, it is projected that 12,000 patients will be referred from emergency rooms to community based primary care and that 24,000 primary care visits will be delivered. Competitive Initiatives funding also supports twenty smaller projects which seek to strengthen community-based preventive and primary care resources.

The outcome of the CIP projects as alternative preventive and primary care delivery systems will be monitored by the Department of Health to determine their effectiveness in reducing inappropriate emergency room use and in developing other ambulatory health care systems in the state, particularly for indigent populations.

Expansion of Services for Pregnant Women and Infants. Two other programs funded by the Health Care Cost Reduction Act are designed to make primary and prenatal care available to infants and pregnant women. The first expands Medicaid coverage for pregnant women and infants who live in families with incomes between 133% and 185% of the Federal poverty level. In its first year of operation, 576 infants and 480 pregnant women received benefits solely because of this expansion.

Capital Expansion Support. Community-based primary care providers are often unable to expand capacity due to unstable funding and limited knowledge of the capital financing process. As a result, they are frequently geographically isolated, and situated in inadequate or antiquated facilities with few options for expansion or renovation. Access to capital is critical if the number of primary care providers is to be expanded.

The New Jersey Health Care Facilities Financing Authority (HCFFA) recently received funding in the amount of \$111,462 from the Robert Wood Johnson Foundation to improve access to capital financing for non-hospital-based providers. The purpose of the program is to develop an outreach and training program as well as new financing mechanisms to assist community providers in obtaining capital financing. The product of this project will be an identifiable program within the Authority that will serve nonhospital providers, offer financing options to meet capital needs, and provide assistance and training to allow community providers to obtain the capital. After development, the program will be self-funding from the fees charged by the Authority in connection with the financing.

School-Based Youth Services Programs. Adolescents face a number of very tangible obstacles when accessing health care: lack of a payment source, geographic inaccessibility, inconvenient office hours, parental consent problems, lack of confidentiality, and the inability to follow a provider's recommendations.

According to the National Center for Health Statistics, in 1985 adolescent visit rates to ambulatory providers were the lowest of all age groups at 1.7 visits per year per person for the 11-20 age group. Younger adolescents between 11 and 14 had the lowest rate of all at 1.5 visits per year (Nelson, 1991). While their health care needs may be met at this level of visit, associated health and social problems, such as family planning counseling, cannot be adequately addressed without increased access.

School-based youth services programs are increasingly becoming an access point for health and social services for the adolescent segment of the population, particularly in medically underserved areas. Although there are insufficient data to indicate wholesale establishment of school based programs, access to health care for adolescents has been found to be improved through the program (OTA, 1991).

Historically, school based programs have linked education and health through screening programs. As school based programs have become more comprehensive, most of the controversy around the programs has focused on the issue of reproductive care, including counseling and distribution of contraceptive devices and/or family planning. School based programs, however, have demonstrated the potential to increase access and utilization of health care services by otherwise underserved youths through a number of mechanisms, including the identification and treatment of health problems and coordination of related health and social services.

Evaluation of 23 centers across the nation, funded by the Robert Wood Johnson Foundation's School-Based Adolescent Health Care Program, revealed that males used the school services more frequently than other community services and that 20 percent of students using the school based programs have not received medical care in more than two years.

The New Jersey School Based Youth Services Program (SBYSP) operated by the Department of Human Services is located in 30 urban, rural, and suburban school districts with at least one site per county. Each site provides the following core services: health care, mental health and family counseling, job and employment training, and substance abuse counseling. Currently, all sites provide recreation, information and referral services. Many sites also provide teen parenting education, transportation, day care, tutoring, family planning, and hotlines. The programs open before, during and after school as well as during the summer. Some are open on weekends.

In 1990, the program served over 18,000 teenagers, of which more than half were classified or considered at risk of dropping out. The SBYSP has also expanded into elementary and middle schools.

HealthStart. This program provides coverage for pregnant women, and infants less than one, whose family incomes are between 185 and 300 percent of the federal poverty level. It benefits needy women whose family incomes are too high to allow them to receive Medicaid services. A new program in New Jersey, HealthStart Plus utilizes a managed care model to improve maternal and child health status.

State-Supported Categorical Programs. State and federally supported categorical programs such as family planning, WIC, prenatal clinics, STD clinics and AIDS early intervention and treatment, among others, provide a substantial number of services to high risk, low-income populations. Some of these services are tied into existing delivery systems such as FQHCs, local health departments and OPDs while others are free-standing sites.

There are also other categorical programs such as preventive services and addictions treatment which do not provide direct preventive and primary care services, although many persons in these programs lack a comprehensive source of preventive and primary care. These programs and the categorical preventive and primary care programs listed above are often overlapping and targeted at the same populations, suggesting a need for better integration and linkages between services. Treatment directed toward pregnant drug-addicted women, for example, frequently contributes to the prevention of AIDS. Presently, however, there might be one delivery point for addiction treatment, another for AIDS counseling and testing, and a third for prenatal care.

Each of these programs operates relatively autonomously according to the standards and requirements developed by funding sources such as the Maternal and Child Health Services block grant and the Centers for Disease Control, among others. Virtually none provide comprehensive family-oriented preventive and primary care from a central location as well as specialized categorical services such as addictions treatment from the same location. The categorical nature of the funding, therefore, encourages the provision of isolated health care services de-

livered by multiple specialized providers and ultimately reinforces fragmentation and duplication in the delivery system.

A substantial amount of the \$73 million supporting categorical programs in New Jersey is channeled through the federal Health Resources and Services Administration (HRSA), which has been characterized as "... a 'holding company' for disparate legislative initiatives in health care." (Public Health Reports, 1991). An additional source of funding for the public insurance system could be redirected categorical program monies.

Hospital Outpatient Departments. New Jersey's Health Care Trust Fund allows hospitals to charge paying patients to subsidize the care of those patients who meet certain eligibility tests based on income and assets. The revenue collected through this mechanism is available to hospitals for the care of those patients for whom there is no other public or private payment source. The cost of funding the Health Care Trust Fund was \$839 million in 1991, and is estimated to be \$754 million in 1992. Since reimbursement is not available in other settings, provision of primary care in a costly and inappropriate setting is reinforced, particularly for the uninsured population. However, the situation may change given the recent Wolin decision, which found the method of revenue generation for the Trust Fund to be illegal.

In 1989, New Jersey hospitals reported a total of 10 million outpatient visits. These visits include emergency room visits, outpatient preventive and primary care and specialty clinics, private referred visits, off-site health services, same-day surgery, outpatient surgery, same-day psychiatry, outpatient dialysis, home dialysis, mobile intensive care and other mobile intensive care services. Of these services, the last four are not included under the Chapter 83 reimbursement system and therefore hospitals are not guaranteed payment, regardless of the individual's ability to pay. The Table below details outpatient volume for the state's 86 hospitals.

New Jersey Hospital Outpatient Department Volume—1989

Service	Volume
Emergency Room	2,100,000
Outpatient Clinics	1,800,000
Private Referred	4,400,000
Off-site Health Services	630,000
Same-Day Psychiatry	330,000
Same-Day Surgery	219,000
Outpatient Surgery	69,000
Other	477,000
Total	<u>10,025,000</u>

Almost half of all outpatient visits are the private referred, or those patients sent to the hospital by their own physician. Presumably physicians refer to the hospital only those patients needing care at a level which they cannot provide, thus many of these referrals may be from a primary level of care to a subspecialty level, or from a general practice to a more specialized practice. The next largest categories are emergency room and clinic visits at 21 percent and 18 percent respectively. Appendix B breaks down emergency room and clinic visits by county and LAB region. Appendices C and D graphically illustrate the number and rate per 1000 residents of hospital outpatient clinic visits and emergency room encounters at New Jersey hospitals in 1989.

Of the 1.8 million OPD clinic visits in 1989, 58 percent were for primary care services, including general medicine, obstetrics and gynecology, and pediatrics (see Appendix E). Dental visits represented an additional six percent of total outpatient clinic visits. As the Table below indicates, almost 50 percent of primary care clinic visits are for general medicine, while obstetrics and pediatric visits account for 18 percent each. Dental visits represent 11 percent of primary care outpatient clinic visits.

HOSPITAL OUTPATIENT DEPARTMENT PRIMARY CARE CLINIC VOLUME

Clinic	Volume	Percent*
Medicine	485,574	48%
Obstetrics	179,885	18%
Gynecology	43,235	4%
Pediatrics	186,136	18.5%
Total	902,395	
Dental	108,659	11%
Total	1,003,489	

*Percentages will not equal 100 due to rounding.

Of total outpatient department clinic visits, 64 percent were made by Medicaid, self-pay (uninsured) and charity (less than 250% of poverty level) patients.

Using 1988 cost and volume data, the estimated statewide average cost per clinic visit in 1992 is about \$114. Based on this estimate, Region III visits represents a total annual cost to the system of approximately \$72 million. In Region III, more than 50 percent of the clinic visits are reported by University Hospital, Newark Beth Israel and United Hospitals. In 1988, the cost of providing clinic services varied significantly among these three hospitals.

At an average cost of \$114, the 1.8 million outpatient clinic visits represent an annual cost of about \$200 million to the system. The cost of providing primary care in OPD clinics was about \$100 million in 1989 for a million primary care and dental clinic visits.

Of the 2.1 million emergency room visits, 50 percent are made by Medicaid, self-pay, or charity patients even though these persons constitute less than 20 percent of the state's population. High rates of emergency room visits by these populations may indicate a need to develop additional preventive and primary care services outside of hospitals.

On the basis of 1988 cost and volume data, the estimated statewide average cost per emergency room visit in 1992 is about \$134. Using this estimate, emergency room visits represent an annual cost to the system of approximately \$300 million. It is conservatively estimated that one-third of emergency room visits are primary care encounters; therefore, the annual cost of providing primary care in emergency rooms in New Jersey could be estimated to be \$100 million.

Using existing data, an accurate accounting of the cost of providing preventive and primary care in hospital outpatient and emergency departments is impossible. Furthermore, comparison of hospital and FQHC costs, for example, is also not possible because of different methodologies used to determine costs. The need for standardized reporting is clear.

E. GEOGRAPHICAL AREAS OF UNMET NEED FOR PREVENTIVE AND PRIMARY CARE SERVICES

Some statistical data place New Jersey at or above the national average in several economic categories. Personal per capita income in New Jersey in 1989 was \$23,726, as compared to the national average of \$17,592. Fewer individuals fall below the poverty level, 9.7 percent in comparison to 12 percent. Also New Jersey has a lower rate of uninsured persons, 11.7 percent of those under the age of 65, as compared to 17.6 percent nationally. However, these statistics mask a lack of access to health care for specific areas or populations. Other statistics indicate significant unmet health care needs in the state. To identify areas of unmet need for preventive and primary care services, two methodologies were utilized: (1) Ambulatory Care Sensitive Conditions (ACS) from the Codman Research Group, Inc., and (2) the New Jersey Medically Underserved Index (NJMUI).

Ambulatory Care Sensitive Conditions

An analysis of inappropriate hospital admissions in New Jersey indicates that citizens in many parts of the State lack access to primary care services. "Ambulatory Care Sensitive (ACS) conditions," listed in Appendix F, are those conditions or diagnoses of hospital inpatients that could have been prevented, or lessened in severity, by adequate preventive and primary care in an outpatient setting. The cost associated with these generally preventable ACS conditions is more than half a billion dollars annually for all payers.

New Jersey hospitalization experience in 1989 for all ACS conditions was obtained from the Codman small area analysis database. This

software provides the age- and sex-adjusted admission rates for each of the state's counties and hospital market areas (HMAs) of New Jersey. A hospital market area is defined as a group of contiguous zip codes in which a plurality and in some cases a majority of the residents use the same health care providers. For these purposes, New Jersey has been divided into 102 hospital market areas. The HMAs are not coextensive with municipalities, however, in many cases data for larger towns and cities can be approximated by the use of a single HMA or through combining the data for several HMAs.

Age- and sex-adjusted admission rates for the ACS conditions ranged from 9.48 to 48.17 per 1,000 residents; the highest rate was five times the lowest admission rate in 1989. The total New Jersey adjusted rate was 18.30 admissions for ACS conditions per 1000 residents of the state. This wide variation in admission rates for ACS conditions has been found in other states (Billings and Hasselblad, 1989) and is thought to be related to health care access issues.

A list of the counties and HMAs that had age- and sex-adjusted admission rates above the state rate of 18.30 follows.

COUNTY	ADMISSION RATE*
Hudson	25.14
Essex	24.41
Cumberland	22.73
Atlantic	22.54
Salem	22.08
Ocean	19.45
Warren	19.02
Mercer	18.61
Camden	18.55

HOSPITAL MARKET AREA	ADMISSION RATE*
Newark-South East	48.17
Newark-North	43.76
Newark Central	42.73
Newark-Roseville	37.20
East Orange	35.73
Newark-South	35.44
Greenville	33.66
Perth Amboy	33.21
Camden	33.12
Jersey City	30.94
Bayonne	30.58
Hammonton	30.26
Orange	28.37
Trenton-City	28.20
Atlantic City	26.85
Trenton-West	26.29
Newark-Irvington	26.09
Paterson	25.84
Kearny	24.99
Hudson City	24.67
Millville	23.94
Paterson-Little Falls	23.58
Salem	23.32
Bridgeton	22.67
Sussex	22.59
Elizabeth	22.35
Vineland	21.27
Newark-East	21.21
Lakewood	21.08
Brick Town	21.05
Willingboro	21.04
Hoboken	20.93
Union City	20.89
Phillipsburg	20.02
Linden	19.39
Cape May	19.30
Avenal	19.14
Warren County	19.02
Matawan	19.00
Trenton-East	18.98
North Bergen	18.87

Woodbridge	18.82
South Amboy	18.68
Mercer County	18.61
Clementon	18.60
Egg Harbor	18.56
Camden County	18.55
Toms River	18.49

West New York	13
Pemberton	13
Linden	12

*Age- and sex-adjusted rate per 1,000 residents of the county or Hospital Market Area.

High admission rates for ACS conditions indicate a need for intensive study of the available health care resources and barriers to care existing in these areas. Further research will be needed, both at the State and LAB level, to identify the factors causing the high admission rates for ACS conditions, and to devise strategies to improve access for those populations not currently receiving optimum preventive and primary care.

New Jersey Medically Underserved Index

The New Jersey Medically Underserved Index (NJMUI), using a different approach than ACS conditions, also indicates that citizens in many parts of the State lack access to preventive and primary care. This Index ranks New Jersey's counties and municipalities with populations of 30,000 or more according to seven indicators that address a variety of factors likely to be associated with a lack of access to comprehensive and timely health care services. A complete explanation of the NJMUI is found in Appendix G.

The NJMUI was developed to comply with Chapter 187, the Health Care Cost Reduction Act (HCCRA) which specifically requires the DOH to "... designate and establish a ranking of medically underserved areas of the state ..." for the purpose of placing physicians and dentists who participate in the newly established primary care Physician and Dentist Loan Redemption Program.

Areas with values at or above a minimum threshold of 12 for the seven indicators are considered to be underserved, so are included on the NJMUI. The areas below are the counties and municipalities which had an aggregate value of 12 or greater, in order of highest to lowest rank. Appendix H breaks down the areas listed below by county and LAB region.

The NJMUI evaluates economic and health status indicators that point to relatively more underserved areas. The list does not address specific health care needs, such as number of pediatricians. Therefore the index cannot indicate why the health status statistics are so poor. Additional data would be needed to determine whether an area's greatest need is for more providers, higher pay for existing providers, or an FQHC, for example. Quite possibly, several disincentives are operating simultaneously, and several approaches may be needed.

NEW JERSEY MEDICALLY UNDERSERVED AREAS

Geographic Area	Ranking
Atlantic City	35
Camden City	35
Paterson	34
Newark	33
Trenton	33
East Orange	32
Jersey City	31
Plainfield	30
Irvington	28
Orange City	27
New Brunswick	26
Passaic	26
Elizabeth	25
Perth Amboy	20
Long Branch	20
Vineland	19
Willingboro	18
Bayonne	18
Union City	18
Lakewood	16
Hoboken	15
Salem County	14
Kearny	13

In comparing the high-need areas identified by the ACS and NJMUI rankings, significant overlap is revealed, even when differences between Hospital Market Areas (HMAs) and municipalities are taken into consideration. For the most part, the areas of greatest need appear to be New Jersey's poorest urban areas, which are home to a disproportionate percentage of the State's ethnic/racial minorities: Newark, Atlantic City, Camden, East Orange, Jersey City, and so forth. Each of the high-need areas identified on the ACS and the NJMUI lists needs to be analyzed in depth to determine the prevailing social, economic and behavioral factors that determine health care utilization in a particular area.

Of particular concern in both the ACS and NJMUI lists is the high percentage of minority residents. Comparing them with the lists in Appendix I of areas by percent minority population reveals striking correlations:

- Essex and Hudson counties, the two counties with the highest ACS admission rates, are also the two counties with the highest percentage of minority residents, 54.9 and 52.6 percent, respectively;
- Of the geographic areas with the highest medically underserved rankings, all have very high percentages of minorities, ranging from 93.8 percent in East Orange to 62.5 percent in Trenton, compared to a State average of 26.0 percent.

It is apparent that these relationships must be investigated further to determine specific factors that are contributing to limited access for minorities in certain areas of New Jersey.

The New Jersey Primary Care Physician and Dentist Loan Redemption Program. At the present time, New Jersey is sponsoring one major effort to recruit and retain primary care physicians and dentists for practice in the medically underserved areas. The New Jersey Primary Care Physician and Dentist Loan Redemption Program, established under the Health Care Cost Reduction Act, authorizes \$1 million annually to be used in retiring educational debts of physicians and dentists entering primary care practices in medically underserved areas. Approximately 12 individuals can be funded annually through this payment source. A request to the Federal Department of Health and Human Services (HHS) for additional funding for loan redemption was recently awarded. It is expected that eight more individuals can be supported annually through the federal program.

F. RESTRUCTURING THE EXISTING SYSTEM

Development of comprehensive preventive and primary care systems is in its infancy in the United States. The health care systems of other industrialized countries are instructive, and should be considered in the establishment of an appropriate preventive and primary care model. An excellent example is the research of Barbara Starfield at Johns Hopkins University, who used multinational comparisons to develop a list of characteristics of preventive and primary care-oriented health systems. They include: government support for an organized system to deliver and finance preventive and primary care; widespread use of coordinated care to ensure appropriate use of specialty services; an equal proportion of primary care practitioners to specialists and subspecialists; and widespread utilization of nonphysician personnel, such as nurse practitioners and health educators. The existing primary care health delivery system in the United States shows sparse evidence of incorporating these characteristics.

To restructure the health care delivery system in New Jersey, Starfield's characteristics can serve as a guide, in conjunction with related reform strategies that will redirect the organization and financing of services to attain the same general objectives. A system based on Starfield's characteristics would incorporate:

- Access to affordable health insurance coverage for all New Jerseyans;
- Standardization of a minimum benefit package of all persons, regardless of payer, that would make preventive and primary services much more accessible than they are at present; features should include payment changes such as 100 percent first dollar coverage of preventive and primary care services, or very small copayment amounts, and higher copayments for inpatient hospitalization and emergency room;

- Availability of this package for all New Jerseyans, regardless of health status, employment status, place of employment, or previous insurance claims;
- Standardization of claims, billing, and payment for all payers;
- Coordination of care for all patients, regardless of payer, to utilize more appropriately the services of different kinds of providers; provision of linguistically and culturally sensitive care for ethnic/racial minority populations;
- An increase in the number of primary care providers statewide;
- Monitoring of providers' patient volume and rate of payment increase.

Health Insurance Reform

It is imperative that all New Jerseyans be enrolled in an insurance plan, whether public or private. To accomplish this within the framework of the current insurance marketplace, coverage must be expanded to include all citizens, regardless of workplace, health status, or income. The nature of insurance coverage must change as well, so that primary and preventive services are included. Every citizen must have, at a minimum, a standard insurance package that incorporates not only hospitalization and catastrophic illness insurance, but also payment for health promotion and preventive and primary care, including but not limited to immunizations, screening, prenatal and well-baby care, and physician visits.

While the pluralistic system of insurance in the United States is duplicative, expensive, and does not cover many of those who need it most, for example, those with pre-existing conditions, it is firmly entrenched into our system of health care. The recommendations that follow assume continuance of the existing system, but with specific structural changes designed to improve coverage, access, and affordability. Likewise, in the absence of fundamental changes in the national health care system, the continuation of Medicare and Medicaid are assumed.

Standard Insurance Package

Preventive and Primary Care Coverage. The goal is to give every New Jerseyan, whether privately or publicly insured, equal access to a standard insurance package that emphasizes preventive and primary services. By improving access to these services, the standard package should also improve health status.

The standard insurance package, could, through its payment structure, promote preventive and primary care in several ways. There should be no copayment or deductibles for preventive care, and very low copayments and deductibles for primary care. Higher copayment should be reserved for other kinds of care such as hospitalization and emergency room services, with a ceiling or stop/loss provision to protect consumers from unusually high costs. Health care services that are not part of the standard benefits package should be available through increased premiums, deductibles, or co-payments. The Department of Health should collaborate with the Departments of Insurance and Human Services to assure the availability of the standard policy.

This Chapter recommends no deductible or copayment for preventive care. For primary care, it recommends coverage for at least three visits per year with no deductible and a copayment not to exceed \$5.00. Medicaid and commercial managed care programs, including HMOs and PPOs, already provide or exceed the level of preventive and primary coverage recommended. The type of plan which will be most affected by this recommendation is the traditional indemnity plan which now covers most New Jerseyans.

Health Promotion. The standard benefit package should have a strong health promotion component. Providers should support strategies of this type, and encourage their patients to make the appropriate health habit changes. Some HMOs in New Jersey already include health promotion benefits in the form of vouchers for their enrollees who join fitness clubs. Insurers might offer discounts for healthy habits or coverage for health promotion programs such as smoking cessation classes. In addition, there should be a statewide public information plan for health promotion/disease prevention, so that consumers who lack awareness of the usefulness of health promotion efforts can be educated. Communication with the consumer needs to increase in a way which brings the consumer, particularly in underserved areas, into the health care system as a full participant in care.

Coordinated Care. An integral component of the standard insurance package should be a coordinated care element that serves to ensure the provision of appropriate levels of health care. Within the context of this Chapter and the broader issue of health care system reform, the focus

is on managing health care rather than the role of managed care in strategies for reform. The term coordinated care is used to define the traditional gatekeeper role of primary care physicians in controlling access to subspecialty care. It also entails adequately managing the varied health and social needs of individuals with complex medical problems to ensure that care is integrated and that services are not duplicative. Coordinated care is distinguished from managed care programs that generally require some form of retrospective review, or preauthorization monitoring. These elements are not necessarily proposed.

There is also a need for provider education. Those who serve to coordinate care must be aware of the full range of health care services available in their areas, and be trained to educate their patients accordingly.

Coordinated care, as conceptualized for the restructured health care system, can be incorporated into most models of service provision, from health maintenance organizations (HMOs), preferred-provider organizations (PPOs), and point-of-service plans, to the traditional fee-for-service model, given the appropriate financial incentives.

Other Systems Reforms

Outcomes Research and Physician Profiling. Preventive and primary care has not received the same research attention as acute care—particularly in the areas of outcomes research and medical effectiveness research. Nominal attention is paid in this country to using medical practices that provide similar outcomes at lower cost. In fact, intervention is viewed as a necessary treatment approach in the United States, partly due to a physician's training and partly to reimbursement systems which reward intervention. To move forward with meaningful change in the health care delivery system, quality needs to be measured by outcomes. These outcomes can be in the form of increased utilization of preventive and primary care services, reduced inpatient admissions for ACS conditions, decrease in non-emergent emergency room utilization and, ultimately, in improved health status.

The Federal Agency for Health Care Policy and Research (AHCPR) has recognized the dearth of preventive and primary care research being conducted and has supported a Task Force on Building Capacity for Research in preventive and primary care. In addition, the AHCPR has established a Division of Primary Care within the Center for General Health Services Extramural Research and is promoting research in primary care as one of the priority areas for its five year plan. These efforts should serve to advance preventive and primary care outcomes research in the foreseeable future and provide valuable information regarding the efficacy of preventive and primary care. New Jersey should take advantage of all studies of this type, the results of which will serve to define the content of the standard insurance package that is available in the state.

Physician profiling on a statewide basis as an analytic tool to compare practice patterns of providers in areas such as cost, use of services, and quality of care is increasingly being used to evaluate provider performance. Physician profiling is also used to conduct research into the effectiveness and appropriateness of care. It is recommended that the use of physician profiling be considered at the State level to compare the medical care provided by different organizations, or care received by different populations of patients. If profile data were available quickly, to both the public and to case managers, patients would be able to make rational decisions about their sources of care.

Non-Exclusionary Insurance Coverage. There is widespread consensus that insurers have responded to the increase in the cost of health care by adopting policies of risk avoidance, rather than risk sharing. The purpose of these recommendations is to reorient the insurance industry in New Jersey to provide insurance, rather than deny it.

In order to level the competitive playing field, all insurers should use community-rating to establish a single standard rate. This means that actuarial calculations would be based on geographical areas, rather than on individual or group characteristics. The entire state of New Jersey should be considered one community for insurance rating purposes, in order to spread the burden of high-risk cases to the greatest extent. In this manner premiums, could be kept to a minimum for all New Jerseyans, without denying coverage to anyone.

Insurers should not engage in medical underwriting, or exclude persons because of their place of employment, or their use of insurance benefits. Neither should they be allowed to raise premiums because of claim history. Both insurers and insured would benefit from this change in rating methodology. Competition between insurers will then be on the basis of benefits offered above the minimum level, and the problem of

adverse selection will disappear. In addition, more people who are currently unable to buy acceptable insurance coverage due to pre-existing medical conditions or their claims history will be able to afford insurance. This will reduce the number of uninsured and their costs to the State's Health Care Trust Fund.

The Employer Retirement Income Security Act (ERISA) has been broadly interpreted to preclude a state from setting enrollment criteria for self-insured groups. Therefore prohibitions or benefit structures such as those listed above in the standard benefit package could not be enforced for this group. Incentives must be devised to encourage self-insured companies to offer the standard preventive and primary package, and also disincentives will be needed to discourage other companies from moving to self-insurance. One option for consideration, perhaps in combination with others, is a minimum policy value. States may legislate a minimum actuarial value for all policies written, and if that value is set according to the cost of the standard insurance package, there may be sufficient incentive to change behaviors.

Universal Employer Participation. All businesses, regardless of size or number of employees, should offer at least the standard health insurance benefit package to all employees working 20 hours per week or more, and the families of these employees. This is already being done by most large businesses and employers, but incentives must be implemented to encourage smaller businesses and employers to do likewise. Using the actuarial value option mentioned above and other incentives, self-insured groups should also be encouraged to offer at a minimum, the standard insurance package described in this chapter.

The costs of insuring small businesses have historically been higher than costs for larger ones, but this series of recommendations has several components that will serve to lower small business premiums. Costs for businesses will be lower because of the standardizing processing of claims, billing, and payment. Funding from the New Jersey SHIELD Plan (discussed below) should be available to assist small businesses and employers to buy into the plan.

Standardized Claims, Billing, and Payment. Implementation of a program to coordinate, automate, and standardize the processing of claims, billing, and payment would help to address many of the problems related to reimbursement. A model for a program of this kind is being pursued on a demonstration basis in New York State, and expectations are that it will not only streamline the administration, but will also reduce costs. Savings may be expected when electronic billing and payment procedures decrease interest costs related to cash flow problems. Administrative reductions will also result in cost savings. An initial step in this direction is New Jersey's Medicaid Management Information System (MMIS), that is reducing paperwork associated with claims submission and correction through electronic claims processing.

A central coordinating point, with adequate computer support, will be needed to support a system of this sort. One possibility is to use a Medicare intermediary or carrier that could take advantage of existing administrative structures, experience, expertise, and economies of scale.

While there may be initial disruption of existing processing systems and upfront development costs, a system of the type recommended in this chapter will benefit all parties involved in health care service delivery. Providers will experience drastic reduction in accounts receivable and bad debt, due to immediate transfer of funds. Payers will have standardized insurance forms that are easier to administer, and online systems to request corrections or additional information about patient records, thus speeding their process of record review. Patients will find online insurance information at their initial point of service, thus benefits will be known immediately, and coordinated instantly by computer. In addition, separate bills will not be needed from each payer, thus reducing the paperwork involved.

Physician Reimbursement. Nationally, a number of private insurers and Medicaid health care programs have expressed an interest in adopting the Medicare Fee Schedule. Private payers are currently analyzing the patterns of differences between Medicare fees and their own physician fees. States such as Maine, Michigan and Texas have adopted versions of the Medicare Fee Schedule for Medicaid. California and Washington are considering adoption of the schedule for their Medicaid programs. The national trend of adopting fee schedules based on the Medicare relative value fee schedule should be implemented in New Jersey.

It is recommended that a relative value scale fee schedule, or a similar mechanism, be used to pay for the entire range of services, including preventive and primary care. This would serve to reimburse for services based on the level of resources required to provide a given service and,

to encourage service delivery at an appropriate level of care. The RVS fee schedule should cover all practitioners regardless of whether they are private or facility based providers although the schedule would have to be modified for facility based providers. It is also recommended that insurance reform incorporate other elements of the Federal physician payment reform such as charge limits and VPS in an effort to encourage appropriate remuneration of preventive and primary care practitioners and to control costs.

In contrast to cost-based payment at hospitals and FQHCs, the very low rate of Medicaid reimbursement to private practitioners is the major factor restricting access to preventive and primary care for the Medicaid-eligible population. A survey of the National Governors' Association and the Physician Payment Review Commission in 1990 ranked New Jersey 49 out of 50 states in terms of Medicaid reimbursement; New York ranked lowest.

Increasing Medicaid payments to primary care physicians, dentists and other community providers is one mechanism to increase access to preventive and primary care. It has been suggested that there is a relationship between Medicaid physician fees and beneficiary access to particular sites of care. In areas with low Medicaid fees, beneficiaries will use hospital outpatient departments and emergency rooms more heavily. Conversely, raising Medicaid fees would improve access to care provided in physicians' offices (Davidson, 1982). Because of the transitional costs inherent in converting Medicaid to RVS, a demonstration should be attempted in a selected area of the State.

Increasing reimbursement can be accomplished in a number of ways including across the board fee increases, fee increases for selected services to encourage utilization of, for example, preventive and primary care, by increasing reimbursement to primary care specialists serving medically underserved inner city and rural populations. This is similar to the Medicare bonus payment in which physicians receive a 10 percent payment above the Medicare fee for services delivered in Health Professional Shortage Areas.

It is recommended that the DOH work with the Department of Human Services and the Office of Management and Budget to review strategies to increase reimbursement for private providers to improve the availability of providers for Medicaid recipients.

Advisory Panel. To refine each of these recommendations and develop an implementation plan, an advisory panel should be constituted. The panel would include representatives from each of the major health care organizations in New Jersey, legislators, and business representatives. There should also be strong representation by consumers, because they are the group upon whom the policies impact most directly. All of the representatives should be willing to work together in order to oversee the creation of a better and more effective health care system for this State's citizens.

This panel would have initial responsibility for determining the services to be included in the standard insurance package. Subsequently it may also choose to assume other responsibilities, using the input of experts when warranted. The panel could review data about the cost and outcomes of different procedures, technologies, and medical practice patterns, so as to include the most cost-effective and appropriate in the standard benefits package. It could also provide budget oversight at the State level to assure that systemwide health care costs do not exceed what the state can afford to pay, and that the growth in patient volume is within expected ranges. This movement toward increased fiscal responsibility in health care service provision should benefit all citizens and taxpayers in New Jersey.

New Jersey SHIELD Plan

Participation. It is a fundamental value of this proposal that those who lack insurance should have the same access to preventive and primary care as well as other forms of health care that the insured population enjoys. For the uninsured, a publicly financed/subsidized plan, New Jersey SHIELD, is proposed. New Jersey SHIELD (State Health Insurance Enrollment and Local Care Delivery) would provide insurance coverage so that people can receive coordinated care from practitioners in their local communities.

Assuming that most of those who are employed will receive health insurance as a work-related benefit, the group that is the focus of this portion of the Chapter is those who are not able to work, part-time and seasonal workers, the working uninsured (including those employed by small businesses), Medicare and Medicaid-eligible individuals who would choose to participate, and anyone else who would opt for this Plan. It will subsidize insurance for people who cannot afford it and replace the

current system of subsidizing hospitalization for the care of these people, that is, the New Jersey Health Care Trust Fund.

Including the Medicaid population in the New Jersey SHIELD Plan would offer very important benefits. For clients, it would offer portability. The many people who experience frequent changes in employment status and Medicaid eligibility could continue in the same program, receiving care from the same providers, regardless of that status. Children, who lose Medicaid eligibility as they get older, would also be able to remain in the same program, with continuity of care assured.

While the New Jersey SHIELD Plan is intended to be comprehensive in scope, its initial implementation could be less so. The first step in moving the Plan toward its goal would be to enroll uninsured persons, whether employed or unemployed. Other groups could join the plan subsequently, as technical details for each are worked out. For example, the Federal waivers needed for Medicare and Medicaid participation could be negotiated after the initial period.

Coverage. The key components of the standard benefit package discussed in the private insurance section above should be incorporated into New Jersey SHIELD (see pp. 35-36). Preventive and primary care services, as well as health promotion and disease prevention strategies, should be integral components of the standard package of services that is provided to all clients.

To overcome the inherent limitations of the current system, integrate the multiplicity of services, and improve the organization and delivery of health care services, a coordinated care approach to services should be implemented. One provider, or group of providers, would assume responsibility for coordinating or managing all health care services required by the individual in exchange for a case coordination fee. Coordination would require that they comply with certain responsibilities such as arranging 24 hour, seven day a week coverage, coordinating referrals to specialists and social services, authorizing emergency room visits, and providing or coordinating inpatient hospital services. Appropriate management of health care services should result in improved integration and utilization of care for all members of the New Jersey SHIELD Plan.

By making coordinated care available and easily accessible, the New Jersey SHIELD Plan would be offering an alternative to emergency room utilization. Research has indicated that the majority of services rendered in emergency rooms is for non-urgent care (Hurley et al., 1989). At the present, the poor are forced to use emergency rooms as the "family physician," because no other option is available. Reduced utilization of emergency services would be preferable for patients, and it also has the potential of reducing costs because services would be provided in the lower-cost setting. At the same time, strategies must be put into place to increase the supply of primary care practitioners to meet the population's needs for coordination of care.

Premiums and Other Payments. All participants in the New Jersey SHIELD Plan would pay according to their income. The poorest should pay nothing, or perhaps a very small copayment. Others with low incomes might pay nothing for preventive care coverage, but pay a copayment according to a sliding scale for primary care. Higher out-of-pocket payments would be stipulated for other kinds of care such as hospitalization and emergency room services, based upon the enrollee's ability to pay. Based on a sliding scale, those with higher incomes would pay up to the full cost of insurance premiums. All participants should be protected by an annual out-of-pocket limit on health care expenditures, with the limit dependent upon income.

Provider Reimbursement. Private practitioners are not reimbursed for care provided to uninsured persons nor were they reimbursed under the Health Care Trust Fund except as a salaried hospital employee. The New Jersey SHIELD Plan seeks to resolve this fundamental access issue by providing adequate coverage for preventive and primary care, including physician fees. This should occur through precapitated rates or the use of relative value scale reimbursement or some other similar mechanism.

Because of their location in high-need areas, FQHCs should be actively encouraged to participate as primary care sites for the New Jersey SHIELD Plan. Aggressive efforts must be made to support FQHCs that provide cost-efficient care in these areas, as part of a multifaceted approach to improve the availability of providers in underserved areas.

Strategies used by FQHCs and also by CIP projects must be encouraged in other settings, so that access can be further improved. Extended hours based on the needs of the particular community (for example, early morning, weekend, and evening hours), flexible appointment scheduling, follow-up care, satellite clinics, and referral arrange-

ments for specialty care are critical components of a preventive and primary care system delivering comprehensive, family-centered, preventive and primary care. They are particularly needed in inner-city and other high need areas.

Contracts with major employers might enable FQHCs to expand capacity. Because FQHCs provide a comprehensive package of preventive and primary services, employees using such a facility would receive better services at the same, or lower cost. Thus, contracts with private employers could be mutually beneficial, because the quality of care provided to the privately-insured population would improve, and financial support for the facility would be stabilized, thus improving its ability to provide services to the underserved.

As part of the Department's multifaceted approach to improving access to preventive and primary care, school based programs represent a critical link to adolescents. The Department is interested in having school based programs participate in the New Jersey SHIELD Plan. The Department would also like to be more involved in the development and review of health services provided by the programs to ensure that a standardized set of preventive and primary care services are offered by all school based youth services programs with specific emphasis on adolescent and pre-adolescent needs. In view of the critical role reproductive services can play in an adolescent's life, the Department is interested in encouraging linkages between family planning agencies and in developing adolescent pregnancy programs that are sensitive to local needs.

Several bills have been introduced at the federal level to allow states to develop comprehensive health care plans. Demonstration grants permitting states to consolidate federally funded categorical programs for health services to Medicaid and low income groups and to provide universal uniform health care coverage is another alternative that would address categorical program issues. The recommendation in this chapter, that the state work toward developing a standardized health care system for all publicly insured persons, is consistent with these bills, and, if implemented, would place New Jersey in a good position to receive monies from the comprehensive health reform demonstration grants.

Outpatient Departments. An analysis of the types of hospital department outpatient visits, and the volume by LAB region, shows that the current system is neither efficient nor cost-effective. Hospital OPDs, however, cannot be discounted in a preventive and primary care system. These sites are often the last resort for health care for persons unable to access care in a private community setting, usually for financial reasons. Since hospitals may serve as the point of entry into the health care delivery system in communities where private practitioners are non-existent or do not accept Medicaid patients, the need for preventive and primary care outpatient departments is significant.

To participate in a preventive and primary care oriented health system, a hospital should meet two criteria. First, the primary and preventive services offered should conform to models in other sectors by including components such as coordinated care and resource value based payment for providers. Second, it should offer the services at competitive rates. When hospitals provide the same services that other types of facilities provide, their payment should be comparable also.

Hospital outpatient rates should be standardized, just as inpatient rates are, in order to reward more efficiently-provided care, and avoid cost-based reimbursement. That can only be achieved, however, with complete information about all the different services provided in outpatient settings, and the associated costs and charges.

This information is not available in New Jersey at the present time, nor in most other states. One survey of hospital CEOs across the country found that only half of the hospitals separate outpatient from inpatient costs (Anderson, 1991). To obtain this essential data, the New Jersey State Department of Health has begun a study of the costs of delivering outpatient care. Data from a broad range of ambulatory care delivery sites will be included: same day surgery units, hospital emergency rooms, and outpatient clinics. Similar data from Competitive Initiative institutions, ambulatory surgery centers, and community health centers will also be studied.

The study will analyze sample outpatient data from all hospitals, classify patient visits according to one of the currently-available classification systems, then determine what different mixes of outpatient services cost on average in the State. The goal of this study will be to relate the payment for outpatient services more closely to the costs of providing those services. Comparison of data from non-hospital, or hospital off-site settings will be useful in determining the lowest cost setting for outpatient services. There will also be classification across a

wide spectrum of hospitals, including major teaching, community, inner city and suburban hospitals.

It is recommended that facility-based practitioners be reimbursed for outpatient services according to a relative value scale, just as inpatients are under Medicare. In its analysis of outpatient costs, the Department of Health should consider ways to incorporate physician payment, based on relative value, into the payment rates for outpatient services. It is further recommended that facility fees be capped so that incentives exist for the institution to provide care requiring lower levels of technology whenever possible, rather than higher, more sophisticated and expensive levels. This subject needs to be further explored with the national Physician Payment Review Commission and ProPAC, Federal agencies which are currently studying the subject. Redirecting these resources from hospital outpatient departments to pay for less expensive and more cost-effective preventive and primary care delivered in private practitioner settings would serve to increase access and have the potential to provide care to additional unserved persons.

In summary, if this plan is to be successful, there must be an adequate number of providers who are paid appropriate fees, providers must be willing to work with each other, community involvement must be assured, educational information must be universally accessible, and streamlined medical/information systems must be put into place. Logistical barriers such as transportation, inadequate day care, inflexible provider hours, and waiting lists would also need to be addressed. Better integration of health, social services, and education services will be instrumental in helping this plan achieve its goal of better access to preventive and primary care.

A number of other states have begun to address ways of providing care to all citizens, particularly the uninsured. Appendix J summarizes the approaches several states have taken.

Primary Care Practitioner Supply

Increasing the supply of primary care physicians will necessitate profound changes in values inculcated during the period of undergraduate and graduate medical education. At both undergraduate and graduate levels, trainees should experience preventive and primary care in settings outside the hospital. Regardless of their stated specialty or subspecialty orientation, every trainee should rotate to community health centers as well as outpatient clinics, and to inner cities as well as suburbs. This would prepare not only primary care providers, but subspecialists as well, to provide appropriate primary care services when needed. In addition, the instructors of these trainees, particularly those in primary care fields, can be influential by serving as strong role models, and encouraging students to consider seriously a primary care area for a career choice.

Among practitioners who accept Medicaid clients, provider distribution is a problem. In areas with few, or no providers, such as inner cities, clients are forced to travel inordinate distances for care, or forego care altogether. The practitioners in these areas who accept Medicaid clients are then asked to fill the void, resulting in practitioner saturation. The solution involves an increase in the total number of practitioners participating in the Medicaid system, as well as better geographic distribution of those practitioners. Changes in provider supply and reimbursement are needed, and they must be implemented simultaneously; neither can solve the problem in isolation.

An inadequate number of minority primary care physicians for minority populations is among the barriers to accessing health care. The persistent under-representation of minority health professionals is due to several factors, including: inadequate academic preparation at the elementary and secondary school level, which limits the pool of qualified applicants; insufficient or inappropriate career counseling; admission policies of some health professional schools and programs; significant attrition rates after matriculation; and the high cost of education. Targeted student mentoring, recruitment and training strategies are needed to increase the proportion of minority primary care physicians in all areas of primary care.

To improve the availability of minority health care providers, Adewale Troutman, M.D., Chairman of the State of Black Health Steering Committee, introduced the concept of Health Enterprise Zones in a position paper for the New Jersey Public Policy Research Institute. The Commissioner's Advisory Committee on Minority Health considered this concept a bold new initiative that would make positive changes in the delivery of primary health care services. Successful implementation of the initiative will require that health care providers, local and state governments, and private industry, both profit and nonprofit, join in a

cooperative effort to redirect health care financing, and create primary care community health care networks that can meet the needs of residents in the year 2000.

The zones will be administered by an authority established under the direct control of the Commissioner of Health. This authority will also designate the geographic areas in which providers in the program will serve, based on the federal Medically Underserved Area Index, and criteria such as physician-patient ratios; birth rates; infant mortality rates; percentage of the population below poverty level; and the percentage of State dollars spent on health care services.

In turn for making a commitment to society and practicing their profession in a designated Health Enterprise Zone, providers would receive a package of benefits including, but not limited to tax rebates, tax abatements on property, higher Medicaid reimbursement, and insurance subsidies.

Similar packages could also be developed for Medicaid providers. Higher Medicaid reimbursement could be combined with financial incentives such as tax credits, subsidized mortgages, and similar cost abatements. More providers might accept Medicaid patients in response to package of this type.

Increased utilization of nurse practitioners is another strategy to expand the supply of primary care providers and thereby increase access to care. Nurse practitioners and physician assistants were only recently given prescriptive powers in New Jersey; prior to January 1, 1992, physician assistants were not even permitted to practice in this State. Training models need to be developed to help physicians learn to collaborate more effectively with nurse practitioners and physician assistants, and additional training programs for certified nurse midwives should be instituted. Scholarship and loan programs for these professionals, as well as for physicians, should be developed in areas where the need is greatest. The State should encourage industry to support these goals. Also, the State should support Medicaid efforts to recognize midlevel providers for Medicaid patient care.

Major efforts have been initiated by the University of Medicine and Dentistry of New Jersey (UMDNJ) to increase the number of primary care practitioners graduating from New Jersey medical schools. Efforts include development of a primary care plan and a Quality Education Initiative. The objective of the primary care plan is to increase to 50 percent primary care trainees in medical school and residency positions along with the development of clinical training sites for the joint preparation of midlevel practitioners and physicians. The focus of the Quality Education Initiative is to increase access for underserved populations and to develop systems of comprehensive care.

Regardless of strategies employed, there will not be enough practitioners unless the payment system includes financial incentives. These incentives must be directed to both recruitment and retention of providers, so that an adequate supply of primary care physicians, as well as midlevel practitioners, is available. To address provider availability issues, support should continue for existing programs such as the National Health Service Corps. To encourage the location of professionals in underserved areas, at least two models are useful. Loan repayment programs for primary care health professionals should be continued and expanded. Increasing payments to providers located in underserved areas will aid in retention of providers who are already serving in areas of great need.

Conclusion

Given the state of the health care system, it is not a surprise that numerous plans and proposals for reform are being developed (see Appendix L: "State Legislative Bills for Health Care Reform"). The many initiatives recommended in this Chapter are consistent with some of them and at odds with others. Regardless of what plan for reform of the health care system is adopted, preventive and primary care must be the centerpiece of any proposal to restructure the system.

A greater emphasis on primary and preventive care during an era when primary care practitioners are in short supply or maldistributed will seriously strain the current system. Even with all the proper incentives put into place, it will take years before a substantial shift of practitioners into the primary care field will occur to the extent that is needed. For this reason, it will probably be necessary to phase in many of the suggested changes. Time, consensus, and concerted effort will be required. Nonetheless, the urgency of the health care crisis and the magnitude of the benefits to be gained in terms of the health of New Jerseyans compel us to move forward now.

Recommendations

HEALTH INSURANCE REFORMS

1. Health insurance coverage should be extended to all New Jersey citizens, regardless of workplace, health status, or income.
2. In order to promote primary care and a healthier citizenry, all health insurers in New Jersey should be encouraged to provide the following benefits, at a minimum, as a standard part of all health insurance policies:
 - Three primary care practitioner office visits per year, with no deductible and a copay not to exceed \$5.00 per visit;
 - Preventive and health promotion care, including routine immunizations, with no deductible and no copay;
 - Health promotion programs or inducements (e.g., smoking cessation classes, vouchers for fitness club membership, etc.); and
 - Coordination of care by the patient's primary care practitioner, including authorization for emergency care (except life threatening emergencies) and for referrals to specialists as needed.
3. Coverage of the standard benefits identified in #2 above should be achieved **not** by raising consumers' premiums, but rather by increasing as needed the deductibles and copays for emergency and inpatient care, non-routine diagnostic testing, and specialists' care.
4. Due to the shortage of primary care practitioners and to the preference of some consumers and their current providers, specialty physicians should be permitted the designation as primary care practitioners, if desired, provided that they are able to fulfill all of the requirements stated in #1 above. However, insurers should pay these physicians at the same rate as other primary care physicians for comparable services.
5. Until the time that #2 above can be uniformly achieved in New Jersey, employers should take actions to encourage their workers to choose a health insurance plan that offers the benefits identified in #2 above.
6. Public policy should be aimed at eliminating exclusionary insurance coverage; for example, community-rating by insurers should be mandated.
7. Incentives should be developed to encourage self-insured companies to offer the standard preventive and primary care package referenced above.
8. A program should be implemented to coordinate, automate, and standardize the processing of claims, billing and payment.
9. Standardized, statewide physician and provider payment reform should be initiated using a mechanism such as a relative value scale to encourage preferential provision of preventive and primary care services.
10. The use of outcomes research and physician profiling should be encouraged to determine the efficacy and cost of specific treatments and to determine which services are included in the standard insurance package.
11. An Advisory Panel that includes representation by insurance and health care experts, business leaders, consumers, and the appropriate agencies of State government, should be convened to refine and plan implementation of the standard insurance benefit package.
12. A public education campaign should be conducted to inform people of the health insurance reforms and encourage them to choose a primary care physician.
13. Especially in underserved areas of the State, the use of nurse practitioners and physician assistants as primary care providers should be encouraged and reimbursed by all insurers.

New Jersey SHIELD (State Health Insurance Enrollment and Local Care Delivery) Plan

1. Replace the New Jersey Health Care Trust Fund with the New Jersey SHIELD Plan to cover all uninsured persons in the state, including seasonal and part-time workers, the working uninsured, Medicaid-eligible recipients who choose to participate, and anyone else who would select this Plan.
2. The New Jersey SHIELD Plan should include the standard benefit package. Persons below 150 percent of poverty level would be eligible to receive all available services at little or no cost; persons between 150 percent and 300 percent of poverty level would be eligible for services based on a sliding fee scale.

3. To encourage the provision of preventive and primary care, practitioners serving participants in the New Jersey SHIELD Plan should be adequately reimbursed based on a statewide, standardized payment system using precipitated rates, a relative value scale, or a similar mechanism.
4. Develop strategies through the New Jersey SHIELD Plan to reduce the fragmentation of funding sources for primary and ambulatory care to assure more efficient utilization of resources.
 - The Department of Health should apply for Federal demonstration programs for comprehensive health care reform that permit states to consolidate Federally funded categorical programs for health services to Medicaid and low income groups to provide universal uniform health care coverage for residents of New Jersey.
 - The Department of Health should study the feasibility of consolidating some of the Department's categorical grant funds for preventive and primary care. Since many of these grants are issued at the federal level, any recommendation for consolidating categorical grants would also have to be directed to the federal level.
 - The New Jersey SHIELD Plan should emphasize enhanced health care management for participants in the plan to coordinate and integrate referrals and establish smooth transitions between services, e.g., AIDS treatment, addiction services, and family planning.

PRIMARY CARE DELIVERY

1. Expand the availability of Federally Qualified Health Centers in medically underserved areas and in areas geographically contiguous with underserved areas to increase access to primary care.
 - Implement the FQHC expansion program.
 - Encourage the development of new FQHC sites in the state by providing seed money to enable centers to meet FQHC requirements. Encourage existing community agencies which already serve as points of entry into the delivery system to become FQHCs.
 - Work with the U.S. Public Health Service to obtain new monies for the development of additional Section 330 and 329 federally funded community and migrant health centers. These centers are automatically designated as Federally Qualified Health Centers.
 - Work with the New Jersey Health Care Facility Financing Authority (HCFFA) to improve access to capital financing for non-hospital-based primary care providers.
2. Encourage FQHCs to conform their services to a concept of primary care that assures continuity and coordination of care.
3. Expand the number of sites for the Department of Human Services' School-Based Youth Services Program.
4. As another means of improving access to services, establish linkages and cooperative programs between the School-Based Youth Services Program (SBYSP) and the New Jersey SHIELD Plan.
 - Encourage school-based health programs to provide a uniform set of preventive and primary care services, with specific emphasis on the adolescent and pre-adolescent health needs. These services should include family planning information with documented linkages to the state funded family planning agencies.
 - Coordinate with the Departments of Education and Human Services to ensure that a basic set of preventive and primary care services is **uniformly** provided in all schools, including family planning information and a link to services.
 - Encourage formal linkages between school based family life education programs and family planning agencies. Work with individual communities to develop adolescent pregnancy programs that are sensitive to local needs.
5. Encourage coordination of services between providers, so that clients have easy access to addictions and AIDS counseling, family planning, and other related services.
6. Enact legislation to continue the Health Care Cost Reduction Fund to finance primary care programs.
7. Analyze outpatient information to determine appropriate payment levels for all outpatient services, in different types of settings.
8. Encourage further research at the LAB and state level to identify factors contributing to high-need status of areas on the Ambulatory

Sensitive Care Condition list as well as those identified on the New Jersey Medically Underserved Index.

9. Develop and implement a model demonstration project to establish a health enterprise zone in a predominantly minority community that is medically underserved.

PRIMARY CARE PRACTITIONER SUPPLY

1. Increase the supply of primary care physicians, particularly family practitioners, in this State, thus enhancing the availability and accessibility of these providers, particularly for underserved populations.
 - Provide incentives to enroll and retain larger numbers of medical school students and residents in primary care specialties.
 - Expand the New Jersey Physician and Dentist Loan Repayment Program to provide a personnel pool for high-need shortage areas.
2. Increase the supply and improve the utilization of nurse practitioners and physicians' assistants in primary care settings.
 - Expand existing education programs for certified nurse midwives in the State to mitigate shortages in the availability of obstetricians/gynecologists, especially for low income groups.
 - Develop retention strategies to retain mid-level practitioners in underserved areas.
 - Increase the payment level for mid-level practitioners serving the Medicaid population, particularly in medically underserved areas.
 - Expand the New Jersey Physician and Dentist Loan Redemption Program to include certified nurse midwives, nurse practitioners and physician assistants among those eligible to participate in the program.
 - Encourage the establishment of nurse-run clinics, without the requirement for physicians on-site.
3. Improve needs assessment, recruitment, retention, and training strategies to increase the number and representation of minority physicians and other health care providers serving minority communities.
 - Develop and implement recruitment policies and procedures to increase the proportion of race/ethnic minority elementary, junior high and high school students receiving career counseling on the health care professions and public health, and the proportion of underrepresented race/ethnic minority students being enrolled, retained, and graduated from New Jersey schools of health professions.
 - Develop and implement a collaborative initiative between the Departments and Health and professional health associations to design and implement recruitment policies and procedures to increase the proportion of minority health care providers serving minority populations.
 - Develop a statewide training curriculum and require continuing education on ethnically and linguistically relevant and culturally sensitive methods of practice for all health professionals and providers.

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THE LOCAL PUBLIC HEALTH DELIVERY SYSTEM

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EXECUTIVE SUMMARY

This section will discuss the role of preventive health services, characterize New Jersey's local public health delivery system, describe the desirable capabilities of local health departments in a coordinated system, and make recommendations to help develop an effective, coordinated system.

The basic recommendation of this section involves incorporating reimbursement from the New Jersey SHIELD Plan to pay for preventive health services to provide a stable funding source for local health departments and other preventive health care providers. Strategies to support and implement this recommendation include developing a tier system for ranking both the needs and the capabilities of local health departments at different levels to more effectively guide policy development and program implementation, involving Local Advisory Boards (LABs) in area-wide needs assessment and program planning, and funding a small number of demonstration projects in which local health departments are reimbursed for providing prevention-focused coordinated care services to persons at high risk of preventable complications of disease.

The social impact of the proposed improvements of the local public health delivery system would hopefully be more rational priority setting and resource allocation for preventive services, better coordination of public health activities, and the prevention of unnecessary illness. These outcomes would most benefit low income persons.

The economic impact of the recommended changes to the system is difficult to gauge. Coordination of services should result in some decrease in the cost of providing preventive health services, while providing reimbursement for currently unreimbursed services will increase expenditures short-term. However, prevention of disease and unnecessary complications of illness should produce long-term savings to the health care system.

PROBLEM IDENTIFICATION

New Jersey's existing local health department system, while providing minimum levels of basic public health service in most areas of the State, does not naturally lend itself to area-wide planning and coordination of services.

New Jersey's local health department system supports the presence of many small units. Some local health departments are staffed by a single professional since each department is required by law to have a full-time health officer. The cost of supporting smaller units for basic support and administrative services, however, is relatively fixed. The formation of larger units might allow significant savings in such resources. For example, Morris County, with a population of 421,000, has 16 local health departments serving its 39 municipalities. The Burlington County Health Department serves all of that county's 40 municipalities and 395,000 people. For public health activities requiring cooperation with local hospitals, Burlington County's hospitals only have to work with a single entity; in Morris County hospitals have to coordinate with multiple local health departments within their service areas.

New Jersey's current system for determining mandated public health services to be provided by all local health departments, the Minimum Standards of Performance for Local Boards of Health, also discourage need-based planning by these agencies. All local health departments must provide certain services (unless a waiver for a particular activity is requested), and often health departments do not formally prioritize the

need for these programs. Instead, effort is concentrated on meeting the Minimum Standards requirements rather than on addressing the unique needs of the agency's jurisdiction.

Small local health department jurisdictions are not effective for regional planning. The areas that they are responsible for are generally too small for meaningful analysis of morbidity and mortality data (for example, infant mortality rates). Even if data are available and numbers of cases are large, the absence of dedicated planning staff and/or enough persons in the community interested in public issues will most often hamper planning efforts. For example, a municipal health department serving a population of 25,000 might have only 10-20 high risk pregnancies occurring in its jurisdiction in a year. It is less likely that such a department would organize community input and involvement to improve pregnancy outcomes than a department serving jurisdictions with a total of over 500 high risk births, and it would also be difficult to document the effectiveness of intervention programs.

Smaller local health departments also generally have limited political clout in large part because they are not responsible for issues of regional concern. Regional health planning is beyond the scope of these departments, and thus in the past there has been limited input from Local Health Departments. As of 1992, however, each Local Advisory Board is required to have at least one local health officer on its board.

Small local health departments also do not necessarily cooperate on issues of regional concern. For example, each of the local health departments in Essex County is free to develop its own responses to HIV control, to cardiovascular disease prevention, or to rabies control. Instances of cooperative ventures between local health departments exist, such as in Somerset County, where each department contributes a per capita payment to fund tuberculosis services at the county's hospital, but even in this situation, no one local health official is responsible for ensuring the effective functioning of that program.

In Passaic County an attempt has been made to coordinate the activities of the county's seven municipal and contracting local health departments through the formation in 1990 of a county health department, which is staffed by a health officer only. Even if the county's local health departments trust that the long-term goal of the health department is not to absorb their agencies, coordinated efforts are still dependent upon the voluntary cooperation of each of these independent agencies.

Few incentives for operating efficiently or opportunities for expanding services exist for local health departments. No state match is available for increased local expenditures, and there is no significant reimbursement source for preventive services. Medicaid reimbursement is available for well child visits for infants and pre-school children, but reimbursement rates are well below the cost of providing such services. Furthermore, no reimbursement source exists for low income children whose families are not Medicaid eligible or for most preventive services that local health departments provide to adults. There are also no clear cut rewards for coordinating services with other local health departments—in fact, such coordination carries the perceived risk of eventual consolidation.

Almost no New Jersey local health departments provide preventive and primary care services; their personal health activities are limited to preventive health services, and no services are provided for persons with acute illness. Only the Atlantic City and Camden County, Morristown, and Newark health departments operate preventive and primary care clinics.

The lack of funding for local health departments to provide personal health services and the existence of other local agencies that provide some of these services has not encouraged development of local health department programs in these areas. This limitation of such programs increase the relative importance of environmental health programs of local health departments. Most of New Jersey's health officers have environmental health backgrounds, and while local health departments do provide personal health services, health officers are often less involved in these programs than in environmental health areas.

GOALS AND OBJECTIVES**Goals for the Year 2000**

The overall goal of the Department of Health for the Year 2000 is to develop a local public health delivery system in which there is maximal coordination of effort between various local agencies, duplication of activities is minimized, and all local health departments have the capacity to plan for, provide, and coordinate public health activities within their jurisdictions. Ideally, one agency should also serve as the focal point of

its jurisdiction for public health at the local level. Local health departments should have at a minimum the following capacities:

- The ability to do formal public health planning, including the ability to gather, analyze, and interpret data to determine need and establish priorities.
- The ability to perform epidemiologic analysis, both for purpose of planning as well as for the performance of investigations of acute disease outbreaks and ongoing causes of morbidity.
- The possession of basic computer skills to allow data processing, record keeping, and the rapid and simple transmittal of data and reports to and from other agencies.
- The ability to effectively coordinate the public health efforts of various community agencies.
- The ability to effectively communicate with and educate the populations that they serve.
- The ability to work effectively with the media.
- The ability to communicate with local decision makers, including those who influence and determine local funding, and educate them about the public health needs of the communities that they serve.
- The ability to implement necessary activities to address identified needs.

UNMET HEALTH NEEDS

The Role of Prevention

Although most people think of medical care as synonymous with health care, medical care is only one aspect of a health care system. Medical care is important when people are sick, but ideally the health care system should include efforts to prevent illness. Preventive services are aimed at keeping people healthy; medical care is only necessary when this goal has not been met and individuals become sick. Effective preventive services not only produce savings in medical care costs, but they also prevent suffering among persons who might otherwise have become ill.

Preventive services are often simple and non-technical and thus have lower status in the health care system. For example, almost 300,000 Americans undergo coronary artery bypass surgery annually at a cost of approximately \$30,000 for each procedure (U.S. Dept. of Health and Human Services). This highly delicate surgery has become almost routine and can be performed on frail elderly patients as well as persons with significant heart disease. Even more impressively, the entire heart can be replaced through transplant surgery, and the development of artificial hearts is advancing.

In American society and in New Jersey these high tech services are seen as more impressive than simple interventions and personal actions that could prevent the need for much cardiac surgery. The incidence of cardiovascular disease could be significantly reduced through activities that promoted weight control, dietary change to decrease cholesterol, increased exercise, and smoking prevention and cessation among the population. However, while public and private health insurance programs pay for bypass surgery, little reimbursement or public funding is available to encourage the development of such preventive programs.

Similarly, prenatal care programs including regular visits to physicians or nurse midwives can decrease the incidence of low birth weight by two-thirds, thus eliminating the need for expensive neonatal care for these babies (See *Healthy New Jersey 2000*). However, millions of American women with low income and lack of health insurance receive no prenatal care in the first trimester of their pregnancies (U.S. Dept. of Health and Human Services).

The case of AIDS is even more compelling, since there is currently no cure for the disease and the current treatment is intensive and expensive. While the behavioral changes necessary to prevent AIDS are not easy to produce, comparatively little funding is directed to the development of new HIV prevention efforts or even to the funding of known effective prevention strategies.

Preventive services can be provided by the medical system; physicians and mid-level practitioners measure blood pressure, administer immunizations, perform cancer screenings, and provide behavior change counseling (for example, on stopping smoking). However, preventive services are also provided by other health care providers through the public health system. Through health departments and other public health agencies, such as visiting nurse associations and family planning agencies, other professionals provide preventive services. Public health nurses and personnel from agencies such as family planning programs and WIC, who generally spend little of their time providing care for

ill patients, instead counsel, educate, and screen their patients in clinic settings or through home visits. Health educators and nutritionists also provide counseling and education to help people avoid becoming ill, or for persons with chronic diseases such as diabetes or asthma, to help them avoid unnecessary complications of those diseases.

Preventive services are generally less intensive and less resource intensive than even primary medical care. Further, fewer technical skills are necessary for the providers of these services. Therefore, the per unit cost of providing these services is smaller than for medical care services.

Often the need for preventive services is seen as being most important for low income persons who do not have adequate access to medical care services. Preventive services are particularly vital in situations where access to medical care is limited. However, even in areas of New Jersey where almost everyone has a private physician, preventive services can prevent illness and the need for costly medical treatment. In such cases preventive services can be provided through the private physician, but there must be a recognition of the importance and value of these services.

Appendix M consists of the preventive services recommendations of the United States Preventive Health Services Task Force convened by the U.S. Department of Health and Human Services, which issued its report in 1989 (U.S. Preventive Services Task Force).

Description of the Local Public Health Delivery System

New Jersey's local public health delivery system is not a monolithic, easily defined system, but rather a pluralistic one that has developed in a number of divergent ways in different parts of the state. The public health system is not unlike the preventive and primary care system which is characterized by fragmentation and duplication of services due to the diversity of funding sources and individual program requirements.

Local health departments have the statutory responsibility and authority for a broad range of public services. There is also universal coverage of the State by local health departments. These agencies, however, do not directly deliver the entire range of public health services in most cases.

A number of other types of agencies provide public health services, either through contractual arrangements with local health departments, grants from the State Department of Health or from Federal agencies, or through voluntary commitment to delivering such services.

Provider organizations include hospitals, home health agencies (including visiting nurse associations), community health centers, other government agencies such as county alcoholism councils, and other voluntary health agencies such as family planning agencies, substance abuse treatment programs, or cancer societies, for example. Thus, for example, efforts to control Human Immunodeficiency Virus (HIV) in a community could involve State funding of a HIV counseling and testing site administered by a voluntary agency, efforts to educate intravenous drug users by a drug treatment agency, reimbursement for coordinated care of infected individuals by a home health agency, and strengthening of treatment capabilities of a hospital. The local health department could have a nominal or no role in the provision of these services, although some of New Jersey's local health departments are the direct providers of a number of these activities.

This patchwork system works well in some instances when local agencies cooperate actively and work together to address gaps in services; it works less well in other parts of the State, when the various agencies each address distinct areas of public health but do not compete with each other or duplicate services; and it works poorly in still other areas, where significant public health problems are not addressed because of lack of planning or coordination, or because of duplication of services. What generally does not exist therefore, is a recognition of the local health department, or another agency, as responsible for determining community needs or assuring that these services are available.

Although New Jersey's local health departments do not always play a central role in coordinating the delivery of services, they are the only part of the health care system whose primary focus is on preventive services. Local health departments do have certain authorities and abilities that other possible providers of public health services do not. Health departments, along with the voluntary nursing associations and other home health agencies that work with local health departments, have on staff public health nurses, whose focus is on prevention of disease, not treatment. As such, the local health departments are experienced in reaching out to various populations to provide preventive services. Such services range from home visits to pregnant women or new mothers to provide education and referrals for medical care or social services as appropriate, to screening for lead poisoning in preschool children, to

performing assessments of the health and social needs of the elderly in order to prevent unnecessary institutionalization, among others.

It is very important to note that local health departments in New Jersey are also the State's local environmental protection agencies. The County Environmental Health Act of 1977 designated county health departments as the local environmental protection agencies, however in many cases, other local health departments, particularly those in the counties without county health departments, provide environmental protection services. The vast majority of New Jersey's health officers have environmental health backgrounds, and most local health departments have more of an environmental than non-environmental orientation.

Under current law dating back to 1887, every municipality in New Jersey is required to have a board of health. In municipalities which have adopted a form of government allowed by the Optional Municipal Charter Act, however, the municipal governing body itself serves as a board of health. The role of municipal boards of health is to provide policy direction for and oversee the operation of public health activities within the municipality. Public health services are provided by the health department responsible for the municipality.

Municipalities may choose to have their own health departments; they may contract with another municipal health department for local health services; they may join with other municipalities to form a regional health commission which has ordinance-making powers for all the participating municipalities; or they may join a county health department, if one exists. It is important to note that county health department services may operate with or without the existence of a county board of health. Only four counties in New Jersey have county board of health systems (Atlantic, Cumberland, Monmouth, and Ocean), and even in these counties municipalities may elect whether to participate in the county health department and participating municipalities maintain municipal boards of health.

There are currently 115 local health departments in New Jersey: 55 individual municipality health departments, 39 contracting arrangements, six regional health commissions, and fifteen county health departments although the fifteenth county health department in Passaic County does not provide public health services to any municipalities (see Table 1). Every county from Middlesex and Burlington Counties south has a county health department, as do Hunterdon, Warren, Sussex, Passaic, and Bergen Counties. However, many local health departments also exist in some of these counties, e.g. Bergen, which also has six municipal, five contract, and three regional health departments, and Monmouth, which has four municipal, four contracting, and a regional health department as well as a county health department. None of the state's major cities with the exception of Camden are served by a county health department. Furthermore, there are 31 local health departments that serve fewer than 25,000 persons, and most of them serve suburban communities (see Table 2).

While there are a large number of local health departments in New Jersey, it should be noted that this number was much greater before the passage of the Local Health Services Act in 1975, which mandated that each local health department be administered by a full-time state-licensed health officer. In 1974 there were 291 local health departments in the state, many of which were staffed with part-time personnel; by 1980 there were only 120 local health departments, all of which employed full-time health officers. Since that time the number of local health departments has remained in the range of 110-120 (see Figure 1).

Reimbursement and Funding. Local health departments have limited access to reimbursement for the services they provide, particularly personal health preventive services. Medicaid will pay for well child visits for infants and preschool children and Medicare pays for home visits that require nursing care. However, insurers do not reimburse for activities such as cholesterol screening and counseling, education for persons with diabetes or asthma, contact tracing for tuberculosis or sexually transmitted diseases, or investigation of communicable disease outbreaks. Local governments generally are resistant to billing their residents for such services because taxpayers are perceived as already having paid for access to these services. Most local health departments also do not want to develop billing systems since potential revenue is limited and such revenue by law goes into the general revenue of the health department's governmental entity rather than back to the local health department. The ability to expand services therefore, is dependent on increased local funding and is thus very constrained.

Current Federal law requires state Medicaid agencies to provide, at the request of the state health department, cost-based reimbursement for maternal and child health activities provided by maternal and child

health grantee agencies. Although there are problems with cost-based reimbursement, such reimbursement would have short-term benefits in encouraging expansion of services by local health departments and other providers of preventive and primary care services. While reimbursement should reflect the actual cost of providing quality preventive services, it should not be cost-based. Cost-based reimbursement rewards high-cost operation. The reimbursement rate should offer an incentive to operate efficiently by paying a fair fixed rate for well-defined services.

A fixed price reimbursement system would reward local health departments and other preventive health care providers for operating efficiently. It would enable providers the ability, if not the incentive, to offer additional services and to expand the number of persons they serve. High cost programs would be penalized since fixed fee reimbursement would not fully reimburse high cost providers. A fixed fee reimbursement system would also provide encouragement for smaller units to coordinate or consolidate services with other local health departments in order to decrease costs, but it would not limit small local health departments that operate efficiently from continuing to maintain their own programs.

Making reimbursement for preventive health services available through the New Jersey SHIELD Plan will provide incentives for other providers to serve low income persons currently served by local health departments. While expanded access for this population to preventive care is a desired outcome, it will be important to ensure that local health departments maintain the capacity to provide health promotion and disease prevention services. Local health departments have a unique role in coordinating community-wide and individual prevention programs.

The Public Health Priority Funding Act of 1977 provides for per capita funding of local health departments serving a population of at least 25,000 which is adjusted based on tax valuations, poverty population, and senior citizen population, thus providing enhanced funding for poorer jurisdictions and decreased support for well-off ones. The current average 38 cents per capita allocation ranges from 75 cents per capita to the city of Newark to only 4 cents per capita in Paramus (Bergen County). Statewide, Public Health Priority Funding provided only about 3% of total local health department budgets in 1991 following a reduction in the Public Health Priority Funding appropriation from \$6.239 million to \$3 million in state fiscal year 1991. See Table 2.

Local health departments in New Jersey spent over \$95,000,000 in 1989 on the provision of public health services for their residents. The services on which these dollars were spent have been broken down into the following areas: Administration, Environmental Health, Communicable Diseases, Maternal and Child Health and Chronic Illness. Figure 2 shows actual dollars and percentage of the total budget allocated to each of the areas. As can be seen from Figure 2, local health expenditures were fairly evenly distributed with the exception of Communicable Diseases.

A majority (61%) of total dollars expended by local health departments are generated by local tax dollars. Other sources of income include state dollars, Public Health Priority Funding and federal dollars. For a complete breakdown of funding sources for public health activities see Figure 3.

State and federal monies provided to local health departments are generally in the form of categorical grants earmarked for specific types of services such as hypertension screening and diabetes education and/or treatment, prenatal care, drug and alcohol abuse treatment and prevention, WIC, and special child health services. Public Health Priority Funding monies are used by local governments to support those services identified as priority services in the Minimum Standards of Performance.

Tier System. To minimize the inefficiency and duplication associated with having multiple various sized local health departments operating in the state, the implementation of a tier system is recommended. The health status and resource capacity of each region would be assessed, with higher need areas assigned to high level providers to ensure adequate capacity of the health department to meet the needs.

The tier system would use a set of specific indicators to assess the overall health status of each region as well as the capacity of the current public health delivery system to meet those needs. Indicators such as infant mortality, disease morbidity and mortality rates, incidence and prevalence, and specific local data would be used to determine the health status of the community while capacity would be measured in terms of existing programs, resources, and effectiveness.

In order to obtain high capability designation, a local health department would have to provide coordinated care, health promotion activities, and be a Medicaid and Medicare provider. Moderate capability

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health departments would be providers of some preventive services, and low capability departments would be those providing minimal preventive services.

The implementation of the tier system would assure that local health department providers of service have adequate capacity to service the jurisdictions that they serve. For example, a high need community could only contract for services with a local health department that meets the standard as a high level provider. A low need community could contract with any nearby local health department regardless of its capability level. High capability health departments (those in the highest tier) would be eligible to receive cost-related reimbursement from Medicaid and for serving low income uninsured persons. Also, Department of Health grant monies could be preferentially directed to those agencies with proven service capacity as reflected in their tier ranking. (However, the need to build capacity in high-need areas would require making some funds available to high-need communities with low-level capabilities.

Minimum Standards. It is recommended that the services required to be offered by local health departments be more comprehensive for those jurisdictions designated as high-need and less intensive for low-need communities. Local health departments are required to provide an array of public health services. Some of these are mandated by statute, e.g. licensing and inspection of retail food establishments and rabies control. These and other activities are also required by Department of Health regulation. The Minimum Standards of performance for Local Boards of Health regulation is promulgated by the Public Health Council. These standards list mandated "core" activities that all local health departments must provide as well as "elective" ones, unless they seek a waiver on the grounds that a particular service is not needed in their jurisdiction.

Public Health Activities listed in Minimum Standards

Core Activities	Elective Activities
Administration	Emergency Medical Services
Administrative Services	Institutional Sanitation
Health Promotion	Ambulatory Health Care for Children
Public Health Nursing Services	Dental Health—Children
Environmental Health	Family Planning
Recreational Bathing	Obstetrics
Campgrounds	School Health
Youth Camps	Alcoholism Control
Food Surveillance	Ambulatory Health Care for Adults
Occupational Health	Drug Abuse Control
Public Health Nuisances	Nutrition
Communicable Diseases	Dental Health—Adults
Reportable Diseases	Vision, Health and Speech
Immunization	Home Health Care
Rabies and Zoonosis Control	
Tuberculosis Control	
Sexually Transmitted Diseases	
Maternal and Child Health	
Infants and Preschool Children	
Childhood Lead Poisoning	
Improved Pregnancy	
Adult Health Services	
Cancer Services	
Diabetes Services	
Cardiovascular Disease Services	
Health Services for Older Adults	

The services provided by local health departments in accordance with Minimum Standards represent the major points at which these departments intersect the health care system. Their accountability as preventive and protective community health service providers can be measured in terms of the service level these units provide. The following list highlights their most significant services delivered in 1988:

- Comprehensive child health services provided through Child Health Conferences reached 53,101 unduplicated users through over 100,000 visits
- Immunizations were administered to 59,499 unduplicated school age children
- Blood tests for lead poisoning screening were administered to 59,817 children

- Risk assessment/screening for hypertension were conducted for 189,049 New Jerseyans
- Risk factor assessments for diabetes was conducted for 111,495 persons
- Influenza immunizations were administered to 72,178 older adults
- Vaccinations were administered to 66,774 dogs and cats to prevent rabies
- Sexually Transmitted Disease clinics served 41,461 state residents
- Investigations of public health nuisances totaled 91,555
- Food service inspections totaled 44,293
- Communicable Disease investigations totaled 6,720
- Health education services were provided directly to 625,000 persons in AIDS, Alcohol and Drug Abuse, Cancer, Diabetes, Cardiovascular Disease, and general lifestyle behavior modification.

By definition, however, the **Minimum Standards** outline the **least** that local health departments must do. The level of services required is in almost all cases the same for all local health departments, and thus the **Minimum Standards** do not address the distinct needs of different jurisdictions, that is, they do not speak to what each local health department **should** be doing beyond the minimum. For example, an urban health department may meet all of the standards but be providing a depth of services that barely addresses that city's public health needs. It might operate a well child clinic but be able to accommodate only 10% of the infants and preschool children that do not otherwise have access to preventive health services, including immunizations.

The **Minimum Standards** also do not account for the unique needs of individual local health departments. While this approach requires that local health departments provide a broad range of services, it does not encourage them or boards of health to assess the needs of their communities in formulating their work plans. The **Minimum Standards** represent the public health safety net, but there is less attention to situations in which local health departments might need to be taking a more proactive role in their communities.

The **Local Health Services Act** also requires that the Department of Health revise its minimum performance standards for local health departments and periodically evaluate the performance of local health departments to determine whether they were meeting the performance standards. Further, it requires that, in cases in which it is determined that a local health department is not providing services meeting the standards, the Department arrange for the provision of such services at the expense of the municipality. This provision of the law has never been exercised, partly because the threat of it is generally enough to convince local officials to provide adequate services and partly because local funding accounts for about 75% of local health department budgets and the Department of Health thus has somewhat limited authority to demand increased local expenditures.

Role of Local Advisory Boards. It is recommended that the Local Advisory Boards be involved in area-wide needs assessment and program planning for local health departments and other providers of preventive services to more appropriately tie **Minimum Standards** to the public health needs of the region. Local Health Department jurisdictions would be assigned a tier based on health status indicators.

Each local health advisory board will provide the necessary leadership for its designated region to identify and formulate plans to address the unmet health care and public health needs using existing resources whenever possible. It will be the responsibility of each board to assess these needs by collecting, analyzing, and interpreting data within its assigned area. On the basis of this data, each board will formulate a strategic plan to improve the health status of its residents. Local advisory boards will focus their efforts on those local health department jurisdictions in their regional health planning areas that have been designated as high-need in the tier ranking.

The **LAB** assessments and recommendations should be in line with the **New Jersey Health Objectives** for the year 2000. The objective of the board will be to coordinate the preventive services offered by local health departments with those of the other community health providers to fully address the needs of the resident within the region. A more intense integration of preventive services with treatment services will yield better accessibility, continuity, and cost effectiveness for the entire system.

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The planning staff of the Local Advisory Board will work closely with local boards of health and health department staffs to place a greater emphasis on building more preventive interventions into the delivery system of care as well as on the regional application of preventive techniques. In this model, local health departments would share resources to meet public health needs that are not limited within the boundaries of individual jurisdictions, for example tuberculosis, sexually transmitted diseases, cancer, and cardiovascular diseases.

The combination of the planning skills of the Local Advisory Board and the county health departments and/or county health officer associations will enable the mapping out of a direction by which to improve the regional delivery of public health services. Formal channels of communication between the board of health members and public health officials of each county and the LABs will enable exchange of information. The concentration of these efforts will be focused on health promotion, early detection through acceptable screening methods, individual consultation, and more sophisticated marketing and outreach. Their regional planning will require that quantifiable objectives be established and evaluated to measure progress and improve upon service delivery wherever possible.

The concerted effort between private and public health planners will probe the entire system to identify where existing resources can be best utilized. This relationship will result in a cohesive delivery system and provide for the identification of unmet health needs within each region. The integration of services, coordination of services and sharing of resources will limit costly services, help slow the increase in health care costs, and provide for definitive roles of providers to reduce duplication of services.

Giving this role to LABs will establish them as a regional agency with some authority to require coordination of LHD services and would formally bring LHDs into the health planning process through representation on and involvement with LABs.

Demonstration Programs. To demonstrate the feasibility of these proposals, it is recommended that the Department of Health work intensively with a small number of selected local health departments, preferably those serving regions or counties with significant public health needs, to develop "model" local health departments that have the capacity to provide quality public health services. Such an approach would include the reimbursement of these local health departments for preventive services provided to low income persons. The participation of the LABs in whose jurisdictions the demonstration local health departments were located would be essential.

It is proposed that up to three "model" or demonstration projects be funded to enhance and redefine the role of the local health department in an effort to create a better coordinated health care system. Among other objectives, the demonstration projects would provide a source of funding and seek to establish or improve the relationship between local health departments and other providers, particularly physicians and hospitals. A major focus of the projects would be coordinated care by public health nurses of all patients hospitalized for ambulatory-care-sensitive conditions. Emphasis should also be placed on the identification and management of patients with tuberculosis, hypertension and diabetes in order to avoid preventable hospital admissions. It is estimated that 17 percent of Americans who suffer from diabetes and high blood pressure are going without treatment. The risk is high that these individuals will be hospitalized at significant cost to the health care system. Public health agencies can play a vital role through coordinated care and the provision of preventive health services including health promotion, in reducing high risk behaviors and preventable hospital admissions.

The following are suggested criteria for selecting local health departments as demonstration project sites:

- The local health department jurisdiction should serve a large population with high public health needs as demonstrated by health status indicators such as infant mortality rate, STD and TB rates, high unemployment, high hospital admission rates for ambulatory care sensitive admissions, high numbers of Medicaid eligible and uninsured persons, size of the population below poverty, high rating on the NJMUI, designation as a HPSA, MUA or MUP or other high need indicators.
- The local health department shall demonstrate the ability to establish a working referral relationship with hospitals, community health centers, private physicians, social service agencies and other providers to identify and enroll high risk persons in

a coordinated case managed system of care designed to address health and health related needs. Among the objectives would be the prevention or control of chronic conditions and ACS hospital admissions and to identify sources of preventive and primary care for clients lacking access.

- The health department shall assess the availability and adequacy of preventive and primary care services within its jurisdiction and adjacent areas. If preventive and primary care access is a problem, the health department shall plan for the provision of increased preventive and primary care services either directly by the local health department or through an alternative provider. A portion of the demonstration project funding shall be committed for this purpose.

Conclusion. The local health system in New Jersey is at a critical juncture. The system has been weakened by years of inadequate funding, limited reimbursement potential, and a broadly defined role which overlaps with that of other providers in many areas. State budget cap legislation, which limits the growth of local government services, has resulted in the loss of personnel by many local health departments. The implementation of the recommendations in this section, most importantly the need to enhance funding and reimbursement and the designation of a more defined and coordinated role for local health departments within the context of the overall health care system, will improve health service delivery and can be reasonably expected to result in reduced health care expenditures.

The feasibility of redefining the role of local health departments on a statewide basis that is consistent with the focus of the proposed demonstration projects is contingent upon the implementation of an established cost related reimbursement mechanism for Medicaid and medically indigent clients and the cooperation of other health care providers, especially hospitals, private physicians and community health centers. Historically the burden of cooperating with other health providers to avoid duplication of services has been directed at local health departments through Minimum Standards (N.J.A.C. 8:52). If such a goal is to be achieved, the burden and responsibility of establishing a functioning system of referrals between health care providers must be equally shared by all involved parties.

Recommendation

1. Incorporate reimbursement for preventive services through the New Jersey SHIELD Plan to provide a stable funding base for local health departments and other preventive health care providers which reflects the actual cost of providing services efficiently. This reimbursement system would ideally be part of the standardized statewide provider payment system for services provided to all persons. Local health departments that met facility, personnel, and clinical standards and had a mechanism for coordinating their services with those of primary care providers could provide preventive services to persons enrolled in the New Jersey SHIELD Plan. The unique community health focus of local health departments must be recognized to ensure that they maintain a significant role in providing these services.

Strategies:

Develop a system of placing local health departments at different levels with regard to both needs and capabilities. Minimum Standards of Performance for Local Health Departments should be tiered to more accurately tie required activities to needs. Jurisdictions with lesser needs would have fewer and/or less intensive activities required, and those with more significant needs would be required to provide more comprehensive services.

Involve Local Advisory Boards (LABs) in area-wide needs assessment and program planning for local health departments and other providers of preventive health care services. Formal communication channels between county health departments or county health officer associations and the LABs should be established. Eligibility for reimbursement of services would be based on their compatibility with the regional LAB plan.

Fund several demonstration projects in which local health departments are reimbursed for coordinating care of patients with conditions that have complications preventable through public health interventions. Local health departments selected would work closely with other health care providers.

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TABLE I
Local Health Department Types in New Jersey, 1992

LAB	County	County Health Departments	Municipal Health Departments	Contracting Health Departments	Regional Health Commissions	Total LHDs
I	Morris	no	10	6		16
	Passaic	yes	4	2		7
	Sussex	yes	2	1		4
	Warren	yes				1
		<u>3</u>	<u>16</u>	<u>9</u>		<u>28</u>
II	Bergen	yes	6	5	3	15
	Hudson	no	5	2		7
		<u>1</u>	<u>11</u>	<u>7</u>	<u>3</u>	<u>22</u>
III	Essex	no	8	5		13
	Union	no	2	6		8
		<u>0</u>	<u>10</u>	<u>11</u>		<u>21</u>
IV	Hunterdon	yes				1
	Mercer	no	2	4	1	7
	Middlesex	yes	5	1	1	8
	Somerset	no	4	3		7
		<u>2</u>	<u>11</u>	<u>8</u>	<u>2</u>	<u>23</u>
V	Burlington	yes				1
	Camden	yes				1
	Cumberland	yes	1			2
	Gloucester	yes				1
	Salem	yes				1
		<u>5</u>	<u>1</u>			<u>6</u>
VI	Atlantic	yes	1			2
	Cape May	yes				1
	Monmouth	yes	4	4	1	10
	Ocean	yes		1		2
		<u>4</u>	<u>5</u>	<u>5</u>	<u>1</u>	<u>15</u>
TOTAL		<u>15</u>	<u>54</u>	<u>40</u>	<u>6</u>	<u>115</u>

TABLE II

Local Health Agency	Non Instit. Populat.	CY 1990 Health Budget	Per Capita Health Expend.	PHPF 1991 Allocation	Per Capita PHPF
LAB I					
MORRIS COUNTY	423,119	\$ 5,049,584	\$12	\$ 55,470	\$0.13
East Hanover	9,926	129,158	13	0	0.00
Denville	13,812	148,000	11	0	0.00
Dover	15,115	183,802	12	6,132	0.41
Jefferson	17,814	36,420	2	0	0.00
Kinnelon	12,036	106,381	9	0	0.00
Lincoln Park	13,348	160,921	12	0	0.00
Morristown	15,858	346,728	22	0	0.00
Mt. Olive	21,282	225,000	11	0	0.00
Parsippany	47,777	329,187	7	8,604	0.18
Pequannock	22,555	408,439	18	0	0.00
Randolph	26,217	242,744	9	7,166	0.27
Rockaway Twp.	31,219	599,882	19	9,232	0.30
Roxbury	20,429	237,696	12	0	0.00
Madison Boro	140,131	1,678,336	12	24,336	0.17
Montville Twp.	15,600	216,890	14	0	0.00
PASSAIC COUNTY	423,781	\$ 5,189,282	\$12	\$200,174	\$0.47
Clifton	71,152	735,060	10	25,636	0.36
Passaic City	57,905	635,682	11	37,570	0.65
Paterson	196,277	2,587,445	13	116,830	0.60
Pompton Lakes	14,386	148,000	10	0	0.00
Ringwood	12,623	166,226	13	0	0.00
Wayne	46,008	613,131	13	11,100	0.24
West Milford	25,430	303,738	12	9,038	0.36

HEALTH**PROPOSALS**

SUSSEX COUNTY	130,396	\$ 1,837,350	\$14	\$ 25,860	\$0.20
Hopatcong	15,586	195,677	13	0	0.00
Sparta	21,272	208,974	10	0	0.00
Sussex County	72,327	1,137,054	16	25,860	0.36
Vernon	21,211	295,645	14	0	0.00
WARREN COUNTY					
Warren County	91,199	\$ 3,037,277	\$33	\$ 33,070	\$0.36
TOTAL LAB I	1,068,495	\$15,113,493	\$14	\$314,574	\$0.29
LAB II					
BERGEN COUNTY	788,721	\$ 5,958,891	\$ 8	\$175,120	\$0.22
Bergen County	254,230	777,085	3	69,488	0.27
Bergenfield	24,458	142,872	6	9,572	0.39
Closter	8,364	70,217	8	0	0.0
DuRidge Regional	60,776	800,696	13	13,902	0.23
Elmwood Park	17,623	149,901	9	0	0.0
Englewood	24,850	499,135	20	5,480	0.22
Fair Lawn	35,395	295,209	8	8,508	0.24
Fort Lee	31,995	373,708	12	4,708	0.15
Hackensack	36,085	372,336	10	10,774	0.30
MidBergen Regional	88,088	662,691	8	19,882	0.23
NW Bergen Regional	57,617	298,390	5	9,798	0.17
Palisades Park	14,536	80,650	6	0	0.0
Paramus	25,067	300,913	12	1,076	0.04
Ramsey	30,243	445,574	15	1,918	0.06
Teaneck	36,828	376,180	10	11,180	0.30
Washington	42,566	313,334	7	8,834	0.21
HUDSON COUNTY	551,032	\$ 6,941,666	\$13	\$267,694	\$0.49
Bayonne	61,378	496,269	8	29,434	0.48
Harrison	13,425	253,642	19	3,642	0.27
Hoboken	32,855	520,693	16	21,272	0.65
Jersey City*	227,628	3,000,000	13	110,652	0.49
Kearny	85,174	556,084	7	30,100	0.35
Secaucus	13,782	717,384	52	0	0.00
Union City	116,790	1,397,594	12	72,594	0.62
TOTAL LAB II	1,339,753	\$12,900,557	\$10	\$442,814	\$0.33
LAB III					
ESSEX COUNTY	792,724	\$14,411,104	\$18	\$446,996	\$0.56
Belleville	34,213	430,998	13	16,534	0.48
Bloomfield	65,233	732,572	11	26,172	0.40
East Orange	73,112	3,591,561	49	53,000	0.72
Fairfield (Newark)	297,553	6,411,301	22	232,030	0.78
Irvington	61,900	502,256	8	42,262	0.68
Livingston	26,609	313,154	12	3,544	0.13
Maplewood	21,649	159,143	7	0	0.00
Millburn	26,637	180,311	7	2,684	0.10
Montclair	62,986	879,532	14	19,896	0.32
Nutley	27,099	—	—	10,562	0.39
South Orange	14,206	122,138	9	4,582	0.32
West Caldwell	10,422	63,459	6	0	0.00
West Orange	71,105	1,024,679	14	35,730	0.50
UNION COUNTY	502,723	\$ 2,592,529	\$ 5	\$183,142	\$0.36
Cranford	22,633	154,840	7	6,816	0.30
Elizabeth	121,861	319,587	3	61,012	0.50
Linden	57,007	636,040	11	15,034	0.26
Plainfield	65,383	313,245	5	30,604	0.47
Rahway	83,732	295,034	4	32,154	0.38
Summit	56,596	322,850	6	8,250	0.15
Union	48,247	346,431	7	17,400	0.36
Westfield	47,264	204,502	4	11,872	0.25
TOTAL LAB III	1,295,447	\$17,003,633	\$13	\$630,138	\$0.49
LAB IV					
HUNTERDON COUNTY	105,093	\$ 1,112,709	\$11	\$ 20,568	\$0.20
Hunterdon County					
MERCER COUNTY	317,371	\$ 5,065,789	\$16	\$133,501	\$0.42
East Windsor	27,479	224,744	8	11,412	0.42
Ewing Twp.	30,943	210,583	7	13,750	0.44
Hamilton Twp.	86,552	1,384,466	16	36,678	0.42
Hopewell Twp.	15,634	152,000	10	0	0.00
Lawrence Twp.	23,644	221,872	9	5,396	0.23
Princeton Reg Hlth	25,214	235,816	9	2,040	0.08
Trenton	86,069	2,157,496	25	62,258	0.72

PROPOSALS

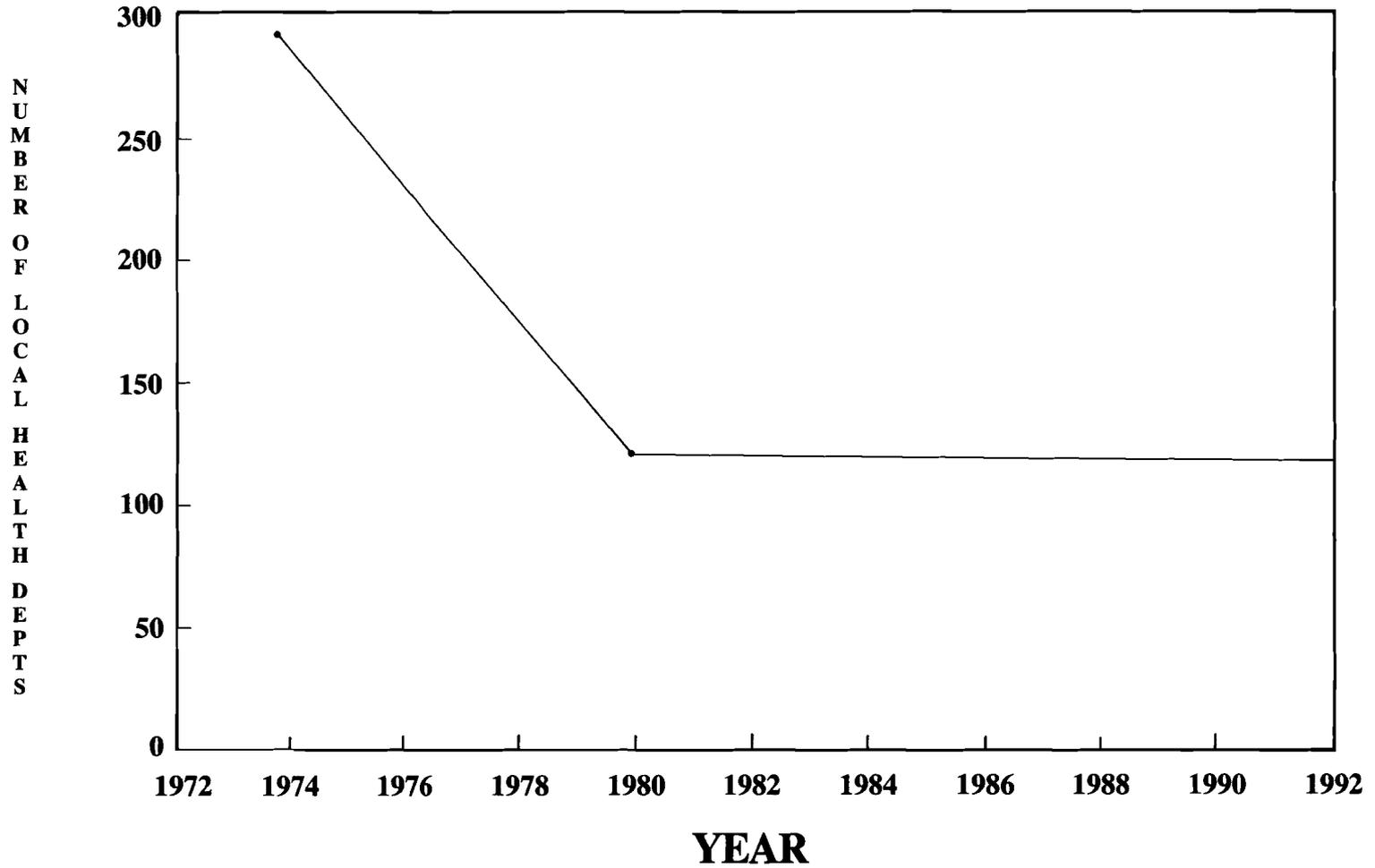
Interested Persons see Inside Front Cover

HEALTH

Washington	5,815	56,900	10	0	0.00
West Windsor	16,021	421,912	26	1,967	0.12
MIDDLESEX COUNTY	676,630	\$ 5,119,769	\$ 8	\$200,504	\$0.30
Madison Twp.	88,292	721,302	8	16,628	0.19
Middle-Brook Reg.	47,127	651,800	14	10,964	0.23
Middlesex County	307,343	1,714,790	6	109,354	0.36
Old Bridge Twp.	56,475	343,626	6	23,626	0.42
Piscataway Twp.	40,564	262,853	6	10,134	0.25
South Brunswick	26,485	337,204	13	3,104	0.12
South Plainfield	20,489	179,500	9	0	0.00
Woodbridge	89,855	908,694	10	26,694	0.30
SOMERSET COUNTY	185,175	\$ 1,405,809	\$ 8	\$ 32,542	\$0.18
Bernards Twp.	33,154	329,416	10	2,108	0.06
Branchburg	10,888	116,055	11	0	0.00
Bridgewater Twp.	32,509	188,626	6	3,106	0.10
Franklin Twp.	43,230	410,179	9	10,524	0.24
Hillsborough	28,808	66,099	2	6,872	0.24
Montgomery Twp.	8,899	129,002	14	0	0.00
Somerville Boro	27,687	166,432	6	9,932	0.36
TOTAL LAB IV	1,284,269	\$12,704,076	\$10	\$387,115	\$0.30
LAB V					
BURLINGTON COUNTY					
Burlington County	484,392	\$ 4,876,588	\$10	\$177,280	\$0.37
CAMDEN COUNTY					
Camden County	499,215	\$ 6,954,331	\$14	\$282,412	\$0.57
CUMBERLAND COUNTY					
Cumberland County	133,257	\$ 3,312,015	\$25	\$ 89,218	\$0.67
Vineland City	79,746	1,639,526	21	53,202	0.67
	53,511	1,672,489	31	36,016	0.67
GLOUCESTER COUNTY					
Gloucester County	228,017	\$ 2,943,068	\$13	\$120,856	\$0.53
SALEM COUNTY					
Salem County	65,027	\$ 931,110	\$14	\$ 37,188	\$0.57
TOTAL LAB V	1,409,908	\$19,017,112	\$13	\$706,954	\$0.50
LAB VI					
ATLANTIC COUNTY					
Atlantic City	221,952	\$ 7,483,519	\$34	\$ 80,942	\$0.36
Atlantic County	37,986	3,732,316	98	5,730	0.15
	183,966	3,751,203	20	75,212	0.41
CAPE MAY COUNTY					
Cape May County	93,491	\$ 742,205	\$ 8	\$ 25,114	\$0.27
MONMOUTH COUNTY					
Colts Neck	548,154	\$ 4,215,037	\$ 8	\$ 187,530	\$0.34
Freehold	8,340	46,268	6	0	0.00
Hazlet	43,183	267,586	6	12,586	0.29
Long Branch	39,014	232,503	6	17,676	0.45
Manalapan Twp.	28,653	362,086	13	13,746	0.48
Matawan Boro	26,716	210,432	8	9,786	0.37
Middletown	45,613	370,115	8	17,314	0.38
Monmouth County	67,126	309,629	5	21,410	0.32
Monmouth Co. Reg.	201,791	1,862,481	9	71,728	0.36
Red Bank	59,390	361,231	6	16,222	0.27
	28,328	192,706	7	7,062	0.25
OCEAN COUNTY					
Ocean County	431,884	\$ 7,752,869	\$18	\$ 144,630	\$0.33
Long Beach Twp.	423,271	7,501,603	18	144,630	0.34
	8,613	251,266	29	0	0.00
TOTAL LAB VI	1,295,481	\$20,193,630	\$16	\$ 438,216	\$0.34
TOTALS	7,693,353	\$96,932,501	\$13	\$2,919,811	\$0.38

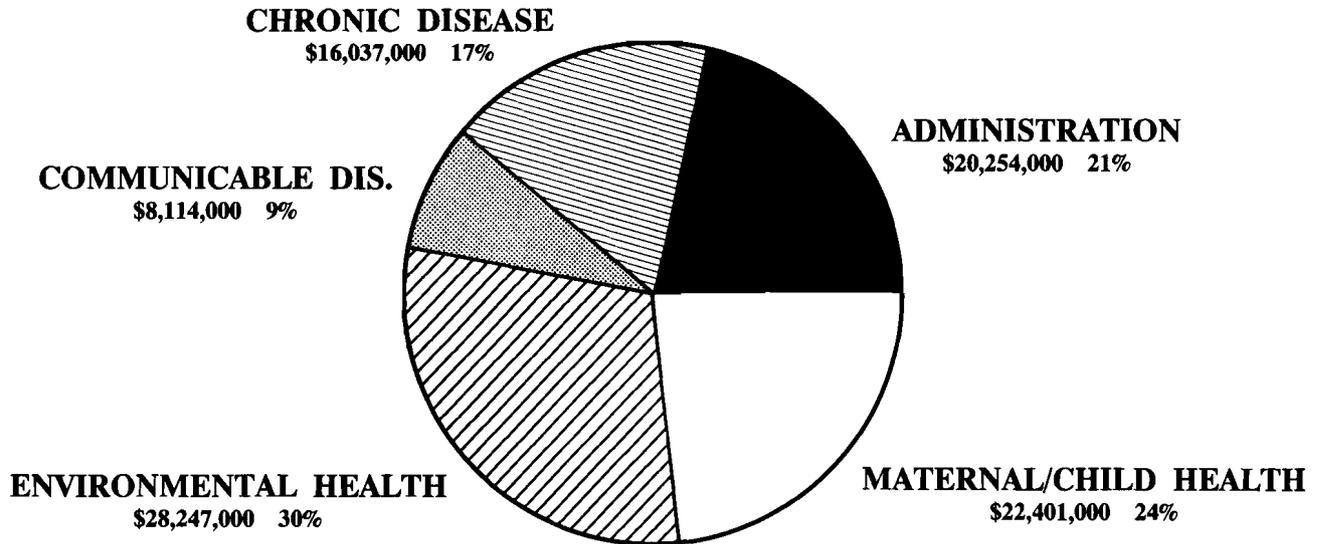
*Jersey City CY 1990 budget is an estimate

FIGURE 1: LOCAL HEALTH DEPARTMENT JURISDICTIONAL TREND



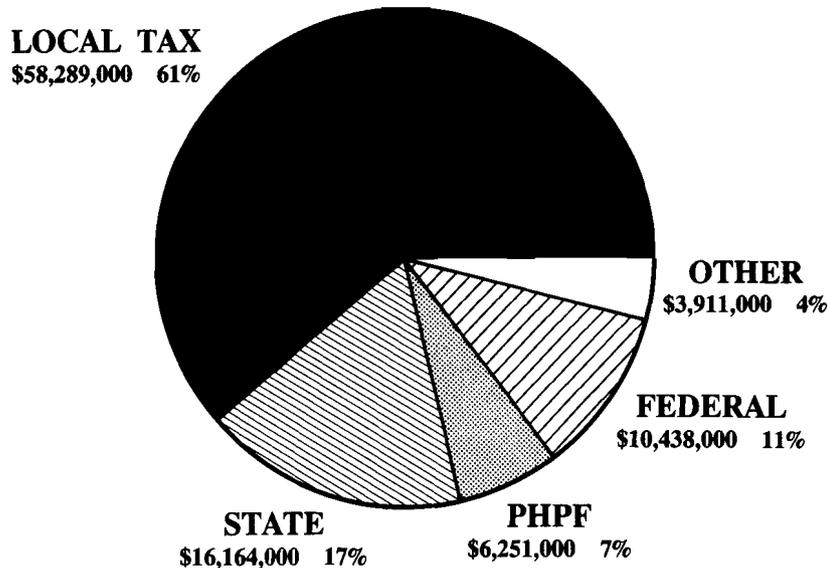
SOURCE: NEW JERSEY DEPARTMENT OF HEALTH

**FIGURE 2: LOCAL HEALTH EXPENDITURES
BY FUNCTIONAL AREA CY 1988**



SOURCE: NEW JERSEY DEPARTMENT OF HEALTH

**FIGURE 3: LOCAL HEALTH EXPENDITURES
BY SOURCE CY 1988**



SOURCE: NEW JERSEY DEPARTMENT OF HEALTH

Appendix A

ESTIMATED NUMBER OF UNINSURED PERSONS BY COUNTY AND LAB—1989

Lab/County	1989 Estimated # Uninsured	Estimated Population	Percent Uninsured
LAB I	115969	1097752	10.6
Morris	41778	421915	9.9
Passaic	56032	454460	12.3
Sussex	11675	130167	9
Warren	6484	91210	7.1
LAB II	156538	1386512	11.3
Bergen	61886	830154	7.5
Hudson	94652	556358	17
LAB III	162591	1282740	12.7
Essex	119350	786063	15.2
Union	43241	496677	8.7
LAB IV	120621	1337100	9
Hunterdon	10088	106424	9.5
Mercer	22823	324937	7
Middlesex	61354	668358	9.2
Somerset	26356	237381	11.1
LAB V	117453	1326822	8.9
Burlington	27012	393507	6.9
Camden	51070	501914	10.2
Cumberland	13112	137909	9.5
Gloucester	20785	228117	9.1
Salem	5474	65375	8.4
LAB VI	114415	1295194	8.8
Atlantic	25911	222311	11.7
Cape May	9673	94416	10.2
Monmouth	49170	550900	8.9
Ocean	29661	427567	6.9
TOTAL	787587	7726120	10.2

as of February 19, 1992

Appendix B

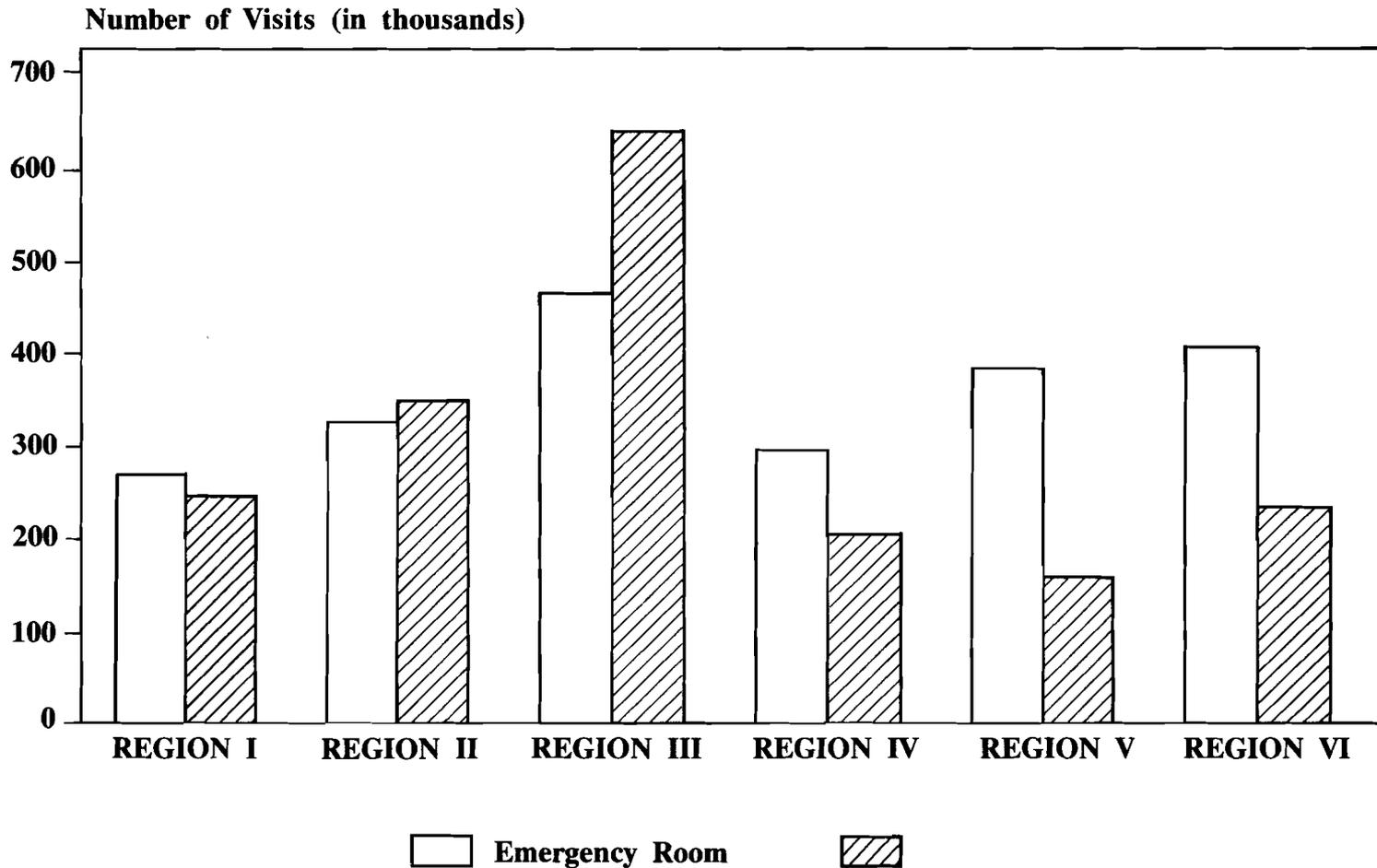
NEW JERSEY HOSPITAL OUTPATIENT DEPARTMENTS VOLUME BY SELECTED AREAS—1989*

	ER	Clinic	Total OPD Visits Net of Admissions
REGION I			
Sussex County	25042	50818	156964
Morris County	102480	27249	445836
Bergen County	29673	21540	97519
Passaic County	113077	146723	604648
TOTAL REGION I	<u>270272</u>	<u>246330</u>	<u>1304967</u>
REGION II			
Bergen County	134465	181861	1094927
Hudson County	189792	163386	878896
TOTAL REGION II	<u>324257</u>	<u>345247</u>	<u>1973823</u>
REGION III			
Essex County	293074	434792	1388653
Union County	164835	193952	860013
TOTAL REGION III	<u>457909</u>	<u>628744</u>	<u>2248666</u>
REGION IV			
Hunterdon County	13529	0	149558
Somerset County	20175	14714	86232
Middlesex County	128827	128033	552839
Mercer County	126550	57193	644526
TOTAL REGION IV	<u>289081</u>	<u>199940</u>	<u>1433155</u>
REGION V			
Burlington County	59108	44484	227821
Camden County	186081	88438	772703
Salem County	21281	2190	73406
Cumberland County	56437	9913	249479
Gloucester County	48697	8534	102549
TOTAL REGION V	<u>371604</u>	<u>153559</u>	<u>1425958</u>
REGION VI			
Monmouth County	141940	171402	703155
Ocean County	134249	25389	592604
Atlantic County	94608	21942	262203
Cape May	21363	6582	63280
TOTAL REGION VI	<u>392160</u>	<u>225315</u>	<u>1621242</u>
OVERALL TOTAL	<u>2105283</u>	<u>1799135</u>	<u>10007811</u>

*These figures represent 1989 unaudited hospital reports.

APPENDIX C

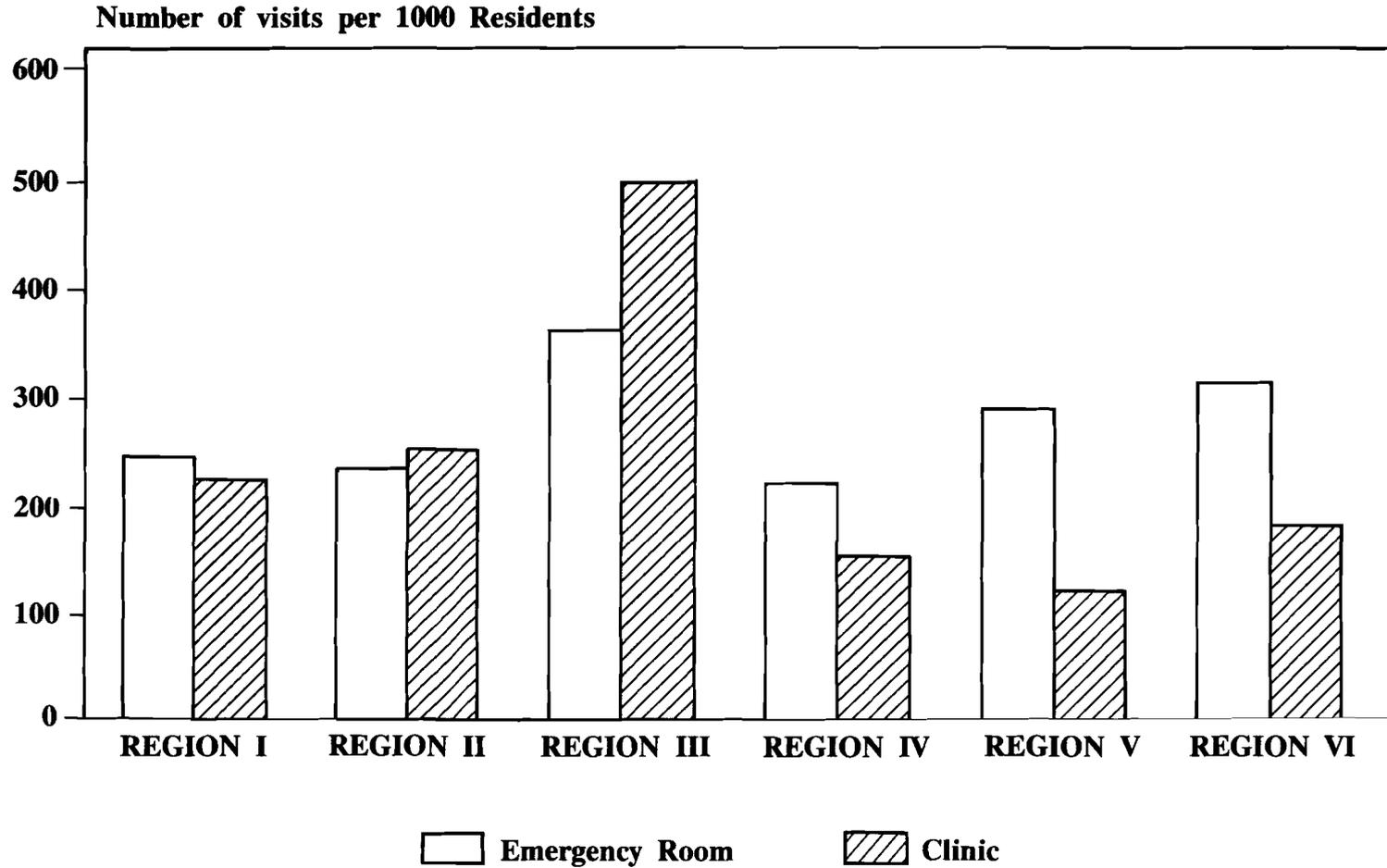
NUMBER OF HOSPITAL OUTPATIENT VISITS NEW JERSEY, 1989



SOURCE: DATA AS REPORTED BY N.J. HOSPITALS 1989 CHAPTER 83 ACTUALS

APPENDIX D

HOSPITAL OUTPATIENT VISITS PER 1000 RESIDENTS NEW JERSEY, 1989



SOURCE: DATA AS REPORTED BY N.J. HOSPITALS 1989 CHAPTER 83 ACTUALS

Appendix E

**NEW JERSEY HOSPITAL OUTPATIENT DEPARTMENTS
PRIMARY CARE CLINIC VISITS—1989*
NET OF ADMISSIONS**

	<u>Med</u>	<u>Obst</u>	<u>Gyn</u>	<u>Peds</u>	<u>Dent</u>	<u>Total Primary Care</u>
REGION I						
Sussex County	11883	1167	0	0	0	13050
Morris County	3723	4175	1525	1768	5902	16256
Warren County	17666	0	0	0	32	17698
Passaic County	55923	23547	1520	25256	14746	121829
TOTAL REGION I	<u>89195</u>	<u>28889</u>	<u>3045</u>	<u>27024</u>	<u>20680</u>	<u>168833</u>
REGION II						
Bergen County	23524	8992	3585	8450	12001	56552
Hudson County	27336	17197	3950	10334	5655	64472
TOTAL REGION II	<u>50860</u>	<u>26189</u>	<u>7535</u>	<u>18784</u>	<u>17656</u>	<u>121024</u>
REGION III						
Essex County	165349	27036	12150	85260	30015	319810
Union County	28326	15452	4004	8371	13196	69349
TOTAL REGION III	<u>193675</u>	<u>42488</u>	<u>16154</u>	<u>93631</u>	<u>43211</u>	<u>389159</u>
REGION IV						
Hunterdon County	0	0	0	0	0	0
Somerset County	14714	0	0	0	0	14714
Middlesex County	16171	11145	3040	10810	10618	51784
Mercer County	35720	2622	417	3864	208	42831
TOTAL REGION IV	<u>66605</u>	<u>13767</u>	<u>3457</u>	<u>14674</u>	<u>10826</u>	<u>109329</u>
REGION V						
Burlington County	22024	3986	0	0	0	26010
Camden County	20150	27019	8567	16331	5307	77374
Salem County	1917	273	0	0	0	2190
Cumberland County	0	5341	0	2488	0	7829
Gloucester County	6715	1819	0	0	0	8534
TOTAL REGION V	<u>50806</u>	<u>38438</u>	<u>8567</u>	<u>18819</u>	<u>5307</u>	<u>121937</u>
REGION VI						
Monmouth County	23664	12254	3344	11329	10633	61224
Ocean County	2592	9679	1133	1875	346	15625
Atlantic County	8057	3570	0	0	0	11627
Cape May County	120	4611	0	0	0	4731
TOTAL REGION VI	<u>34433</u>	<u>30114</u>	<u>4477</u>	<u>13204</u>	<u>10979</u>	<u>93707</u>
OVERALL TOTAL	<u>485574</u>	<u>179885</u>	<u>43235</u>	<u>186136</u>	<u>108659</u>	<u>1003489</u>

*These figures represent 1989 unaudited hospital reports.

Appendix F

Ambulatory-Sensitive Conditions

- Adult Otitis Media and URI
 - DRG 68 Otitis Media and URI, Age ≥ 70
 - DRG 69 Otitis Media and URI, Age 18-69
- Pediatric Otitis Media and URI
 - DRG 70 Otitis Media and URI, Age 0-17
- Respiratory Infections and Inflammations
 - DRG 79 Respiratory Infections and Inflammations, Age ≥ 70
 - DRG 80 Respiratory Infections and Inflammations, Age 18-69
 - DRG 81 Respiratory Infections and Inflammations, Age 0-17
- Chronic Obstructive Pulmonary Disease
 - DRG 88 Chronic Obstructive Pulmonary Disease
- Adult Pneumonia
 - DRG 89 Simple Pneumonia and Pleurisy, Age ≥ 70
 - DRG 90 Simple Pneumonia and Pleurisy, Age 18-69
- Pediatric Pneumonia
 - DRG 91 Simple Pneumonia and Asthma, Age 0-17
- Adult Bronchitis and Asthma
 - DRG 96 Bronchitis and Asthma, Age ≥ 70
 - DRG 96 Bronchitis and Asthma, Age 18-69
- Pediatric Bronchitis and Asthma
 - DRG 96 Bronchitis and Asthma, Age 0-17
- Congestive Heart Failure and Shock
 - DRG 127 Heart Failure and Shock
 - DRG 129 Cardiac Arrest
- Hypertension
 - DRG 134 Hypertension
- Angina Pectoris
 - DRG 140 Angina Pectoris
- Chest Pain
 - DRG 143 Chest Pain
- Cellulitis
 - DRG 277 Cellulitis, Age ≥ 70
 - DRG 278 Cellulitis, Age 18-69
 - DRG 279 Cellulitis, Age 0-17
- Diabetes
 - DRG 294 Diabetes, Age ≥ 36
 - DRG 295 Diabetes, Age 0-35

Appendix G

**NEW JERSEY PRIMARY CARE PHYSICIAN AND DENTIST
LOAN REDEMPTION PROGRAM
New Jersey Medically Underserved Index
1992**

The New Jersey Medically Underserved Index (NJMUI) ranks New Jersey's counties and municipalities with populations of 30,000 or more according to seven indicators that address a variety of factors which are potentially indicative of a lack of access to comprehensive and timely health care services.

The NJMUI was developed to comply with specific requirements of Chapter 187, the Health Care Cost Reduction Act (HCCRA) which established the New Jersey Primary Care Physician and Dentist Loan Redemption Program. The legislation stipulated that the New Jersey Department of Health "... designate and establish a ranking of medically underserved areas of the state ..." for the purpose of placing primary care physicians and dentists participating in the loan redemption program in appropriate medically underserved areas of the state.

A wide variety of indicators were evaluated and the seven factors listed below were identified as being appropriate for inclusion in the Index. While the indicators selected are factors which could be related to or indicate a lack of access to appropriate health care, it should be noted

that the indicators may change from year to year, as more appropriate or useful indicators are identified and tested for use in the Index.

The indicators* used in the 1992 NJMUI include:

- Per Capita Income
- Infant Mortality Rate per 100,000 Population
- Percent of Teen Births under Age 20
- Adequacy of 1st Trimester Prenatal Care
- Hospital Discharges for Preventable Diabetes Conditions per 100,000 Population
- Incidence of AIDS per 100,000 Population
- Years of Potential Life Lost per 100,000 Population

To rank the list of medically underserved areas, the following approach was used:

- Only municipalities with a 1990 population of 30,000 or more were included, with the exception of Orange City and Long Branch whose populations fell just below 30,000.
- Percentages, rates or per capita amounts were computed for each indicator. A scale for each indicator was then developed based on 5 ranking levels, with a rank of 5 having the most weight and 0 having the least.
- The weights of each indicator were added to arrive at a numeric ranking of underserved areas for each municipality and county.
- The weights for each respective municipality or county were then arranged from highest to lowest to show the relative ranking of the municipalities of 30,000 or more and counties with respect to each other.
- Any municipality or county with an aggregate weight above 12 is considered eligible for placement on the NJMUI in 1992.

Appendix G

**New Jersey Medically Underserved Placement List
Eligible Geographic Areas—1992**

The following geographic areas have been designated as eligible for the placement of physicians and dentists participating in the New Jersey Primary Care Physician and Dentist Loan Redemption Program. The areas on the list were identified using the New Jersey Medically Underserved Index (NJMUI). The NJMUI ranks geographic areas with populations of 30,000 or more according to seven indicators which are potentially indicative of a lack of access to appropriate health care. Higher ranked areas indicate greater need and will be given a higher priority in placing physicians and dentists.

Municipalities or service areas with populations below 30,000 will be considered for inclusion on the list if the area meets or exceeds the minimum threshold of 12 used by the NJMUI. These areas will be considered on a case-by-case basis since the NJMUI was only calculated for municipalities with populations of 30,000 or more.

Service Areas	
Atlantic City	35
Camden City	35
Paterson	34
Newark	33
Trenton	33
East Orange	32
Jersey City	31
Plainfield	30
Irvington	28
Orange City	27
New Brunswick	26
Passaic	26
Elizabeth	25
Perth Amboy	20
Long Branch	20
Vineland	19
Willingboro	18
Bayonne	18
Union City	18
Lakewood	16
Hoboken	15
Salem County	14
Kearny	13
West New York	13
Pemberton	13
Linden	12

PROPOSALS

Interested Persons see Inside Front Cover

HEALTH

Federally designated Health Professional Shortage Areas (HPSAs) are automatically considered eligible placement areas for participants in the program.

*Data Sources for the indicators are: resident population data from the Bureau of the Census or from the New Jersey State Data Center in the New Jersey Department of Labor; birth, pregnancy and death statistics collected by the Center for Health Statistics in the New Jersey Department of Health; per capita income figures from *The New Jersey Municipal Data Book*, 1989, 1988 and 1985 editions; statistics on AIDS from the New Jersey Department of Health, Division of AIDS Prevention and Control; and information on preventable** hospital diabetes discharges from Medix UB-82/MIDS tapes.

**Preventable hospital diabetes discharges are defined as the following ICD-9 codes: 250.1, 250.3, 250.4, 250.5, 250.7, and 84.1.

Appendix G

(March 1992)

NEW JERSEY MEDICALLY UNDERSERVED INDEX

Factors and Weights Used in the Determination of NJMUIs of Greatest Need

ECONOMIC

FACTOR 1: Per Capita Money Income

<8,500	5
< 8,500- 9,350	4
9,351-10,225	3
10,225-11,100	2
11,101-11,975	1
>11,976	0

PEDIATRIC

FACTOR 2: Infant Mortality Rate Per 1000 Population

>14	5
>12.8-14	4
>11.6-12.7	3
>10.4-11.5	2
≥ 9.2-10.3	1
< 9.2	0

ADOLESCENT

FACTOR 3: Percent of Teen Birth—19 and Under

>17.1%	5
15.1%-17%	4
13.1%-15%	3
11.1%-13%	2
9% -11%	1
<9%	0

PRENATAL

FACTOR 4: Adequacy of 1st Trimester Prenatal Care

<56%	5
56%-60%	4
61%-65%	3
66%-70%	2
71%-75%	1
>75%	0

ADULT

FACTOR 5: Hospital Discharges for Preventable Diabetes Conditions Per 100,000 Population

>500	5
450-499	4
400-449	3
350-399	2
300-349	1
<300	0

SPECIAL POPULATIONS

FACTOR 6: Incidence of AIDS Per 100,000 Population

>70	5
57 -70	4
44.1-57	3
31.1-44	2
18 -31	1
<18	0

FACTOR 7: Years of Potential Life Lost Per 100,000 Population

>9000	5
8000-8999	4
7000-7999	3
6000-6999	2
5000-5999	1
<5000	0

Appendix H

**SELECTED HEALTH STATUS INDICATORS
GEOGRAPHIC AREAS WITH HIGH RANKINGS
NEW JERSEY MEDICALLY UNDERSERVED INDEX
BY LAB, COUNTY & MUNICIPALITY**

Lab/County/ Municipality	Per Capita Money Income	Infant Mortality	Teen Births	Prenatal Care	Preventable Diabetes Discharges	AIDS Incidence	Years of Potential Life Lost	Total Weight
LAB I								
PATERSON	6,952	12.9	21	53	502.4	210.1	10192.4	34
PASSAIC CITY	9,370	12.1	16	47	444.2	158.5	7931.9	26
PASSAIC CO.	10,432	9.5	12	66	367.9	32.6	6328.3	13
LAB II								
BAYONNE	10,887	10.4	7	77	514.4	74.9	7018.2	18
HOBOKEN	9,118	6.3	11	62	160.6	194.6	6463.3	15
JERSEY CITY	8,181	13.7	16	60	463.7	267.8	10269.1	31
KEARNY	10,517	12.0	6	81	376.7	71.7	5776.5	13
UNION CITY	7,650	12.0	10	61	238.1	127.5	5461.4	18
W. NEW YORK	8,417	7.9	7	65	170.6	115.4	4982.2	13
HUDSON CO.	9,267	9.7	11	77	349.2	56.4	7554	14
LAB III								
EAST ORANGE	8,446	18.7	18	66	737.6	439.1	14044.3	32
ELIZABETH	8,963	13.8	13	56	459.1	158.2	6094.2	25
IRVINGTON	9,565	13.5	16	68	519.8	239.3	10431.2	28
LINDEN	11,439	7.9	8	68	477.9	68.1	5630.4	12
NEWARK	6,214	19.8	23	65	712.3	494.5	15533.1	33
ORANGE	9,748	16.4	14	67	669.2	287.4	8386.8	27
PLAINFIELD	10,214	16.9	17	61	624.9	171.8	9385.1	30
ESSEX COUNTY	11,022	14.2	14	74	480.3	84	9987.7	25
LAB IV								
NEW BRUNSWICK	8,155	21.5	20	58	638.9	213.4	6571.5	26
PERTH AMBOY	8,556	9.9	14	57	336.8	166.8	6225	20
TRENTON	8,034	17.7	25	61	1193.4	103.7	10194	33
LAB V								
CAMDEN CITY	5,403	22.5	29	49	832.1	93.7	11825.7	35
PEMBERTON	8,588	2.2	15	70	397.1	19.1	504.1	13
VINELAND	8,859	14.6	18	61	298.2	36.5	4993.5	19
WILLINGBORO	10,617	9.6	14	69	417.8	79.9	6816.9	18
CUMBERLAND CO.	8,494	12.6	20	57	381.2	7.7	6095.7	21
SALEM COUNTY	9,520	7.9	16	51	201.1	25.3	5436.4	14
LAB VI								
ATLANTIC CITY	8,398	15.3	24	48	1173	150	15793.8	35
LAKEWOOD	9,843	11.7	8	64	349.8	77.7	4260.5	16
LONG BRANCH	10,347	7.1	14	65	457.8	115.1	7945.4	20
ATLANTIC CO.	10,794	10.6	13	63	411.3	38.3	6673.9	14
NEW JERSEY	11,762	9.3	8.5	76	373.8	25.3	6021.8	7

NOTES:

PER CAPITA MONEY INCOME: Figures for 'Per Capita Income' were obtained from *The New Jersey Municipal Data Book*, 1989, 1988, and 1985 editions for the years 1987, 1985 and 1980 respectively.

INFANT MORTALITY: Infant Mortality is the number of deaths under 1 year of age per 1,000 live births. Municipal data is based on 1988; county data is based on 1987-1989.

TEEN BIRTHS: Teen Births is the number of births to females under the age of 20 as a percent of total live births. Municipal data is based on 1986-1988; county data is based on 1988-1990.

PRENATAL CARE: Prenatal Care is the number of women first receiving prenatal care in the 1st trimester as a percent of total live births. Municipal data is based on 1988; county data is based on 1987-1989.

PREVENTABLE DIABETES DISCHARGES: Preventable diabetes hospital discharges are defined by the following ICD-9 codes: 250.1, 250.3, 250.4, 250.5, 250.7, and 84.1. The data is obtained from Medix UB-82/MIDS tapes for years 1986-1988.

AIDS INCIDENCE: Incidence of AIDS in 1988-1990 per 100,000 population for both municipal and county data.

YEARS OF POTENTIAL LIFE LOST: Years of Potential Life Lost to age 65 is the summation of all years not lived by residents who died before reaching the age of 65 and was computed for all deaths occurring in 1988.

WEIGHTED SCORE: Sum of the scores assigned to each of the 7 indicators from a range of 0 to 5 with 5 indicating the greatest need. Total scores ranged from 0-35 with 35 indicating most disadvantaged health status.

March 19, 1992

PROPOSALS

Interested Persons see Inside Front Cover

HEALTH

Appendix I

**PERCENT OF MINORITY POPULATION BY COUNTY
NEW JERSEY, 1990**

Area Name	Percent Minority Population
Atlantic County	26.3*
Bergen County	17.3
Burlington County	19.5
Camden County	25.2*
Cape May County	8.3
Cumberland County	31.1*
Essex County	54.9*
Gloucester County	11.8
Hudson County	52.6*
Hunterdon County	5.0
Mercer County	27.5*
Middlesex County	23.0
Monmouth County	15.2
Morris County	11.6
Ocean County	6.9
Passaic County	37.3*
Salem County	17.5
Somerset County	14.8
Sussex County	4.2*
Union County	34.7*
Warren County	4.3
New Jersey	26.0

Source: U.S. Bureau of the Census, 1990

*Federally designated Health Professional Shortage Area (HPSA)

Appendix I

**PERCENT OF MINORITY POPULATION BY SELECTED AREAS
New Jersey, 1990**

Area	Percent Minority Population
Atlantic County	
Atlantic City	69.2*
Egg Harbor City	32.3
Pleasantville	66.1
Bergen County	
Englewood	58.9
Englewood Cliffs	28.5
Hackensack	42.6
Teaneck	37.4
Burlington County	
Burlington	27.1
Chesterfield	38.5
New Hanover	42.9
Pemberton	34.7
Willingboro	62.6
Wrightstown	52.1
Camden County	
Camden City	85.6*
Lawnside	98.5
Winslow	27.1
Cape May County	
Wildwood City	26.5
Woodbine	46.2
Cumberland County	
Bridgeton	47.8*
Fairfield	60.6
Maurice River	37.2
Vineland	35.1*

Essex County	
City of Orange	81.5
East Orange	93.8
Irvington	81.4
Montclair	36.4
Newark	83.5*
Gloucester County	
Paulsboro	30.7
Swedesboro	26.4
Hudson County	
East Newark	39.1
Guttenberg	50.8
Harrison	35.9
Hoboken	38.2
Jersey City	63.4*
North Bergen	47.3
Union	79.1
Weehawken	46.3
West New York	76.7
Mercer County	
Trenton	62.5*
Middlesex County	
New Brunswick	50.8
Perth Amboy	64.9
Piscataway	37.1
Monmouth County	
Asbury Park	67.5
Freehold	31.6
Long Branch	33.8
Neptune	38.8
Red Bank	33.4
Morris County	
Dover	47.8
Morristown	38.9
Victory Gardens	64.7
Ocean County	
South Toms River	26.6
Passaic County	
Passaic	71.9
Paterson	75.5
Salem County	
Mannington	27.2
Penns Grove	43.6
Salem	54.1
Somerset County	
Franklin	32.6
Union County	
Elizabeth	60.3
Hillside	57.4
Plainfield	80.4*
Roselle	51.3
New Jersey	26.0

Source: U.S. Bureau of the Census, 1990

*Federally designated Health Professional Shortage Area

Appendix J

Selected Model Health Care System Reform Programs in Other States

Hawaii. Hawaii was the first state to try to extend health care coverage to all residents, and its rate of uninsurance is the lowest in the nation. Approximately 88 percent of Hawaiians under age 65 are insured through employer-related insurance that requires employers to provide health insurance for all full-time workers. Antedating ERISA provisions, the enabling legislation was passed in 1974, thus exempting the state from the ERISA preemption provisions.

HEALTH**PROPOSALS**

In addition, Medicaid covers another group of Hawaiians, comprising about 7 percent of the population. This Medicaid-eligible group receives a broad range of benefits that ranks Hawaii third among the states for the greatest number of Medicaid service options.

Those Hawaiians not covered by employer insurance, and not Medicaid-eligible, constitute the remaining 5 percent of the population. Those not covered by employer insurance include workers who work part-time (less than 20 hours per week), government employees, and low-wage earners. Most residents not covered by employers or Medicaid are eligible for state-subsidized insurance, providing less extensive coverage than that offered through employment or Medicaid.

Minnesota. In Minnesota, legislation was passed in April, 1992 to provide state-subsidized insurance coverage for persons below 275 percent of poverty level. Persons enrolled in the program pay a premium that ranges from 1.5 percent of income for less well off persons to 10 percent. Not all of the 400,000 Minnesotans who have no health insurance are expected to enroll due to the premium; the program is expected to cost the state about \$250 million a year. Support for the program is from a 5-cent-a-pack increase in the state's cigarette tax, by a two percent tax on the gross revenue of health care providers including hospitals, doctors and dentists, and by a one percent tax on health maintenance organizations and other health service corporations.

Rochester, NY. Many health care experts believe that Rochester has one of the few health care systems that works. Per capita costs are lower than for the nation, fewer people are uninsured, and costs were lower than Medicare costs.

Several initiatives are responsible for this success. State planning laws require approval for big projects, and business executives on hospital boards have limited expenditures for capital and technology; no additional hospital beds have been authorized since the 1960s, for example. Community rating is utilized throughout the region, so that small groups of employees have the same premiums and benefits enjoyed by those working for the largest employers in the area. More than half of the people in the area belong to one of two local HMOs, which offer comprehensive coverage, including regular checkups, and efforts to avoid expensive hospitalization. United support for these initiatives, by business and the health care industry, has produced this success story.

In addition to the Rochester region, several states have begun using some version of community rating. They include Maine, Vermont, Oregon, and New York.

Florida. Florida Health Access, a nonprofit corporation created and heavily subsidized by the state Legislature, is a program to offer health insurance coverage to small businesses. Companies with 19 or fewer employees that have been uninsured for six months are eligible for the program. Established three years ago, Florida Health Access has 2,921 businesses with 12,700 individuals covered. The state subsidy of \$5.5 million is used to pay for administrative costs and to reduce individual premiums. The program contracts with HMOs to provide medical and dental coverage (Carlson, 1992).

Appendix K**Report on Improving Medicaid Provider Participation and Program Administration, Department of Human Services, 1992****Report on Improving Medicaid Provider Participation and Program Administration, Pursuant to the Health Care Cost Reduction Act, Public Law 1991, Chapter 187, Section 44.****Message to the Governor and the Legislature
August, 1992**

On July 1, 1991, Governor Jim Florio signed into law the Health Care Cost Reduction Act, P.L. 1991, c.187. This landmark legislation provided a mandate and blueprint for the reform of the health care delivery system in the State.

Section 44 of the Act requires the preparation and submittal of a report specifically addressing ways to increase the number of providers in the Medicaid program, improve provider relations with the Medicaid program, reduce administrative burdens encountered by Medicaid providers, and streamline statewide administration of the Medicaid program.

With this report we attempt to identify significant actions already taken or underway. Medicaid, however, is a constantly evolving program. We

must, therefore, continue our efforts to reform and improve administrative policies and procedures in order to adapt to new circumstances and new opportunities. We are committed to continuing our efforts to remove disincentives for providers to participate in New Jersey's Medicaid program.

In keeping with this legislative mandate, I am pleased to submit this report on behalf of the Department of Human Services.

Sincerely,

(signed)
Alan J. Gibbs
Commissioner

OVERVIEW

On July 1, 1991, Governor Florio signed the Health Care Cost Reduction Act into law (P.L. 1991, c.187). This legislation impacted many areas of the health care delivery system in the State, including hospitals, physicians, government, and its residents.

LEGISLATIVE REQUIREMENTS

Section 44 of the law requires the Department of Human Services to report to the Governor and the Legislature on ways to increase the number of Medicaid providers, improve provider relations, reduce provider administrative burdens, and streamline the administration of the Medicaid program.

The following discussion focuses on the approaches the Department is taking to address these issues and activities underway to make improvements.

DISCUSSION

The Inspector General of the United States Department of Health and Human Services recently issued a report entitled "Medicaid Hassle: State Responses to Physician Complaints." In this report the Inspector General noted that administrative red tape, "the hassle factor," discourages many doctors from treating Medicaid-eligible patients. The perceived "hassle" compounds other disincentives for participating in Medicaid, most notably low provider fees. The purpose of the report was to review State efforts and identify noteworthy "best practices" that might be adopted by other Medicaid programs to improve claims processing and expedite provider payments, and simplify programs, policies and procedures (e.g., through clearer, simpler provider manuals).

As detailed in this report, New Jersey has already implemented a number of the initiatives identified by the Inspector General in an effort to reduce administrative burdens on its provider community. Many have only recently been made possible as a result of the implementation of our new Medicaid Management Information System (MMIS). For example, our new MMIS is dramatically reducing the amount of paper associated with claims submission and claims correction.

Our new fiscal agent is encouraging all provider types to utilize electronic media claims (EMC) to submit claims. Moreover, we offer providers flexibility in the medium utilized for transmitting their claims (modem, tape or diskettes). EMC is paperless, allows claims to be automatically prescreened by the provider before they are transmitted, by-passes labor intensive manual data entry at the fiscal agent, and dramatically accelerates payment turnaround.

The transition of fiscal agents has also prompted the Department to undertake a range of related activities, also highlighted by the Inspector General. These include general and individualized provider training sessions, updated and simplified manuals, and automated teleservice systems for accessing information on client eligibility and weekly payment runs. In addition, the state-of-the-art post-payment review capabilities of the new system have allowed the Medicaid program to reduce the number of services and procedures that require prior authorization.

Detailed descriptions of these and other provider related activities are outlined below:

I. WAYS TO INCREASE THE NUMBER OF MEDICAID PROVIDERS**A. IMPLEMENTATION OF INTERVENTION PROGRAMS**

A wide range of intervention strategies are underway to increase provider participation.

1. THE MEDICAL SOCIETY OF NEW JERSEY (MSNJ)

The Division of Medical Assistance and Health Services is working with the Medical Society of New Jersey to increase physician participation in the Medicaid program. The Chairman of the Medical Society's Committee on Medicaid has agreed to issue a letter of encouragement to all members of the Medical Society which will urge members to accept Medicaid patients, even if limited in number.

The Division has discussed with the Medical Society the possibility of its promoting participation in the Medicaid program with physicians seeking practice opportunities in New Jersey. Physicians who are interested in being Medicaid providers would be given information about established physicians who are Medicaid providers seeking associates. This initiative is in the early stages.

The Division will staff a booth at the annual meeting of the MSNJ to promote the New Jersey Medicaid program. Current Medicaid providers may also be utilized to help promote the program. A Medicaid promotion packet will be developed for this recruitment purpose.

2. STATE BOARD OF MEDICAL EXAMINERS

The State Board of Medical Examiners' mailing lists of newly licensed physicians will be utilized for outreach to providers. Alan J. Gibbs, Commissioner of Human Services, will issue personal letters encouraging physicians to participate in the Medicaid program. Communication channels will be established for those physicians interested in talking to a program representative. A listing of all licensed physicians may be utilized for additional recruitment efforts.

3. MEDICAL SCHOOLS

Key staff of the Office of the Medical Director will visit the deans of the medical schools in the state (University of Medicine and Dentistry of New Jersey (UMDNJ) in Newark, Camden, and New Brunswick) and urge them to consider setting up clinical rotations in practices that accept Medicaid clients. Such rotations will help to eradicate the myths about problems associated with serving Medicaid patients. Staff will also outreach senior graduating classes to promote interest in the Medicaid program.

4. DENTAL SCHOOLS

Medicaid's Bureau of Dental Services has been working closely with deans at UMDNJ's dental schools regarding the treatment of Medicaid clients by dental students and through their Faculty Practices. In addition, in consultation with Medicaid, two special care clinics have been established (in Newark and in Camden) to assist in the dental treatment of those patients with infectious diseases such as AIDS and Hepatitis.

In consultation with Medicaid, satellite dental clinics have been established by UMDNJ in some areas of the state where there are few private dental providers available. Clinics have been in operation for some time in Camden and Stratford. Recently, the Northfield Clinic opened, located just south of Atlantic City, and plans are being considered for clinics in Woodbine and Cape May Court House, both located in Cape May County.

5. FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)

Efforts will be made to ensure that federally qualified health centers are up to full staffing levels. Recruitment activities may be coordinated with numbers 1, 2, 3, and 4 above.

Part-time physicians will be solicited regarding their interest in becoming Medicaid providers in their private practices, in addition to their employment at the FQHCs.

6. MID-LEVEL PRACTITIONERS

The Division is working toward recognizing nurse practitioners (family planning practitioners and pediatric nurse practitioners) and physician assistants as Medicaid providers. When fully implemented, the addition of these mid-level practitioners should help to alleviate some aspects of Medicaid's manpower shortage in underserved parts of the state, and improve access to care.

B. LEGISLATIVE PROPOSALS/OPTIONS TO CONSIDER

Tax credits, loan forgiveness programs, subsidized mortgages for professional offices and similar cost abatements may be another approach worth reviewing for physicians who serve Medicaid recipients. Certain medically underserved areas of the state could be targeted for such special relief. Offsetting reductions in inappropriate use of hospital outpatient departments and emergency rooms would surely be realized.

Malpractice relief measures are also worth considering, as is implementation of one or more of the following options: tort reform, malpractice subsidies to providers accepting Medicaid patients, settlement caps, and the development of state indemnification plans for providers serving Medicaid recipients to effect malpractice premium reductions are worthy of consideration.

C. MARKETING TO GARDEN STATE HEALTH PLAN PROVIDERS

The Garden State Health Plan (GSHP) is using several marketing approaches to increase the number of physicians enrolled in the Plan. GSHP provider marketing staff visit doctors' offices to present the Plan and discuss GSHP and Medicaid participation. GSHP marketing materials and physician case manager (PCM) contracts are left by marketing staff for the doctor's review, and a follow-up appointment is made to discuss the contract and the benefits of becoming a GSHP provider.

Telemarketing is another means of outreach to physicians for recruitment as potential PCMs. Physicians are sent mailings which include a solicitation letter to participate in the Plan and a marketing brochure. Then a follow-up telephone call to the provider is made by the marketing staff. Additional leads are identified through conversations with current PCMs and through interviews with Medicaid recipients to obtain the names of doctors most frequently visited.

Radio and television Public Service Announcements (PSAs), targeted to potential members, are generating interest from providers as well. PSAs have been a successful tool in recruiting clients.

GSHP marketing staff participate in various health fairs throughout the state and distribute marketing materials to interested providers.

D. CONTRACTING WITH PRIVATE HEALTH MAINTENANCE ORGANIZATIONS

The Medical program currently has a contract with one private Health Maintenance Organization (HMO), HIP of New Jersey, to provide services to Medicaid recipients in three counties (Hudson, Burlington and Gloucester). There are plans underway to expand to additional counties. The Division has also entered into negotiations with other private HMOs and is actively pursuing contracts with them as well.

In addition, as a result of the Health Care Cost Reduction Act, P.L. 1991, c.187, all New Jersey HMOs are required to submit plans to the Medicaid program outlining proposals to significantly increase the number of Medicaid-eligible persons enrolled in a managed care program. There have been preliminary meetings with individual HMOs and the New Jersey HMO Association. Data concerning Medicaid eligibles and expenditures was supplied to the HMOs to assist in plan preparation.

HMOs will provide a major provider resource since these organizations can offer and provide an entirely new, comprehensive statewide provider network for clients.

E. ASSESSMENT AND MONITORING OF PROVIDER PARTICIPATION

The Division has plans to develop baseline data to assess provider participation in its programs. Existing data sources will be assessed for quality in providing the information about the distribution of physician specialties by geographic area. Data bases will be defined.

As a result of assessment and monitoring activities, short-term and long-term objectives will be developed, such as increasing overall physician participation by a designated percent within a specified time frame. Program effectiveness will be monitored on a quarterly basis.

II. WAYS TO IMPROVE PROVIDER RELATIONS**A. OPEN BUDGET PROCESS**

For two years the Department has formally engaged the provider community in extensive discussions regarding the formulation of the Human Services budget. Through this effort, the Department has engaged all Medicaid provider groups in attempting to set funding priorities for its programs.

The Department and the Division of Medical Assistance and Health Services strongly believe that the community involvement in the budget process has improved relationships with our providers. It has provided an opportunity for the Division and providers to discuss the Division's budget and its priorities and to compare them with the issues and concerns of the providers. It has also further opened the lines of communication on other issues.

B. ADVISORY COMMITTEES

In addition to Medical Assistance Advisory Council and Pharmaceutical Assistance to the Aged and Disabled Advisory Council meetings, the Division has regular ongoing meetings with the provider community to discuss certain Medicaid issues as they arise. Some of the committees that meet regularly are the Long-Term Care Advisory Committee, the Home Care Advisory Committee and the Child Health Advisory Committee. These meetings are particularly helpful in addressing emerging issues before they become problems.

C. FISCAL AGENT TRANSITION TRAINING

In preparation for the federally mandated fiscal agent transition, the State and Paramax/Unisys conducted provider training sessions between July 23, 1991 and September 27, 1991. Training was conducted at nine sites located throughout the state. Over the ten-week period, Paramax/Unisys provider service training staff conducted 94 sessions. Approximately 4,730 (out of 20,000) provider representatives participated throughout the ten weeks. Every provider on the current fiscal agent files was contacted.

The Paramax/Unisys training sessions were designed to give providers a general overview of New Jersey's new Medicaid Management Information System (MMIS). The sessions included a brief overview of the Paramax/Unisys Corporation, claims completion, prior authorization form completion, electronic media claims (EMC), the voice information processing system (VIPS), recipient eligibility verification system (REVS), the inquiry response form, claim adjustment form, and how to interpret the redesigned remittance advice (RA) statement.

In an effort to provide continued assistance, Division and Paramax/Unisys staff have outreached provider associations and attended meetings to review New Jersey's new Medicaid Management Information System. Additionally, Medicaid Alerts and Newsletters have been and will continue to be mailed to providers in order to keep them informed of transition activities and related policy clarifications. A Remittance Advice (RA), which explains the status of each claim, is also sent to providers.

D. DIRECT CONTACT WITH CONSULTANTS IN DENTAL PROGRAM

The Division is encouraging all Medicaid dental providers to call and speak directly with its dental consultants when problems arise. The dental consultants will advise them how to handle the problem and will take necessary action to ensure that the problem is resolved.

E. COMPLAINT INVESTIGATION

Provider complaints, including those regarding the Paramax/Unisys transition, are being investigated in a timely manner to promptly address provider concerns and thereby stem provider attrition which may result if there is dissatisfaction with the claims processing or policy related aspects of the program.

F. PROVIDER RELATIONS UNIT

A professional Provider Relations unit composed of present staff will be activated within the Division of Medical Assistance and Health Services. The unit's goal will be to strengthen relations between Medicaid and the provider community.

III. WAYS TO REDUCE PROVIDER ADMINISTRATIVE BURDENS AND STREAMLINE THE ADMINISTRATION OF THE MEDICAID PROGRAM**A. PRIOR AUTHORIZATION**

The Division has taken a number of steps to reduce provider administrative burdens. Particularly noteworthy is a reduction in the number of procedures requiring prior authorization. The implementation of a new Medicaid Management Information System has provided New Jersey with a state-of-the-art Surveillance and Utilization Review System. A reduction in the number of services which previously required prior authorization has therefore been possible due to our enhanced retrospective (post-payment) review capabilities. The threshold for certain prior authorized services has also been raised. The result of this liberalization is expected to be less paperwork for providers, and greater access to services for Medicaid recipients with no program integrity sacrifice resulting in inappropriate program expenditures.

PROGRAM SAFEGUARDS

A regulatory amendment has been proposed authorizing the DMAHS Director to impose selective provider-specific requirements for prior authorization of claims based on provider conduct. Upon adoption, providers found to be abusive of new administrative latitude will have prior authorization requirements reimposed.

The following is a summary of the Division's prior authorization cutbacks:

1. PHARMACY SERVICES

Prior authorization of preventive drugs, vaccines, biologicals and therapeutic drugs was removed.

2. PSYCHIATRY SERVICES

The prior authorization threshold was increased from \$300 to \$900 per service year for psychiatry services in office and settings other than nursing facilities and residential health care facilities.

A prior authorization threshold of \$400 for psychiatric services in a nursing facility and residential health care facility was established. Previously, all psychiatric services required prior authorization in these settings.

3. PROSTHETIC & ORTHOTIC (P&O) SERVICES

Previously, there was no threshold for prosthetic appliances and orthotic services. A prior authorization threshold of \$1,000 for all prosthetic appliances, except preparatory (temporary) upper and lower prostheses, was established.

A prior authorization threshold of \$500 for orthotic services was established.

A prior authorization threshold of \$250 for the replacement of P&O parts, except in an emergency, was established. The definition of what constitutes an emergency was revised.

A prior authorization threshold of \$250 for labor charges for repair of P&O items or appliances not under warranty was established.

4. DENTAL SERVICES

The prior authorization requirement was removed for over 180 dental procedures; the latest changes went into effect June 1, 1992.

5. OPTICAL SERVICES

A prior authorization threshold of \$150 for low vision devices was established. Originally, all low vision devices needed prior authorization.

The prior authorization requirement for two pair of glasses in lieu of bifocals was removed.

The prior authorization requirement for optical appliance repair was increased from \$5.00 to \$15.00.

6. LONG-TERM CARE SERVICES

The prior authorization requirements were removed for physical, speech and occupational therapies rendered by a nursing facility. These costs are now included in the nursing facility's per-diem rate.

7. HEARING AID SERVICES

The prior authorization requirements were removed except for nursing facility residents, replacement aids within three years, and repeated overbillers or dispensers who fail to follow program requirements.

8. MEDICAL DAY CARE SERVICES

The prior authorization requirements were removed *except* for new programs or during a probationary period if a center has been shown to provide substandard services and/or provides inadequate documentation of services.

The prior authorization requirement for Social Adult Day Care Center services was removed.

9. INDEPENDENT CLINIC SERVICES

The prior authorization threshold for mental health serving in Community Mental Health Centers was increased from \$800 to \$6,000 in any 12-month service period.

10. PSYCHOLOGICAL SERVICES

The prior authorization threshold was increased from \$400 to \$900 in any 12-month service period for psychological services provided in other than a nursing facility and residential health care facility.

A prior authorization threshold of \$400 in any 12-month service period for psychological services provided in a nursing facility or residential health care facility was established.

11. CHIROPRACTIC SERVICES

Prior authorization requirements were removed.

B. DRUG UTILIZATION REVIEW AND DAY-SPECIFIC ELIGIBILITY

The Division plans to issue a Request for Proposals to implement a new rapid on-line system to provide day-specific eligibility information to providers.

Currently, Medicaid clients are given a paper card each month, good for the entire month, which the provider uses to verify the client's eligibility. Under this process, if the client is eligible at any point during the month, the client is deemed eligible for the entire month.

Under the proposed system, the client would be issued a plastic Medicaid card. Medicaid eligibility would be entered on the provider accessible eligibility file from any day in a month to any other day in the month, based upon applicable eligibility criteria. The provider, using the plastic card, would verify the client's eligibility by using a Touch-tone telephone or a card reading device similar to those used by credit card companies to provide credit verification. This system will assure providers that the individual receiving services is actually eligible on that date, and enable the Division to limit a client's eligibility to specific days in a month. Under this arrangement, the Medicaid program is able to save money by not paying for those extra days a client is not eligible and providers are assured of reliable eligibility information.

In addition, this system will be expanded to meet the federally mandated Drug Utilization Review (DUR) program. This program enhancement will improve the quality of prescription care for Medicaid clients and will address cost containment relevant to drug therapy. The on-line application of edits unique to therapeutic drug classes will prospectively reduce potential drug abuses and underutilization of prescribed medications, avoid potential drug interactions, and generally support the optimal utilization of drug therapies reimbursed by the Medicaid program. In addition to giving the provider up-to-date eligibility information and drug utilization information, such a system could be expanded to produce on-line adjudication of pharmacy claims. A pharmacist using the system would also have access to a complete history of all drug claims paid for any client, regardless of which pharmacy filled the prescription within a recent time period.

These two enhancements, day-specific eligibility and DUR, are expected to reduce costs and improve services provided to Medicaid and PAAD clients and improve the providers' access to reliable, up-to-date program information.

C. NEW MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

On November 29, 1991, the Division of Medical Assistance and Health Services officially changed its fiscal agents. Blue Cross/Blue Shield (BC/BS) of New Jersey, Prudential, and the Office of Telecommunication and Information Systems (OTIS) were replaced by the Paramax/Unisys Corporation. Until this transition, BC/BS, Prudential, and OTIS were the fiscal agents for New Jersey's Medicaid program since its inception in 1970.

Although the State, BC/BS and Prudential enjoyed a harmonious and effective working relationship over the years, the federal Health Care Financing Administration (HCFA) directed New Jersey to conduct a competitive procurement or risk forfeiture of federal matching funds for administrative expenditures. The state selected Paramax/Unisys as its new fiscal agent as a result of the competitive bidding process. Paramax/Unisys currently operates certified Medicaid Management Information System (MMIS) projects in several other states, and also the National Practitioner Data Bank. The State expects to operate a superior MMIS, utilizing state-of-the-art technology and system design offered by Paramax/Unisys.

The design features of the new MMIS include improvements in claims processing, speed of payment, enhanced communications and other factors to reduce provider administrative burdens and thus streamline the program.

Improvements such as more timely updates of the recipient eligibility records to include new eligibles and all other changes will result in a more expeditious claims payment system. An added feature includes recycling of claims against the recipient file for several weeks to resolve eligibility verification problems prior to the denial of a claim. Also, a newly designed remittance advice (RA) is generated to providers each week along with their payments. The RA reflects the number of claims processed each week, status of all claims, amount paid, claims denied and claims pending.

Paramax/Unisys has introduced a new system with a capacity to process electronic media claims (EMC) for all provider types. EMC, which is available to providers in three media forms (magnetic tape, diskettes, or direct telecommunication transmissions) dramatically speeds up processing and reduces administrative costs.

Additionally, claim payments can now be directly deposited into provider bank accounts through an automated check clearinghouse system. This improves the speed and certainty of Medicaid funds being available to providers.

All efforts are being made to eliminate paperwork that is needed to process a claim, thus encouraging the provider to take advantage of electronic claims submission. EMC is more efficient and reliable for the provider and cost effective for the State.

A utilization review system has been developed to show how the total Medicaid-related care delivery system is meeting program objectives. With this information, program management

will be in a better position to work with the provider population in shaping health care programs to meet the needs of the Medicaid clients.

Labor intensive tasks that were very much a part of the old MMIS design have been addressed through automated applications. A dial-up, voice response, eligibility verification system has been designed to eliminate the need for providers to go through telephone operators to request Medicaid coverage information. Additionally, through the same system, providers can secure status information on specific claims submitted to Paramax/Unisys to determine if a claim has been paid, pending, or denied. This enhancement is of significant benefit to state staff who have reason to investigate the status of claims in an effort to better service Medicaid clients and providers. Recently, Paramax/Unisys added an automated telephone access capacity to advise providers of the payment amount of the latest check runs. This information is responsible for nearly one-third of all weekly telephone inquiries.

This development effort continues to strive towards producing a system that, in addition to meeting the needs of both the State and Medicaid recipients, also provides a level of claims processing, efficiency of payment and communication that promotes good provider relations and encourages provider participation.

D. ELIGIBILITY TASK FORCE

A Task Force has been formed to review eligibility processes, including the existing application forms, to assess options for streamlining intake and disposition. Members include representatives of the Division of Medical Assistance and Health Services, the Division of Family Development, and the County Welfare Agencies. Initial efforts will be focused on assessing the existing application forms, which are used to process requests for assistance for adults and for families with children, including a review of the two model federal forms which were recently developed by the U.S. Department of Health and Human Services through the efforts of a federal interagency task force.

E. OUTSTATIONING OF MEDICAID ELIGIBILITY WORKERS

The outstationing of county welfare agency eligibility workers has commenced, as mandated under Federal and State statute. These workers initiate Medicaid application processing at designated hospitals and federally qualified health centers.

The Commissioner of Health, in consultation with the Commissioner of Human Services, has designated 13 hospital facilities in five counties as primary outstation sites. County welfare agencies must commit at least one full-time equivalent employee to each such facility so that application/intake access is available full-time during county welfare agency operating hours.

An additional 45 hospitals in 16 counties have been designated as secondary outstation sites requiring the county welfare agency to assign staff at the facilities at least 16 hours per week. In addition, the county welfare agency must train hospital personnel on initial client intake procedures and authorize the hospital to take applications during those hours when the county welfare agency staff is not on-site. If the county welfare agency elects not to authorize the facility to take applications, the county worker must be present full-time.

Further, application/intake availability is now required at federally qualified health centers. Currently, there are 13 health center sites in 9 counties. The county welfare agencies are required to assure that initial application processing is available full-time during the agencies' normal working hours. This requirement can be met by either locating a worker at the facility or authorizing the facility to begin initial application processing.

F. PRIVATE SECTOR ELIGIBILITY SOFTWARE AND APPLICATION ASSISTANCE

In support of the outstationing of eligibility worker activities, as required by OBRA '90 and P.L. 1991, Chapter 187, the Division is working with known vendors of products or services designed to facilitate the processing of Medicaid applications at the designated hospital and federally qualified health center

outstation sites. Rapid eligibility determination will facilitate earlier coverage for applicants and, thus, quicker payment for providers.

One firm has developed computer software to automate the Medicaid application process. The system is built upon the collection of financial data at a single intake point with the generation of multiple outputs, including computer facsimiles of referral documents, applications, and computer generated requests for collateral verifications (e.g., bank letters) as appropriate.

Two other vendors have expanded their marketing initiatives to capitalize on outstationing opportunities. As a result, the county welfare agency and the designated hospital or health center could agree to introduce these new state-of-the-art services to take Medicaid applications. To date, the activities of these companies were limited to application support services for discharged patients who appeared to be potentially eligible for Medicaid benefits. These services included locating applicants, appointment scheduling, transportation, and facilitation of post application information verification. The process would be significantly improved if this expertise were used during the inpatient hospital stay.

G. CENTRALIZATION OF PRESUMPTIVE ELIGIBILITY PROCESSING

To facilitate the expeditious entry of eligibility information to the eligibility system, so that incoming provider claims can be paid without delay, the State centralized presumptive case processing for pregnant women. As a result, approved providers submit their determinations to the Division, instead of the twenty-one county welfare agencies. Upon receipt of the provider presumptive eligibility determinations, eligibility records and Medicaid identification cards are produced using computer program supports developed for the Division's PRIME computer network. This is another way in which the Division is trying to decrease burdens on the provider community and streamline an administrative function.

H. REQUEST FOR PROPOSAL (RFP) FOR MANAGEMENT CONSULTANT FOR THE GARDEN STATE HEALTH PLAN (GSHP)

The Division has engaged the firm of Ernst and Young to assist the Department of Human Services in implementing Sections 42-45 of P.L. 1991, c.187, which requires the expansion of managed care services in the State. The consultant will provide information, data, and advice during the design, development, and implementation phases required for these sections of the law.

The RFP includes several important functions to streamline statewide administration. Some of these are: 1) a review and assessment of the Garden State Health Plan as it relates to the small employer buy-in program for non-Medicaid participants and the significant expansion to Medicaid recipients; 2) a review of the adequacy of provider relations under the New Jersey Medicaid fee-for-service program for the purpose of increasing and improving provider participation in the Medicaid program; 3) identification of methods to streamline the statewide operation of the Medicaid program through direct contacts and a literature search on organization and procedures, including privatization, used in other states, with recommendations for implementing best practices and procedures; and 4) advice on other administrative improvement opportunities.

Section 45 of the Health Care Cost Reduction Act, relating to item #1 above, requires the Garden State Health Plan to offer coverage to persons who are not eligible for Medicaid and are employed either on a full-time or part-time basis and do not have health insurance coverage by the employer or spouse's employer, or cannot afford health insurance offered by the employer or spouse's employer.

In addition, small employers who have not offered to provide health insurance coverage anytime during the 12-month period immediately preceding the effective date of coverage shall be eligible to purchase coverage through the Garden State Health Plan.

This section also requires the design of one or more plans of benefits for employees and small employers. This shall include a schedule of premiums for enrollment in the Plan, and shall ensure that the premiums are adequate to fund the costs of the benefits.

Additionally, a five-year plan will be written to develop a statewide network of managed care providers for Medicaid recipients.

Activities are already underway to expand the GSHP for Medicaid-eligible persons. The Plan's membership goal is 36,000 members by June 30, 1993, and there is a major thrust to enroll members. This is being accomplished on a full-time basis by both existing GSHP staff and staff newly hired for this purpose.

Finally, another requirement of the management consultant will be to determine whether it may be more efficient and cost-effective to privatize, either in whole or in part, the operations of the GSHP.

Appendix L

State Legislative Bills for Health Care Reform

ASSEMBLY, No. 211

An Act concerning the development and implementation of a small business health insurance plan and appropriating \$500,000.

STATEMENT

This bill directs the Commissioner of Commerce and Economic Development to assist in designing a health insurance plan appropriate to the needs of small businesses for their employees and their dependents and to provide educational and marketing assistance in order to help small business employees attain coverage under that plan.

Currently, uninsured small business employees account for more than 40 percent of the cost of uncompensated hospital care, and the dependents of these workers account for an additional 30 percent of the cost. Preliminary results of several pilot projects in other states as well as information attained from surveys, and studies within New Jersey indicate that small businesses are generally willing to provide health insurance coverage for their employees and their dependents, but cannot afford to pay the premiums for standard health insurance policies or contracts. In order to lower premium costs, the plan would use cost containment strategies such as: exemption from mandatory benefit and provider provisions; screening for preexisting high risk medical conditions; and the use of copayments and deductibles for certain medical and hospital expenses. The plan would be available only to those small businesses that meet eligibility criteria developed pursuant to the bill's definition.

State involvement would be limited to assisting with the design of the plan; assisting with initial marketing, advertising, and educational functions; and monitoring and oversight functions.

The health insurance coverage under the plan would be provided through private insurers.

The sum of \$500,000 is appropriated to effectuate the purposes of this act. An amount, not to exceed \$5 per enrollee premium, shall be added to the premium cost and remitted to the State Treasurer in order to pay back moneys appropriated from the General Fund.

ASSEMBLY, No. 1672

An Act concerning hospital service corporations and amending P.L. 1964, c.104.

STATEMENT

This bill allows hospital service corporations to write group health insurance contracts on two or more employees or members instead of the current 10 or more employees or members.

ASSEMBLY, No. 1104

An Act allowing certain organizations to enter into preferred provider arrangements and supplementing Chapter 17 of Title 17B of the New Jersey Statutes.

STATEMENT

This bill allows insurers to enter into preferred provider arrangements with physicians, chiropractors, hospitals and other health care providers to lower the cost of health care services while preserving the quality of care provided. Currently, some 30 states permit preferred provider arrangements.

ASSEMBLY, No. 1654

An Act requiring all health insurers, health service corporations, health maintenance organizations and certain others to provide individual health benefits coverage on an open enrollment basis and creating the New Jersey Individual Health Coverage Program.

STATEMENT

This bill reforms the individual health insurance market by requiring all health insurers, including health maintenance organizations, to provide individual health insurance on a continuous open enrollment, guaranteed issue basis. Premiums are to be based upon a community rating system, although non-standard rates may be charged individuals with high risk health status.

Under the provisions of the bill, all health insurers are required, as a condition of doing business, to offer at least two individual health benefits plans: a basic health benefits plan and an enhanced health benefits plan. The coverage provided under the basic health benefits plan is based upon the coverage required in basic health care contracts or policies under the "Health Care Cost Reduction Act." The coverage provided under the basic health benefits plan may not exceed 80% of the actuarial value provided under the enhanced health benefits plan.

The bill also creates the New Jersey Individual Health Coverage Program governed by a nine-member board consisting of the Commissioner of Insurance, the Commissioner of Health, three public members, and, among others, a representative of a commercial insurer, a health service corporation, and a health maintenance organization. The program is authorized by the bill to: establish the specific terms of basic and enhanced health benefits plans; approve rates for individual health benefits plan; and establish a formula for permitting increases in premiums to reflect trend increases in the cost of health care. In addition, the program will apportion losses in the individual health benefits market among all insurers, health maintenance organizations, health, hospital and medical service corporations, multiple employer arrangements and third-party administrators in accordance with their respective shares of the total group and individual health benefits market.

ASSEMBLY, No. 1792

An Act requiring the offer of health insurance benefits for expenses incurred in testing and counseling to promote health and reduce health risks. This act shall be known and may be cited as the "Health Wellness Promotion Act."

STATEMENT

This bill requires hospital service corporations (Blue Cross), medical service corporations (Blue Shield), health service corporations (Blue Cross/Blue Shield), commercial individual and group insurers and health maintenance organizations to offer as part of a basic contract or policy, benefits for expenses incurred in a health promotion program for adults through wellness health examinations and counseling.

The bill establishes a Health Wellness Promotion Advisory Council consisting of the Commissioners of Health and Insurance or their designees and seven additional members appointed by the Governor, with the advise and consent of the Senate. Representatives from each of the following groups are to be appointed to the advisory council: the University of Medicine and Dentistry of New Jersey; The New Jersey Medical Society; the Academy of Medicine of New Jersey; the New Jersey Hospital Association; health service corporations, commercial individual and group insurers, and health maintenance organizations.

A cap is placed upon the dollar amounts an insurer is required to pay for the tests and consultation services specified in the bill, which amounts vary based on the age and sex of the insured. The bill provided for an annual adjustment of these threshold amounts based on changes in the consumer price index.

No additional tests or services may be added to those provided by the bill unless two organizations with established expertise in the areas

of epidemiology, sensitivity, specificity and predictive value of screening, disease protection and health promotion tests, which have been selected by the council, agree that the test or service being considered has been shown to improve the quality of life, prolong good quality life or reduce mortality; and subsequent to the agreement of these two organizations, the council recommends to the Legislature that such an additional test or service should be added. Any subsequent changes with regard to those tests and services provided by this bill would therefore require a legislative initiative.

SENATE, No. 371

An Act requiring certain health insurers, service corporations and health maintenance organizations to offer basic health benefits programs to certain employers and establishing a reinsurance program.

NO SUMMARY

SENATE, No. 712

An Act concerning the State Health Benefits Program and amending and supplementing P.L. 1961, c.49.

STATEMENT

This bill makes various statutory changes in the provisions of the State Health Benefits Program. It (1) raises the annual deductible from \$100 to \$200 for each enrolled employee and, separately, for all of the employee's enrolled dependents; (2) provides for payment by the program of 80% of the first \$5,000, rather than the first \$2,000, after the deductible has been met; (3) requires a co-payment of \$5 for each prescription of nongeneric drugs and of \$3 for each prescription of generic drugs; and (4) requires each State employee to pay 25% of the premium or periodic charges for the health benefits provided to the employee and the employee's enrolled dependents.

SENATE, No. 761

An Act concerning major medical expense benefits in the State Health Benefits Program and amending P.L. 1961, c.49.

STATEMENT

This bill increases the employee deductible and copayment portion of major medical expense benefits. The State Health Benefits Program offers health care coverage to public employees through different plans such as health maintenance organizations and a traditional program with a basic plan that relates to Blue Cross nationwide. The traditional program has three elements: (1) basic and extended hospital benefits; (2) basic and extended medical-surgical benefits; and (3) major medical benefits.

Current law provides that employees shall pay a deductible and coinsurance payment under major medical. The deductible is the first \$100 of eligible expenses incurred by an employee or dependent during a calendar year and after the deductible has been satisfied, major medical pays 80 percent and the employee pays 20 percent of the remaining eligible expenses up to the first \$2,000 of charges. Thereafter, major medical pays 100 percent of the remaining eligible expenses subject to the maximums and other terms of the program. This bill increases the major medical deductible from the current \$100 to \$250 and the employee coinsurance payment on the first \$2,000 of charges from 20 percent to 30 percent.

SENATE, No. 1023

An Act requiring all health insurers, health service corporations, health maintenance organizations and certain others to provide individual health benefits coverage on an open enrollment basis and creating the New Jersey Individual Health Coverage Program.

STATEMENT

This bill reforms the individual health insurance market by requiring all health insurers, including health maintenance organizations, to provide individual health insurance on a continuous open enrollment, guaranteed issue basis. Premiums are to be based upon a community rating system, although non-standard rates may be charged individuals with high risk health status.

Under the provisions of the bill, all health insurers are required, as a condition of doing business, to offer at least two individual health benefits plans: a basic health benefits plan and an enhanced health benefits plan. The coverage provided under the basic health benefits plan is based upon the coverage required in basic health care contracts or policies under the "Health Care Cost Reduction Act." The coverage provided under the basic health benefits plan may not exceed 80% of the actual value provided under the enhanced health benefits plan.

This bill also creates the New Jersey Individual Health Coverage Program governed by a nine-member board consisting of the Commissioner of Insurance, the Commissioner of Health, three public members, and, among others, a representative of a commercial insurer, a health service corporation, and a health maintenance organization. The program is authorized by the bill to: establish the specific terms of basic and enhanced health benefits plans; approve rates for individual health benefits plan; and establish a formula for permitting increases in premiums to reflect trend increases in the cost of health care. In addition, the program will apportion losses in the individual health benefits market among all insurers, health maintenance organizations, health, hospital and medical service corporations, multiple employer arrangements and third-party administrators in accordance with their respective shares of the total group and individual health benefits market.

APPENDIX M

**RECOMMENDATIONS OF THE UNITED STATES
PREVENTIVE SERVICES TASK FORCE**

With permission from the Office for Disease Prevention and Health Promotion, US Department of Health and Human Services, we include for your information a reprint of specific recommendations for preventive services by age group. These recommendations are the result of the Preventive Health Services Task Force's review of the effectiveness of clinical preventive services based on scientific evidence.

The recommendations apply only to persons who have no symptoms or clinical evidence of the target conditions. Many of the preventive services are recommended only to high risk groups and are not considered appropriate for the general population. To effectively conduct these services, a clinical setting is necessary; they are not particularly suited to shopping mall health screening demonstrations or public education campaigns, for example.

For more information on the methods used to derive the Preventive Health Services Recommendations, as well as time intervals for implementation of these preventive health services, the reader should consult the *Guide to Clinical Preventive Services*, US Preventive Health Services Task Force, Baltimore, MD, Williams and Wilkins, 1989.

<p>Table 1. Birth to 18 Months Schedule: 2, 4, 6, 15, 18 Months*</p>			<p>Leading Causes of Death: Conditions originating in perinatal period Congenital anomalies Heart disease Injuries (nonmotor vehicle) Pneumonia/influenza</p>
<p>SCREENING</p> <p>Height and weight Hemoglobin and hematocrit¹</p> <p><i>HIGH-RISK GROUPS</i> Hearing² (HR1) Erythrocyte protoporphyrin (HR2)</p>	<p>PARENT COUNSELING</p> <p>Diet</p> <p>Breastfeeding Nutrient intake, especially iron-rich foods</p> <p>Injury Prevention</p> <p>Child safety seats Smoke detector Hot water heater temperature Stairway gates, window guards, pool fence Storage of drugs and toxic chemicals Syrup of ipecac, poison control telephone number</p> <p>Dental Health</p> <p>Baby bottle tooth decay</p> <p>Other Primary Preventive Measures</p> <p>Effects of passive smoking</p>	<p>IMMUNIZATIONS & CHEMOPROPHYLAXIS</p> <p>Diphtheria-tetanus-pertussis (DTP) vaccine³ Oral poliovirus vaccine (OPV)⁴ Measles-mumps-rubella (MMR) vaccine⁵ <i>Haemophilus influenzae</i> type b (Hib) conjugate vaccine⁶</p> <p><i>HIGH-RISK GROUPS</i> Fluoride supplements (HR3)</p> <p>FIRST WEEK</p> <p>Ophthalmic antibiotics⁷ Hemoglobin electrophoresis (HR4)⁷ T4 TSH⁸ Phenylalanine⁸ Hearing (HR1)</p> <p>Remain Alert For:</p> <p>Ocular misalignment Tooth decay Signs of child abuse or neglect</p>	
<p>This list of preventive services is not exhaustive. It reflects only those topics reviewed by the U.S. Preventive Services Task Force. Clinicians may wish to add other preventive services on a routine basis, and after considering the patient's medical history and other individual circumstances. Examples of target conditions not specifically examined by the Task Force include:</p> <p>Developmental disorders Musculoskeletal malformations Cardiac anomalies Genitourinary disorders Metabolic disorders Speech problems Behavioral disorders Parent family dysfunction</p>			

*Five visits are required for immunizations. Because of lack of data and differing patient risk profiles, the scheduling of additional visits and the frequency of the individual preventive services listed in this table are left to clinical discretion (except as indicated in other footnotes).

1. Once during infancy. 2. At age 18-month visit, if not tested earlier. 3. At ages 2, 4, 6, and 15 months. 4. At ages 2, 4, and 15 months. 5. At age 15 months. 6. At age 18 months. 7. At birth. 8. Days 3 to 6 preferred for testing.

Table 1. Birth to 18 Months

High Risk Categories

HR1 Infants with a family history of childhood hearing impairment or a personal history of congenital perinatal infection with herpes, syphilis, rubella, cytomegalovirus, or toxoplasmosis; malformations involving the head or neck (e.g., dysmorphic and syndromal abnormalities, cleft palate, abnormal pinna); birthweight below 1500 g; bacterial meningitis; hyperbilirubinemia requiring exchange transfusion; or severe perinatal asphyxia (Apgar scores of 0-3, absence of spontaneous respirations for 10 minutes, or hypotonia at 2 hours of age).

HR2 Infants who live in or frequently visit housing built before 1950 that is dilapidated or undergoing renovation; who come in contact with

other children with known lead toxicity; who live near lead processing plants or whose parents or household members work in a lead-related occupation; or who live near busy highways or hazardous waste sites.

HR3 Infants living in areas with inadequate water fluoridation (less than 0.7 parts per million).

HR4 Newborns of Caribbean, Latin American, Asian, Mediterranean, or African descent.

<p>Table 2. Ages 2-6 Schedule: See Footnote*</p>		<p>Leading Causes of Death: Injuries (nonmotor vehicle) Motor vehicle crashes Congenital anomalies Homicide Heart disease</p>
<p>SCREENING</p> <p>Height and weight Blood pressure Eye exam for amblyopia and strabismus¹ Urinalysis for bacteriuria</p> <p>HIGH-RISK GROUPS Erythrocyte protoporphyrin² (HR1) Tuberculin skin test (PPD) (HR2) Hearing³ (HR3)</p>	<p>PATIENT & PARENT COUNSELING</p> <p>Diet and Exercise</p> <p>Sweets and between-meal snacks, iron-enriched foods, sodium Caloric balance Selection of exercise program</p> <p>Injury Prevention</p> <p>Safety belts Smoke detector Hot water heater temperature Window guards and pool fence Bicycle safety helmets Storage of drugs, toxic chemicals, matches, and firearms Syrup of ipecac, poison control telephone number</p> <p>Dental Health</p> <p>Tooth brushing and dental visits</p> <p>Other Primary Preventive Measures</p> <p>Effects of passive smoking</p> <p>HIGH-RISK GROUPS Skin protection from ultraviolet light (HR4)</p>	<p>IMMUNIZATIONS & CHEMOPROPHYLAXIS</p> <p>Diphtheria-tetanus-pertussis (DTP) vaccine⁴ Oral poliovirus vaccine (OPV)⁴</p> <p>HIGH-RISK GROUPS Fluoride supplements (HR5)</p> <p>Remain Alert For:</p> <p>Vision disorders Dental decay, malalignment, premature loss of teeth, mouth breathing Signs of child abuse or neglect Abnormal bereavement</p>
<p>This list of preventive services is not exhaustive. It reflects only those topics reviewed by the U.S. Preventive Services Task Force. Clinicians may wish to add other preventive services on a routine basis, and after considering the patient's medical history and other individual circumstances. Examples of target conditions not specifically examined by the Task Force include:</p> <p>Speech problems Behavioral and learning disorders Parent family dysfunction</p>		
<p>*One visit is required for immunizations. Because of lack of data and differing patient risk profiles, the scheduling of additional visits and the frequency of the individual preventive services listed in this table are left to clinical discretion (except as indicated in other footnotes).</p>		

1. Ages 3-4. 2. Annually. 3. Before age 3, if not tested earlier. 4. Once between ages 4 and 6.

Table 2. Ages 2-6

High Risk Categories

HR1 Children who live in or frequently visit housing built before 1950 that is dilapidated or undergoing renovation; who come in contact with other children with known lead toxicity; who live near lead processing plants or whose parents or household members work in a lead-related occupation; or who live near busy highways or hazardous waste sites.

HR2 Household members of persons with tuberculosis or others at risk for close contact with the disease; recent immigrants or refugees from countries in which tuberculosis is common (e.g., Asia, Africa, Central and South America, Pacific Islands); family members of migrant workers; residents of homeless shelters; or persons with certain underlying medical disorders.

HR3 Children with a family history of childhood hearing impairment or a personal history of congenital perinatal infection with herpes, syphilis, rubella, cytomegalovirus, or toxoplasmosis; malformations involving the head or neck (e.g., dysmorphic and syndromal abnormalities, cleft palate, abnormal pinna); birthweight below 1500 g; bacterial meningitis; hyperbilirubinemia requiring exchange transfusion; or severe perinatal asphyxia (Apgar scores of 0-3, absence of spontaneous respirations for 10 minutes, or hypotonia at 2 hours of age).

HR4 Children with increased exposure to sunlight.

HR5 Children living in areas with inadequate water fluoridation (less than 0.7 parts per million).

<p>Table 3. Ages 7-12 Schedule: See Footnote*</p>		<p>Leading Causes of Death: Motor vehicle crashes Injuries (nonmotor vehicle) Congenital anomalies Leukemia Homicide Heart disease</p>
<p>SCREENING</p> <p>Height and weight Blood pressure</p> <p><i>HIGH-RISK GROUPS</i> Tuberculin skin test (PPD) (HR1)</p>	<p>PATIENT & PARENT COUNSELING</p> <p>Diet and Exercise</p> <p>Fat (especially saturated fat), cholesterol, sweets and between-meal snacks, sodium Caloric balance Selection of exercise program</p> <p>Injury Prevention</p> <p>Safety belts Smoke detector Storage of firearms, drugs, toxic chemicals, matches Bicycle safety helmets</p> <p>Dental Health</p> <p>Regular tooth brushing and dental visits</p> <p>Other Primary Preventive Measures</p> <p><i>HIGH-RISK GROUPS</i> Skin protection from ultraviolet light (HR2)</p>	<p>CHEMOPROPHYLAXIS</p> <p><i>HIGH-RISK GROUPS</i> Fluoride supplements (HR3)</p> <p>Remain Alert For:</p> <p>Vision disorders Diminished hearing Dental decay, malalignment, mouth breathing Signs of child abuse or neglect Abnormal bereavement</p>
<p>This list of preventive services is not exhaustive. It reflects only those topics reviewed by the U.S. Preventive Services Task Force. Clinicians may wish to add other preventive services on a routine basis, and after considering the patient's medical history and other individual circumstances. Examples of target conditions not specifically examined by the Task Force include:</p> <p>Developmental disorders Scoliosis Behavioral and learning disorders Parent family dysfunction</p>		
<p>*Because of lack of data and differing patient risk profiles, the scheduling of visits and the frequency of the individual preventive services listed in this table are left to clinical discretion.</p>		

Table 3. Ages 7-12

High Risk Categories

HR1 Household members of persons with tuberculosis or others at risk for close contact with the disease; recent immigrants or refugees from countries in which tuberculosis is common (e.g., Asia, Africa, Central and South America, Pacific Islands); family members of migrant workers; residents of homeless shelters; or persons with certain underlying medical disorders.

HR2 Children with increased exposure to sunlight.

HR3 Children living in areas with inadequate water fluoridation (less than 0.7 parts per million).

Table 4.
Ages 13-18
Schedule: See Footnote*

Leading Causes of Death:
Motor vehicle crashes
Homicide
Suicide
Injuries (nonmotor vehicle)
Heart disease

<p>SCREENING</p> <p>History</p> <p>Dietary intake Physical activity Tobacco/alcohol/drug use Sexual practices</p> <p>Physical Exam</p> <p>Height and weight Blood pressure</p> <p><i>HIGH-RISK GROUPS</i> Complete skin exam (HR1) Clinical testicular exam (HR2)</p> <p>Laboratory/Diagnostic Procedures</p> <p><i>HIGH-RISK GROUPS</i> Rubella antibodies (HR3) VDRL/RPR (HR4) Chlamydial testing (HR5) Gonorrhea culture (HR6) Counseling and testing for HIV (HR7) Tuberculin skin test (PPD) (HR8) Hearing (HR9) Papanicolaou smear (HR10)¹</p>	<p>COUNSELING</p> <p>Diet and Exercise</p> <p>Fat (especially saturated fat), cholesterol, sodium, iron,² calcium² Caloric balance Selection of exercise program</p> <p>Substance Use</p> <p>Tobacco: cessation primary prevention Alcohol and other drugs: cessation primary prevention Driving/other dangerous activities while under the influence Treatment for abuse</p> <p><i>HIGH-RISK GROUPS</i> Sharing using unsterilized needles and syringes (HR12)</p> <p>Sexual Practices</p> <p>Sexual development and behavior³ Sexually transmitted diseases: partner selection, condoms Unintended pregnancy and contraceptive options</p> <p>Injury Prevention</p> <p>Safety belts Safety helmets Violent behavior⁴ Firearms⁴ Smoke detector</p> <p>Dental Health</p> <p>Regular tooth brushing, flossing, dental visits</p> <p>Other Primary Preventive Measures</p> <p><i>HIGH-RISK GROUPS</i> Discussion of hemoglobin testing (HR13) Skin protection from ultraviolet light (HR14)</p>	<p>IMMUNIZATIONS & CHEMOPROPHYLAXIS</p> <p>Tetanus-diphtheria (Td) booster⁵</p> <p><i>HIGH-RISK GROUPS</i> Fluoride supplements (HR15)</p> <p>This list of preventive services is not exhaustive. It reflects only those topics reviewed by the U.S. Preventive Services Task Force. Clinicians may wish to add other preventive services on a routine basis, and after considering the patient's medical history and other individual circumstances. Examples of target conditions not specifically examined by the Task Force include:</p> <p>Developmental disorders Scoliosis Behavioral and learning disorders Parent family dysfunction</p> <p>Remain Alert For:</p> <p>Depressive symptoms Suicide risk factors (HR11) Abnormal bereavement Tooth decay, malalignment, gingivitis Signs of child abuse and neglect</p>
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*One visit is required for immunizations. Because of lack of data and differing patient risk profiles, the scheduling of additional visits and the frequency of the individual preventive services listed in this table are left to clinical discretion (except as indicated in other footnotes).

1. Every 1-3 years. 2. For females. 3. Often best performed early in adolescence and with the involvement of parents. 4. Especially for males. 5. Once between ages 14 and 16.

Table 4. Ages 13-18

High Risk Categories

HR1 Persons with increased recreational or occupational exposure to sunlight, a family or personal history of skin cancer, or clinical evidence of precursor lesions (e.g., dysplastic nevi, certain congenital nevi).

HR2 Males with a history of cryptorchidism, orchiopexy, or testicular atrophy.

HR3 Females of childbearing age lacking evidence of immunity.

HR4 Persons who engage in sex with multiple partners in areas in which syphilis is prevalent, prostitutes; or contacts with persons with active syphilis.

HR5 Persons who attend clinics for sexually transmitted diseases; attend other high-risk health care facilities (e.g., adolescent and family planning clinics); or have other risk factors for chlamydial infection (e.g., multiple sexual partners or a sexual partner with multiple sexual contacts).

HR6 Persons with multiple sexual partners or a sexual partner with multiple contacts, sexual contacts of persons with culture-proven gonorrhea, or persons with a history of repeated episodes of gonorrhea.

HR7 Persons seeking treatment for sexually transmitted diseases; homosexual and bisexual men; past or present intravenous (IV) drug users; persons with a history of prostitution or multiple sexual partners; women whose past or present sexual partners were HIV-infected, bisexual, or IV drug users; persons with long-term residence or birth in an

area with high prevalence of HIV infection; or persons with a history of transfusion between 1978 and 1985.

HR8 Household members of persons with tuberculosis or others at risk for close contact with the disease; recent immigrants or refugees from countries in which tuberculosis is common (e.g., Asia, Africa, Central and South America, Pacific Islands); migrant workers; residents of correctional institutions or homeless shelters; or persons with certain underlying medical disorders.

HR9 Persons exposed regularly to excessive noise in recreational or other settings.

HR10 Females who are sexually active or (if the sexual history is thought to be unreliable) aged 18 or older.

HR11 Recent divorce, separation, unemployment, depression, alcohol or other drug abuse, serious medical illnesses, living alone, or recent bereavement.

HR12 Intravenous drug users.

HR13 Persons of Caribbean, Latin American, Asian, Mediterranean, or African descent.

HR14 Persons with increased exposure to sunlight.

HR15 Persons living in areas with inadequate water fluoridation (less than 0.7 parts per million).

Table 5.
Ages 19-39
Schedule: Every 1-3 Years*

Leading Causes of Death:
Motor vehicle crashes
Homicide
Suicide
Injuries (nonmotor vehicle)
Heart disease

SCREENING	COUNSELING	IMMUNIZATIONS
<p>History</p> <p>Dietary intake Physical activity Tobacco/alcohol/drug use Sexual practices</p> <p>Physical Exam</p> <p>Height and weight Blood pressure</p> <p>HIGH-RISK GROUPS Complete oral cavity exam (HR1) Palpation for thyroid nodules (HR2) Clinical breast exam (HR3) Clinical testicular exam (HR4) Complete skin exam (HR5)</p> <p>Laboratory/Diagnostic Procedures</p> <p>Nonfasting total blood cholesterol Papanicolaou smear¹</p> <p>HIGH-RISK GROUPS Fasting plasma glucose (HR6) Rubella antibodies (HR7) VDRL/RPR (HR8) Urinalysis for bacteriuria (HR9) Chlamydial testing (HR10) Gonorrhea culture (HR11) Counseling and testing for HIV (HR12) Hearing (HR13) Tuberculin skin test (PPD) (HR14) Electrocardiogram (HR15) Mammogram (HR3) Colonoscopy (HR16)</p>	<p>Diet and Exercise</p> <p>Fat (especially saturated fat), cholesterol, complex carbohydrates, fiber, sodium, iron,² calcium² Caloric balance Selection of exercise program</p> <p>Substance Use</p> <p>Tobacco: cessation/primary prevention Alcohol and other drugs: Limiting alcohol consumption Driving/other dangerous activities while under the influence Treatment for abuse</p> <p>HIGH-RISK GROUPS Sharing/using unsterilized needles and syringes (HR18)</p> <p>Sexual Practices</p> <p>Sexually transmitted diseases: partner selection, condoms, anal intercourse Unintended pregnancy and contraceptive options</p> <p>Injury Prevention</p> <p>Safety belts Safety helmets Violent behavior³ Firearms³ Smoke detector Smoke near bedding or upholstery</p> <p>HIGH-RISK GROUPS Back-conditioning exercises (HR19) Prevention of childhood injuries (HR20) Falls in the elderly (HR21)</p> <p>Dental Health</p> <p>Regular tooth brushing, flossing, dental visits</p> <p>Other Primary Preventive Measures</p> <p>HIGH-RISK GROUPS Discussion of hemoglobin testing (HR22) Skin protection from ultraviolet light (HR23)</p>	<p>Tetanus-diphtheria (Td) booster⁴</p> <p>HIGH-RISK GROUPS Hepatitis B vaccine (HR24) Pneumococcal vaccine (HR25) Influenza vaccine⁵ (HR26) Measles-mumps-rubella vaccine (HR27)</p> <p>This list of preventive services is not exhaustive. It reflects only those topics reviewed by the U.S. Preventive Services Task Force. Clinicians may wish to add other preventive services on a routine basis, and after considering the patient's medical history and other individual circumstances. Examples of target conditions not specifically examined by the Task Force include:</p> <p>Chronic obstructive pulmonary disease Hepatobiliary disease Bladder cancer Endometrial disease Travel-related illness Prescription drug abuse Occupational illness and injuries</p> <p>Remain Alert For:</p> <p>Depressive symptoms Suicide risk factors (HR17) Abnormal bereavement Malignant skin lesions Tooth decay, gingivitis Signs of physical abuse</p>

*The recommended schedule applies only to the periodic visit itself. The frequency of the individual preventive services listed in this table is left to clinical discretion, except as indicated in other footnotes.

1. Every 1-3 years. 2. For women. 3. Especially for young males. 4. Every 10 years. 5. Annually.

Table 5. Ages 19-39

High Risk Categories

- HR1** Persons with exposure to tobacco or excessive amounts of alcohol, or those with suspicious symptoms or lesions detected through self-examination.
- HR2** Persons with a history of upper-body irradiation.
- HR3** Women aged 35 and older with a family history of premenopausally diagnosed breast cancer in a first-degree relative.
- HR4** Men with a history of cryptorchidism, orchiopexy, or testicular atrophy.
- HR5** Persons with family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or clinical evidence of precursor lesions (e.g., dysplastic nevi, certain congenital nevi).
- HR6** The markedly obese, persons with a family history of diabetes, or women with a history of gestational diabetes.
- HR7** Women lacking evidence of immunity.
- HR8** Prostitutes, persons who engage in sex with multiple partners in areas in which syphilis is prevalent, or contacts with persons with active syphilis.
- HR9** Persons with diabetes.
- HR10** Persons who attend clinics for sexually transmitted diseases; attend other high-risk health care facilities (e.g., adolescent and family planning clinics); or have other risk factors for chlamydial infection (e.g., multiple sexual partners or a sexual partner with multiple sexual contacts, age less than 20).
- HR11** Prostitutes, persons with multiple sexual partners or a sexual partner with multiple contacts, sexual contacts of persons with culture-proven gonorrhea, or persons with a history of repeated episodes of gonorrhea.
- HR12** Persons seeking treatment for sexually transmitted diseases; homosexual and bisexual men; past or present intravenous (IV) drug users; persons with a history of prostitution or multiple sexual partners; women whose past or present sexual partners were HIV-infected, bisexual, or IV drug users; persons with long-term residence or birth in an area with high prevalence of HIV infection; or persons with a history of transfusion between 1978 and 1985.
- HR13** Persons exposed regularly to excessive noise.
- HR14** Household members of persons with tuberculosis or others at risk for close contact with the disease (e.g., staff of tuberculosis clinics, shelters for the homeless, nursing homes, substance abuse treatment facilities, dialysis units, correctional institutions); recent immigrants or refugees from countries in which tuberculosis is common; migrant workers; residents of nursing homes, correctional institutions, or homeless shelters; or persons with certain underlying medical disorders (e.g., HIV infection).
- HR15** Men who would endanger public safety were they to experience sudden cardiac events (e.g., commercial airline pilots).
- HR16** Persons with a family history of familial polyposis coli or cancer family syndrome.
- HR17** Recent divorce, separation, unemployment, depression, alcohol or other drug abuse, serious medical illnesses, living alone, or recent bereavement.
- HR18** Intravenous drug users.
- HR19** Persons at increased risk for low back injury because of past history, body configuration, or type of activities.
- HR20** Persons with children in the home or automobile.
- HR21** Persons with older adults in the home.
- HR22** Young adults of Caribbean, Latin American, Asian, Mediterranean, or African descent.
- HR23** Persons with increased exposure to sunlight.
- HR24** Homosexually active men, intravenous drug users, recipients of some blood products, or persons in health-related jobs with frequent exposure to blood or blood products.
- HR25** Persons with medical conditions that increase the risk of pneumococcal infection (e.g., chronic cardiac or pulmonary disease, sickle cell disease, nephrotic syndrome, Hodgkin's disease, asplenia, diabetes mellitus, alcoholism, cirrhosis, multiple myeloma, renal disease, or conditions associated with immunosuppression).
- HR26** Residents of chronic care facilities or persons suffering from chronic cardiopulmonary disorders, metabolic diseases (including diabetes mellitus), hemoglobinopathies, immunosuppression, or renal dysfunction.
- HR27** Persons born after 1956 who lack evidence of immunity to measles (receipt of live vaccine on or after first birthday, laboratory evidence of immunity, or a history of physician-diagnosed measles).

<p>Table 6. Ages 40-64 Schedule: Every 1-3 Years*</p>			<p>Leading Causes of Death: Heart disease Lung cancer Cerebrovascular disease Breast cancer Colorectal cancer Obstructive lung disease</p>
<p>SCREENING</p> <p>History</p> <p>Dietary intake Physical activity Tobacco/alcohol/drug use Sexual practices</p> <p>Physical Exam</p> <p>Height and weight Blood pressure Clinical breast exam¹</p> <p>HIGH-RISK GROUPS Complete skin exam (HR1) Complete oral cavity exam (HR2) Palpation for thyroid nodules (HR3) Auscultation for carotid bruits (HR4)</p> <p>Laboratory/Diagnostic Procedures</p> <p>Nonfasting total blood cholesterol Papanicolaou smear² Mammogram³</p> <p>HIGH-RISK GROUPS Fasting plasma glucose (HR5) VDRL/RPR (HR6) Urinalysis for bacteriuria (HR7) Chlamydial testing (HR8) Gonorrhea culture (HR9) Counseling and testing for HIV (HR10) Tuberculin skin test (PPD) (HR11) Hearing (HR12) Electrocardiogram (HR13) Fecal occult blood/sigmoidoscopy (HR14) Fecal occult blood/colonoscopy (HR15) Bone mineral content (HR16)</p>	<p>COUNSELING</p> <p>Diet and Exercise</p> <p>Fat (especially saturated fat), cholesterol, complex carbohydrates, fiber, sodium, calcium⁴ Caloric balance Selection of exercise program</p> <p>Substance Use</p> <p>Tobacco cessation Alcohol and other drugs: Limiting alcohol consumption Driving/other dangerous activities while under the influence Treatment for abuse</p> <p>HIGH-RISK GROUPS Sharing/using unsterilized needles and syringes (HR19)</p> <p>Sexual Practices</p> <p>Sexually transmitted diseases: partner selection, condoms, anal intercourse Unintended pregnancy and contraceptive options</p> <p>Injury Prevention</p> <p>Safety belts Safety helmets Smoke detector Smoking near bedding or upholstery</p> <p>HIGH-RISK GROUPS Back-conditioning exercises (HR20) Prevention of childhood injuries (HR21) Falls in the elderly (HR22)</p> <p>Dental Health</p> <p>Regular tooth brushing, flossing, and dental visits</p> <p>Other Primary Preventive Measures</p> <p>HIGH-RISK GROUPS Skin protection from ultraviolet light (HR23) Discussion of aspirin therapy (HR24) Discussion of estrogen replacement therapy (HR25)</p>	<p>IMMUNIZATIONS</p> <p>Tetanus-diphtheria (Td) booster⁵</p> <p>HIGH-RISK GROUPS Hepatitis B vaccine (HR26) Pneumococcal vaccine (HR27) Influenza vaccine (HR28)⁶</p> <p>This list of preventive services is not exhaustive. It reflects only those topics reviewed by the U.S. Preventive Services Task Force. Clinicians may wish to add other preventive services on a routine basis, and after considering the patient's medical history and other individual circumstances. Examples of target conditions not specifically examined by the Task Force include:</p> <p>Chronic obstructive pulmonary disease Hepatobiliary disease Bladder cancer Endometrial disease Travel-related illness Prescription drug abuse Occupational illness and injuries</p> <p>Remain Alert For:</p> <p>Depressive symptoms Suicide risk factors (HR17) Abnormal bereavement Signs of physical abuse or neglect Malignant skin lesions Peripheral arterial disease (HR18) Tooth decay, gingivitis, loose teeth</p>	
<p>*The recommended schedule applies only to the periodic visit itself. The frequency of the individual preventive services listed in this table is left to clinical discretion, except as indicated in other footnotes.</p>			

1. Annually for women. 2. Every 1-3 years for women. 3. Every 1-2 years for women beginning at age 50 (age 35 for those at increased risk). 4. For women. 5. Every 10 years. 6. Annually.

Table 6. Ages 40-64

High Risk Categories

HR1 Persons with a family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or clinical evidence of precursor lesions (e.g., dysplastic nevi, certain congenital nevi).

HR2 Persons with exposure to tobacco or excessive amounts of alcohol, or those with suspicious symptoms or lesions detected through self-examination.

HR3 Persons with a history of upper-body irradiation.

HR4 Persons with risk factors for cerebrovascular or cardiovascular disease (e.g., hypertension, smoking, CAD, atrial fibrillation, diabetes) or those with neurologic symptoms (e.g., transient ischemic attacks) or a history of cerebrovascular disease.

HR5 The markedly obese, persons with a family history of diabetes, or women with a history of gestational diabetes.

HR6 Prostitutes, persons who engage in sex with multiple partners in areas in which syphilis is prevalent, or contacts with persons with active syphilis.

HR7 Persons with diabetes.

HR8 Persons who attend clinics for sexually transmitted diseases, attend other high-risk health care facilities (e.g., adolescent and family planning clinics), or have other risk factors for chlamydial infection (e.g., multiple sexual partners or a sexual partner with multiple sexual contacts).

HR9 Prostitutes, persons with multiple sexual partners or a sexual partner with multiple contacts, sexual contacts of persons with culture-proven gonorrhea, or persons with a history of repeated episodes of gonorrhea.

HR10 Persons seeking treatment for sexually transmitted diseases; homosexual and bisexual men; past or present intravenous (IV) drug users; persons with a history of prostitution or multiple sexual partners; women whose past or present sexual partners were HIV-infected, bisexual, or IV drug users; persons with long-term resident or birth in an area with high prevalence of HIV infection; or persons with a history of transfusion between 1978 and 1985.

HR11 Household members of persons with tuberculosis or others at risk for close contact with the disease (e.g., staff of tuberculosis clinics, shelters for the homeless, nursing homes, substance abuse treatment facilities, dialysis units, correctional institutions); recent immigrants or refugees from countries in which tuberculosis is common (e.g., Asia, Africa, Central and South America, Pacific Islands); migrant workers; residents of nursing homes, correctional institutions, or homeless shelters; or persons with certain underlying medical disorders (e.g., HIV infection).

HR12 Persons exposed regularly to excessive noise.

HR13 Men with two or more cardiac risk factors (high blood cholesterol, hypertension, cigarette smoking, diabetes mellitus, family history of CAD); men who would endanger public safety were they to experience sudden cardiac events (e.g., commercial airline pilots); or

sedentary or high-risk males planning to begin a vigorous exercise program.

HR14 Persons aged 50 and older who have first-degree relatives with colorectal cancer; a personal history of endometrial, ovarian, or breast cancer; or a previous diagnosis of inflammatory bowel disease, adenomatous polyps, or colorectal cancer.

HR15 Persons with a family history of familial polyposis coli or cancer family syndrome.

HR16 Perimenopausal women at increased risk for osteoporosis (e.g., Caucasian race, bilateral oophorectomy before menopause, slender build) and for whom estrogen replacement therapy would otherwise not be recommended.

HR17 Recent divorce, separation, unemployment, depression, alcohol or other drug abuse, serious medical illnesses, living alone, or recent bereavement.

HR18 Persons over age 50, smokers, or persons with diabetes mellitus.

HR19 Intravenous drug users.

HR20 Persons at increased risk for low back injury because of past history, body configuration, or type of activities.

HR21 Persons with children in the home or automobile.

HR22 Persons with older adults in the home.

HR23 Persons with increased exposure to sunlight.

HR24 Men who have risk factors for myocardial infarction (e.g., high blood cholesterol, smoking, diabetes mellitus, family history of early-onset CAD) and who lack a history of gastrointestinal or other bleeding problems, and other risk factors for bleeding or cerebral hemorrhage.

HR25 Perimenopausal women at increased risk for osteoporosis (e.g., Caucasian, low bone mineral content, bilateral oophorectomy before menopause or early menopause, slender build) and who are without known contraindications (e.g., history of undiagnosed vaginal bleeding, active liver disease, thromboembolic disorders, hormone-dependent cancer).

HR26 Homosexually active men, intravenous drug users, recipients of some blood products, or persons in health-related jobs with frequent exposure to blood or blood products.

HR27 Persons with medical conditions that increase the risk of pneumococcal infection (e.g., chronic cardiac or pulmonary disease, sickle cell disease, nephrotic syndrome, Hodgkin's disease, asplenia, diabetes mellitus, alcoholism, cirrhosis, multiple myeloma, renal disease or conditions associated with immunosuppression).

HR28 Residents of chronic care facilities and persons suffering from chronic cardiopulmonary disorders, metabolic diseases (including diabetes mellitus), hemoglobinopathies, immunosuppression, or renal dysfunction.

**Table 7.
Ages 65 and Over
Schedule: Every Year***

Leading Causes of Death:
Heart disease
Cerebrovascular disease
Obstructive lung disease
Pneumonia/influenza
Lung cancer
Colorectal cancer

<p>SCREENING</p> <p>History</p> <p>Prior symptoms of transient ischemic attack Dietary intake Physical activity Tobacco/alcohol/drug use Functional status at home</p> <p>Physical Exam</p> <p>Height and weight Blood pressure Visual acuity Hearing and hearing aids Clinical breast exam¹</p> <p>HIGH-RISK GROUPS</p> <p>Auscultation for carotid bruits (HR1) Complete skin exam (HR2) Complete oral cavity exam (HR3) Palpation of thyroid nodules (HR4)</p> <p>Laboratory/Diagnostic Procedures</p> <p>Nonfasting total blood cholesterol Dipstick urinalysis Mammogram² Thyroid function tests³</p> <p>HIGH-RISK GROUPS</p> <p>Fasting plasma glucose (HR5) Tuberculin skin test (PPD) (HR6) Electrocardiogram (HR7) Papanicolaou smear⁴ (HR8) Fecal occult blood: Signoidoscopy (HR9) Fecal occult blood: Colonoscopy (HR10)</p>	<p>COUNSELING</p> <p>Diet and Exercise</p> <p>Fat (especially saturated fat), cholesterol, complex carbohydrates, fiber, sodium, calcium³ Caloric balance Selection of exercise program</p> <p>Substance Use</p> <p>Tobacco: cessation Alcohol and other drugs: Limiting alcohol consumption Driving/other dangerous activities while under the influence Treatment for abuse</p> <p>Injury Prevention</p> <p>Prevention of falls Safety belts Smoke detector Smoke near bedding or upholstery Hot water heater temperature Safety helmets</p> <p>HIGH-RISK GROUPS</p> <p>Prevention of childhood injuries (HR12)</p> <p>Dental Health</p> <p>Regular dental visits, tooth brushing, flossing</p> <p>Other Primary Preventive Measures</p> <p>Glaucoma testing by eye specialist</p> <p>HIGH-RISK GROUPS</p> <p>Discussion of estrogen replacement therapy (HR13) Discussion of aspirin therapy (HR14) Skin protection from ultraviolet light (HR15)</p>	<p>IMMUNIZATIONS</p> <p>Tetanus-diphtheria (Td) booster⁵ Influenza vaccine¹ Pneumococcal vaccine</p> <p>HIGH-RISK GROUPS</p> <p>Hepatitis B vaccine (HR16)</p> <p>This list of preventive services is not exhaustive. It reflects only those topics reviewed by the U.S. Preventive Services Task Force. Clinicians may wish to add other preventive services on a routine basis, and after considering the patient's medical history and other individual circumstances. Examples of target conditions not specifically examined by the Task Force include:</p> <p>Chronic obstructive pulmonary disease Hepatobiliary disease Bladder cancer Endometrial disease Travel-related illness Prescription drug abuse Occupational illness and injuries</p> <p>Remain Alert For:</p> <p>Depressive symptoms Suicide risk factors (HR11) Abnormal bereavement Changes in cognitive function Medications that increase risk of falls Signs of physical abuse or neglect Malignant skin lesions Peripheral arterial disease Tooth decay, gingivitis, loose teeth</p>
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*The recommended schedule applies only to the periodic visit itself. The frequency of the individual preventive services listed in this table is left to clinical discretion, except as indicated in other footnotes.

1. Annually. 2. Every 1-2 years for women until age 75, unless pathology detected. 3. For women. 4. Every 1-3 years. 5. Every 10 years.

Table 7. Ages 65 and Over

High Risk Categories

HR1 Persons with risk factors for cerebrovascular or cardiovascular disease (e.g., hypertension, smoking, CAD, atrial fibrillation, diabetes) or those with neurologic symptoms (e.g., transient ischemic attacks) or a history of cerebrovascular disease.

HR2 Persons with a family or personal history of skin cancer, or clinical evidence of precursor lesions (e.g., dysplastic nevi, certain congenital nevi), or those with increased occupational or recreational exposure to sunlight.

HR3 Persons with exposure to tobacco or excessive amounts of alcohol, or those with suspicious symptoms or lesions detected through self-examination.

HR4 Persons with a history of upper-body irradiation.

HR5 The markedly obese, persons with a family history of diabetes, or women with a history of gestational diabetes.

HR6 Household members of persons with tuberculosis or others at risk for close contact with the disease (e.g., staff of tuberculosis clinics, shelters for the homeless, nursing homes, substance abuse treatment facilities, dialysis units, correctional institutions); recent immigrants or refugees from countries in which tuberculosis is common (e.g., Asia, Africa, Central and South America, Pacific Islands); migrant workers; residents of nursing homes, correctional institutions, or homeless shelters; or persons with certain underlying medical disorders (e.g., HIV infection).

HR7 Men with two or more cardiac risk factors (high blood cholesterol, hypertension, cigarette smoking, diabetes mellitus, family history of CAD); men who would endanger public safety were they to experience sudden cardiac events (e.g., commercial airline pilots); or sedentary or high-risk males planning to begin a vigorous exercise program.

HR8 Women who have not had previous documented screening in which smears have been consistently negative.

HR9 Persons who have first-degree relatives with colorectal cancer; a personal history of endometrial, ovarian, or breast cancer; or a previous diagnosis of inflammatory bowel disease, adenomatous polyps, or colorectal cancer.

HR10 Persons with a family history of familial polyposis coli or cancer family syndrome.

HR11 Recent divorce, separation, unemployment, depression, alcohol or other drug abuse, serious medical illnesses, living alone, or recent bereavement.

HR12 Persons with children in the home or automobile.

HR13 Women at increased risk for osteoporosis (e.g., Caucasian, low bone mineral content, bilateral oophorectomy before menopause or early menopause, slender build) and who are without known contraindications (e.g., history of undiagnosed vaginal bleeding, active liver disease, thromboembolic disorders, hormone-dependent cancer).

HR14 Men who have risk factors for myocardial infarction (e.g., high blood cholesterol, smoking, diabetes mellitus, family history of early-onset CAD) and who lack a history of gastrointestinal or other bleeding problems, or other risk factors for bleeding or cerebral hemorrhage.

HR15 Persons with increased exposure to sunlight.

HR16 Homosexually active men, intravenous drug users, recipients of some blood products, or persons in health-related jobs with frequent exposure to blood or blood products.

**Table 8.
Pregnant Women¹**

Table 8. Pregnant Women¹	
FIRST PRENATAL VISIT	
<p>SCREENING</p> <p>History</p> <p>Genetic and obstetric history Dietary intake Tobacco/alcohol/drug use Risk factors for intrauterine growth retardation and low birthweight Prior genital herpetic lesions</p> <p>Laboratory/Diagnostic Procedures</p> <p>Blood pressure Hemoglobin and hematocrit ABO/Rh typing Rh(D) and other antibody screen VDRL/RPR Hepatitis B surface antigen (HBsAg) Urinalysis for bacteriuria Gonorrhea culture</p> <p>HIGH-RISK GROUPS</p> <p>Hemoglobin electrophoresis (HR1) Rubella antibodies (RH2) Chlamydial testing (HR3) Counseling and testing for HIV (HR4)</p>	<p>COUNSELING</p> <p>Nutrition Tobacco use Alcohol and other drug use Safety belts</p> <p>HIGH-RISK GROUPS</p> <p>Discuss amniocentesis (HR5) Discuss risks of HIV infection (HR4)</p> <p>Remain Alert For:</p> <p>Signs of physical abuse</p>
FOLLOW-UP VISITS	
Schedule: See Footnote*	
<p>SCREENING</p> <p>Blood pressure Urinalysis for bacteriuria</p> <p>Screening Tests at Specific Gestational Ages</p> <p>14-16 Weeks Maternal serum alpha-fetoprotein (MSAFP)² Ultrasound cephalometry (HR8)</p> <p>24-28 Weeks: 50 g oral glucose tolerance test Rh(D) antibody (HR9) Gonorrhea culture (HR10) VDRL/RPR (HR11) Hepatitis B surface antigen (HBsAg) (HR12) Counseling and testing for HIV (HR13)</p> <p>36 Weeks: Ultrasound exam (HR14)</p>	<p>COUNSELING</p> <p>Nutrition Safety belts Discuss meaning of upcoming tests</p> <p>HIGH-RISK GROUPS</p> <p>Tobacco use (HR6) Alcohol and other drug use (HR7)</p> <p>Remain Alert For:</p> <p>Signs of physical abuse</p>
<p>1. See also Tables 4-6 for other preventive services for women. 2. Women with access to counseling and follow-up services, skilled high-resolution ultrasound and amniocentesis capabilities, and reliable, standardized laboratories.</p>	
<p>*Because of lack of data and differing patient risk profiles, the scheduling of visits and the frequency of the individual preventive services listed in this table are left to clinical discretion, except for those indicated at specific gestational ages.</p>	

Table 8. Pregnant Women

High Risk Categories

- HR1** Black women.
- HR2** Women lacking evidence of immunity (proof of vaccination after the first birthday or laboratory evidence of immunity).
- HR3** Women who attend clinics for sexually transmitted diseases, attend other high-risk health care facilities (e.g., adolescent and family planning clinics), or have other risk factors for chlamydial infection (e.g., multiple sexual partners or a sexual partner with multiple sexual contacts).
- HR4** Women seeking treatment for sexually transmitted diseases; past or present intravenous (IV) drug users; women with a history of prostitution or multiple sexual partners; women whose past or present sexual partners were HIV-infected, bisexual, or IV drug users; women with long-term residence or birth in an area with high prevalence of HIV infection; or women with a history of transfusion between 1978 and 1985.
- HR5** Women aged 35 and older.
- HR6** Women who continue to smoke during pregnancy.
- HR7** Women with excessive alcohol consumption during pregnancy.
- HR8** Women with uncertain menstrual histories or risk factors for intrauterine growth retardation (e.g., hypertension, renal disease, short maternal stature, low prepregnancy weight, failure to gain weight during pregnancy, smoking, alcohol and other drug abuse, and a history of a previous fetal death or growth-retarded baby).
- HR9** Unsensitized Rh-negative women.
- HR10** Women with multiple sexual partners or a sexual partner with multiple contacts, or sexual contacts of persons with culture-proven gonorrhea.
- HR11** Women who engage in sex with multiple partners in areas in which syphilis is prevalent, or contacts of persons with active syphilis.
- HR12** Women who engage in high-risk behavior (e.g., intravenous drug use) or in whom exposure to hepatitis B during pregnancy is suspected.
- HR13** Women at high risk (see HR4) who have a nonreactive test at the first prenatal visit.
- HR14** Women with risk factors for intrauterine growth retardation (see HR8).

(a)

DIVISION OF HEALTH PLANNING AND RESOURCES DEVELOPMENT

Certificate of Need: Computerized Tomography (CAT/CT) Services

Proposed Repeal: N.J.A.C. 8:33G

Authorized By: Frances J. Dunston, M.D., M.P.H.,
Commissioner, Department of Health (with approval of the
Health Care Administration Board).

Authority: N.J.S.A. 26:2H-5 and 26:2H-8.

Proposal Number: PRN 1992-487.

Submit comments by December 16, 1992 to:

John J. Gontarski, Chief
Health Systems Review Program, Room 604
New Jersey Department of Health
CN 360
Trenton, NJ 08625

The agency proposal follows:

Summary

The 1971 Health Care Facilities Planning Act, N.J.S.A. 26:2H-1 et seq., as amended, requires the Department to assure that New Jersey's hospital and related health care services are of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost. To implement this public policy, the Act gave the Department of Health broad responsibilities in regulating the health care system through authorization of the Certificate of Need Program.

The Department initially adopted Computerized Tomography (CAT/CT) Standards, N.J.A.C. 8:33G, on February 23, 1977. These rules have been amended periodically to respond to the increased clinical acceptance of this imaging modality. The intent of these rules, as amended over the years, continues to be the identification of standards and criteria to be used by the Department of Health, to effectively judge the need for CT services throughout the State.

Many changes have occurred in health care over the 15 years that these rules have been in effect and amendments have been adopted over these years to reflect these clinical changes and to permit greater diffusion of this imaging modality. The Department has reviewed the present rules during the development of the High Technology subchapter of the State Health Plan and determined that they are no longer necessary and should be repealed at this time. Because of the clinical value of this technology to medical diagnosis, it is no longer the proper

subject of the State's regionalization efforts. Rather, it is a technology that should be available in all acute care hospitals.

Social Impact

N.J.S.A. 26:2H-1 (as amended) recognizes as "public policy of the State that hospitals and related health care services of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost are of vital concern to the public health. In order to provide for the protection and promotion of the health of inhabitants of the State, promote the financial solvency of hospitals and similar health care facilities and contain the rising cost of health care services, the State Department of Health . . . shall have the central, comprehensive responsibility for the development and administration of the State's policy with respect to health planning, hospital and health care services, and health facility cost containment programs . . ."

The New Jersey State Health Plan recognizes the underutilization of specialty services as an important factor contributing to the rapidly escalating cost of health care. Regionalization of specialty services is viewed as an important mechanism for promoting health by improving the capabilities of services and quality of care offered, by improving the solvency of facilities offering these services, and by containing the rising costs of health care services. The most recent iteration of the State Health Plan, however, no longer considers the policies contained in these rules to be necessary, since this technology is no longer considered to be a specialized service.

Economic Impact

The economic impact of CAT/CT services is largely dependent on the ability of the imaging modality to provide clinically useful information compared to other existing imaging modalities. To a large extent, the clinical utility and importance of CT has been clearly determined during the past decade. As a result of this clinical acceptance, the application of these rules, over time, has permitted the initiation of CT services at all acute care hospitals in New Jersey. There is, therefore, no longer a need to regionalize this service, given the clinical necessity of this diagnostic imaging modality in the acute inpatient setting and the current distribution of this service.

The elimination of these existing rules will not result in significant economic impact, since the cost of CT is already integrated into the State's reimbursement mechanism for all acute care hospitals.

Regulatory Flexibility Statement

Since the rules requiring a certificate of need for computerized tomography scanners are being repealed, no additional requirements are being imposed on small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Therefore, a regulatory flexibility analysis is not required.

Full text of the rules proposed for repeal appears in the New Jersey Administrative Code at N.J.A.C. 8:33G.

(a)

DIVISION OF HEALTH PLANNING AND RESOURCES DEVELOPMENT

Certificate of Need: Megavoltage Radiation Oncology Services

Proposed New Rules: N.J.A.C. 8:33I

Authorized By: Frances J. Dunston, M.D., M.P.H.,
Commissioner, Department of Health (with approval of the Health Care Administration Board).

Authority: N.J.S.A. 26:2H-1 et seq., specifically 26:2H-5.

Proposal Number: PRN 1992-488.

Submit comments by December 16, 1992 to:

John J. Gontarski, Chief
Health Systems Review Program
New Jersey Department of Health
CN 360, Room 604
Trenton, New Jersey 08625-0360

The agency proposal follows:

Summary

On October 6, 1977, the Department of Health established rules to govern the planning, certification of need, and designation requirements for megavoltage radiation oncology services. Following a comprehensive Statewide planning effort based on the megavoltage rules established at N.J.A.C. 8:33I, a system of regionalized megavoltage radiation oncology services was established. This effort involved the establishment of regional programs to provide appropriate volumes of treatment services at each site to maintain the proficiency of the treatment team and to advance the quality and cost effectiveness of each program. These megavoltage rules remained in effect, with periodic amendments, until their expiration on September 15, 1991 pursuant to the provisions of Executive Order No. 66(1978).

Efforts to readopt these megavoltage radiation oncology rules prior to their impending expiration were interrupted by the promulgation of the Health Care Cost Reduction Act (P.L. 1991, c.187). The new chapter being proposed at this time is consistent with both the previous megavoltage rules and the advice contained in the draft cancer chapter of the State Health Plan. However, since this chapter will become effective prior to the finalization of the cancer chapter of the State Health Plan, the Department views the chapter proposed here as an interim measure that is principally intended to reaffirm the regional nature of this service and serve to guide the consideration of replacement megavoltage services. It is anticipated that future amendments may be necessary in order to refine policies regarding quality assurance measures, in consideration of the advice contained in Phase II of the State Health Plan.

The purpose of the rules continues to be the establishment of a basis for the Department of Health, State Health Planning Board, and Local Advisory Boards (LABs) to:

1. Promote delivery of the highest quality of care to all patients requiring megavoltage radiation oncology services;
2. Maximize utilization of highly trained megavoltage radiation oncology treatment personnel, equipment, and facilities;
3. Promote cost effectiveness throughout the system; and
4. Emphasize a coordinated, cooperative and multi-disciplinary approach to megavoltage radiation oncology services.

The proposed rules establish minimum criteria for the initiation, retention, or expansion of megavoltage radiation oncology services. The rules seek to promote megavoltage services that contain multiple units that are capable of providing a full range of photon and electron beam energies, as opposed to the promotion of multiple single unit programs in the State. The rules also prohibit the establishment of new megavoltage programs in the absence of demonstrated need in an effort to encourage multiple unit services Statewide and to discourage the unnecessary proliferation and duplication of services which would generate unwarranted additional costs to payers of health care.

The new rules being proposed at this time seek to clarify the definition of a megavoltage "program" at N.J.A.C. 8:33I-1.2, and to establish the

parameters for consideration of the need to expand, replace or initiate megavoltage radiation oncology equipment and services at N.J.A.C. 8:33I-1.4. Minimum staffing, equipment, physical plant, quality assurance, support service and data reporting requirements are contained in the rules in order to assure the proper operation of an effective and efficient regional megavoltage radiation oncology service.

Since the new rules are being proposed without the advantage of the relevant advice contained in the State Health Plan, the Department views this proposal as an interim measure that is principally intended to reaffirm the regional nature of this service and can serve to guide the consideration of replacement megavoltage services while awaiting completion of the cancer chapter of the State Health Plan. It is anticipated that future amendments may be necessary to refine policies regarding quality assurance measures. A two year expiration date is also being proposed in order to make clear the Department's intention to review and amend this chapter to conform to the final text of the cancer chapter of the State Health Plan.

Social Impact

N.J.S.A. 26:2H-1 (as amended) recognizes as "public policy of the State that hospitals and related health care services of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost are of vital concern to the public health. In order to provide for the protection and promotion of the health of inhabitants of the State, promote the financial solvency of hospitals and similar health care facilities and contain the rising cost of health care services, the State Department of Health . . . shall have the central, comprehensive responsibility for the development and administration of the State's policy with respect to health planning, hospital and health care services, and health facility cost containment programs. . . ."

The New Jersey State Health Plan and the general health care planning literature recognize the underutilization of inpatient beds, specialty services, and expensive equipment as an important factor contributing to the rapidly escalating costs of health care. Regionalization of specialty services and equipment is viewed as an important mechanism for promoting health by improving the capabilities of services and quality of care offered, by assuring an adequate patient volume for providers offering these expensive services, and by containing the rising costs of health care services.

The Department believes the rules being proposed will be effective in addressing their established goal of promoting appropriate access to a high quality of care for oncology patients in a cost effective manner.

Economic Impact

The rules were established to address both quality of care, access, and cost-effectiveness goals. Through implementation of similar regional policies in the past, delivery of high-cost megavoltage radiation oncology services of high quality have been effectively provided in New Jersey. The economic impact of these rules has thus been to produce initial cost efficiencies in the system of megavoltage oncology services through improving utilization of high-cost services and in avoiding unnecessary duplication of services.

The proposed new rules would limit additional megavoltage oncology programs unless there is documentation of sufficient unmet need to warrant the initiation of an efficient new megavoltage service which can achieve the required patient volumes without negatively impacting existing providers in the region.

The new rules being proposed should reduce the likelihood that megavoltage programs would be permitted to proliferate at separate individual sites, thereby reducing the cost inefficiencies inherent in providing similar services at multiple sites. It is the Department's position that the provision of a wide range of megavoltage services at a single site improves the overall cost effectiveness of providing these services and promotes a comprehensive approach to patient care which is in the best interest of patients.

Regulatory Flexibility Analysis

Facilities affected by these rules consist largely of hospitals with more than 100 beds. These hospitals typically employ well over 100 full-time employees. It is possible, however, that smaller entities that are not specifically affiliated with hospitals will be considered as megavoltage radiation oncology providers under these rules. The requirements contained in these rules do require personnel to perform a limited number of recordkeeping and reporting functions, with attendant administrative costs. Such requirements do not necessitate the dedication of additional non-clinical staff and should not be considered overly burdensome to

the applicants that might be considered small businesses as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq.

In proposing these rules the Department has had to balance the economic impact of added personnel costs with the need to provide a safe and effective health care service. The Department has determined that to minimize the economic impact of this proposed rule would endanger public health and safety and, therefore, no differentiation based on business size is provided.

Full text of the proposed new rules follows:

CHAPTER 33I
CERTIFICATE OF NEED:
MEGAVOLTAGE RADIATION ONCOLOGY

SUBCHAPTER 1. GENERAL CRITERIA AND STANDARDS

8:33I-1.1 Scope and purpose

The purpose of the chapter is to establish criteria and standards for the review of certificate of need applications for existing or potential providers of megavoltage radiation oncology services. The chapter establishes minimum criteria for the initiation, retention, or expansion of megavoltage radiation oncology services. The chapter also seeks to promote megavoltage services that contain multiple units that are capable of providing a full range of photon and electron beam energies, as opposed to the promotion of multiple single unit programs in the State. In addition, the chapter prohibits the establishment of new megavoltage programs in the absence of demonstrated need in an effort to encourage multiple unit services Statewide and to discourage the unnecessary proliferation and duplication of services which would generate unwarranted additional costs to payers of health care.

8:33I-1.2 Definitions

(a) For purposes of this subchapter, the following definitions shall apply.

"Local advisory board region" means a cluster of counties in a particular area of the State. For the purpose of this chapter, the local advisory board regions in New Jersey are as follows:

1. Local Advisory Board Region I: Passaic, Morris, Sussex, and Warren Counties;
2. Local Advisory Board Region II: Bergen and Hudson Counties;
3. Local Advisory Board Region III: Essex and Union Counties;
4. Local Advisory Board Region IV: Hunterdon, Mercer, Middlesex, and Somerset Counties;
5. Local Advisory Board Region V: Burlington, Camden, Cumberland, Gloucester, and Salem Counties.
6. Local Advisory Board Region VI: Monmouth, Ocean, Atlantic and Cape May Counties.

"Megavoltage program" means an entire therapy department or facility which may house single or multiple megavoltage units.

"Megavoltage unit" means an individual piece of radiotherapy equipment generating beam energies in excess of 1,000 kilovolts.

"MeV" refers to a megavoltage unit with both photon and electron beam capability.

"MV" refers to a megavoltage unit with only photon beam capability.

(b) "Energy levels" of megavoltage units shall be defined as follows:

1. Low energy means four to six MV X-ray energy (exclusive of electron energy capability and inclusive of cobalt 60 units with source to skin distance of equal to or greater than 80 centimeters).
2. Medium/high energy means greater than six MV X-ray or MeV electron energy to 20 MV X-ray or MeV electron energy.
3. Higher energy means energies in excess of 20 MV X-ray or MeV electron.

8:33I-1.3 Utilization of megavoltage units and programs

(a) Single unit megavoltage programs shall be subject to the following:

1. Minimum annual utilization for megavoltage unit replacement in single unit megavoltage programs shall be 300 total patients or 6,200 patient visits. Consideration of minimum utilization standard compliance will take into account the output of Cobalt 60 devices

and the age of the equipment. Compliance with these minimum standards will be based on the actual utilization of each megavoltage unit for the calendar year immediately prior to the submission of the certificate of need application to replace the equipment.

2. Failure to achieve an average minimum utilization as defined in (a)1 above, during any 36 consecutive months, may result in a recommendation for denial of reimbursement for the service by the Department to the Hospital Rate-Setting Commission and shall form a sufficient basis for the Commissioner to delicense the service.

i. Megavoltage units with medium/high energy capability or some combination thereof (commonly referred to as dual energy units) will be approved for single unit megavoltage programs where they have documented compliance with minimum utilization requirements as defined in (a)1 above and can justify the equipment in terms of clinical effectiveness and cost efficiency.

(b) Multiple unit megavoltage programs shall be subject to the following:

1. Applicants for a second megavoltage unit at an existing megavoltage program shall document minimum acceptable annual utilization level (on its existing unit) of 9,000 actual patient visits or 500 actual patients and project the achievement of 10,500 patient visits and 600 patients within two years of installation of the second megavoltage unit. Compliance with these minimum utilization standards will be based on the actual utilization of each megavoltage unit for the calendar year immediately prior to the submission of the certificate of need application to replace the equipment.

2. Multiple unit megavoltage programs shall have medium/high energy equipment capability (as defined at N.J.A.C. 8:33I-1.2(b)) and have on-site simulation capability.

3. Dual energy megavoltage units will be considered for second units in multiple unit megavoltage programs that meet the utilization requirements identified in (b)1 above.

4. Applicants for a third megavoltage unit at an existing multiple unit megavoltage program shall meet a minimum acceptable annual utilization level (on its existing two units) of 16,000 actual patient visits or 900 actual patients. Compliance with these minimum utilization standards will be based on the actual utilization of each megavoltage unit for the calendar year immediately prior to the submission of the certificate of need application to replace the equipment.

5. Failure to achieve projected minimum utilization as defined in (b)1 above, within three years of installation of the additional megavoltage equipment, may result in a recommendation for denial of reimbursement for the service by the Department to the Hospital Rate-Setting Commission and shall form a sufficient basis for the Commissioner to delicense the service.

6. Multiple unit programs failing to achieve an average annual minimum utilization level as defined at (b)1 or (b)4 above, whichever is applicable, during any period of 36 consecutive months may result in a recommendation for denial of reimbursement for the service by the Department to the Hospital Rate-Setting Commission and shall form a sufficient basis for the Commissioner to delicense the service.

8:33I-1.4 Megavoltage radiation oncology resource allocation policy

(a) The Department of Health will process certificate of need applications for new radiation oncology programs consistent with the provisions of the Certificate of Need Policy Manual (N.J.A.C. 8:33) and only from local advisory board regions where all existing licensed radiation oncology programs meet minimum annual levels of utilization as specified at N.J.A.C. 8:33I-1.3. In addition, the annual patient treatment capacity levels for existing and approved megavoltage equipment must exceed 90 percent for the calendar year prior to the Commissioner's call for certificate of need applications for new services pursuant to N.J.A.C. 8:33-4.1(a).

1. For purposes of this section, annual megavoltage equipment treatment capacity is defined as 500 patients per unit for linear accelerators and 250 patients per unit for Cobalt-60 units.

(b) No more than one new radiation oncology program shall be approved in each local advisory board region as defined at N.J.A.C. 8:33I-1.2, where all existing megavoltage radiation oncology programs are operating at minimum levels of utilization as specified

of N.J.A.C. 8:33I-1.3. Additional new facilities will be considered only when both existing and approved facilities in a given local advisory board region are operating at minimum levels of utilization as specified at N.J.A.C. 8:33I-1.3.

(c) Applications for new and additional radiation oncology programs in a health service area will be evaluated on the basis of their ability to meet the standards established in this subchapter. In addition, the following factors will also be considered in the review process:

1. Demonstration of institutional and provider competence in delivering the proposed service and the availability of American College of Radiology (ACR) approved detection services (that is, mammography) and other appropriate cancer screening and detection services;
2. Capacity to perform the proposed service at the recommended minimum level within the stated period of time;
3. Commitment from the hospital's Board to establish the proposed service program;
4. Examination of the treatment capacity (as defined at (a)1 above) of existing facilities in the referral area;
5. Evidence that essential support services in the hospital (for example, counseling and social support services) are readily available and are capable of providing the necessary support services to both the patient and family members, when appropriate;
6. Evidence that the project would be financially feasible;
7. Evidence that demographic and cancer disease incidence and prevalence statistics in the local advisory board (LAB) region support service growth;
8. Evidence that the proposed service is compatible with overall health planning goals and recommendations for the State as identified in the State Health Plan and for the local advisory board area; and
9. Evidence that barriers to access to care do not exist, including access to cancer screening and detection programs, and that if no barriers exist, that access to care will remain constant or improve for individuals in the service area.

(d) Waivers from the requirements of (a) and (b) above may be considered where an applicant and the local advisory board have been able to document specific and quantifiable evidence that, in the absence of a waiver, serious problems of access to a needed service would result. Documentation should also be provided that indicates that existing area providers of this service will not be jeopardized (for example, experience a significant decline in volume) by the proposed new provider will meet all requirements contained in this subchapter.

(e) All certificate of need applications for new megavoltage radiation oncology programs shall document the ability of the applicant to meet the minimum standards and criteria contained in this subchapter within three years from the initiation of the service. The inability to achieve minimum utilization levels during the third year of operations or thereafter will form a sufficient basis for the Commissioner to delicense the service and/or recommend reimbursement sanctions as specified at N.J.A.C. 8:33I-1.3(a)2, (b)5 and (b)6.

8:33I-1.5 Personnel standards

(a) Each applicant for a certificate of need for a megavoltage radiation therapy unit shall provide the Department with written documentation that the following minimal staff complement shall be available:

1. One full-time equivalent radiation therapist directing radiation therapy for each program.
 - i. For the purpose of this section, a qualified radiation therapist shall be considered to be one who has been:
 - (1) Certified or is eligible for certification by the American Board of Radiology in general radiology prior to 1976; or
 - (2) Certified or eligible for certification by the American Board or the American Osteopathic Board of Radiology in therapeutic radiology since 1976;
2. Adequate coverage in single unit programs by a qualified radiological physicist to insure that Cobalt-60 units and other energy units are calibrated and employed properly in keeping with the

volume of patients. In multiple unit programs, one full-time equivalent qualified radiological physicist is required.

i. For the purposes of this section, qualified radiologist physicist shall mean one who:

- (1) Is certified by the American Board of Radiology in either radiological physics or therapeutic radiological physics;
 - (2) Is eligible for such certification;
 - (3) Has a bachelor's degree in the physical sciences and three years full-time experience in clinical radiation therapy physics working under the direction of a physicist certified (or board eligible) by the American Board of Radiology or has a doctorate or master's degree in physical sciences and two years' such experience; or
 - (4) Has a doctorate or master's degree in radiological or medical physics and two years of post-graduate clinical therapeutic physics experience.
3. Two full-time equivalent radiotherapy technicians per unit (licensed by the State of New Jersey in accordance with N.J.S.A. 26:2D-24 et seq. and N.J.A.C. 7:28-19;
 4. One full-time equivalent nurse is required in multiple unit programs; and
 5. One full-time equivalent simulator technician is required in multiple unit programs.

8:33I-1.6 General criteria

(a) As part of the application for a megavoltage radiation therapy unit, each application shall meet the following minimum general criteria:

1. Provide full compliance with Nuclear Regulatory Commission (N.R.C.) radiation standards as contained in Title 10, Code of Federal Regulations (1976, section 19 and 20), and the State of New Jersey Department of Environmental Protection radiation standards as contained in N.J.A.C. 7:28-14.1. If not in full compliance, a written estimate of applicable costs necessary to achieve full compliance shall be furnished by the applicant to the Department as part of the certificate of need application;
2. Provide for a multi-disciplinary approach to the management of cancer patients by involving all cancer disciplines in a joint treatment program. Such a program should include the establishment of an American College of Surgeons-approved cancer program, a tumor registry and a follow-up program;
3. Provide full written documentation of the purchase and operational costs of the proposed megavoltage unit. The applicant shall include both direct and indirect costs, that is, personnel, maintenance agreements, supplies and overhead. The cost of the remodeling or renovating necessary to accommodate the therapy unit should be included. Projections of anticipated revenues during the first two years of operation shall be supplied with the certificate of need application;
4. Provide written documentation in the form of an institutional policy statement that the center will accept referrals from physicians not ordinarily having access to the applicant's facilities;
5. Each applicant shall provide evidence that social and psychological counseling services will be available for its therapy patients. Such counseling shall be conducted by staff or by arrangement with other community resources or facilities.
6. Each applicant shall document the availability of adequate radiation treatment planning services;
7. Each applicant shall provide written documentation that it will not, directly or indirectly, refuse referrals on the basis of the patient's race, religion, sexual orientation, age or ability to pay. The applicant shall certify in writing compliance with all Federal and State laws in this regard;
8. Each applicant shall maintain and provide basic statistical data on the operation of the unit and report the data to the New Jersey State Department of Health at least annually, and no more than quarterly on a standardized form prepared by the Department. Data shall include, but not be limited to, number of personnel, number of patients, number of patient visits, and number of patients simulated. Copies of the required reporting forms may be obtained upon written request to the New Jersey State Department of Health, Center for Health Statistics, Room 404, CN 360, Trenton, New Jersey 08625;

9. Megavoltage programs shall be limited to a single licensed facility or single site, for example, the immediate campus location of the service. Existing providers of megavoltage services who submit certificate of need applications to locate megavoltage equipment off the site of their existing service shall be required to satisfy the requirements of N.J.A.C. 8:33I-1.4, concerning new megavoltage programs.

(a)

OFFICE OF HEALTH POLICY AND RESEARCH
Certificate of Need: Rehabilitation Hospitals and
Comprehensive Rehabilitation Services
Bed Need Methodology for Adult Comprehensive
Rehabilitation Services

Proposed Amendment: N.J.A.C. 8:33M-1.6

Authorized By: Frances J. Dunston, M.D., M.P.H.,

Commissioner, Department of Health (with approval of the Health Care Administration Board).

Authority: N.J.S.A. 26:2H-1 et seq., specifically 26:2H-5 and 26:2H-8.

Proposal Number: PRN 1992-489.

Submit comments by December 16, 1992 to:

Nancy Moyer, Ph.D.
 Office of Health Policy and Research
 New Jersey State Department of Health
 CN 360
 Trenton, NJ 08625

The agency proposal follows:

Summary

N.J.A.C. 8:33M, Certificate of Need: Rehabilitation Hospitals and Comprehensive Rehabilitation Services, was first adopted July 17, 1989. When the rules were subsequently applied in reviewing certificate of need applications, questions arose regarding the language contained in N.J.A.C. 8:33M-1.6(c)4 and 5, which states the adult bed need methodology. This methodology, or formula, is used to determine the number of adult comprehensive rehabilitation beds which are projected to be needed in a future target year.

A new methodology was developed and proposed by the Department of Health in 1991 (see 23 N.J.R. 1908(a)). However, the Health Care Administration Board decided against final adoption of that proposal due to other significant developments that had a direct bearing on N.J.A.C. 8:33M. Specifically, the Health Care Cost Reduction Act had recently become law, creating a new health planning process in New Jersey. Because of the Act's mandate that a comprehensive State Health Plan be developed to guide all certificate of need (CN) decision-making, the Department of Health imposed a moratorium on CN activity.

When adopted July 20, 1992, the long-term care planning rules at N.J.A.C. 8:100-18 (see 24 N.J.R. 2561(a)) included a section on comprehensive rehabilitation. The latter recommended that N.J.A.C. 8:33M be "amended to include a new, LAB (Local Advisory Board) region-specific, patient-origin and age-based adult bed need methodology". The amendment proposed here fulfills the recommendation of N.J.A.C. 8:100-18.18. When adopted, the moratorium on certificate of need activity for rehabilitation hospitals will conclude in accordance with the provisions of N.J.A.C. 8:33-5.1(c), and the Commissioner of the Department of Health will call for applications in areas where there is a need.

In proposing the amendment of N.J.A.C. 8:33M-1.6, it is the Department's aim to eliminate confusion about the method to be used in computing the need for adult comprehensive rehabilitation beds. But furthermore, as a result of analyzing alternative approaches to computing bed need, the Department has developed a more straightforward and sensitive methodology for accurately determining comprehensive rehabilitation bed need.

The formula proposed herein does away with the current, cumbersome reliance upon diagnosis-specific rates of acute care hospital utilization and hypothetical diagnosis-specific rates of admission to rehabilitation hospitals from acute care hospitals. It is more sensitive than the existing methodology, in that it is based upon patient origin data.

In addition, the proposed amendment will update N.J.A.C. 8:33M to reflect the recently created local advisory board regions. These regions will form the basis for rehabilitation hospital planning decisions and, as such, will replace the northern, central, and southern regions which are currently designated in the rule.

The Department hereby proposes the following amendments to N.J.A.C. 8:33M-1.6:

1. Modification of N.J.A.C. 8:33M-1.6(a) to delete the now obsolete batching cycles for rehabilitation hospitals. In their place, the applicant is referred to N.J.A.C. 8:33, Certificate of Need Policy Manual and to the fact that applications will now be accepted only in response to a call issued by the Commissioner;

2. Replacement of regional service area with local advisory board regions and specification of the LABs at N.J.A.C. 8:33M-1.6(b);

3. Insertion of a provision at N.J.A.C. 8:33M-1.6(c)3i and ii, to identify the type of information required by the Department in order to implement the proposed new bed need methodology, and the penalty for not providing the data in a timely manner;

4. Deletion of N.J.A.C. 8:33M-1.6(c)4 and 5, eliminating the current methodology used for computing adult bed need;

5. Addition of a new paragraph at N.J.A.C. 8:33M-1.6(c)4, detailing the proposed new methodology for computing adult bed need. The 10-step method entails the computation of age-specific, county-specific rates of actual rehabilitation hospital use. For counties with unusually low rates of utilization, Step 3, contained in subparagraph (c)4iii, requires the calculation and substitution of minimum acceptable rates of utilization. The latter adjustment is intended to improve the availability of, and access to, rehabilitation hospital care in areas that may be underserved. The methodology also entails the use of Statewide, age-specific average lengths of stay. In Steps 6 and 7, proposed in subparagraphs (c)4vi and vii, the projected number of patient days is computed for each county and is then adjusted to allow for 85 percent occupancy. The number of beds needed in each region is the result of summing the bed need for those counties located in each planning region. Step 9, proposed in subparagraph (c)4ix, describes an approach to factoring in the number of beds needed to accommodate non-New Jersey patients who are admitted to New Jersey's rehabilitation hospitals.

6. The replacement of N.J.A.C. 8:33M-1.6(d), to clarify the process for determining the number of beds that can be added to highly occupied rehabilitation hospitals in regions where there is no documented bed need. The proposed new subsection identifies the method to be used in computing the number of beds to be added, basing the increase exclusively on the facility's occupancy of its comprehensive rehabilitation beds during the 12 month period prior to filing the certificate of need application. It differs from the existing policy, which bases allowable bed increases on projected, future utilization at a particular facility. The latter approach has been problematic for the Department, in that applicants have attempted to use this provision to increase their licensed complement of comprehensive rehabilitation beds by as much as 56 percent. Thus, existing rehabilitation hospitals could conceivably make use of the current provision to add such a large number of beds that the bed need formula will never show a net need for the region. In this way, new rehabilitation providers would be precluded from ever getting approved. It is the Department's position that small bed increases should be permitted in order to prevent overcrowding at existing facilities; however, the addition of these beds should not have the ultimate effect of precluding approval of new rehabilitation hospitals, which new hospitals might benefit the public by improving the geographical distribution of beds throughout New Jersey.

Social Impact

It is anticipated that the proposed amendments will have a positive social impact. Deletion of the current methodology for computing adult rehabilitation hospital bed need will eliminate the confusion which was created by its ambiguous wording. The proposed, new methodology is patient origin-based. Through the use of age-specific, county-specific patient origin data, the Department will be able to readily identify particular local advisory board regions of the State that may be underserved for rehabilitation hospital care. New rehabilitation facilities can thus be targeted for development in these areas, thereby improving access to care for New Jersey residents.

Economic Impact

It is not anticipated that the proposed amendments will have a significant economic impact on any State agency or department. Furthermore, the new planning/certificate of need requirements should not have any

appreciable effect on the cost of rehabilitation hospital care. The bed need methodology proposed in N.J.A.C. 8:33M-1.6(c)4 is intended to assure that rehabilitation hospital care will be available to the extent that it is needed in New Jersey. Thus, a goal of planning is to see that there is neither an under-supply nor an over-supply of rehabilitation hospital beds which, in either case, could have a deleterious impact on New Jersey health care consumers and/or service providers. For example, an over-supply of rehabilitation hospital beds would result in low occupancy rates at the facilities, thereby increasing unit costs of care and potentially threatening the fiscal viability of the institutions.

Regulatory Flexibility Analysis

Certificate of need applicants that will be affected by these proposed amendments may include some small businesses that employ fewer than 100 persons, such as real estate development companies or consulting firms. However, the proposed amendments do not impose any additional recordkeeping, reporting, or other compliance requirements on small businesses, as that term is defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The amendments merely modify the current requirement by which the need for adult rehabilitation hospital beds is determined for certificate of need purposes. As such, the amendments will apply to all certificate of need applicants for rehabilitation hospital beds; but they should not require small businesses to utilize any additional professional services in order to comply with their specific terms. The Department has, therefore, elected to provide no differentiation based upon business size in these rules.

Full text of the proposal follows (additions indicated in boldface thus; deletions indicated in brackets [thus]):

8:33M-1.6 Requirements for expansion and new construction

(a) Certificate of need applications for new rehabilitation hospitals or for bed additions to existing rehabilitation hospitals shall be filed with the Department in accordance with the [batching cycles for comprehensive rehabilitation. Filing dates for these batching cycles shall be April 1 and October 1 of each year, beginning with that filing date which falls a minimum of 60 days subsequent to the effective date of the rules contained in this chapter] **provisions of N.J.A.C. 8:33, the Certificate of Need Policy Manual, in response to a call for applications which is issued by the Commissioner.**

(b) To promote the efficient provision of comprehensive rehabilitation, these services shall be provided by rehabilitation hospitals on a regional basis. The applicant shall therefore identify the proposed [regional service area] **local advisory board region** for any new or expanding rehabilitation hospital and shall provide documentation of how the facility will assure access to comprehensive rehabilitation for the population residing throughout that [service area] **region.**

1. For certificate of need purposes, the regional service area proposed by an applicant shall be one of the following:

i. Northern region: Bergen, Passaic, Hudson, Essex, Morris, Sussex, Union, and Warren Counties;

ii. Central region: Hunterdon, Mercer, Middlesex, Monmouth, Ocean and Somerset Counties; or

iii. Southern region: Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, and Salem Counties.]

i. Local Advisory Board Region I: Passaic, Morris, Sussex, and Warren Counties;

ii. Local Advisory Board Region II: Bergen and Hudson Counties;

iii. Local Advisory Board Region III: Essex and Union Counties;

iv. Local Advisory Board Region IV: Hunterdon, Mercer, Middlesex, and Somerset Counties; or

v. Local Advisory Board Region V: Burlington, Camden, Cumberland, Gloucester, and Salem Counties.

vi. Local Advisory Board Region VI: Atlantic, Cape May, Monmouth, and Ocean Counties.

(c) New comprehensive rehabilitation beds shall be approved only in [service areas] **local advisory board regions** where there is a documented, projected bed need.

1. (No change.)

2. For the purpose of computing bed need, the Department shall maintain [an inventory of approved] **separate inventories of approved pediatric and adult comprehensive rehabilitation beds for each [service area,] local advisory board region identified in (b)**

above, and these beds shall be subtracted from the projected number of beds needed in each [service area] respective local advisory board region. Approved comprehensive rehabilitation beds shall include those that are authorized and licensed as described in N.J.A.C. 8:33M-1.1(e) and all comprehensive rehabilitation beds that receive certificate of need approval.

3. Need projections shall be computed using the most recent available data from [acute care hospitals (Uniform Bill-Patient Summary data maintained by the Health Research and Educational Trust of New Jersey), rehabilitation facilities (rehabilitation hospital utilization data—discharge abstracts, which are submitted by all facilities to the Department of Health)] **licensed rehabilitation hospitals, both freestanding and non-freestanding in accordance with N.J.A.C. 8:33M-1.1(b) above, and the New Jersey Department of Labor (population projections).**

i. Rehabilitation hospitals, both freestanding and nonfreestanding, shall submit utilization data to the Department of Health for each calendar year on an annual basis or more frequently, if requested. Data shall include a breakdown of the number of patients and patient days for the reporting period, according to the age and county of residence of patients.

ii. In the event that a licensed rehabilitation hospital does not provide the utilization data in (c)3i above, in a timely manner as requested by the Department of Health, the Department shall exclude that facility's beds from the inventory used in calculating Statewide utilization rates and bed need for the local advisory board region.

[4. The need methodology for rehabilitation beds for adult patients shall include the following factors:

i. The projected population for four age groups (that is, 20-44, 45-64, 65-74 and 75+) for each of the three regions (that is, north, central, south);

ii. The rate of New Jersey acute care discharges per population for each age group for each of eight diagnostic categories that are likely to require comprehensive rehabilitation (that is, amputation, arthritis, brain/head injury, hip fracture and replacement, back pain, multiple sclerosis, spinal cord injury, and stroke/hemiplegia);

iii. The percentage of discharged acute care cases that are treated in rehabilitation facilities for each of the eight categories listed in (c)4.ii. above;

iv. The projected number of rehabilitation cases by diagnosis for the target year;

v. The average length of rehabilitation stay for each of eight diagnoses and for an "all other" category;

vi. An adjustment factor to allow for a number of "other" rehabilitation cases, which are those patient with diagnoses other than the eight aforementioned categories; and

vii. An adjustment factor to allow for 85 percent occupancy of comprehensive rehabilitation facilities.

5. The adult bed need formula is computed as follows:

i. STEP 1: For Each Region, Each Age Group, Each Diagnostic Category:

$$\frac{\text{Current acute hospital cases}}{\text{Current estimated population}} \times \text{Projected Population, Target Year} = \text{Projected Acute Care Cases for Target Year}$$

ii. STEP 2: For Each Region, Each Diagnostic Category:

$$\frac{\text{Sum of Projected Acute Care Cases for All Specified Age Groups, Target Year}}{\text{Percentage of Patients Admitted to Rehab, Current Year}} \times \frac{\text{Average Rehab Length of Stay, Current Year}}{\text{Percentage of "Other" Diagnoses}} \times \text{Desired Occupancy} = \text{Rehab Cases for Target Year}$$

iii. STEP 3: For Each Region:

$$\frac{\text{Sum of Rehab Cases for All Specified Age Groups for Eight Diagnostic Categories, Target Year}}{\text{Percentage of "Other" Diagnoses}} \times \frac{\text{Average Rehab Length of Stay, "Other" Diagnoses}}{\text{Percentage of Rehab, Cases Current Year}} \times \text{Desired Occupancy} = \text{Rehab Cases for Target Year}$$

iv. STEP 4: For Each Region

$$\begin{matrix} \text{Results of} & + & \text{Results of} & - & \text{Current Regional} & = & \text{Projected Bed} \\ \text{Step 2} & & \text{Step 3} & & \text{Bed Supply} & & \text{Need, Target} \\ & & & & & & \text{Year]} \end{matrix}$$

4. The need for adult comprehensive rehabilitation beds shall be calculated in the following manner:

i. STEP 1: For each county, for the age group 20 to 44, 45 to 64, 65 to 74, and 75 and over, the number of county residents who actually occupied licensed comprehensive rehabilitation beds in facilities located in New Jersey during the time period for which the most recent data are available shall be divided by the concurrent, age-specific population of the respective county;

ii. STEP 2: For the State as a whole, for the age groups 20 to 44, 45 to 64, 65 to 74, and 75 and over, the total number of New Jersey residents who actually occupied licensed comprehensive rehabilitation beds in facilities located in New Jersey shall be divided by the total population for the specified age groups for the concurrent year;

iii. STEP 3: A minimum acceptable rate of patients per population shall be set for each age group identified in (c)4i above. The set minimum figure shall be that rate which is 20 percent less than the Statewide average rate computed for each age group, in accordance with (c)4ii above;

iv. STEP 4: In order to project the number of patients expected to need inpatient comprehensive rehabilitation care in the target year, the rate of patients for each age group for each county, as computed in (c)4i above, shall be multiplied by the age-specific, county-specific population that is projected for the target year. However, if the age-specific, county-specific rate of comprehensive rehabilitation bed utilization computed in accordance with (c)4i above is below the applicable minimum rate computed in accordance with (c)4iii above, then this minimum acceptable rate shall be substituted for the actual age-specific, county-specific rate;

v. STEP 5: Using the most recent data available to the Department of Health, the Statewide average length of stay in licensed comprehensive rehabilitation beds for the age groups 20 to 44, 45 to 64, 65 to 74, and 75 and over, shall be computed by dividing the total number of New Jersey comprehensive rehabilitation patient days utilized by each age group during the reporting period in question by the total number of New Jersey rehabilitation patients for each respective age group;

vi. STEP 6: In order to project the number of patient days expected in the target year, the age-specific, county-specific projected number of patients computed in accordance with (c)4iv above shall be multiplied by the age-specific, Statewide average length of stay computed in accordance with (c)4v above;

vii. STEP 7: The projected number of patient days for all age groups, computed in accordance with (c)4vi above, shall be summed for each county. In order to allow for 85 percent occupancy of comprehensive rehabilitation beds in the target year, the projected number of patient days for each county shall then be divided by .85;

viii. STEP 8: The projected number of patient days for each county, computed in accordance with (c)4vii above, shall be divided by 365 to yield the projected number of comprehensive rehabilitation beds needed by county residents in the target year. The projected number of beds needed by each Local Advisory Board region shall then be computed by summing the number of comprehensive rehabilitation beds required for each of the counties in each respective Local Advisory Board region;

ix. STEP 9: In order to take into account those comprehensive rehabilitation beds in New Jersey rehabilitation hospitals which are utilized by non-New Jersey residents and by patients whose residency is unknown, the number of patient days utilized by non-New Jersey residents and by patients of unknown origin at all rehabilitation hospitals located in each local advisory board region during the most recent year for which data are available shall be summed. The latter number, computed for each local advisory board region, shall then be divided by (365 × .85). The resulting region-specific

number of beds shall then be added to the number of beds needed in each particular local advisory board region, computed in accordance with (c)4viii above; and

x. STEP 10: To arrive at the net number of beds needed in each local advisory board region in the target year, the inventory of approved comprehensive rehabilitation beds in each local advisory board region, determined in accordance with (c)2 above, shall be subtracted from the respective region's bed need, computed in accordance with (c)4viii and ix above.

Recodify 6. as 5. (No change in text.)

[(d) In regions where there is no net, projected bed need according to the methodologies described in (c) above, the Department may give consideration to approving certificate of need applications for additional beds at rehabilitation hospitals that offer documentation of an occupancy rate in excess of 90 percent for a period of at least 12 months immediately prior to filing the application, providing that the applicant meets all other applicable requirements of this chapter including the minimum facility size requirements specified in N.J.A.C. 8:33M-1.5. The applicant shall only be approved for that number of beds which can be expected to result in an 85 percent annual occupancy rate during the twelve month period following licensure of the proposed additional beds. The applicant shall submit documentation, to the satisfaction of the Department of Health, that patients' average length of stay at the hospital does not substantially exceed the statewide average for a comparable patient population.]

(d) In local advisory board regions where there is no net projected bed need according to the methodologies described in (c) above, the Department may give consideration to approving certificate of need applications for small numbers of additional comprehensive rehabilitation beds to be located at the site of existing rehabilitation hospitals with high occupancy rates.

1. In order to receive consideration for approval in accordance with (d) above, rehabilitation hospitals shall be in compliance with all other applicable requirements of this chapter and shall submit documentation, to the satisfaction of the Department of Health, that patients' average length of stay in the licensed comprehensive rehabilitation beds does not substantially exceed the statewide average for a comparable patient population.

2. The maximum number of beds that may be added in accordance with (d) above shall be the difference between a facility's total, licensed comprehensive rehabilitation bed complement and that number which results from multiplying the facility's total, licensed comprehensive rehabilitation bed complement by the annual occupancy rate in those beds for the 12 month period prior to filing the application, and dividing this product by .85. The formula for this calculation shall be as follows:

$$\begin{matrix} \text{Maximum} \\ \text{Comprehensive} \\ \text{Rehab Bed} \\ \text{Addition} \end{matrix} = \frac{\begin{pmatrix} \text{Licensed} \\ \text{Comprehensive} \\ \text{Rehab Bed} \\ \text{Complement} \end{pmatrix} \times \begin{pmatrix} \text{Annual Occupancy} \\ \text{Rate in Licensed} \\ \text{Comprehensive} \\ \text{Rehab Beds} \end{pmatrix}}{.85} - \begin{pmatrix} \text{Licensed} \\ \text{Comprehensive} \\ \text{Rehab Bed} \\ \text{Complement} \end{pmatrix}$$

3. In no case shall the bed increase approved in accordance with (d) above exceed the difference between a facility's total licensed comprehensive rehabilitation bed complement and that number which results from multiplying the facility's total, licensed comprehensive rehabilitation bed complement by an occupancy rate of 100 percent and dividing this product by .85.

(e)-(i) (No change.)

(a)

DIVISION OF HEALTH FACILITIES EVALUATION**Long Term Care Licensing Standards****Use of Restraints and Psychoactive Drugs; Pharmacy Supplies; Establishment of Alzheimer's and Dementia Care Services****Proposed Amendments: N.J.A.C. 8:39-13.4, 27.8, 29.4 and 33.2****Proposed Repeal and New Rule: N.J.A.C. 8:39-27.1****Proposed New Rules: N.J.A.C. 8:39-45 and 46**

Authorized By: Frances J. Dunston, M.D., M.P.H.,

Commissioner, Department of Health (with approval of the Health Care Administration Board).

Authority: N.J.S.A. 26:2H-1 et seq., specifically 26:2H-5.

Proposal Number: PRN 1992-490.

Submit comments by January 6, 1993 to:

Robert J. Fogg

Acting Director of Licensing, Certification, and Standards
Health Facilities EvaluationNew Jersey State Department of Health
CN 367

Trenton, New Jersey 08625-0367

The agency proposal follows:

Summary

The Department of Health is proposing to amend the Long-Term Care Facilities Licensing standards at N.J.A.C. 8:39-13.4, 27.8, 29.4 and 33.2, repeal and add a new rule at N.J.A.C. 8:33-27.1, and add new subchapters 45 and 46, to address the use of restraints and psychoactive drugs, pharmacy supplies, and establishment of Alzheimer's and dementia care services. The Department believes it is important to address the use of restraints in all licensed long term care facilities to ensure protection of the rights, well-being, and dignity of all residents. The amended rules enhance and broaden the application of Federal standards regarding restraints mandated by the Omnibus Budget Reconciliation Act (OBRA) to all licensed facilities in the State. Currently, only those facilities participating in Federal Medicaid and Medicare programs are subject to the enhanced Federal requirements governing use of restraints.

With respect to pharmacy standards, the proposed amended standard at N.J.A.C. 8:39-29.4 is intended to make the standard more responsive to the needs of residents. The amendment is intended to offer more flexibility to facilities in the maintenance of stock supplies of both prescription and over-the-counter medications.

The Department proposes to further amend N.J.A.C. 8:39, Licensing Standards for Long-term Care Facilities, by adding a new mandatory subchapter 45, and an advisory subchapter 46. These new rules are intended to allow for the establishment of programs to meet the needs of patients with Alzheimer's disease or other dementias within the long-term care facility. Alzheimer's/dementia programs must provide patients with individualized care based on assessment of the cognitive and functional abilities of patients who have been admitted to the program.

The proposed standards were developed with the assistance of the Nursing Home Advisory group. This group includes nursing home administrators, industry representatives, a representative of the Ombudsman's Office for the Institutionalized Elderly, members of citizens' groups representing senior citizens, and staff of the Division of Medical Assistance and Health Services, Department of Human Services, and the New Jersey Department of Health. The proposed rules and amendments at N.J.A.C. 8:39-13.4, 27.1 and 33.2 were derived from sources which included Title 30 of N.J.S.A., the American Psychiatric Association Task Force Report on Seclusion and Restraint, proposed psychiatric rights legislation developed by a broad-based coalition of agencies and interest groups, and literature on restraints and general nursing care.

N.J.A.C. 8:39-13.4(a) through (d) remain unchanged. The current subsection (e) is recodified to subsection (f). A new subsection (e), which specifies the minimum restraint training all nursing and professional staff in a long-term facility shall receive at orientation and annually, is inserted.

The current standards at N.J.A.C. 8:39-27.1 are being deleted and replaced with new standards at N.J.A.C. 8:39-27.1 which will require all long-term care facilities in New Jersey to have written policies and

procedures for the use of restraints. The statement of scope for the rule also includes a definition of restraints. N.J.A.C. 8:39-27.1(b) requires a facility to have an interdisciplinary committee or equivalent process that has responsibility for the use of restraints in the facility. N.J.A.C. 8:39-27.1(c) requires the interdisciplinary committee or equivalent process to develop and regularly review policies and procedures which address protocols for the use of alternatives to physical restraint, a protocol for the use of a progressive range of restraints, indicators for the use of restraint, contraindications for the use of restraint, the identification of restraints which may be used in the facility, a protocol for informing residents and obtaining consent for the use of restraints, a protocol for informing the family or guardian and obtaining consent for the use of restraints, and a protocol for the removal of restraints.

N.J.A.C. 8:39-27.1(d) requires an interdisciplinary committee or an equivalent process to monitor, evaluate, and document the effects of all psychopharmacologic agents. N.J.A.C. 8:39-27.1(e) establishes procedures for the use of restraints in an emergency that includes at least: who may initiate the use of emergency restraints; the use of the least restrictive method that is clinically feasible; basic parameters for the use of emergency restraints; physician notification and orders; evaluation of a resident's physical and mental condition while in emergency restraints; assessment of the resident by a registered nurse and interdisciplinary committee; and the continued use of an emergency restraint under a physician order.

N.J.A.C. 8:39-27.1(f) permits the use of restraints in non-emergency cases under a physician order as part of the resident's plan of care. N.J.A.C. 8:39-27.1(g) requires continuous attempts to remediate the resident's condition in order to eliminate or lessen the need for restraint, while N.J.A.C. 8:39-27.1(n) requires evaluative steps by professional personnel if restraint usage is to continue beyond 30 days. N.J.A.C. 8:39-27.1(i) and (j) require policies and procedures for interventions by nursing personnel in accordance with the nursing scope of practice while a resident is being restrained. These include periodic visual observation, periodic release of restraints, adequate fluid intake, adequate nutrition, daily bathing, periodic ambulation, and arrangements for toileting. N.J.A.C. 8:39-27.8(a) through (e) are not changed and subsection (f), which defines items not permitted to be used as restraints, is recodified to N.J.A.C. 8:39-27.1(c)5.

N.J.A.C. 8:39-33.2(a) remains unchanged. The current subsection (b) is recodified to subsection (d). New subsections (b) and (c), which require the interdisciplinary committee or equivalent to develop a quality assurance program for the use of restraints and the periodic collection and evaluation of restraint data, are inserted.

The following changes are proposed with respect to pharmacy standards: N.J.A.C. 8:39-29.4(a) remains unchanged. N.J.A.C. 8:39-29.4(b) is amended to reflect the movement of long-term care facilities to different drug distribution systems such as unit dose and unit of use (Bingo cards). This amendment also recognizes the need to have medications readily available for the administration of stat doses, lost doses, or doses not sent by a provider pharmacy. Under this amendment, a long-term facility would be permitted to add prescription medications to over-the-counter medications, approved by the facility's pharmacy and therapeutics committee. Monitoring for accountability and proper labeling of medications would be required. N.J.A.C. 8:39-29.4(c)-(j) remain unchanged.

The Department is proposing two new subchapters addressing identifiable programs for individuals with Alzheimer's Disease and/or dementias. According to the *Final Report-New Jersey Alzheimer's Disease Study Commission*, there may be as many as 1.5 million Americans with severe dementia. This number may increase to 7.4 million Americans as those individuals who now have a milder form of the disease live long enough to progress to the severe dementia which occurs in later stages of the disease. Presently, an estimated 30,000 New Jersey residents who are over age 65 experience a severe dementia, and this number, too, is expected to increase. Throughout the United States, the number of units dedicated to caring for individuals with Alzheimer's, estimated to be 1,500 at present, is expected to double in the next few years. In New Jersey, the number of facilities purporting to offer units have also proliferated. Some New Jersey long-term care facilities have succeeded in implementing unique programs which truly address the special needs of Alzheimer's/dementia patients. These programs are varied. Some utilize existing staff and space and meet the needs with little additional expense to the long-term care facility. Other programs have built extensive and costly special units with numerous environmental modifications. There are, however, many long-term care facilities which advertise

that they provide special care units for Alzheimer's/dementia patients, yet are unable to demonstrate any aspects of the unit or program which are in fact "special" in the ways which they address the particular needs of such patients.

In order to provide guidelines for the establishment of Alzheimer's/dementia units by long-term care facilities, and to protect the interests of New Jersey consumers who are seeking care for family members with Alzheimer's/dementia, the Department is proposing to amend N.J.A.C. 8:39 by adding both a mandatory subchapter, with requirements which must be met by all facilities offering Alzheimer's/dementia programs, N.J.A.C. 8:39-45, and a subchapter of advisory standards, 65 percent of which are to be met by the facility, N.J.A.C. 8:39-46.

Proposed N.J.A.C. 8:39-45, Alzheimer's/dementia programs—mandatory standards, includes the scope and purpose of Alzheimer's/dementia programs at N.J.A.C. 8:39-45.1, and defines such a program to mean an organized plan of special services which may be provided to patients who are located either in a distinct physical unit or integrated throughout the facility. Proposed N.J.A.C. 8:39-45.2(a) specifies that no facility may advertise or hold itself out as providing an Alzheimer's/dementia unit unless it meets at least 65 percent of the advisory standards in proposed N.J.A.C. 8:39-46. Proposed N.J.A.C. 8:39-45.2(b) requires that a facility seeking to establish an Alzheimer's/dementia unit or program must obtain a determination of whether a certificate of need is required, prior to implementing the program.

Advisory standards for Alzheimer's/dementia programs are contained in proposed Subchapter 46. According to proposed N.J.A.C. 8:39-46.1, the facility develops written policies and procedures and also establishes criteria for admission and discharge from the program, based on interdisciplinary assessment of the patient's cognitive and functional status.

According to proposed N.J.A.C. 8:39-46.2, the facility provides sufficient staff to provide care, based on patient census and assessment of patients. In addition, the facility has established criteria for the determination of staff qualifications and to provide an ongoing educational, training and support program for staff. Staff education includes at least the causes and progression of dementia and the provision of care to such patients. The program designates a full-time coordinator/director who has specialized training and/or experience in the care of patients with dementia. A consultant gerontologist is available as needed, to address the medical needs of patients.

Advisory environmental modifications which may be included in the Alzheimer's/dementia program are listed at proposed N.J.A.C. 8:39-46.3, and include safety policies and procedures and a security monitoring system which are specific to the program. According to proposed N.J.A.C. 8:39-46.4, the program provides a daily schedule of special activities, daily and at least two evenings per week. Advisory nutritional interventions are delineated at proposed N.J.A.C. 8:39-46.5(a), and the provision of a small dining room or designated area is specified at N.J.A.C. 8:39-46.5(b).

At proposed N.J.A.C. 8:39-46.6, Advisory social services, the facility provides appropriate counseling to patients and families as well as support groups and referrals to community support groups for families. Discharge care plans are discussed with the next of kin, and the patient, if possible at the time of admission to the program.

Social Impact

The issue of restraints has received a great deal of attention at many levels throughout the State and the nation, including Federal regulations promulgated as a result of statutory requirements in OBRA 1987 for long-term care facilities, as well as policies adopted by the American Psychiatric Association, many practitioners in long-term care, psychiatric communities, legislators, and the New Jersey Office of the Ombudsman for the Institutionalized Elderly. The proposed amendments and rules, while not mandating a restraint-free environment, require long-term care facilities to use alternatives to restraints whenever possible and use a "least-restrictive environment" as the framework for policies, procedures, and practice. Adoption of proposed N.J.A.C. 8:39-27.1, requiring all residents occupying long-term care health facility beds to be as free of restraints as possible and permitting the use of restraints only when clearly justified, will have a positive social impact by enhancing resident's rights, health, and safety. This will assure a consistent level of assessment prior to the use of restraints and improve the continuity of care by requiring the involvement of the interdisciplinary committee or equivalent in the decision to continue the use of restraints. The addition of requirements at N.J.A.C. 8:39-13.4 to train staff at orientation and annually will assure that staff is familiar with facility policies and

procedures regarding less restrictive alternatives, the use of restraints in emergency and non-emergency situations, and required evaluations and interventions during the use of restraints.

Inclusion of new standards at N.J.A.C. 8:39-33.2, Quality assurance, will ensure that the facility monitors the appropriate use of restraints by means of specific indicators which include: emergency restraint usage, frequency of restraint use, evaluation of cases where procedures are not followed or have a negative outcome, and frequency of the use of psychopharmacologic agents. The proposed amendment at N.J.A.C. 8:39-29.4 permitting long-term care facilities to maintain stock precription medications, requiring medications to be monitored for accountability, and requiring the labeling of over-the-counter medications, will have a positive social impact by increasing the availability of these medications to residents and reducing or eliminating the number of missed administrations.

The proposed new rules at N.J.A.C. 8:39-45 and 46 will help to protect consumers who are seeking care for family members afflicted with Alzheimer's or other dementias, by ensuring that care providers are aware of, and trained in, "state-of-the-art" techniques for communicating with and offering services to these patients. Both consumers and patients will benefit from such advisory standards as continuing specialized educational programs for staff and families, on-going support groups, and the availability of consultation from gerontological specialists who have training and/or experience in caring for dementia patients. The proposed mandatory subchapter, N.J.A.C. 8:39-45, will provide further protection for patients and families by ensuring that only those facilities which meet 65 percent of the advisory standards delineated in N.J.A.C. 8:39-45 will be permitted to advertise themselves as providers of Alzheimer's/dementia programs.

These amendments and new rules have been reviewed and recommended by the Department's Nursing Home Advisory Group which is composed of representatives from the long-term industry and representatives of other State agencies knowledgeable in long-term care and patient's rights.

Economic Impact

The proposed standards at N.J.A.C. 8:39-13.4, 27.1 and 33.2 concerning restraints may require some additional staff time devoted to promulgating additional policies and procedures, but this should not impose any additional costs to long-term care facilities. Medical and nursing interventions required at certain intervals were written to generally be in keeping with current practices utilized in restraint-free long-term care facilities, to minimize any additional costs. The standards also promote least-restrictive alternatives to physical restraint and it is anticipated that a reduction in the use of restraints will occur. A decrease in the use of restraints has been evidenced in long-term care facilities since new OBRA requirements went into effect in 1990. Long-term care facilities which are restraint-free have indicated lower nursing costs. Thus, it is believed that the reduction in the use of restraint devices will offset any increase in staffing which may be necessitated by the proposed new standards.

The Department anticipates that the proposed amendment at N.J.A.C. 8:39-29.4 will have a positive economic impact by saving staff time in the ordering of additional medications from provider pharmacies and in some cases an additional cost for these orders. There will also be a saving of staff time by both facilities and the Department in the approving of additions and deletions to a facilities stock supply of medications. There will be no additional recordkeeping required.

The Department anticipates no significant economic impact to providers associated with the above amendments. There may be a minimal cost to acquire new forms on which to record the assessment information.

The Department anticipates only minimum economic impact on long-term care facilities which choose to offer Alzheimer's/dementia programs. Several facilities are presently offering an environment for dementia patients, utilizing existing staff and space to develop creative programs which enhance the quality of life for these patients. Facilities may choose to modify existing areas of the facility, at low or moderate cost, or to provide additional training to staff by utilizing community resource persons who have knowledge of and/or expertise in care of dementia patients. More elaborate environmental modifications may be pre-planned and included as part of new construction if the facility so desires. It is not the intent of the Department to allow long-term care facilities to develop Alzheimer's/dementia programs in order to raise the cost of care to patients or to third-party payors.

Adoption of proposed new rules N.J.A.C. 8:39-45 and 46 should not increase existing costs associated with the survey process.

Regulatory Flexibility Analysis

Approximately half of New Jersey's 364 long-term care facilities may be considered small businesses, as the term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed amendment at N.J.A.C. 8:39-13.4 does not impose any additional reporting or recordkeeping requirements. The requirement to provide training to staff in the use of restraints will require the use of staff time, but it is anticipated that this will not require additional staff and therefore have little or no impact on long-term care facilities. Proposed new rule N.J.A.C. 8:39-27.1 does not impose any additional reporting requirements and requires additional recordkeeping in line with standards of professional practice and only in those cases where restraints are used. Other requirements include an interdisciplinary committee composed of facility staff, which will review the use of restraints on a regular basis. Facilities that are restraint free will experience no financial impact. The proposed change at N.J.A.C. 8:39-29.8 will have no impact, as this is only the transfer of a standard to another part of N.J.A.C. 8:39. The proposed amendment at N.J.A.C. 8:39-29.4, which permits the expansion of stock medications, does not impose any additional reporting, recordkeeping or other requirements and will have no negative and possibly a positive impact on facilities. The amendment at N.J.A.C. 8:39-33.2 requires the collection and analyzing of data regarding the use of restraints which should be included in already existing quality assurance policies and procedures. The use of findings to eliminate inappropriate use of restraints should be a cost savings to facilities. The proposed new rules at N.J.A.C. 8:39-45 and 46 will result in no increases in the recordkeeping and reporting requirements already placed upon small businesses by the current rules. The program and evaluation requirements in these new subchapters, which require particular attention to be paid to the needs of Alzheimer's patients, and full compliance in at least 65 percent of the advisory standards, may increase staffing costs, to the extent that more staff is required to meet the specific needs of the specific patients of a facility which chooses to develop an Alzheimer's program. There will be no additional professional services required, since the functions are carried out by regular staff members.

Changes in the rules have been designed to minimize the adverse economic impact on small businesses, while ensuring the provision of quality care to residents. While the facility must meet 65 percent of the standards, the facility may choose the standards. The Department of Health has determined that compliance with the proposed amendments and new rules is necessary for all facilities which provide long-term care services, in the interest of public health and safety, and that there should be no differentiation based on business size. However, the Department notes that facilities are not required to comply with the standards of N.J.A.C. 8:39-45 and 46, unless the facility declares itself to be providing special services for Alzheimer's patients.

Full text of the proposal follows (additions indicated in boldface thus; deletions indicated in brackets [thus]):

8:39-13.4 Mandatory staff education and training for communication

(a)-(d) (No change.)

(e) All nursing and professional staff of the facility shall receive orientation and annual training in the use of restraints including at least:

- 1. Policies and procedures in accordance with N.J.A.C. 8:39-27.1;**
- 2. Emergency and nonemergency procedures;**
- 3. Practice in the application of restraints and alternative methods of intervention; and**
- 4. Interventions by licensed and non-licensed nursing personnel.**

[(e)](f) (No change in text.)

[8:39-27.1 Mandatory restraint policies and procedures

(a) Physical restraints shall not injure or discomfort the patient, and opportunity for motion and exercise shall be provided for at least ten minutes during each two-hour period that the restraint is in use.

(b) Restraints shall not be used for punishment or for the convenience of the facility or staff.

(c) The family or guardian shall be notified when a physician initiates an order that the patient be physically or chemically restrained.]

8:39-27.1 Mandatory policies and procedures for the use of restraints

(a) The standards in this section shall apply to the use of restraints in all resident care areas. Physical restraints are defined as devices, materials, or equipment that are attached or adjacent to a person and that prevent free bodily movement to a position of choice with the exception of devices used for protective supports.

(b) The facility shall have an interdisciplinary committee, or an equivalent process, which includes at least representatives of medical staff, nursing, social work, pharmacy, and resident activities. The committee shall have responsibility for the use of restraints in the facility, shall meet at least quarterly, and shall document its activities, findings, and recommendations.

(c) The interdisciplinary committee or equivalent shall develop, review at least annually, revise as needed, and ensure implementation of written policies and procedures addressing at least the following:

1. Protocol for the use of alternatives to physical restraints, such as staff or environmental interventions, structured activities, or behavior management. Alternatives shall be utilized whenever possible to avoid the use of restraints;

2. Protocol for the use and documentation of a progressive range of restraining procedures from the least restrictive to the most restrictive;

3. A delineation of indications for use, which shall be limited to:

- i. Prevention of imminent harm to the resident or other persons when other means of control are not effective or appropriate; or
- ii. Prevention of serious disruption of treatment or significant damage to the physical environment;

4. Contraindications for use, including at least clinical contraindications, convenience of staff, or discipline of the resident;

5. Identification of restraints which may be used in the facility, which shall be limited to methods and mechanical devices that are specifically manufactured for the purpose of physical restraint. Locked restraints, double restraints on the same body part, four-point restraints, and confinement in a locked or barricaded room shall be not permitted;

6. Protocol for informing the resident and obtaining consent when clinically feasible, and documenting the consent in the resident's record;

7. Protocol for notifying the family or guardian, obtaining consent if the resident is unable to give consent, and documenting the consent in the resident's record; and

8. Protocol for removal of restraints when goals have been accomplished.

(d) The interdisciplinary committee shall monitor, evaluate, and document the effects of all psychopharmacologic agents. These agents shall be administered only upon written physician orders as part of the resident's treatment plan and shall not be used as a method of restraint, discipline, or for the convenience of staff.

(e) Procedures for the application of physical restraints in an emergency shall include at least the following:

1. Licensed nursing staff only shall be authorized to initiate the use of emergency restraints;

2. The application of restraints shall begin with the least restrictive alternative that is clinically feasible;

3. Emergency restraints shall be used only when the safety of the resident or others is endangered, or there is imminent risk that the resident will cause substantial damage to the physical environment;

4. The facility shall notify the attending physician or another designated physician and request an order within two hours;

5. The facility shall obtain a physician order within eight hours;

6. Licensed nursing personnel shall evaluate and document the physical and mental condition of the resident in emergency restraints at least every two hours;

7. There shall be an assessment of the resident by a registered professional nurse within 24 hours; and

8. Continuation of emergency restraints shall occur only upon physician orders, which must be renewed every 24 hours to a maximum of seven days.

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(f) In non-emergency cases, a resident shall be physically restrained only after the attending physician or another designated physician has executed an order for restraint as part of the resident's plan of care.

(g) The facility shall continuously attempt to remediate the resident's condition to eliminate or lessen the need for restraints. If the use of restraints is required beyond one week, at least the following shall be included:

1. The need for the continued use of restraints shall be implemented only as part of the physician's medical care plan;
2. Every resident in restraints shall be assessed by a registered professional nurse at least every 48 hours for the continued use of restraints; and

3. After remediation attempts, there shall be an interdisciplinary review of the record of any resident whose assessment indicates the need for continued use of restraints. This review shall occur within thirty days of the initiation of the use of restraints.

(h) Continuation of the use of restraints beyond 30 days shall occur only upon written approval of the committee or its equivalent, and shall include at least the following:

1. The registered professional nurse shall assess the need for continued restraints at least weekly; and
2. An interdisciplinary review shall be conducted at least every 30 days to approve the continued use of restraints.

(i) The facility shall have written policies and procedures to ensure that interventions while a resident is restrained, except as indicated at (j) below, are performed by nursing personnel in accordance with nursing scope of practice. The policies and procedures shall include at least the following and shall be implemented:

1. Periodic visual observation which is performed with the following frequency:
 - i. Continuously if clinically indicated by the resident's condition; or
 - ii. At least every 15 minutes while the resident's condition is unstable; and
 - iii. Thereafter, at least every one to two hours based upon an assessment of the resident's condition;
2. Release of restraints at least once every two hours in order to:
 - i. Assess circulation;
 - ii. Perform skin care;
 - iii. Provide an opportunity for exercise or perform range of motion procedures for a minimum of five minutes per restrained limb and repositioning; and
 - iv. Assess the need for toileting and assist with toileting or incontinence care;
3. Ensuring adequate fluid intake;
4. Ensuring adequate nutrition through meals at regular intervals, snacks, and assistance with feeding if needed;
5. Assistance with bathing as required at least daily; and
- 6.. Ambulation at least once every two hours if clinically feasible.

(j) The facility shall have written policies and procedures for interventions by nursing personnel for residents in restraints for overnight sleeping. These policies and procedures shall include at least the following and shall be implemented in accordance with nursing scope of practice:

1. Visual observation based on resident's condition occurring at least every one to two hours;
2. Administration of fluids as required;
3. Toileting as required; and
4. Release of restraints at least once every two hours for repositioning and skin care, if clinically indicated.

8:39-27.8 Mandatory supplies and equipment for patient care

(a)-(e) (No change.)

[(f) Locked restraints, double restraints on the same body part, sheet restraints, four-point restraints, and confinement in a locked or barricaded room shall be not permitted.]

8:39-29.4 Mandatory pharmacy control policies and procedures

(a) (No change.)

(b) If the facility uses and contracts with a provider pharmacy, [only] both over-the-counter and prescription medications shall be kept as stock. [Stock over-the-counter] These medications shall be approved by the pharmacy and therapeutics committee, monitored for accountability, and labeled to include drug name, drug strength, manufacturer's name, lot number, expiration date, recommended dosage for over-the-counter medications, and applicable cautionary and/or accessory labels.

(c)-(j) (No change.)

8:39-33.2 Mandatory quality assurance policies and procedures

(a) The quality assurance program shall identify problems in the care and services provided to the patients and shall include the audit of medical records.

(b) The interdisciplinary committee or equivalent shall develop a program of quality assurance for the use of restraints that is integrated into the facility quality assurance program and includes regularly collecting and analyzing data to help identify problems and their extent, and recommending, implementing and monitoring corrective actions where needed.

(c) The quality assurance program shall include the collection and evaluation of data at least quarterly. This data shall include at least the following:

1. All emergency restraint applications;
2. Indicators of the frequency of the use of restraints in the facility;
3. Evaluation of all cases in which there is:
 - i. A failure to obtain or receive a physician's order;
 - ii. A failure to follow and monitor procedures in accordance with N.J.A.C. 8:39-27.1(f) through (j); or
 - iii. A negative clinical outcome; and
4. Indicators of the frequency of the use of psychopharmacologic agents.

[(b)](d) (No change in text.)

SUBCHAPTER 45. ALZHEIMER'S/DEMENTIA PROGRAMS—MANDATORY STANDARDS

8:39-45.1 Scope and purpose

Long-term care facilities may establish programs to meet the needs of patients with Alzheimer's disease or other dementias. In addition to meeting all mandatory requirements specified in N.J.A.C. 8:39-1 through 43 of the long-term care licensing standards, and the rules in this subchapter, the program shall provide individualized care based upon assessment of the cognitive and functional abilities of Alzheimer's and dementia patients who have been admitted to the program. The standards in this subchapter shall apply only to those long-term care facilities that operate an Alzheimer's/dementia program.

An Alzheimer's/dementia program means an organized plan of special services which may be provided to patients who are located either in a distinct physical unit or integrated throughout the existing facility.

8:39-45.2 Program requirements

(a) No facility shall advertise or hold itself out as providing an Alzheimer's/dementia program, unless it is recognized by the Department of Health as meeting at least 65 percent of the advisory standards in N.J.A.C. 8:39-46, Advisory Alzheimer's/dementia programs.

(b) A facility seeking to establish an Alzheimer's/dementia unit or program shall obtain a determination of whether a Certificate of Need is required prior to establishment of or implementing the program. An Alzheimer's/dementia program alone shall not constitute a new health care service within the meaning of N.J.A.C. 8:33-1.6 or 2.6 and shall not be eligible for increased reimbursement as a special care program funded through the Division of Medical Assistance.

HUMAN SERVICES**PROPOSALS****SUBCHAPTER 46. ADVISORY ALZHEIMER'S/DEMENTIA PROGRAMS—ADVISORY STANDARDS****8:39-46.1 Advisory Alzheimer's/dementia program policies and procedures**

(a) The long-term care facility should have written policies and procedures for the Alzheimer's/dementia program that are retained by the administrative staff and available to all staff and to members of the public, including those participating in the program.

(b) The facility should establish criteria for admission to the program and criteria for discharge from the program when the patient's needs can no longer be met, based upon an interdisciplinary assessment of the patient's cognitive and functional status.

8:39-46.2 Advisory staffing

(a) Staffing levels should be sufficient to provide care and programming, based upon patient census in the program and an interdisciplinary assessment of the cognitive and functional status of patients in the program.

(b) The facility should establish criteria for the determination of each staff member's abilities and qualifications to provide care to patients in the program.

(c) The facility should provide an initial and ongoing educational, training and support program for each staff member which includes at least the causes and progression of dementias, the care and management of patients with dementias, and communication with dementia patients.

(d) Each Alzheimer's/dementia program should have a full-time employee, with specialized training and/or experience in the care of patients with dementia, who has been designated as coordinator/director and whose duties include responsibility for the operation of the program.

(e) A consultant gerontologist should be available to patients and to the program, as needed, to address the medical needs of the patient. "Consultant gerontologist" means a physician, psychiatrist, or geriatric nurse practitioner who has specialized training and/or experience in the care of patients with dementia.

8:39-46.3 Advisory environmental modification

(a) The program should include appropriate facility modifications to ensure a safe environment which allows each Alzheimer's/dementia patient to function with maximum independence and success.

(b) The facility should develop safety policies and procedures and a security monitoring system which are specific to the program, based upon the physical location of the program, as well as the individual needs of the Alzheimer's/dementia patients.

(c) The facility should provide indoor and outdoor arrangements which allow patients freedom to ambulate in a controlled setting, such as pathways and gardens with non-toxic flora.

(d) Doors should be marked with items familiar to the individual patient which enhance the patient's ability to recognize his or her room, and bathrooms are specially marked and easily accessible.

8:39-46.4 Advisory activity programming

(a) The activity program should provide a daily schedule of special activities, seven days a week and at least two evenings per week, designed to maintain patients' dignity and personal identity, enhance socialization and success, and to accommodate the various cognitive and functional abilities of each patient.

8:39-46.5 Advisory nutrition

(a) The nutrition program should provide nutritional intervention as needed, based upon assessment of the eating behaviors and abilities of each patient. Interventions may include, but are not limited to, the following:

1. Verbal and non-verbal eating cues;
2. Modified cups, spoons, or other assistive devices; and
3. Simplified choices of foods or utensils.

(b) The nutrition program should provide a small dining room, separate room, or designated dining area furnished to meet the needs of the patients, with staff members or trained volunteers to assist.

8:39-46.6 Advisory social services

(a) The facility should provide individual and group counseling to patients if appropriate, utilizing techniques designed to reach the dementia patient and to maintain the patient's maximum level of functioning.

(b) Families should be encouraged to, and provided with, opportunities to participate in planning and providing patient care.

(c) The facility should provide individual and group counseling, support and education groups for families, and information and referral on bioethical and legal issues related to dementia, including competence, guardianship, conservatorship and advance directives.

(d) Family members should be referred to community Alzheimer's Disease Support Groups or other family counseling agencies, as required.

(e) Discharge care plans, including preparation for discharge from the unit, should be discussed with the legal next of kin, and, if possible, with the patient at the time of admission to the program.

HUMAN SERVICES**(a)**

DIVISION OF MENTAL HEALTH AND HOSPITALS
Patient Supervision at State Psychiatric Hospitals
Proposed Readoption with Amendments: N.J.A.C.
10:36

Authorized By: Alan J. Gibbs, Commissioner, Department of Human Services.

Authority: N.J.S.A. 30:1-12 and 30:4-27.21a.

Proposal Number: PRN 1992-498.

Submit comments by December 16, 1992 to:

Raymond M. Deeney, Esq.
 Administrative Practice Officer
 Division of Mental Health and Hospitals
 CN 727
 Trenton, NJ 08625-0727

The agency proposal follows:

Summary

Pursuant to Executive Order No. 66(1978), N.J.A.C. 10:36, Patient Supervision at State Psychiatric Hospitals, expires on December 31, 1992. The Department of Human Services has reviewed these rules and determined that they continue to be necessary for the purpose for which they were originally promulgated.

N.J.A.C. 10:36 is comprised of three subchapters. N.J.A.C. 10:36-1 provides a uniform process for each State psychiatric hospital patient to receive the level of clinical supervision appropriate to his or her condition while hospitalized. N.J.A.C. 10:36-2 provides a mechanism for the comprehensive review of the clinical treatment and management of certain hospitalized special status patients at State psychiatric hospitals, including those involved with the criminal justice system. N.J.A.C. 10:36-3 defines factors and delineates procedures related to evaluation of the need for transfers between State psychiatric hospitals. The purpose and effect of these rules is to provide uniform policies and procedures regarding patient supervision at State psychiatric hospitals within various applicable legal parameters.

N.J.A.C. 10:36 was readopted without amendments on August 3, 1992, to allow for additional review of N.J.A.C. 10:36-1, Level of Supervision System, and N.J.A.C. 10:36-2, Clinical Review Procedures for Special Status patients. As a result of this review, several proposed amendments have been included in this proposed readoption. These proposed amendments include: clarification of the intent of N.J.A.C. 10:36-1.2 regarding the administrative approval needed for certain special status patients; deletion of the specific treatment plan review schedules at N.J.A.C. 10:36-1.3(c) and replacement with a provision which pegs the schedules to the standards for the applicable accrediting body for the hospital; amendment of text at N.J.A.C. 10:36-1.3(f) of patient legal status from "Discharged Pending Placement" to "Conditional Extension Pending Placement" to reflect the same amendment which has been previously made in the New Jersey Rules governing Civil Practice by the New Jersey Supreme Court; additional text added at N.J.A.C. 10:36-1.4 through 1.7

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to clarify that the intent of the listing of mental condition criteria for the various levels was not to exclude other potential criteria for those levels. These listings of mental condition criteria within subchapter 1 in the current Administrative Code were never intended to be exhaustive. Since level determination is based primarily upon the unique clinical condition of each individual patient, these mental condition criteria can provide only general guidance to hospital staff; those listed represent only some of the most typically encountered criteria. Additional proposed amendments include: clarification at N.J.A.C. 10:36-2.1(b) that these rules are not intended to alter the responsibility of hospital staff to comply with the provisions of valid court orders regarding specific patients; additional flexibility regarding the composition of Clinical Review Committees at N.J.A.C. 10:36-2.2(b); and deletion of the quality assurance functions assigned to the Division's Chief Psychiatric Consultant and Central Office professional discipline leadership at N.J.A.C. 10:36-2.5 because these personnel are no longer employed within the Division's Central Office, and additional assignment of quality assurance functions to the Quality Assurance Department within each hospital (see N.J.A.C. 10:36-2.3(g)). Subchapter 3, Transfers of Involuntarily Committed Patients between State Psychiatric Facilities, is being readopted without change.

Social Impact

By providing uniform policies and procedures regarding patient supervision at State psychiatric hospitals within applicable legal parameters, the rules proposed for readoption will have a positive social impact on the patients at those facilities and other parties interested in the quality of their care. These rules will help ensure that these patients receive appropriate treatment in an appropriate program consistent with applicable law and balanced with the need to protect the general public from potentially dangerous behavior by some patients.

To the extent the proposed amendments clarify the original intent of the rules, delete outdated functions and promote desirable flexibility regarding the scheduling of treatment plan reviews and the composition of Clinical Review Committees, they can be expected to improve understanding of the rules and promote more efficient accomplishment of the rules' purposes.

Economic Impact

By providing uniform hospital policies and procedures regarding patient supervision, the rules proposed for readoption foster cost-effective programs, which is a form of social savings for both patients and the general public. The Department does not anticipate a direct economic effect on any specific individuals by these rules including the proposed amendments. No additional administrative costs are required by them and no funding sources are affected by them.

Regulatory Flexibility Statement

The rules proposed for readoption with amendments govern patient supervision at the seven State psychiatric hospitals. Being public institutions, these hospitals are not small businesses as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Therefore, a regulatory flexibility analysis is not required.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 10:36.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

10:36-1.1 Introduction and purpose

(a)-(b) (No change.)

(c) The Interdisciplinary Treatment Team will [assign] **determine** the appropriate level for each patient upon admission with periodic review of the assigned level during the course of hospitalization. Level determinations will be made in accordance with guidelines set forth herein. Treatment teams should utilize these guidelines to promote increased responsibility, accountability and independence on the part of the patient while decreasing structure and intensity of supervision provided by the staff. Incremental steps taken towards this goal should be viewed as part of a continuum that progresses through each level of the system.

(d) (No change.)

10:36-1.2 General provisions

(a) (No change.)

(b) All "Not Guilty by Reason of Insanity and Incompetent to Stand Trial" status patients and others identified as appropriate for special treatment review procedures must have [administrative and/or] court approval prior to implementation of an increase in level recommended by the treatment team. **Each hospital may determine whether the Interdisciplinary Treatment Teams need administrative approval in addition to court approval for their Level of Supervision determinations for these patients and, if so, in what manner the administrative approval shall be obtained.**

(c)-(h) (No change.)

10:36-1.3 Procedures

(a)-(b) (No change.)

(c) Each patient's level will be evaluated minimally in accordance with the treatment plan review schedule or sooner if clinically indicated or requested by the patient. **The treatment plan review schedule shall minimally comply with the standards set by the applicable accrediting body for the hospital.** [The treatment plan review schedule is 72 hours from the date of admission 30 days afterward, 60 days, 90 days, and at 90-day intervals thereafter.]

(d)-(e) (No change.)

(f) All patients ordered ["Discharged Pending Placement"] "**Conditional Extension Pending Placement**" by the court will be considered to be on LEVEL IV unless there is documentation in the clinical record to show that the responsible treatment team has identified clinical considerations which require and justify that the patient be placed at a level which provides the necessary structure and supervision. In such instances, a treatment team note shall be entered into the clinical record which documents the clinical considerations which justify the level determined necessary by the treatment team.

10:36-1.4 Level I definition, criteria and program structure

(a) (No change.)

(b) Mental condition criteria include, **but are not limited to:**

1. Suicidal/homicidal ideation or behavior (High Suicide Risk)[.];
2. Severe impulse control problems[.];
3. Imminent arson risk[.];
4. So severely confused or disoriented as to be unable to adjust to unfamiliar surroundings[.];
5. So grossly psychotic or mood disordered that an imminent risk of harm to self or others is present[.]; **and**
6. High elopement/walkaway risk as indicated by verbal intent and/or recent history.

(c)-(d) (No change.)

10:36-1.5 Level II definition, criteria and program structure

(a) (No change.)

(b) Mental condition criteria include, **but are not limited to:**

1. No longer high suicide, elopement/walkaway, medical or assault risk[.];
2. Follows general directions and generally attends onward therapies and programs on a regular basis[.];
3. Psychotic symptoms or mood disturbances may be present but does not act in response to them in such a way as to create an imminent risk of harm[.];
4. Mildly confused and disoriented but able to adapt to unfamiliar surroundings[.]; **and**
5. Able to control impulses except when severely stressed.

(c)-(d) (No change.)

10:36-1.6 Level III definition, criteria, and program structures

(a) (No change.)

(b) Mental condition criteria include, **but are not limited to:**

1. Absence of psychotic or mood disordered symptoms, or if chronic residual symptoms are still present, does not act in response to them[.];
2. Oriented and aware of surroundings[.];
3. Cooperative with established plan and schedule of activities[.];

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4. Appropriate on and off ward behavior resulting in no precautions for a certain number of day/weeks (to be set by treatment team)[.];

5. Minimal elopement/walkaway risk[.];

6. Able to control impulses except when severely stressed[.]; and

7. If recent behavior indicates substance abuse risk, is willing to agree to search upon return if team determines necessary and documents in master treatment plan.

(c)-(d) (No change.)

10:36-1.7 Level IV definition, criteria and program structure

(a) (No change.)

(b) Mental condition criteria include, **but are not limited to:**

1. No recent instances of substance abuse[.];

2. Oriented to and capable of utilizing community or transportation services[.];

3. Resident exhibits sound judgement under reasonable conditions[.]; and

4. Resident exhibits accountability and responsibility through adherence to treatment plan program schedule.

(c)-(d) (No change.)

10:36-2.1 Statement, purpose, and scope

(a) (No change.)

(b) The purpose of this procedure is to establish a mechanism which provides a comprehensive review of the clinical treatment and management of special status patients through insuring appropriate treatment interventions, levels of supervision and planning at the time of movement to less restrictive settings, decrease of structures and security, or discharge. **However, nothing in these procedures is intended to alter the responsibility of hospital staff to comply with the provisions of valid court orders regarding specific patients.**

(c) (No change.)

10:36-2.2 Committee composition

(a) (No change.)

(b) The composition of the Special Status Patient Clinical Review Committee should include, **but need not be limited to:** the Medical Director or Chief of Psychiatry, the Director of Psychology, the Director of Nursing Services, the Director of Rehabilitation Services, and the Director of Social Services. **These individuals may appoint designees to the committee.**

10:36-2.3 Procedures

(a)-(f) (No change.)

(g) **The Clinical Director will periodically attend Clinical Review Committee meetings in his or her institution in order to monitor the thoroughness and quality of clinical recommendations and compliance with this policy and procedure. Additionally, the Quality Assurance Department within each hospital shall also monitor the hospital's compliance with the rules within this subchapter.**

[10:36-2.5 Quality assurance activities

(a) The Clinical Director, Chief Psychiatric Consultant for the Division of Mental Health and Hospitals, and Central Office professional discipline leadership will periodically attend Clinical Review Committee meetings in each of the institutions in order to monitor the thoroughness and quality of clinical recommendations and compliance with this policy and procedure.

(b) The minutes of Clinical Review Committee meetings in each of the hospitals will be routinely forwarded to the Division of Mental Health and Hospitals' Chief Psychiatric Consultant to enable him or her to monitor and ensure the proper functioning of the hospital review process.

(c) The Division of Mental Health and Hospitals' Chief Psychiatric Consultant may utilize whatever other mechanisms he or she deems appropriate to ensure the proper functioning of the hospital review process.]

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(a)

DIVISION OF WORKPLACE STANDARDS

Procedural Standards for Public Employees

Proposed Readoption with Amendment: N.J.A.C. 12:110

Authorized By: Raymond L. Bramucci, Commissioner,
Department of Labor.

Authority: N.J.S.A. 34:6A-25 et seq., specifically 34:6A-32.

Proposal Number: PRN 1992-500.

Submit written comments by December 16, 1992 to:

Linda Flores

Special Assistant for External and Regulatory Affairs

Office of the Commissioner

Department of Labor

CN 110

Trenton, New Jersey 08625-0110

The agency proposal follows:

Summary

Pursuant to the sunset provisions of Executive Order No. 66(1978), N.J.A.C. 12:110, Procedural Standards for Public Employees, expires on January 19, 1993. These rules set forth the administrative procedures deemed necessary for the enforcement and administration of the Public Employees Occupational Safety and Health Act (Act), N.J.S.A. 34:6A-25 et seq. The rules instruct compliance officers, public employers and public employees in New Jersey on the methods necessary to achieve the goal of a safe and healthy work environment. The Department has reviewed these rules and has determined them to be necessary, reasonable and proper for the purpose for which they were originally promulgated.

The proposed readopted rules, N.J.A.C. 12:110, are divided into eight subchapters. General provisions and definitions applicable to the chapter are covered in subchapters 1 and 2. Subchapter 3 sets forth the duties of the employer and the employee's responsibilities and rights, as well as the dissemination of program information requirements; subchapter 4 establishes the procedural rules relating to inspections, orders to comply and penalties. Subchapter 5 addresses the recording and reporting of occupational injuries and illnesses, while subchapter 6 discusses the rules governing applications for variances and hearings relating thereto before the Commissioner. Subchapter 7 sets forth the procedures and methods to protect employees against discrimination for exercising their rights under the Act or rules. The final subchapter makes reference to the availability of the standards and publications referred to in this chapter, the location at which these documents may be inspected and the organizations from which copies of the standards referred to in the chapter may be obtained.

The Department believes the current text is sufficient for the purpose of administering the occupational safety and health procedural standards applicable to public employees. The Department is **only** amending the chapter heading to more accurately reflect the purpose of the rules.

Social Impact

The rules proposed for readoption will furnish required guidance to those charged with the duty of enforcement and administration of the New Jersey Public Employees Occupational Safety and Health Act. The direction from these rules will assist in achieving a uniform level of standard performance by enforcement officers. The rules establish simple procedures that enhance the public employer's understanding of the Act and help prevent inconsistent individual behavior. They also help minimize the opportunity for allegations of discrimination or persecution arising from the uneven application of the Act. In addition to the rules' function as a compliance manual for officers administering the program, they provide detailed direction and assistance to the public employer achieving compliance with the provisions of the Act.

Economic Impact

Currently, these rules place a substantial economic impact on public employers and will continue to do so under the proposed readoption because they must provide the manpower and time necessary to carry out the administrative responsibilities imposed by these rules and the

Act. A public employer must provide each of its employees with a place of employment free from recognized hazards. Therefore, inspections must be made to insure that there is compliance with the adopted safety and health standards. Consequently, substantial recording and reporting requirements for occupational injuries and illnesses to public employees must be maintained.

Regulatory Flexibility Analysis

The rules proposed for re-adoption impose reporting, recordkeeping and other compliance requirements upon public employers, some of which may be considered small businesses as that term is defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq.

The detailed reporting, recordkeeping and compliance requirements are already specified in N.J.A.C. 12:110-5. These statutory requirements, which are an expression of existing policy and regulations of the New Jersey Public Employee Occupational Safety and Health Act (PEOSHA), require the public employer to keep sufficient records of all occupational illnesses and/or injuries through the use of a log and summary form. The form, NJOSH No. 200, may be obtained by contacting the Office of Workers Safety Statistics, Division of Program Analysis and Evaluation, or by drafting an equivalent one which is as readable and comprehensible as the preprinted form.

The public employers are required to submit the above records annually as indicated in N.J.A.C. 12:110-5.5. The purpose of this requirement is to review and study all incidents and, if necessary, to develop additional standards which the public employers should follow in the future in order to provide a safer and healthy work environment.

Additional compliance requirements are imposed by N.J.A.C. 12:110-6, which sets forth the process for seeking a waiver from the chapter's requirements, and N.J.A.C. 12:110-7, which prohibits discrimination against employees for actions taken under the Act.

Compliance with the above-described requirements does not necessitate the employment of professional services by small businesses. The costs associated with these requirements are probably less for smaller businesses and can be absorbed within the administrative costs of the employer. In fact, the employer or a designated employee may supervise the company's compliance with these rules.

The Department recognizes that imposition of such requirements may appear to be burdensome, and it has tried to minimize any adverse economic impact by not imposing any requirements other than those already established by Federal and/or State laws or regulations. The New Jersey PEOSHA rules are adopted from the Federal Occupational Safety and Health Act regulations. In order to protect the personal health and safety of public employees and the public at large by providing a work environment free from recognized hazards, the rules cannot provide exemptions or lesser requirements based upon the size of the regulated employer.

Full text of the proposed re-adoption appears in the New Jersey Administrative Code at N.J.A.C. 12:110.

Full text of the proposed amendment follows (additions indicated in boldface **thus**):

CHAPTER 110

OCCUPATIONAL SAFETY AND HEALTH PROCEDURAL STANDARDS FOR PUBLIC EMPLOYEES

(a)

DIVISION OF WORKPLACE STANDARDS

Explosives

Proposed Re-adoption: N.J.A.C. 12:190

Authorized By: Raymond L. Bramucci, Commissioner,
Department of Labor.

Authority: N.J.S.A. 21:1A-128, specifically 21:1A-131.

Proposal Number: PRN 1992-492.

Submit written comments by December 16, 1992 to:

Linda Flores
Special Assistant for External and Regulatory Affairs
Office of the Commissioner
Department of Labor
CN 110
Trenton, New Jersey 08625-0110

The agency proposal follows:

Summary

Pursuant to Executive Order No. 66(1978), the rules on explosives found at N.J.A.C. 12:190 expire on January 4, 1993. These rules regulate the manufacture, sale, storage, use, possession and transportation of explosives for the protection of the public. The Department has reviewed these rules and has determined them to be necessary, reasonable and proper for the purpose for which they were originally intended.

The chapter has been amended since the last re-adoption. The fee schedule at N.J.A.C. 12:190-3.14, Annual fees for permits, was revised in accordance with the amendments to N.J.S.A. 21:1A-134 enacted under P.L. 1991, c.205. These amendments authorize the Commissioner to increase the fees established by regulation for permits to manufacture, sell, store or use explosives.

N.J.A.C. 12:190 contains 12 subchapters. Subchapter 1 contains general provisions dealing with purpose, scope and jurisdiction. The definition of terms used in the chapter are located in subchapter 2. Subchapter 3 covers the procedures for the issuance of permits, the payment of fees, the recordkeeping required by permit holders, and reporting procedures. Subchapter 4 addresses the manufacture of explosives. Subchapter 5 applies to the storage of explosives in magazines and tunnels and the storage of explosives for underground mining operations. Subchapter 6 establishes the standard for off-the-highway, underground and manual transportation of explosives. Subchapter 7 sets forth the rules governing the use of explosives in various operations including blasting and demolition. Subchapter 8 is reserved. The rules applicable to the storage, mixing and handling of blasting agents are found in subchapter 9. Subchapter 10 contains the provisions for the storage and distribution of smokeless powder and black powder, while subchapter 11 provides the rules applicable to the sale of commercial explosives. The final subchapter lists the availability of the various standards and publications referred to by reference throughout the chapter, the location at which these documents may be inspected and the organizations from which copies of the standards referred to in the chapter may be obtained.

N.J.A.C. 12:190 is not being amended on re-adoption. The Department believes the current text of the chapter is suitable for its purpose of establishing reasonable standards for the manufacture, sale, transportation, storage and use of explosives.

Social Impact

These rules have had and should continue to have a positive social impact in safeguarding the public from the hazards associated with explosives. The manufacturers, sellers, users and transporters of explosives are the persons who are impacted by these rules because they must adhere to the standards established by these laws.

Economic Impact

The re-adoption of these rules without amendments will not present any additional changes in the economic impact on the public or others. The costs the rules for re-adoption currently impose on those regulated appear in the form of permit fees, penalties for non-compliance with the rules, the acquisition of special precautionary equipment for storage and special signs for off-the-highway transportation of the explosives. In addition, those subject to this chapter will also bear the administrative and maintenance costs of the reporting and recordkeeping requirement as described in the Regulatory Flexibility Analysis below.

Because of the diversity of the various companies within the explosive industry, an exact dollar amount for this impact can not be established. It varies from business to business. However, over the past fiscal year, the Department has collected nearly \$62,000 in fees and \$32,000 in penalties. It must be noted that the need for most of the explosive industry to acquire the precautionary equipment does not exist because they already have it. Therefore, for the majority of the companies affected, large, medium or small, no foreseeable financial burden exists because they are already in compliance with the rules.

Continued compliance with the rules will help prevent a significant negative economic impact, such as that resulting from a public disaster caused by the unsafe use of explosives. As in the past, operators found in violation during inspections will still be required to take corrective actions. There will be no additional costs to those operators in compliance with these rules. Only violators will incur additional costs in the form of penalties for noncompliance. As a result of these rules, the public will continue to benefit from the reduced risk of injuries and loss of life and property.

Regulatory Flexibility Analysis

The rules proposed for re-adoption impose some recordkeeping and reporting requirements upon the explosives industry sector, some of which may be considered small business as that term is defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq.

The recordkeeping and reporting requirements are specified in N.J.A.C. 12:190-3, Administration. These statutory requirements call upon the explosives industry to maintain accurate information regarding the supplier, quantities, brand, type and manufacturer's identifying marks, the date of all invoices and transactions and the disposition and/or disposal of all explosives. A set time frame is also established by the rules indicating how long these permanent records must be maintained. The rules request detailed information for each individual permit to manufacture, sell, store or use explosives. All accidents resulting in injury to a person or serious property damage, as well as, losses by theft or otherwise must be immediately reported by the permit holder for the explosive(s) involved to the Office of Safety Compliance, Division of Workplace Standards. All persons holding permits to store, use or sell commercial explosives must also file monthly reports on special forms which may be secured from the Office of Safety Compliance.

Those subject to this chapter are also required to obtain permits, to acquire special precautionary equipment for storage, and to obtain and display special signs for off-the-highway transportation of the explosives. The costs of these requirements are discussed in the Economic Impact above.

The employment of professional services outside the regulated explosives' sector is not necessary in order for this regulated industry to come into compliance with the rules which require the acquisition of permits, precautionary equipment for storage and the display of special signs for off-the-highway transportation of explosives. As stated above, the vast majority of this regulated industry already possess the permits, precautionary equipment for storage and the special signs for off-the-highway transportation of explosives. New businesses to this industry will be able to comply with all the chapter's requirements without the assistance of outside professional services. The newcomers will be able to pay the permit fees as stated in the rules at N.J.A.C. 12:190-3.14, buy the precautionary storage equipment, and make the special signs for off-the-highway transportation of explosives by following the detailed specifications contained in N.J.A.C. 12:190-6.4.

Any exemption from these rules would endanger the health, safety and general welfare of the public. Because of the dangerous and sometimes disastrous nature of injuries caused by the unsafe use of explosives, no differentiation based on business size is necessary or appropriate. All businesses must equally comply.

Full text of the proposed re-adoption can be found in the New Jersey Administrative Code at N.J.A.C. 12:190.

LAW AND PUBLIC SAFETY**(a)****DIVISION OF MOTOR VEHICLES****Equipment for Emergency Vehicles and Other Specified Vehicles****Proposed Amendments: N.J.A.C. 13:24-4.1 and 4.2**

Authorized By: Stratton C. Lee, Jr., Director, Division of Motor Vehicles.

Authority: N.J.S.A. 39:3-54.21.

Proposal Number: PRN 1992-485.

Submit written comments by December 16, 1992 to:

Stratton C. Lee, Jr., Director
Division of Motor Vehicle Services
Attention: Legal Services Office
25 South Montgomery Street
CN 162
Trenton, New Jersey 08666

The agency proposal follows:

Summary

A recently passed law, N.J.S.A. 39:3-54.21, allows rural route letter carriers to display flashing amber warning lights while performing their assigned duties in motor vehicles owned or leased by them or their

families. It will add this new classification of vehicles to those classifications of vehicles which are already authorized to display amber lights such as wreckers and service vehicles which bear commercial or governmental registration and snow-removal and/or sanding equipment.

The proposed amendments will bring Division of Motor Vehicles rules into compliance with the new law. The amendments also authorize postmasters to sign rural route letter carrier applications for amber light permits which are submitted to the Division of Motor Vehicles.

Social Impact

The proposed amendments add another classification of authorized users of amber warning lights. The use of amber warning lights will provide an increased margin of safety to rural route letter carriers while performing their assigned duties.

Economic Impact

The proposed amendments permit rural route letter carriers to apply for permits to use amber warning lights. They do not require rural route letter carriers to apply for the permits nor do they require the rural route letter carriers to use the amber warning lights. Those deciding to apply will bear the minor administrative costs of application. No costs are being imposed on the public.

The Division will incur costs to create and print new forms and permits and to process the permit applications.

Regulatory Flexibility Statement

The proposed amendments do not impose any reporting, recordkeeping or other compliance requirements on small businesses as defined in N.J.S.A. 52:14B-16 et seq. and N.J.A.C. 1:30-3.1. The amendments permit, per statute, rural route letter carriers to apply for a permit to display an amber warning light on the owned or leased motor vehicle used in the performance of his or her duties. Thus, a regulatory flexibility analysis is not required.

Full text of the proposal follows (additions indicated in boldface text; deletions indicated in brackets [thus]):

13:24-4.1 Persons eligible

(a) Owners or [lessees] lessees of the following types of vehicles may be considered eligible for amber light permits.

1.-3. (No change.)

4. Vehicles being operated by rural route letter carriers, employed by the United States Postal Service, while they are performing their official duties.

i. The vehicle must be either owned or leased by the rural route letter carrier or a member of his or her family.

13:24-4.2 Application procedure

(a) Application for a flashing amber light permit pursuant to this subchapter must be made in writing to the Division of Motor Vehicles.

(b) The application for vehicles bearing governmental registration, after completion, is to be signed by the chief official of the governmental agency which owns or leases the vehicles, and returned to the Division of Motor Vehicles.

[(b)](c) The application for vehicles not bearing governmental registration, after completion, is to be signed by the chief law enforcement official in the municipality in which the service is being provided, and returned to the Division of Motor Vehicles. **However, a rural route letter carrier shall have his or her application signed by the postmaster of the post office which employs him or her, instead of the chief law enforcement official in a municipality.**

[(c) The application for vehicles bearing governmental registration, after completion, is to be signed by the chief official of the governmental agency which owns or leases the vehicles, and returned to the Division of Motor Vehicles.]

(d) (No change.)

(a)

STATE BOARD OF OPTOMETRISTS

Permissible Advertising

Proposed Amendments: N.J.A.C. 13:38-1.2 and 1.3 Proposed Repeal and New Rule: N.J.A.C. 13:38-2.5

Authorized By: State Board of Optometrists, Vincent Martucci,
President.

Authority: N.J.S.A. 45:12-4 and 45:12-11.1.

Proposal Number: PRN 1992-497.

Submit written comments by December 16, 1992 to:

Susan Gartland, Executive Director
State Board of Optometrists
124 Halsey Street
P.O. Box 45012
Newark, New Jersey 07101

The agency proposal follows:

Summary

The Board of Optometrists is proposing to amend N.J.A.C. 13:38-1.2 and 1.3, and repeal and add a new rule at N.J.A.C. 13:38-2.5, in order to clarify and to expand the scope of permissible advertising for optometric services and related merchandise. The proposal incorporates previously proposed amendments published on July 1, 1991 (23 N.J.R. 2002(a)) with new and amended standards to guide licensees in their advertising practices. The consolidation of the previously proposed amendments into the present format is to allow for a single integrated format for the purpose of additional public comment and further Board consideration thereof.

In order to encourage the free flow of relevant consumer information and to permit licensees to truthfully offer optometric services and related merchandise in a competitive marketplace, the amendments and new rule effect a number of changes intended to both increase competition and consumer information and to guard against deceptive and misleading advertising practices. As such the amendments will delete the current prohibition against advertising free or reduced fee exams contingent upon the purchase of ophthalmic goods or services since the prior restriction inhibits a practice which is not *per se* deceptive and which may limit legitimate consumer transactions. The deletion of this provision will allow the Board to investigate and determine deceptive claims of free or reduced fee services relating to eye examinations on a case-by-case basis. Claims of professional superiority with regard to the rendering of services or merchandise will be permitted where any such claim can be substantiated by a licensee (N.J.A.C. 13:38-1.2(e)). While the amendments continue the prohibition against using the terms "specialist," "specialty" or the substantial equivalents thereof in any advertising by virtue of the fact that specialties are not established or recognized within the profession of optometry in a fashion similar to that established in the medical profession (that is, advanced education and training leading to specialty board examination and certification), they would permit factual statements and the use of the term "practice limited to" recognized areas of optometric care (for example, contact lens services, low vision services, vision training services, etc.) (N.J.A.C. 13:38-1.2(f)2). Similarly, the truthful representation of certain post-graduate professional fellowships from recognized academies and colleges is deemed not to be a claim of professional superiority and, therefore, may be used by licensees possessing such credentials. Truthful and non-deceptive statements with regard to accumulated periods of experience in particular areas are also permitted. N.J.A.C. 13:38-1.2(f).

Similarly, in order to clarify current advertising standards relating to the advertising of contact lenses, the amendments require that an advertisement which states a price for such lenses must also disclose both the type (for example, daily, extended wear) and brand (for example, Bausch and Lomb) of the lens. The current regulation requires only that the type be disclosed. This change is being proposed in order to further clarify the disclosures which are required and to guard against bait and switch and other types of deceptive advertising. Consistent with the requirement of "brand disclosure," language is being inserted which would require the advertising optometrist to evaluate responding patients in relation to both the brand and type of the advertised lens. Finally, the disclosure that advertised lenses may not be appropriate for all patients will be required whenever a price is set forth in the advertisement.

The amendments also for the first time recognize the right of an advertiser to utilize lay or expert testimonials based upon personal knowledge or experience obtained from a provider relationship or direct personal knowledge of the subject matter of the testimonial. While recognizing this advertising method, the amendments set limits on the manner in which such testimonials may be presented with the fundamental requirement that the advertiser be able to substantiate any objective, verifiable statement of fact appearing in a testimonial. The failure to do so may render the advertiser subject to findings of professional misconduct. In any advertisement where a testimonial is utilized and where compensation is provided, a required disclosure is to be set forth in the advertisement. The amendments also require that certain verifying documents be established and maintained when testimonials are utilized. (N.J.A.C. 13:38-1.2(k)).

Through the proposed repeal and new rule at N.J.A.C. 13:38-2.5, the current prohibition against paying referral fees for patients or purchasers of goods and services is clarified. At the same time it is made clear that this prohibition does not prohibit the division of fees among licensees engaged in bona fide employment or practice relationships. Finally, the amendments clarify the obligation of an advertiser to disclose that not all contact lenses are suitable to all patients whenever a price is contained for such lenses in an advertisement. N.J.A.C. 13:38-1.2(c)6.

Social Impact

The proposed amendments will provide licensees with more clearly defined standards to guide the advertising of their services to the public. They will also provide the public with an increased information flow concerning optometric services and related merchandise. The standards are intended to recognize the licensee's right to provide truthful, non-deceptive information concerning professional services and merchandise offered by the licensee and at the same time to provide consumers with information from which decisions may be made in purchasing optometric services and related merchandise. By deleting or relaxing certain current advertising standards, the amendments foster a more competitive marketplace by factual disclosure and substantiation requirements where claims are made regarding optometric services and related merchandise. Both price and quality competition are, therefore, enhanced to the consumer's and the profession's benefit. The requirement to make specific disclosures when advertising contact lenses both assures patient safety and guards against deceptive bait and switch practices. By clarifying the prohibition against the payment of referral fees, consumer's choice of an optometrist will be made on the basis of factors such as the licensee's reputation for quality services and merchandise, the courtesy exhibited and other factors directly relating to the rendering of professional services and related merchandise rather than being influenced directly or indirectly by the amount of monies being paid for the referral. The prohibition also operates to strengthen competition among providers of optometric services to the benefit of consumers by removing a financial element which is unrelated to the quality of services or merchandise supplied by the licensees.

Economic Impact

The proposed amendments should have no adverse economic impact either upon individual licensees or the profession as a whole. Increased information to allow for improved decision making is consistent with an open and competitive marketplace while at the same time provides standards to guard against deceptive and misleading advertising practices. While a minimal impact will be created upon licensees by the requirements to disclose contact lens brands and to maintain information to verify testimonials, there is no perceived adverse economic impact upon either the public or the Board in its administration of these rules. To the extent that referral fees have been paid, the recipients thereof will suffer negative economic impact. On the other hand, licensees will receive an economic benefit by not having to make such payments. The elimination of such payments will also tend to reduce licensee costs of operation thus allowing for price reductions of the overall goods and services to the consuming public. To the extent that testimonials provide additional information to consumers to allow for informed decision making, competition within the marketplace is enhanced with economic benefits being realized by consumers. While the extent of the economic effect anticipated by the adoption of the amendments cannot be measured, the changes will clearly tend to enhance competition to the benefit of consumers and economically efficient licensees. Testimonial advertisements, to the extent they are compensated, will increase advertisers' costs but with a corresponding potential for increased income through increased fees. Similarly, the right to announce factually correct

areas of practice and experience without claiming specialization provides important consumer information and may tend to increase licensee income.

Regulatory Flexibility Analysis

If, for the purpose of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., optometrists are deemed "small businesses" within the meaning of the statute, the following statement is applicable:

The proposed amendments and new rule will apply to the approximately 1,065 active licensed optometrists in this State regardless of the size of the optometric practice. The amendments establish standards for advertising practice and certain limited recordkeeping requirements where the use of testimonial advertising is undertaken. This is a new record retention requirement which is intended to create minimal impact on the licensee while at the same time providing important information in the event that Board scrutiny of a testimonial advertisement is required. The amendments and new rule involves no capital cost or reporting requirements, and it is unlikely that any professional services will be needed to comply with the amendments and rule. Since the intent of the amendments is both to provide a more specific standard in certain areas of advertising and to allow for a clear and truthful flow of information to the consuming public, all of which, in turn, is contemplated to create a more competitive marketplace, the benefits flowing to both the public and the regulated class are uniform. While certain of the amendments' requirements may involve additional disclosures in advertisements, the cost of such disclosures will be minimal and when considered in view of the intended improvement of information flow, the limited costs are clearly justifiable. The clarification of the referral fee prohibition imposes no new requirement but rather relates solely to a regulation already in effect. Since the economic impact of the amendments and new rule, if any, upon licensees is minimal, a design to further minimize any adverse economic impact on small businesses is not feasible. Similarly, no exemptions, whether for small or large practices, are possible, since this would frustrate the intent of the rules.

Full text of the proposal follows (additions indicated in boldface thus; deletions indicated in brackets [thus]):

13:38-1.2 General advertising practices

(a)-(b) (No change.)

(c) An optometrist may advertise fees for services to be rendered and prices for ophthalmic goods and merchandise offered for sale provided that:

1.-2. (No change.)

3. A statement of a fee or price for professional services shall be set forth in a single dollar amount and shall not be stated in the form of a range of fees or prices. A statement of price relating to ophthalmic goods or merchandise may be set forth in a range provided such range is stated in terms of a minimum and maximum dollar amount[.];

4. Where a separate or additional fee for the service of dispensing ophthalmic goods is to be charged, the advertisement shall disclose the dollar amount of such fee[.];

5. Where prices are set forth for ophthalmic goods and services for eyeglasses (lenses and frames), the advertisement shall indicate the type of frames and corrective lenses being offered such as clear or tinted, single vision or multifocal, and plastic, glass or other material. The lenses and frames may be priced separately or as a combined item[.]; **and**

6. When prices are set forth for ophthalmic goods and services for contact lenses, the advertisement shall include, but not be limited to, the fee for the eye exam appropriate to a contact lens evaluation, the type **and brand** of lens being offered, fitting instruction and follow-up care. These items may be priced separately or as a combined package. If the cost of a contact lens care kit is not indicated as a separate item or as a part of a package, the following statement shall be set forth: "The proper maintenance of contact lenses requires sterilization, storage and cleansing in special containers and solutions, the cost of which is not included in this offer." In all advertisements which include a price for a contact lens care kit, the type of kit shall be set forth. When the [brand name and] price of a contact lens is advertised, a statement shall be made to note that such lens may not be appropriate for all patients.

[7. An advertised offer of a free or reduced fee eye examination shall not be contingent upon a resultant purchase of ophthalmic goods or services.]

(d) (No change.)

(e) An advertisement shall not state that the advertiser possesses professional superiority with regard to services or merchandise offered or with regard to apparatus, equipment or technology utilized by such advertiser **unless such claims can be substantiated by the licensee.** [The use of such terms as specialist, specialty, expert or words of similar import shall be deemed to indicate a claim of professional superiority.]

(f) When an advertisement contains information on professional credentials, it shall only contain the highest academic degrees obtained relating to the practice of optometry and certifications from bona fide accrediting bodies directly related to the practice of optometry.

1. The use of titles of post-graduate professional fellowships in optometry from the American Academy of Optometry and the College of Optometrists in Vision Development shall not be deemed to be a claim of professional superiority.

2. It shall be deemed to be the use or employment of deception and misrepresentation for a licensee to utilize or authorize the use of the terms "specialist," "specialty" or the substantial equivalent thereof in any advertising as defined by (a) above; provided, however, that nothing in this section shall prohibit a licensee from utilizing such terminology as "practice limited to," where the advertising licensee's practice is exclusively or primarily devoted to one or more recognized areas of optometric care or services, for example, contact lens services, low vision services, vision training service, etc.

3. Nothing in this section shall preclude any truthful and non-deceptive statement in regard to experience in a particular area of optometry (for example, 10 years experience in contact lens fitting and dispensing).

(g)-(i) (No change.)

(j) It shall be an unlawful advertising practice for an optometrist licensed by the New Jersey Board of Optometrists to:

[1. Employ endorsements or personal testimonials attesting to the technical, optometric quality of services rendered or merchandise received;

i. A testimonial advertised shall arise from a bona fide patient-optometrist relationship.

ii. Any compensation, direct or indirect, received by a person giving a testimonial shall be disclosed by specifying the type of compensation and amount or value of compensation in the testimonial advertisement. Such disclosure shall be as visible and/or audible as the rest of the advertisement.

iii. An optometrist who advertises through the use of testimonials shall maintain documentation relating to such testimonial for a period of three years from the date of the last use of the testimonial. Such documentation shall include, but not be limited to, the name, address and telephone number of the individual in the advertisement, the type and amount or value of compensation, and a signed, notarized statement and release, obtained prior to the time the testimonial is advertised, verifying the truthfulness of the information contained in the testimonial and indicating that person's willingness to have his or her testimonial used in the advertisement.]

[2.]1. Guarantee that services rendered will result in cures of any optometric or visual abnormality;

[3.]2. Fail to retain a copy or duplicate of any advertisement for a period of three years following the date of publication or dissemination. Such copies or tapes shall be made available on request by the Board or its designee; or

[4.]3. Fail to be able to substantiate any objective material claim or representation set forth in an advertisement.

(k) An advertisement may contain either a lay or expert testimonial, provided that such testimonial is based upon personal knowledge or experience obtained from a provider relationship with the licensee or direct personal knowledge of the subject matter of the testimonial. A lay person's testimonial shall not attest to any technical matter. An expert testimonial shall be rendered only by

an individual possessing specialized expertise sufficient to allow the rendering of a bona fide statement or opinion. An advertiser shall be able to substantiate any objective, verifiable statement of fact appearing in a testimonial, and the failure to do so, if required by the Board, may be deemed professional misconduct.

1. Where an advertiser directly or indirectly provides compensation to a testimonial giver, the fact of such compensation shall be conspicuously disclosed in a legible and readable manner in any advertisement in the following language or its substantial equivalent:

COMPENSATION HAS BEEN PROVIDED FOR THIS TESTIMONIAL.

2. An optometrist who advertises through the use of testimonials shall maintain documentation relating to such testimonials for a period of three years from the date of the last use of the testimonial. Such documentation shall include, but not be limited to, the name, address and telephone number of the individual in the advertisement, the type and amount or value of compensation, and a signed, notarized statement and release, obtained prior to the information contained in the testimonial and indicating that person's willingness to have his or her testimonial used in the advertisement.

13:38-2.3 Records of examinations and prescriptions

(a)-(d) (No change.)

(e) Every optometrist shall be required to evaluate a patient for the specifically advertised brand and type of contact lenses which attracted or induced the patient to seek such goods. In the event that the patient is fitted with another brand or type of contact lens, the patient record shall reflect that decision and the justification therefor.

13:38-2.5 Division of fees

[(a) No optometrist shall divide or share any fee or compensation for optometric services rendered by him with anyone who is not licensed to practice optometry in New Jersey.

(b) No division of fees for services shall be made except with another optometrist, based upon a division of services.]

It shall be professional misconduct for a licensee to pay, offer to pay, to solicit or to receive from any person any fee or other form of compensation for the referral of a patient or purchaser of goods and services. The within prohibition shall not prohibit the division of fees among licensees engaged in a bona fide employment, partnership or corporate relationship for the delivery of professional services.

(a)

VIOLENT CRIMES COMPENSATION BOARD

Moneys Received from Other Sources

Proposed Amendment: N.J.A.C. 13:75-1.19

Authorized By: Violent Crimes Compensation Board,
Jacob C. Toporek, Chairman.

Authority: N.J.S.A. 52:4B-9.

Proposal Number: PRN 1992-471.

Submit comments by December 16, 1992 to:

Amedeo A. Gaglioti, Esq.
Violent Crimes Compensation Board
60 Park Place
Newark, New Jersey 07102

The agency proposal follows:

Summary

N.J.A.C. 13:75-1.19 authorizes the Board to consider moneys received from other sources before determining the amount of compensation to be awarded. The Board is not empowered to make any award for pain and suffering. This proposed amendment will enable the Board to consider the first \$1,000 of any related civil suit for damages as compensation for pain and suffering by the victim. Any net recovery over and above the \$1,000 will be considered as moneys received from other sources, or in satisfaction of the Board's lien against any related third party action.

Social Impact

By permitting compensation for a greater number of victims and compensation in increased amounts, the Board hopes to more fully ameliorate the problems incurred by innocent victims of crimes. No social impact on the Board or society in general is anticipated.

Economic Impact

The proposed amendment will allow both increased amounts of compensation and compensation of a greater number of innocent victims. This change will not have an effect on the Board's funding each year.

Regulatory Flexibility Statement

The Violent Crimes Compensation Board's rules govern the process by which victims of violent crimes and their attorneys may make claims for compensation.

The proposed amendment imposes no reporting, recordkeeping or other compliance requirements upon small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., since it establishes an amount of compensation factor for individual victims. Therefore, a regulatory flexibility analysis is not required.

Full text of the proposal follows (additions indicated in boldface thus; deletions indicated in brackets [thus]):

13:75-1.19 Moneys received from other sources

(a) (No change.)

(b) "Source or sources" means a source of benefits or advantages which the claimant has received in lieu of economic loss or which is readily available to the claimant from, but not limited to:

1.-8. (No change.)

9. **The net amount received by the victim or claimant in excess of \$1,000 in the case of any related civil suit for damages and [All] all proceeds or recovery to the victim or claimant from any collateral action or claim based upon or arising out of the circumstances giving rise to claimant's petition before the Board.**

i. (No change.)

TREASURY-GENERAL

(b)

DIVISION OF PENSIONS AND BENEFITS

Administration

Purchase Terms; Grace Period

Proposed Amendment: N.J.A.C. 17:1-4.12

Authorized By: Margaret M. McMahon, Director, Division of Pensions and Benefits.

Authority: N.J.S.A. 52:18A-96.

Proposal Number: PRN 1992-491.

Submit comments by December 16, 1992 to:

Peter J. Gorman, Esq.
Executive Assistant
Division of Pensions and Benefits
CN 295
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The proposed amendment changes the current 30 days of grace period to 60 days during which a member of the various State-administered retirement systems must decide whether or not to agree to the terms of the cost of purchase of certain eligible service credit. The current 30 days of the grace period predates legislation (P.L. 1991, c.153) permitting such purchases as military and Federal service, which require the member to bear the full cost of the purchase. As purchase costs have risen and private savings and investment tools have become more complex, members are apparently having difficulty in meeting the 30 days requirement for authorization to purchase. The proposed amendment would be beneficial to the members and would reduce administrative costs associated with the processing of delinquent purchase payments.

Social Impact

This proposed amendment will affect members of the various State-administered retirement systems (TPAF, PERS and PFRS) who are

considering the purchase of eligible service credit within their particular retirement system. The amendment would have a positive impact by allowing such individuals more time in which to decide to purchase service credit, after being informed of the cost of that purchase.

Economic Impact

It does not appear that this proposed amendment will have any significant adverse effect upon the persons affected by this amendment or the State-administered retirement systems. The proposed amendment would allow the purchase amount quoted to remain the same for a longer period, 60 days, and may, therefore, lead to the easing of a financial burden to the members. A member who elects to purchase service time will pay an actuarially-determined amount into the pension system. The State or local employer will not pay any part of the cost of the purchase.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required because the proposed amendment does not impose reporting, recordkeeping or other compliance requirements on small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Since the rules of the Division of Pensions and Benefits only impact upon public employers and/or employees, this amendment will not have any effect upon small business.

Full text of the proposal follows (additions indicated in boldface thus; deletions indicated in brackets [thus]):

17:1-4.12 Purchase terms; grace period

A member who receives a written optional purchase cost quotation is given a [30]60-day grace period to confirm that he or she wishes to make the purchase of credit. If the confirmation of the purchase is not received [form] from the member within [30]60 days, the cost of purchase must be recalculated to determine if any change in the cost is warranted as a result of change in age or salary.

TREASURY-TAXATION

(a)

DIVISION OF TAXATION

Organization of the Division of Taxation Office of Inspection Background Investigations Proposed New Rule: N.J.A.C. 18:1-1.3

Authorized By: Leslie A. Thompson, Director, Division of Taxation.

Authority: N.J.S.A. 52:14B-3 and 54:1-8.

Proposal Number: PRN 1992-481.

Submit comments by December 16, 1992 to:

Nicholas Catalano
Chief, Tax Services Branch
Division of Taxation
50 Barrack Street
CN 269
Trenton, New Jersey 08646

The agency proposal follows:

Summary

The proposed new rule supplements the Division's organizational rules at N.J.A.C. 18:1 to indicate that the Division's Office of Inspection is authorized to conduct background checks on prospective appointees to Division positions. The background investigation will consist of a routine inquiry to confirm a job applicant's education, prior employment, references, and a check to investigate the applicant's criminal record, if any, and tax compliance record. The implementation of this procedure will be coordinated with civil service rules administered by the State Department of Personnel.

Social Impact

The proposed new rule will alert applicants for Division positions that a background investigation will be performed to confirm claims of prior education and employment. The new rule should make clear the Division's goal of hiring only individuals of good character and appropriate experience, and facilitate uniformity in the application of background review procedures.

Economic Impact

The proposed new rule should have negligible economic impact, since the rule does not affect tax rules. The new rule informs the public of a Division personnel-hiring procedure. The rule should not add to administrative costs since the Division has already allocated the necessary administrative resources to this function.

Regulatory Flexibility Statement

This proposed new rule does not impose reporting, recordkeeping or other compliance requirements on small businesses as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Accordingly, a regulatory flexibility analysis is not required. The new rule does not affect tax rules and only applies to individuals applying for positions in the Division.

Full text of the proposal follows (additions indicated in boldface thus; deletions indicated in brackets [thus]):

18:1-1.3 [(Reserved)] Office of Inspection background investigations

(a) The Office of Inspection may conduct background inquiries on applicants for Division positions to ensure that only qualified individuals of good character are appointed and that information contained on Taxation employment applications is accurate and complete. The inquiry will be conducted and the acquired information will be kept confidential in accordance with the Civil Service Act (N.J.S.A. 11A:1-1, et seq.) and any other applicable laws, and may include the following:

1. Appropriate checks of records of criminal convictions and pending criminal charges;
2. State of New Jersey tax filing and payment record check, to assure that the applicant has complied with State tax laws;
3. Credit checks, to compare an applicant's credit information with the following:
 - i. The information listed on the application for employment with the Division of Taxation; and
 - ii. The information obtained through the New Jersey tax filing and payment record check, authorized under (a)2 above;
4. Confirmation of employment and checking on the reasons for separation;
5. Contacting references, as required;
6. Confirmation of any education listed on a candidate's application; and
7. Other inquiries, including interviews, which stem from the above inquiries and which directly relate to criminal convictions or pending charges, tax compliance, financial responsibility, employment history, references, education, or other qualifications for the position sought.

(b)

DIVISION OF TAXATION

Transfer Inheritance and Estate Tax Interest

Proposed Amendment: N.J.A.C. 18:26-3.7

Authorized By: Leslie A. Thompson, Director, Division of Taxation.

Authority: N.J.S.A. 54:50-1.

Proposal Number: PRN 1992-482.

Submit comments by December 16, 1992 to:

Nicholas Catalano
Chief, Tax Services
Division of Taxation
CN 269
Trenton, NJ 08646

The agency proposal follows:

Summary

The proposed amendment modifies N.J.A.C. 18:26-3.7 to bring the rule into conformance with N.J.S.A. 54:38-5, as amended by P.L. 1992, c.39, which was signed into law on June 30, 1992. The new law changed the deadline for the payment of estate taxes from 18 months from the

date of death to nine months from the date of death. The new law also raised the interest rate to be applied to late payments from six percent to 10 percent. If an extension is granted to file the Federal estate tax return, the Director is allowed under the new law to reduce the interest rate from 10 to six percent until the end of the extension. If the decedent was a member of the Armed Forces, no interest will apply until nine months after the decedent's husband, wife, father, mother or next of kin receives official notification of the death of the decedent. The new law requires the imposition of a 10 percent interest rate if the Director, Division of Taxation, applies his or her discretionary authority to extend the payment period for causes other than a Federal extension.

Social Impact

The proposed amendment should have a positive social impact by bringing the existing rule into conformance with the statute as amended. The amendment will alert estate administrators as to the Division's interpretation of the statutory changes and thereby facilitate administration of estates.

Economic Impact

The proposed amendment itself should have negligible economic impact since it only reflects changes made to the statute itself. The statement to the Assembly version of the bill estimated that the amendments made to N.J.S.A. 54:38-5 made by P.L. 1992, c.39 could increase State revenues by \$25 million per year for each of the first two calendar years the law is fully operational.

Regulatory Flexibility Statement

The proposed amendment does not impose reporting, recordkeeping or compliance requirements on small businesses as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. N.J.A.C. 18:26-3.7 only applies to the payment date of estate taxes by the estates of decedents. Accordingly, a regulatory flexibility analysis is not required.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

18:26-3.7 Payment; due date; interest; extension of time

(a) The New Jersey estate tax is due at the date of a decedent's death; provided, however, payment may be made at any time within [18] **nine** months from the date of death. All or any part of the estate tax due this State, if not paid within [18] **nine** months from the date of death, shall bear interest at the rate of [six]**10** percent per annum from the expiration of the said [18] **nine** months until the date of actual payment[.], **unless an extension of time to file the Federal estate tax return is granted, in which case the Director may reduce the interest rate to six percent per annum until the expiration of the extension. If the decedent was a member of the United States Armed Forces, the estate tax will not bear interest until the expiration of nine months after receipt of official notification of the decedent's death by the decedent's husband, wife, father, mother, or next of kin.**

(b)-(c) (No change.)

(d) The Director may, for cause shown, extend the time for payment with [or without] interest **at the rate of 10 percent per annum** for such period as the circumstances, in his or her discretion, may require. [and the failure of the Federal Government to finally determine the amount of estate tax due within said period of 18 months or the subsequent assessment of an additional or increased estate tax shall always be sufficient grounds for the waiving of interest until the tax has been definitely determined by the government. If the New Jersey estate tax is not paid, however, within 60 days after receipt of notification from the Federal Government stating the amount of the Federal estate tax and the credit for State taxes allowable the New Jersey estate tax shall bear interest at the rate of six percent per annum from the expiration of such 60 day period to the date of payment.]

OTHER AGENCIES

(a)

NEW JERSEY HIGHWAY AUTHORITY Notice of Reopening of Comment Period Garden State Parkway Speed Limits

Proposed Amendment: N.J.A.C. 19:8-1.2

Take notice that the New Jersey Highway Authority has reopened the comment period for the proposed amendment to N.J.A.C. 19:8-1.2 published in the September 21, 1992 New Jersey Register at 24 N.J.R. 3222(a).

Submit written comments by December 16, 1992 to:

Peter E. Markens, Esq.
New Jersey Highway Authority
P.O. Box 5050
Woodbridge, New Jersey 07095

(b)

CASINO CONTROL COMMISSION Casino Service Industries License Requirements

Proposed Amendment: N.J.A.C. 19:43-1.2

Authorized By: Casino Control Commission, Joseph A. Papp,
Executive Secretary.

Authority: N.J.S.A. 5:12-69, 70a, 92 and 94.

Proposal Number: PRN 1992-494.

Submit written comments by December 16, 1992 to:

Mary S. LaMantia, Assistant Counsel
Casino Control Commission
Tennessee and Boardwalk
Atlantic City, New Jersey 08401

The agency proposal follows:

Summary

The Casino Control Act requires that any casino service industry offering goods or services which directly relate to casino or gaming activity shall be licensed before conducting any business with a casino licensee. N.J.S.A. 5:12-92a. The proposed amendments clarify, reorganize and update the standards for determining whether an enterprise is subject to licensure as a gaming-related casino service industry pursuant to subsection 92a of the Act. However, in that such decisions are often fact-specific, the list of criteria is not intended to be, and should not be viewed as, exclusive.

Certain of the current standards are retained. One consideration in determining if an item is "gaming-related" is whether the item in question is "specifically designed for use in" a casino or casino simulcasting facility, or if it is "needed to conduct" an authorized game or simulcast wagering. Similarly, a new criteria would consider "the capacity to affect the play or outcome of an authorized game or simulcast wagering" (see N.J.A.C. 19:43-1.2(a)1iii). Services provided have been viewed as gaming-related if directly related to the operation, regulation and management of a casino.

Proposed text at N.J.A.C. 19:43-1.2(a)4 addresses those goods and services which, though not captured by the other standards, are "so utilized in or incident to" casino or simulcasting activity as to require licensure "to contribute to the public confidence and trust in the credibility and integrity of the gaming industry." N.J.S.A. 5:12-1b(6), 1b(9).

Proposed text at N.J.A.C. 19:43-1.2(b) provides examples of gaming-related casino service industries. Again, this list is not exclusive. The amended rule adds computerized gaming monitoring systems, roulette balls, totalisators, pari-mutuel machines and self-service parimutuel machines, casino credit reporting services and simulcasting hub facilities.

The list of non-gaming related enterprises under subsection 92c of the Act is amended to include suppliers of gaming table layouts, in-State and out-of-State sending tracks and licensors of authorized games to casino licensees and applicants. N.J.A.C. 19:43-1.2(c). Subsection (c)

continues to prohibit non-gaming enterprises from conducting business with a casino licensee or applicant "on a regular or continuing basis" until licensed or exempted, a standard defined in subsections (e) and (f), without amendment. However, new text proposed at N.J.A.C. 19:43-1.2(g) recognizes the Commission's discretion to determine that certain enterprises, though not "directly" related to gaming under subsection 92c, should be licensed prior to conducting any business whatsoever with a casino licensee or applicant "in order to contribute to the public confidence and trust in the credibility and integrity of the gaming industry in New Jersey." The amended rule includes in this category manufacturers, suppliers and distributors of gaming table layouts and licensors of authorized games.

Such license applicants would be required to apply for a transactional waiver, in accordance with N.J.A.C. 19:43-1.2(h), in order to conduct any business transaction with a casino licensee or applicant prior to licensure. Under the amended rules, a transactional waiver may be granted by the Commission a minimum of 30 days from the date the application is filed, provided that the Division interposes no objection. N.J.A.C. 19:43-1.2(h).

Social Impact

The Casino Control Act extends strict State regulation not only to casino licensees but to "all related service industries" as well. N.J.S.A. 5:12-1b(6) and 1b(9). The proposed amendments further the purposes of the Act by ensuring the integrity of such ancillary industries and thus furthering the public confidence and trust in the regulatory process and of casino operations.

Economic Impact

Those enterprises that are required to file for casino service industry licensure under section 92 of the Casino Control Act will incur the costs of license application and renewal as set forth at N.J.A.C. 19:41-9. However, the licensing process is necessary to enable the Commission to ensure the integrity of the casino industry and ancillary industries as mandated by the Casino Control Act.

Regulatory Flexibility Analysis

Some of the enterprises which will be required to file for casino service industry licensure under section 92 of the Casino Control Act may qualify as small businesses as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-17. These enterprises will incur the costs involved in filing an application for such licensure and renewal. See N.J.A.C. 19:41-9. No professional services are required for compliance. Nonetheless, the licensing process is necessary to enable the Commission to ensure the integrity of the casino industry and ancillary industries as mandated by the Casino Control Act. The rules, therefore, are applied consistently with no differentiation based on business size. Moreover, the fees imposed reflect the Commission's consideration of the amount which "to the extent fairly possible" can be assessed upon the applicant or licensee. N.J.A.C. 19:41-9.1(c).

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

19:43-1.2 License requirements

(a) No enterprise shall provide goods or services directly related to casino, **simulcast wagering** or gaming activity to, or otherwise transact business directly related to casino, **simulcast wagering** or gaming activity with, a casino applicant or licensee, its employees or agents unless licensed in accordance with subsections 92a and b of the Act; provided, however, that upon a showing of good cause by a casino applicant or licensee for each business transaction, the Commission may permit an applicant for a casino service industry license to conduct business transactions with such casino applicant or licensee prior to the licensure of the casino service industry license applicant pursuant to N.J.S.A. 5:12-92a. **In determining whether an enterprise shall be licensed pursuant to this subsection, the Commission shall consider, without limitation, whether the enterprise satisfies one or more of the following criteria:**

[1. The following enterprises shall be required to be licensed as casino service industry enterprises in accordance with subsections 92a and b of the Act;

i. Any form of] **1. Whether the enterprise [which] manufactures, supplies or distributes devices, machines, equipment, items or articles which:**

i. Are specifically designed for use in the operation of a casino or casino simulcasting facility;

ii. Are needed to conduct [a] an authorized game or simulcast wagering; or

iii. Have the capacity to affect the play or outcome of an authorized game or simulcast wagering; [including, but not limited to, roulette wheels, roulette tables, big six wheels, craps tables, tables for card games, layouts, slot machines, cards, dice, gaming chips, gaming plaques, slot tokens, card dealing shoes and drop boxes; and

ii. Any form of]

2. Whether the enterprise [which] provides maintenance, service or repair pertaining to devices, machines, equipment, items, or articles [specifically designed for use in the operation of a casino or needed to conduct a game] governed by (a)1 above; [and]

[[iii. Any form of] 3. Whether the enterprise [which] provides services directly related to the operation, regulation or management of a casino or casino simulcasting facility [including, but not limited to, schools teaching gaming and either playing or dealing techniques, casino security enterprises, casino credit collection enterprises]; [and] or

[[iv. Any form of] 4. Whether the enterprise [which] provides such other goods or services determined by the Commission to be so utilized in or incident to gaming, [or] casino or simulcast wagering activity as to require licensing in order to contribute to the public confidence and trust in the credibility and integrity of the gaming industry in New Jersey.

(b) Enterprises required to be licensed in accordance with subsections 92a and b of the Act and (a) above shall include, without limitation, the following:

1. Manufacturers, suppliers, distributors, servicers and repairers of roulette wheels, roulette balls, big six wheels, gaming tables, slot machines, cards, dice, gaming chips, gaming plaques, slot tokens, dealing shoes, drop boxes, computerized gaming monitoring systems, totalisators, pari-mutuel machines and self-service pari-mutuel machines;

2. Schools teaching gaming and dealing techniques; and

3. Casino credit reporting services, casino simulcasting hub facilities and suppliers of casino security services.

[(b)](c) Unless otherwise licensed in accordance with (a) above, no enterprise shall, on a regular or continuing basis, provide goods or services regarding the realty, construction, maintenance, or business of a proposed or existing casino hotel or related facility, to a casino [applicant or] licensee or applicant, its employees or agents unless such enterprise is licensed or exempted in accordance with subsections 92c and d of the Act or authorized to do so pursuant to N.J.A.C. 19:41-11.3(g). In determining whether an enterprise is subject to the requirements of this subsection, it shall not matter whether the casino [applicant or] licensee or applicant is a party to any agreement pursuant to which said goods or services are being provided. Enterprises subject to the provisions of this subsection shall include, without limitation, suppliers of alcoholic beverages, food and nonalcoholic beverages, **gaming table layouts, non-value gaming chip sorters, in-State and out-of-State sending tracks, licensors of authorized games to casino licensees and applicants, garbage handlers, vending machine providers, linen suppliers, maintenance companies, shopkeepers located within the approved hotel, limousine services and construction companies contracting with casino [applicants or] licensees or applicants or their employees or agents.**

[(c)](d) No enterprise shall, on a regular or continuing basis, conduct business as a junket enterprise with a casino [applicant or] licensee or applicant, its employees or agents unless such enterprise is licensed in accordance with subsections 92c and d and section 102 of the Act or is authorized to do so pursuant to N.J.A.C. 19:41-11.3.

[(d)](e) In determining if a person or enterprise does or will, on a regular or continuing basis, conduct business as a junket enterprise or provide goods or services regarding the realty, construction, maintenance, or business of a proposed or existing casino hotel or related facility to casino [applicants or] licensees or applicants, their employees or agents, the following factors, **without limitation, shall be considered:**

1. Number of transactions;
2. Frequency of transactions;
3. Dollar amounts of transactions;
4. Nature of goods or services provided or business transacted;
5. Maximum potential period of time necessary to fully provide the goods, perform the services, or complete the business which is the subject of the transaction;

6. The recommendation of the Division of Gaming Enforcement; and

7. The public interest and the policies established by the Act.

[(e)](f) Notwithstanding the provisions of [(d)] (e) above, persons and enterprises which conduct business as a junket enterprise or provide, or imminently will provide, goods or services regarding the realty, construction, maintenance, or business of a proposed or existing casino hotel or related facility to casino [applicants or] licensees or applicants, their employees or agents shall, unless otherwise determined by the Commission, be deemed to be transacting such business on a regular or continuing basis if:

1. The total dollar amount of such transactions with a single casino [applicant or] licensee or applicant, its employees or agents, is or will be equal to or greater than \$75,000 within any 12-month period; or

2. The total dollar amount of such transactions with all casino [applicants or] licensees or applicants, their employees or agents, is or will be equal to or greater than \$225,000 within any 12-month period.

(g) Based upon an analysis of the factors contained in (e) above, the Commission may, in its discretion, require an enterprise which is otherwise governed by the provisions of N.J.S.A. 5:12-92c, N.J.A.C. 19:41-11.3(g), and (c) above to be licensed as a subsection 92c casino service industry enterprise prior to conducting any business whatsoever with a casino licensee or applicant if the Commission determines that such action is necessary in order to contribute to the public confidence and trust in the credibility and integrity of the gaming industry in New Jersey. Enterprises subject to this requirement shall include manufacturers, suppliers and distributors of gaming table layouts and non-value gaming chip sorters and licensors of authorized games to casino licensees and applicants.

(h) Notwithstanding the provisions of (a) or (g) above, upon application for a transactional waiver by a casino licensee or applicant for each business transaction, the Commission may permit an applicant for a casino service industry enterprise license to conduct a business transaction with the casino licensee or applicant prior to the licensure of the casino service industry license applicant if:

1. A completed application for the appropriate casino service industry enterprise license required by (a) or (g) above has been filed by the applicant;

2. At least 30 days has elapsed since the filing of the completed application required by (h)1 above, unless the Division reports on an application for a transactional waiver prior thereto;

3. The Division does not object to the granting of the transactional waiver; and

4. The casino licensee or applicant shows good cause for granting the transactional waiver.

[(f)](i) (No change in text.)

[(g)](j) In determining whether a person or enterprise has exceeded or will exceed the dollar thresholds established in [(e)] (f) above, all types of business, including junket business, transacted by that person or enterprise with casino [applicants or] licensees or applicants, their employees or agents shall be accumulated.

(a)

CASINO CONTROL COMMISSION

Accounting and Internal Controls Exchange of Coupons for Gaming Chips at Gaming Tables

Reproposed Amendments: N.J.A.C. 19:45-1.1, 1.2, 1.16, 1.18, 1.20, 1.33 and 1.46

Authorized by: Casino Control Commission, Joseph A. Papp,
Executive Secretary.

Authority: N.J.S.A. 5:12-69(a), 70(f), (g) and (l); 99(a)(4)-(a)(9),
(100)(k) and 102(m)(3).

Proposal Number: PRN 1992-495.

Submit comments by December 16, 1992 to:

Seth Brilliant

Assistant Counsel

Casino Control Commission

Arcade Building

Tennessee Avenue and the Boardwalk

Atlantic City, NJ 08401

The agency proposal follows:

Summary

On July 20, 1992, the Commission proposed amendments to its rules which would have permitted promotional coupons to be redeemed at gaming tables in exchange for gaming chips, in accordance with recent amendments to section (100)(k) of the Casino Control Act, N.J.S.A. 5:12-100(k). See 24 N.J.R. 2536(a). Current coupon redemption programs are limited to coupons which can be redeemed only for coin or slot tokens; this amendment would have permitted similar coupon redemption programs for table games.

The comments to the proposal were generally in favor of the concept, but raised several objections to the manner in which the concept would be implemented. After considering these comments, the Commission has determined to repropose the amendments and to incorporate several of these suggestions and comments. These reproposed amendments supersede the earlier proposed amendments at 24 N.J.R. 2536(a).

Greate Bay Hotel and Casino, Inc. (Sands), Marina Associates (Harrah's), Trump's Castle Associates (Trump Castle), Atlantic City Showboat, Inc. (Showboat), Boardwalk Regency Associates (Caesars) and Resorts International Hotel, Inc. (Resorts), objected to the proposed amendment at N.J.A.C. 19:45-1.33(h)8(v), requiring that casino licensees must record the serial number and amount of each coupon tendered in redemption for gaming chips. They indicated such a requirement would be unnecessarily burdensome, difficult to comply with, and would serve no regulatory purpose. In response to these comments, the reproposal would still require that the denominations be recorded, but the requirement that each coupon's serial number be recorded has been replaced by a verification procedure similar to that employed by the cage cashier to verify the amount of cash counted. See N.J.A.C. 19:45-1.33(i)1. The coupons are then sent to the accounting department for processing, where they are reviewed for proper cancellation, then recounted and examined for proper calculation, summarization and recording (see N.J.A.C. 19:45-1.33(i)2 and 19:45-1.46(l)1 and 2).

Caesars noted that proposed N.J.A.C. 19:45-1.33(h)4 only permits the manual counting of coupons, and suggested that the subsection be revised to permit the use of automatic coupon counting equipment which has been approved by the Commission. The reproposed amendments would permit coupons to be sorted manually or by automatic coupon sorting and counting machines approved by the Commission (see N.J.A.C. 19:45-1.33(h)2, 4 and 5).

Caesars also suggested that proposed N.J.A.C. 19:45-1.33(h)6, which requires any uncanceled coupons to be cancelled immediately by the first count team member, be revised to permit coupon cancellation to occur at the end of the count as well. Caesars feared that cancellation of a coupon prior to counting might interfere with the readability of the coupon by barcoding or other equipment. Under these reproposed amendments, coupons could now be cancelled either upon acceptance at a gaming table, during the count or at the conclusion thereof, so long as cancellation is accomplished before the count has been concluded (see N.J.A.C. 19:45-1.18(b) and 1.33(h)7).

Resorts suggested that proposed N.J.A.C. 19:45-1.46(i) should not limit the redemption of coupons to gaming tables "on the casino floor," in view of recently enacted simulcasting legislation which permits certain gaming activities in simulcasting facilities. The intention of the proposal was simply to limit redemption of such coupons to gaming tables, since that is the only location in a casino hotel where gaming chips may be obtained. Redemption of these coupons should be permitted wherever a gaming table may lawfully be located. Accordingly, the phrase "on the casino floor" is being deleted from the above-referenced subsection of the repropoed amendments.

Resorts objected to the provision in proposed N.J.A.C. 19:45-1.33(h)4 that would require the coupons in each drop box to be separated in the count room into separate stacks by denomination. Resorts contends that such a procedure is unnecessary, and that simply separating all of the coupons from the remaining contents of the drop box should be adequate. This suggestion was rejected. Since the coupons could be used just like currency at a gaming table, they should be treated as such, and should be segregated and counted in the same manner as currency is counted in the count room.

Resorts also questioned why coupons should not be permitted to be redeemed for a chip which could not be exchanged for slot tokens or cash. Such a chip, which would be known as a "match play" chip, could only be wagered at a table game in conjunction with, and in addition to, a wager equal to or greater than the table minimum. If the wager won, the entire bet, including the match play chip, would be paid; if the wager lost, the bet and the match play chip would be lost as well. Resorts noted that giving casino licensees the option to issue coupons for "match play" chips could eliminate the possibility of a patron exchanging a coupon for chips, and then exchanging the chips for cash and leaving the premises without gaming. This suggestion was not incorporated into the repropoed amendments because it is beyond the scope of the original proposal; the concept may be considered at another time.

Caesars expressed concern about the wording of proposed N.J.A.C. 19:45-1.46(c), which appeared to require that coupons be redeemable only for chips at gaming tables, or only for coins or tokens at slot booths. Caesars contended that the proposed amendment should be revised to permit the issuance of coupons which could be redeemed for chips, coin or slot tokens, depending upon a patron's desire. The Division of Gaming Enforcement objected to that portion of N.J.A.C. 19:45-1.46(c) which would permit coupons to be redeemable for cash, chips, tokens, "or any combination thereof." The Division contended that the phrase "or any combination thereof" could be misunderstood by a patron, who might attempt to redeem a coupon for chips and cash at a gaming table, where chips would be available, but not cash. The Division, which supported the remainder of the proposal, suggested that this subsection be clarified. After reviewing these comments, the Commission has determined to delete the proposed changes to the subsection from these repropoed amendments.

These repropoed amendments would also make minor non-substantive changes which simplify and clarify the rules in question. See, for example, N.J.A.C. 19:45-1.18(a) and 1.33(h)5, as well as the addition of "gaming chips" to N.J.A.C. 19:45-1.2(c)3.

Also deleted is an obsolete procedure in N.J.A.C. 19:45-1.18(a)3 for retaining quarters and half dollars as change at the gaming tables. Such coins should be placed in the drop box upon their receipt by the dealer; if small denominations of coin are subsequently needed at a gaming table, the coin should be obtained from the cage and carried in the table inventory, pursuant to N.J.A.C. 19:45-1.20.

Social Impact

These repropoed amendments should create new marketing and promotional opportunities for casino licensees, which could be used to interest patrons in table games.

Economic Impact

To the extent that coupon programs for table games create increased interest in such games, it is anticipated that these repropoed amendments may have a favorable economic impact upon casino licensees. However, because of the expenses that may be involved in providing such coupons, the actual economic impact of these repropoed amendments upon the casino industry cannot be predicted with certainty.

Regulatory Flexibility Statement

These repropoed amendments would affect only casino licensees, none of which is a "small business" as that term is defined in the

Regulatory Flexibility Act, N.J.S.A. 52:14B-16, et seq. Accordingly, no regulatory flexibility statement is required.

Full text of the proposal follows (additions indicated in boldface thus; deletions indicated in brackets [thus]):

19:45-1.1 Definitions

The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

... "**Coupon**" means a document which is issued in accordance with the coupon redemption and complimentary distribution programs in N.J.A.C. 19:45-1.46(a).

... "Table game drop" means the sum of the total amount of currency, [and] coin **and coupons**, and the total amounts recorded on issuance copies of Counter Checks removed from the drop box.

"Table game win or loss" means the amount of gaming chips and plaques and cash won from patrons at gaming tables less the amount of gaming chips, plaques and coins won by patrons at gaming tables. The table game win or loss is determined by adding the amount of cash, **coupons**, the amount recorded on the Closer, [and] the totals of amounts recorded on the Credits, and issuance copies of Counter Checks removed from a drop box, and subtracting the amount recorded on the Opener and the total of amounts recorded on Fills removed from a drop box.

19:45-1.2 Accounting records

(a)-(b) (No change.)

(c) The detailed, supporting and subsidiary records shall include, but not necessarily be limited to:

1.-2. (No change.)

3. Records supporting the accumulation of the costs and number of persons, by category of service, for regulated complimentary services. Such records shall include, on a daily basis, the name of each person provided with complimentary services, the category of services provided, the retail value of the aggregate of each category of service provided to such person, and the person authorizing the receipt of such service. A copy of this record shall be submitted to the Division of Gaming Enforcement[']s office located on the casino premises no later than two days subsequent to its preparation. Excepted from this requirement are the individual names of persons authorizing or receiving complimentary tickets for theatre or other entertainment events with a face value of less than \$25.00, parking, beverages served in bars and the casino or complimentary services or items, including cash, **gaming chips** or slot tokens, issued pursuant to a complimentary distribution program regulated by N.J.A.C. 19:45-1.46.

4.-9. (No change.)

19:45-1.16 Drop boxes and slot cash storage boxes

(a) Each gaming table in a casino shall have attached to it a **secure** metal container known as a "drop box" in which shall be deposited all cash, **coupons exchanged at the gaming table for gaming chips and plaques**, issuance copies of Counter Checks exchanged at the gaming table for gaming chips and plaques, duplicate Fill and Credit Slips, Requests for Credit forms, Requests for Fill forms, and Table Inventory forms. Each drop box shall have:

1. (No change.)

2. A separate lock securing the drop box to the gaming table[s], the key to which shall be different from each of the keys to locks securing the contents of the drop box;

3. A slot opening through which currency, coins, **coupons**, forms, records, and documents can be inserted into the drop box;

4. (No change.)

5. Permanently imprinted or impressed thereon, and clearly visible from a distance of 20 feet, a number corresponding to a permanent number on the gaming table to which it is attached and a marking to indicate game and shift, except that emergency drop boxes may be maintained without such number or marking, provided the word "emergency" is permanently imprinted or impressed thereon and, when put into use, are temporarily marked with the number of the

PROPOSALS

gaming table and identification of the game and shift, and provided further, that the casino obtains the express written approval of [a] the Commission [inspector] before placing an emergency drop box into use.

(b) Each bill changer in a casino shall have contained in it a secure metal container known as a "slot cash storage box," in which shall be deposited all cash inserted into the bill changer. Each slot cash storage box shall:

1.-4. (No change.)

5. Have an asset number, at least two inches in height, permanently imprinted, affixed or impressed on the outside of the slot cash storage box which corresponds to the asset number of the slot machine to which the bill changer has been attached, except that emergency slot cash storage boxes may be maintained without such number, provided the word "emergency" is permanently imprinted, affixed or impressed thereon, and when put into use, are temporarily marked with the asset number of the slot machine to which the bill changer is attached, and provided further, that the casino obtains the express written approval of [a] the Commission [inspector] before placing an emergency slot cash storage box into use.

(c)-(d) (No change.)

19:45-1.18 Procedure for accepting cash and coupons at gaming tables

(a) Whenever cash or a coupon is presented by a patron at a gaming table for exchange for gaming chips [and] or plaques[, the following procedures and requirements shall be observed]:

1. The cash or coupon shall be spread on the top of the gaming table by the dealer or [boxman] boxperson accepting it in full view of the patron who presented it and the casino supervisor assigned to such gaming table;

2. The amount of the cash or coupon shall be verbalized by the dealer or [boxman] boxperson accepting it in a tone of voice calculated to be heard by the patron who presented [the cash] it and the casino supervisor assigned to such gaming table; and

3. Immediately after an equivalent amount of gaming chips or plaques has been given to the patron, the cash or coupon shall be taken from the top of the gaming table and placed by the dealer or [boxman] boxperson into the drop box attached to the gaming table; except that fifty cent (\$.50) and twenty-five cent (\$.25) coins may be retained in the table inventory in lieu of gaming chips of like denominations].

(b) A casino licensee may, in its discretion, require the coupon to be cancelled upon acceptance by the dealer or boxperson, in a manner approved by the Commission, so as to preclude its subsequent use.

19:45-1.20 Table inventories

(a) Whenever a gaming table in a casino is opened for gaming, operations shall commence with an amount of gaming chips, coins and plaques to be known as the "table inventory" and no casino shall cause or permit gaming chips, coins or plaques to be added to, or removed from, such table inventory during the gaming day except:

1. In exchange for cash, coupons, or issuance copies of Counter Checks presented by casino patrons in conformity with the provisions of N.J.A.C. 19:45-1.18 and 1.25;

2.-5. (No change.)

(b)-(c) (No change.)

19:45-1.33 Procedure for opening, counting and recording contents of drop boxes and slot cash storage boxes

(a)-(g) (No change.)

(h) Procedures and requirements for conducting the count shall be the following:

1. (No change.)

2. [The] In full view of the closed circuit television cameras located in the count room, the contents of each drop box or slot cash storage box shall be emptied on the count table and either manually counted separately on the count table or counted on [an approved] a currency or coupon counting machine which has been approved by the Commission and is located in a conspicuous location

on, near or adjacent to the count table [, which procedures shall at all times be conducted in full view of the closed circuit television cameras located in the count room];

3. (No change.)

4. The contents of each drop box or slot cash storage box shall be segregated by a count team member into separate stacks on the count table by each denomination[s] of coin [and], currency and coupon, and by type of form, record[,] or document, except that the Commission may permit the utilization of a machine to automatically sort currency or coupons by denomination;

5. Each denomination of coin, [and] currency and coupon shall be counted separately by one count team member who shall place individual bills, [and] coins and coupons of the same denomination on the count table in full view of a closed circuit television camera, after which the coin, [and] currency and coupons shall be counted by a second count team member who is unaware of the result of the original count and who, after completing this count, shall confirm the accuracy of [his or her] the total, either [orally] verbally or in writing, with that reached by the first count team member, except that the Commission may permit a casino licensee to perform [an] aggregate counts by denomination of all currency and coupons collected in substitution of the second count by drop box or slot cash storage box, if the Commission is satisfied that the original counts [is] are being performed automatically by a machine that counts and automatically records the amount of currency or coupons, and that the accuracy of the machine has been suitably tested and proven. The Commission will permit the utilization of currency and coupon counting machines if prior to the start of the count, in the presence of a Commission inspector, the count room supervisor shall:

i. Verify that [all currency] the counting machine[s] have] has a zero balance on [each] its terminal unit display panel and [have] has a receipt printed which denotes "-0- cash or coupons on hand" and "-0- notes or coupons in machine," or some other means to indicate that the machine has been cleared of all currency and coupons.

ii. Visually check the [currency] counting machine[s] to be sure there are no bills or coupons remaining in the various compartments of the machine[s].

iii. Supervise a count team member who shall randomly select a drop box or slot cash storage box and place the entire [currency] contents of the drop box or slot cash storage box into the first [currency] counting machine, which shall [sort] count the currency or coupons by denomination and produce a print out of the total amount of currency or coupons by denomination. Any soiled or off-sorted bills or coupons shall be re-fed into the machine and manual adjustments made to the total. Coins or tokens shall also cause manual adjustments to be made to the total. The total as recorded on the [currency] counting machine and any adjustments thereto shall not be shown to anyone until completion of the final verification process.

iv. Supervise a second count team member, independent of the team member performing the initial count by machine, who shall manually count and summarize the currency and coupons of the drop box or slot cash storage box counted in (h)5iii above. The total shall be posted and maintained separately from the total posted in (h)5iii above. This total shall not be shown to anyone until completion of the final verification process.

v. Supervise the second count team member passing the currency or coupons to a count team member, who is unaware of the results of the manual count. The count team member shall count the contents of the drop box slot cash storage box counted in (h)5iii above using [the] a second [currency] counting machine. Such machine shall produce a printout of the total amount of currency or coupons [as] contained in the drop box or slot cash storage box. Any soiled or off-sorted bills or coupons shall be re-fed into the machine and manual adjustments made to the total. Coins or tokens shall also cause manual adjustments to be made to the total. The total as recorded on the [currency] counting machine and any adjustments thereto shall not be shown to anyone until completion of the final verification process.

vi. Following the completion of the test procedures, compare the totals from the test receipts of both [currency] counting machines, as computed in (h)5iii and (h)5v, to the manual total computed in (h)5iv. If the three totals compared above are in agreement, the count room supervisor will sign and date the test receipts and forward them to the Accounting Department at the end of the count process.

vii. If the three totals do not agree, appropriate repairs shall be made to the [currency] counting machine(s) and the procedures in (h)5i through (h)5vi shall be repeated until all totals are in agreement. [Not] **The Commission shall not permit the counting machine to be used until these totals are in agreement,** shall the Commission permit the utilization of the currency counting machines].

6. Any coupon placed in a drop box shall be counted and included as gross revenue, pursuant to N.J.S.A. 5:12-24, without regard to the validity of the coupon.

7. Any coupon which has not already been cancelled upon acceptance or during the count shall be cancelled prior to the conclusion of the count, in a manner approved by the Commission.

[6.]8. As the contents of each drop box are counted, one count team member shall record on a Master Game Report or supporting documents, by game, table number, and shift, the following information:

i-iv. (No change.)

v. **The total amount of each denomination of coupon;**

vi. **The total amount of all denominations of coupons;**

Recodify existing v.-xiii. as vii.-xv. (No change in text.)

[7.]9. After the contents of each drop box [is] **are** counted and recorded, one member of the count team shall record by game and shift on the Master Game Report, the total amount[s] of currency [and], coin[,] **and coupons**, Table Inventory Slips, Counter Checks, Fills, and Credits counted, and win or loss, together with such additional information as may be required on the Master Game Report by the Commission or the [establishment] **casino licensee.**

[8.]10. Notwithstanding the requirements of [(h)6 and (h)7] **(h)8 and (h)9** above, if the casino licensee's system of internal [accounting] controls provides for the recording on the Master Game Report or supporting documents of Fills, Credits, Counter Checks and Table Inventory Slips by cage cashiers prior to commencement of the count, a count team member shall compare for agreement the totals of the amounts recorded thereon to the Fills, Credits, Counter Checks and Table Inventory Slips removed from the drop boxes.

[9.]11. (No change in text.)

[10.]12. Notwithstanding the requirements of [(h)6 and (h)7] **(h)8 and (h)9** above, if the casino licensee's system of internal [accounting] controls provides for the count team functions to be comprised only of counting and recording currency [and], coin **and coupons**, accounting department employees with no incompatible functions shall perform all other counting, recording, and comparing duties [herein] **required by this section.**

[11.]13. After preparation of the Master Game Report [and/or] or Slot Cash Storage Box Report, each count team member shall sign the reports attesting to the accuracy of the information recorded thereon.

(i) [Procedures and requirements at] **At** the conclusion of the count [for each gaming shift shall be the following]:

1. All cash [removed from the drop boxes or slot cash storage boxes] **and coupons** shall be immediately presented in the count room by a count team member to a reserve cash cashier who, prior to having access to the information recorded on the Master Game Report or the Slot Cash Storage Box Report and in the presence of a count team member and the Commission inspector, shall recount, either manually or mechanically, the cash **and coupons** [received] **presented**, and attest by signature on the Master Game Report and Slot Cash Storage Box Report, if applicable, the amounts of cash **and coupons** [received] **counted**, after which the Commission inspector shall sign the reports evidencing his or her

presence during the count and the fact that both the cashier and count team have agreed on the total amounts of cash **and coupons** counted.

2. The Master Game Report, after signing, and the Requests for Fills, the Fills, the Requests for Credits, the Credits, the issuance copies of the Counter Checks, [and] the Table Inventory Slips **and coupons** removed from drop boxes shall be transported directly to the accounting department and shall not be available to any cashiers' cage personnel. **All coupons shall be received and processed by the accounting department in the manner set forth in N.J.A.C. 19:45-1.46(l).**

3. (No change.)

4. If the casino licensee's system of internal [accounting] controls does not provide for the forwarding from the cashiers' cage of the originals of the Fills, Credits, Requests for Credits, and the Requests for Fills, and the issuance copies of the Counter Checks, directly to the accounting department, the originals of all such slips recorded, or to be recorded, on the Master Game Report shall be transported from the count room directly to the accounting department.

(j) (No change.)

19:45-1.46 Procedure for control of coupon redemption and other complimentary distribution programs

(a) The procedures contained in (c) through (n) below shall apply to casino licensees offering coupon redemption programs which entitle patrons to redeem coupons for complimentary cash, **gaming chips** or slot tokens [including, but not limited to complimentary cash or slot tokens] issued in connection with bus **and other complimentary distribution** programs. No complimentary cash, **gaming chips** or slot tokens may be distributed by a casino licensee under any coupon redemption program that does not comply with the requirements of this section.

(b) Detailed procedures controlling all programs entitling patrons to complimentary cash or slot tokens not regulated by (a) above shall be submitted by the casino licensee to the Commission and Division at least 15 days prior to implementing the program. The procedures for all such programs shall be deemed acceptable by the Commission unless the casino licensee is notified in writing to the contrary. Detailed procedures controlling all programs entitling patrons to complimentary items or services other than cash or slot tokens shall be prepared prior to implementation as an accounting record by the casino licensee. Complimentary items or services, including cash or slot tokens, distributed through programs regulated by this subsection shall be reported in accordance with the procedures contained in [(1) and (n)] **(m) and (o)** below.

(c) Each coupon[,] or part thereof[,] issued by a casino licensee shall only be redeemable for a specific amount of cash, **gaming chips** or slot tokens.

(d)-(h) (No change.)

(i) **A coupon redeemable for gaming chips shall be redeemed only at a gaming table, and only by dealers and boxpersons, who shall accept the coupon in exchange for the stated amount of gaming chips and shall deposit the coupon into a drop box upon acceptance, in accordance with N.J.A.C. 19:45-1.18. All such coupons shall be designed and printed so that the denomination of the coupon is clearly visible from the closed circuit television system when accepted at a gaming table and deposited in a drop box.**

Recodify existing (i)-(j) as (j)-(k) (No change in text.)

[(k)](l) All documentation, unused coupons, voided coupons and redeemed coupons maintained in conformity with (g), (h), [and] (i) **and (j)** above shall be forwarded on a daily basis to the accounting department, where they shall be:

1. Reviewed for propriety of signatures on documentation **and for proper cancellation of all coupons;**

2. [Examined] **Recounted and examined** for proper calculation, summarization and recording on documentation, **including, without limitation, the Master Game Report;**

3.-5. (No change.)

[(l)](m) Each casino licensee shall file a monthly report with the Commission and Division which shall include the following information:

1. For all programs regulated by (a) above, each casino licensee shall list by type of coupon, the total number of coupons used, the total number of coupons redeemed, the total value of the complimentary cash, **gaming chips** or slot tokens given to patrons in redemption of coupons and any liability to patrons remaining on unredeemed coupons; and

2. (No change.)

Recodify existing (m) as (n) (No change in text.)

[(n)](o) In addition to the monthly report required to be filed in [(l)] (m) above, the casino licensee shall accumulate both the dollar amount of and the number of persons redeeming coupons pursuant to (a) above, and the dollar amount of and the number of persons receiving complimentary items or services pursuant to (b) above, and shall include this information on the quarterly complimentary report required by N.J.A.C. 19:45-1.9. Complimentary items or services, including cash, **gaming chips** and slot tokens, distributed through programs regulated by this section shall not be subject to the daily complimentary reporting requirements imposed pursuant to N.J.A.C. 19:45-1.2.

(a)

CASINO CONTROL COMMISSION

Pai Gow Poker

Rules of the Games; Gaming Equipment

Proposed New Rule: N.J.A.C. 19:47-11.8A

Proposed Amendments: N.J.A.C. 19:46-1.18 and

1.19; 19:47-11.2, 11.5, 11.6, 11.7, 11.8, 11.10 and 11.11

Authorized By: Casino Control Commission, Joseph A. Papp, Executive Secretary.

Authority: N.J.S.A. 5:12-69(e), 70(f), 99 and 100(m).

Proposal Number: PRN 1992-496.

Submit comments by December 16, 1992 to:

Catherine A. Walker
Senior Assistant Counsel
Casino Control Commission
Arcade Building
Tennessee Avenue and the Boardwalk
Atlantic City, NJ 08401

The agency proposal follows:

Summary

The proposed amendments and proposed new rule would give a casino licensee the discretion to permit a dealer to deal the game of pai gow poker from the hand rather than from a dealing shoe. The recent legislative amendment to the Casino Control Act, N.J.S.A. 5:12-100(m), gives the Commission authority to permit dealing from the hand (P.L. 1992, c. 9). The proposed amendments and new rule also set forth the procedures to be followed when the cards are dealt from the hand. Specifically, instead of dealing seven cards directly to each player position, the dealer deals seven stacks of seven cards in front of the table inventory container. The seven stacks are distributed to the player and dealer positions in the order determined by the total of the dice, N.J.A.C. 19:47-11.8A. Cards used to play pai gow poker that are dealt from the hand must be changed every four hours.

Social Impact

The proposed amendments and new rule are not anticipated to have any significant social impact. The proposed rules may allow more hands of pai gow poker to be dealt per hour which may result in increased interest and participation among patrons.

Economic Impact

The proposed amendments and new rule would permit casino licensees to make use of an option which may increase the number of hands dealt and as a result may increase revenues at the game of pai gow poker. However, any attempt to quantify the economic impact of this proposal at this point in time would be speculative.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required for these proposed amendments and new rule. The amendments and new rule affect only licensed casinos in Atlantic City, none of which are small businesses as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq.

Full text of the proposal follows (additions indicated in boldface thus; deletions indicated in brackets [thus]):

19:46-1.18 Cards; receipt storage, inspections and removal from use (a)-(f) (No change.)

(g) Any cards which have been opened and placed on a gaming table shall be changed at least every 24 hours. In addition:

1. Cards opened for use on a baccarat table shall be changed at least once during the gaming day; [and]

2. Cards opened for use on a pai gow poker table **and dealt from a dealing shoe shall be changed at least every eight hours[.]; and**

3. **Cards opened for use on a pai gow poker table and dealt from the dealer's hand shall be changed at least every four hours.**

(h)-(p) (No change.)

19:46-1.19 Dealing shoes

(a) (No change.)

(b) Cards used to game at blackjack, pai gow poker, minibaccarat, and red dog shall be dealt from a dealing shoe which shall be secured to the gaming table when the table is open for gaming activity and secured in a locked compartment when the table is not open for gaming activity. Cards used to game at baccarat shall be dealt from a dealing shoe which shall be secured in a locked compartment during non-gaming hours. **Notwithstanding the foregoing, cards used to game at pai gow poker may be dealt from the dealer's hand in accordance with N.J.A.C. 19:47-11.8A.**

(c)-(g) (No change.)

19:47-11.2 Cards; number of decks; dealing shoe

(a) Pai gow poker shall be played with one deck of cards with backs of the same color and design [and], one additional solid yellow or green cutting card **and one additional solid yellow or green cover card to be used in accordance with the procedures set forth in N.J.A.C. 19:47-11.6.** The deck of cards used to play pai gow poker shall meet the requirements of N.J.A.C. 19:46-1.17 and shall include one joker. Nothing in this section shall prohibit a casino licensee from using decks which are manufactured with two jokers provided that only one joker is used for gaming at pai gow poker.

(b) All cards to be used in pai gow poker shall **either** be dealt from a dealing shoe which shall meet the requirements of N.J.A.C. 19:46-1.19 and [which] shall be located on the table to the left of the dealer **or dealt from the dealer's hand in accordance with the procedures set forth in this subchapter.**

19:47-11.5 Opening of the table for gaming

(a)-(c) (No change.)

(d) All cards opened for use on a pai gow poker table **and dealt from a dealing shoe shall be changed at least every eight hours. All cards opened for use on a pai gow poker table and dealt from the hand shall be changed at least every four hours. Procedures for compliance with this subsection must be submitted to the Commission for approval.**

19:47-11.6 Shuffle and cut of the cards

(a) (No change.)

(b) After the cards have been shuffled, the dealer shall **place the stack of cards on top of the cover card. Thereafter, the dealer shall offer the stack of cards to be cut, with the backs facing up and faces facing the layout, to the player determined pursuant to (c) below. If no player accepts the cut, the dealer shall cut the cards.**

(c) (No change.)

(d) The player or dealer making the cut shall place the cutting card in the stack at least 10 cards from either end. Once the cutting card has been inserted, the dealer shall take the cutting card and all the cards on top of the cutting card and place them on the bottom of the stack. [A casino licensee may in its discretion insert an additional cutting card four cards from the bottom of the deck.] **The dealer shall then remove the cover card and place it on the bottom**

of the stack. Thereafter, the dealer shall remove the cutting card and, at the discretion of the casino licensee, either place it in the discard rack or use it as an additional cutting card to be inserted four cards from the bottom of the deck.

1. If the cards are to be dealt from a dealing shoe pursuant to N.J.A.C. 19:47-11.8, [The] the cards shall then be inserted into the dealing shoe for commencement of play.

2. If the cards are to be dealt from the dealer's hand pursuant to N.J.A.C. 19:47-11.8A, the cards may be held by the dealer in either hand. Once the dealer has chosen the hand in which he or she will hold the cards, the dealer must use that hand whenever holding the cards. The cards held by the dealer shall at all times be kept in front of the dealer and over the table inventory container.

(e) If there is no gaming activity at the pai gow poker table, the cards shall be [removed from the dealing shoe and] spread out on the table either face up or face down. If the cards are spread face down, they shall be turned face up once a player arrives at the table. After the first player is afforded an opportunity to visually inspect the cards, the procedures outlined in N.J.A.C. 19:47-11.5(c) shall be completed.

19:47-11.7 Wagers

(a)-(b) (No change.)

(c) All wagers at pai gow poker shall be placed prior to the dealer announcing "No more bets" in accordance with the dealing procedures set forth in N.J.A.C. 19:47-11.8 or 11.8A. No wager at pai gow poker shall be made, increased or withdrawn after the dealer has announced "No more bets."

19:47-11.8 Procedures for dealing the cards from a dealing shoe

(a) [Once] Unless a casino licensee chooses to have the cards dealt from the dealer's hand in accordance with the procedures set forth in this subchapter, once the dealer has completed shuffling the cards and the cards have been placed in the shoe, the dealer shall announce "No more bets" prior to shaking the pai gow poker shaker. The dealer shall then shake the pai gow poker shaker at least three times so as to cause a random mixture of the dice.

(b)-(f) (No change.)

19:47-11.8A Procedures for dealing the cards from the hand

(a) Notwithstanding any other provision of N.J.A.C. 19:46 or this chapter, a casino licensee may, in its discretion, permit a dealer to deal the cards used to play pai gow poker from his or her hand.

(b) When dealing the cards from the hand, once the shuffle and cut of the cards have been completed, the dealer shall announce "No more bets" prior to dealing seven stacks of seven cards each to the area in front of the table inventory container. The dealer shall deal each card by holding the deck of cards in one of his or her hands and with the other hand shall remove the top card of the deck and place it face down on the appropriate area of the layout.

(c) The dealer shall deal the first seven cards moving from left to right and the second seven cards moving from right to left and shall continue alternating in this manner until there are seven stacks of seven cards.

(d) After seven stacks of seven cards have been dealt, the dealer shall determine that exactly four cards are left by spreading them face down on the layout. The cards shall not be exposed to anyone at the table and shall then be placed in the discard rack. If more or less than four cards remain the dealer shall determine if the cards were misdealt. If the cards were misdealt and a stack has more or less than seven cards, the round of play shall be void and the cards reshuffled. If the cards have not been misdealt, the round of play shall be considered void and the entire deck of cards shall be removed from the table pursuant to N.J.A.C. 19:46-1.18.

(e) Once the dealer has completed dealing the seven stacks and placed the four remaining cards in the discard rack, the dealer shall then shake the pai gow poker shaker at least three times so as to cause a random mixture of the dice.

(f) The dealer shall then remove the lid covering the pai gow poker shaker, total the dice and announce the total. The total of the dice shall determine which player receives the first of the seven stacks. The stack farthest to the left of the dealer shall be considered

the first stack and the stack farthest to the right of the dealer shall be considered the seventh stack.

(g) To determine the starting position for delivering the seven stacks, the dealer shall count counterclockwise around the table, with the position of the dealer considered number one and continuing around the table with each betting position counted in order, regardless of whether there is a wager at the position, until the count matches the total of the three dice. A casino licensee may, in its discretion, mark the first position to which a stack will be dealt by use of an additional cut card or similar object. Examples are as follows:

1. If the dice total eight, the dealer would receive the first stack; or

2. If the dice total 14, the sixth wagering position would receive the first stack.

(h) The dealer shall deliver the first stack to the starting position as determined in (g) above and, moving clockwise around the table, deliver the remaining stacks in order to all other positions including the dealer position, regardless of whether there is a wager at the position. The dealer shall deliver all stacks face down.

(i) After the seven stacks have been delivered to each position and the dealer, the dealer shall collect any stacks dealt to a position where there is no wager and place them in the discard rack without exposing the cards.

(j) Once the seven stacks have been delivered to each position and the dealer and any stacks dealt to positions with no wagers have been collected, the dealer shall place the cover on the pai gow poker shaker and shake the shaker once. The pai gow poker shaker shall then be placed to the right of the dealer.

19:47-11.10 Player bank; co-banking; selection of bank; procedures for dealing

(a)-(g) (No change.)

(h) If the cards are to be dealt from a dealing shoe in accordance with N.J.A.C. 19:47-11.8, the following procedures shall apply:

Recodify existing (h) and (i) as 1. and 2. ((No change in text.)

[(j)]3. Each card shall be removed from the dealing shoe with the left hand of the dealer, and placed face down on the appropriate area of the layout with the right hand of the dealer. The dealer shall deal the first card to the starting position as determined in [(i)] (h)2 above and, moving clockwise around the table, deal all other positions including the dealer a card, regardless of whether there is a wager at the position. The dealer shall then return to the starting position and deal a second card in a clockwise rotation and shall continue dealing until each position including the dealer has seven cards.

Recodify existing (k) and (l) as 4. and 5. (No change in text.)

(i) If the cards are to be dealt from the hand in accordance with N.J.A.C. 19:47-11.8A, the following procedures shall apply:

1. Once the dealer has completed dealing the seven stacks and placed the four remaining cards in the discard rack pursuant to N.J.A.C. 19:47-11.8A, the bank shall select the first stack to be delivered by the dealer. This stack shall be designated as the first stack by the dealer moving it toward the players.

2. Once the first stack has been selected in accordance with (i)1 above, the bank shall shake the pai gow poker shaker. It shall be the responsibility of the dealer to ensure that the bank shakes the pai gow poker shaker at least three times so as to cause a random mixture of the dice. Once the bank has completed shaking the pai gow poker shaker, the dealer shall remove the lid covering the pai gow poker shaker, total the dice and announce the total. The dealer shall always remove the lid from the pai gow poker shaker and if the bank inadvertently removes the lid, the dealer shall require the pai gow poker shaker to be covered and reshaken by the bank.

3. To determine the starting position for delivering the seven stacks, the dealer shall count counterclockwise around the table, with the position of the bank considered number one and continuing around the table with each betting position including the dealer, counted in order, regardless of whether there is a wager at the position, until the count matches the total of the three dice.

4. The dealer shall deliver the first stack as determined in (i)1 above to the starting position as determined in (i)3 above. Thereaf-

ter, the dealer shall deliver the remaining stacks in a clockwise rotation beginning with the stack closest to the right of the first stack and proceeding until all stacks to the right of the first stack have been dealt and then moving to the stack farthest to the left of the dealer and proceeding left to right. If there are no stacks to the right of the first stack, the dealer will begin with the stack farthest to the left and proceed to the right. The dealer shall deal all stacks face down to each position including the dealer, regardless of whether there is a wager at the position.

5. After the seven stacks have been delivered to each position and the dealer, the dealer shall collect any stacks dealt to a position where there is no wager and place them in the discard rack without exposing the cards.

6. Once the seven stacks have been delivered to each position and the dealer and any stacks dealt to positions with no wagers have been collected, the dealer shall place the cover on the pai gow poker shaker and shake the shaker once. The pai gow poker shaker shall then be placed to the right of the dealer.

Recodify existing (m)-(q) as (j)-(n) (No change in text.)

19:47-11.11 Irregularities; invalid roll of dice

(a)-(b) (No change.)

(c) If the dealer incorrectly totals the dice and deals the first card or delivers the first stack to the wrong position, all hands shall be called dead and the dealer shall reshuffle the cards.

(d)-(j) (No change.)

(k) If a card is exposed while the dealer is dealing the seven stacks in accordance with N.J.A.C. 19:47-11.8A, the cards shall be reshuffled.

(l) If cards are being dealt from the hand and the dealer fails to deal the seven stacks in accordance with N.J.A.C. 19:47-11.8A(c), the cards shall be reshuffled.

ENVIRONMENTAL PROTECTION AND ENERGY

(a)

DIVISION OF FISH, GAME AND WILDLIFE

Marine Fisheries

Summer Flounder; Otter and Beam Trawls

Proposed Amendments: N.J.A.C. 7:25-18.1 and 18.12

Proposed New Rule: N.J.A.C. 7:25-18.14

Authorized By: Scott A. Weiner, Commissioner, Department of Environmental Protection and Energy.

Authority: N.J.S.A. 23:2B-6 and 23:2B-14.

DEPE Docket Number: 52-92-10.

Proposal Number: PRN 1992-505.

A public hearing concerning the concurrent proposal will be held on Wednesday, December 2, 1992 at 6:30 P.M. at:

Residential Life Center
Multi-Purpose Room
Stockton State College
Pomona, New Jersey

Submit written comments by December 16, 1992 to:

Richard McManus, Director
Office of Legal Affairs
CN 402
Trenton, NJ 08625

The agency proposal follows:

Summary

The purpose of these proposed amendments and new rule is to implement the Summer Flounder Fishery Management Plan developed by the Mid-Atlantic Fishery Management Council (MAFMC) and Atlantic States Marine Fisheries Commission (ASMFC) to protect and manage summer flounder populations in New Jersey. Failure to implement management measures in compliance with the plan would authorize the National Marine Fisheries Service (NMFS) to prohibit landing of sum-

mer flounder from Federal waters (greater than three miles from shore) in New Jersey. The amendments and new rule will also better enable the Department to enforce regulations prohibiting trawling within two miles of the coastline.

Long term trends in abundance and recruitment of summer flounder, derived from several surveys conducted over the range of the species, including NMFS offshore bottom trawl surveys, NMFS commercial landings statistics, the Massachusetts Division of Marine Fisheries ocean trawl and beach seine surveys, and the Virginia Institute of Marine Science trawl and young-of-year surveys, indicate that summer flounder stocks are depressed and severely overfished. In order to allow for stock rebuilding, the MAFMC and ASMFC have recommended several management measures to reduce the harvest of summer flounder. These include minimum size limits, a minimum mesh size for otter and beam trawls, a commercial quota, a recreational fishing season and a recreational bag limit.

In accordance with the size limits and mesh sizes recommended by the MAFMC and ASMFC, the Department proposes to implement a 14-inch recreational possession size limit and a 13-inch commercial possession size limit. Additionally, the Department proposes to implement a 5.5 inch minimum stretched mesh size for otter and beam trawls used in a directed summer flounder fishery. Fly nets are exempt from the mesh size regulation because they are pelagic nets not effective in catching bottom species such as summer flounder. The possession of more than 100 pounds of summer flounder on board a vessel shall constitute a directed fishery for summer flounder as recommended by the MAFMC and ASMFC.

In accordance with a quota system recommended by the MAFMC and ASMFC, the Department proposes to implement a commercial quota system whereby all vessels engaged in a directed summer flounder fishery must possess a permit to harvest summer flounder. To be eligible for a New Jersey Summer Flounder Permit, a vessel must have landed at least 1,000 pounds of summer flounder in New Jersey in each of two years during the period of 1985-1992 and must have possessed a valid New Jersey otter trawl license or valid Federal summer flounder permit during the two years it qualified based on weight landed. Between January 1, 1985 and November 2, 1988, there was no Federal summer flounder permit required and none were issued. Therefore, any vessels providing documentation on landings to establish eligibility during this time period shall be exempt from the requirement to have possessed a New Jersey otter trawl license or Federal summer flounder permit. All summer flounder landed in New Jersey by commercial vessels will be applied to the quota. The total annual quota of summer flounder for New Jersey will be annually determined by the MAFMC and has been set at 2,092,992 pounds for 1993. Based on recommendations of the New Jersey Marine Fisheries Council Summer Flounder Committee, comprised of council members, industry representatives and New Jersey Division of Fish, Game and Wildlife personnel, the annual quota will be divided into three seasons; January to April, May to August, and September to December. Based on historical landings from 1983 to 1991, 39.28 percent of the annual quota will be available from January through April (822,127 pounds in 1993), 16.83 percent of the annual quota will be available from May through August (352,251 pounds in 1993) and 43.89 percent of the annual quota will be available from September through December (918,614 pounds in 1993).

Under the quota system, once a seasonal quota is landed, the Commissioner or his or her designee will close the season and landings will be prohibited for the remainder of that season. In the event the Commissioner closes the season prematurely and the quota has not been taken because of an unanticipated environmental event, then the Commissioner may reopen the season for a specified period of time to permit the entire quota to be taken. If a seasonal quota is not harvested during a particular season, the balance will be added to the next season except that any balance existing as of December 31 will not be reallocated. If a seasonal quota is exceeded, the amount overharvested will be deducted from the next season's quota. If the annual quota is exceeded, the amount overharvested will be deducted from the following year's annual quota. The remaining quota will then be divided into the three seasons as described above. All persons participating in the directed fishery will be required to submit monthly reports providing information on landings, including total amount in pounds of each species taken, date caught, date sold and buyer.

The MAFMC and ASMFC have also recommended a season and bag limit for the recreational summer flounder fishery. In accordance with these recommendations, the Department is proposing to implement a

recreational fishing season from May 15 to September 30 inclusive, with a daily per fisherman bag limit of six summer flounders.

In order to facilitate better enforcement of regulations prohibiting otter trawling within two miles of the coastline and further protect overfished stocks of summer flounder from illegal harvest, the Department proposes to restrict the availability of trawl nets onboard vessels. The new rule will require all trawl net doors to be indelibly branded or stamped with the official documentation number or State registration number of the vessel to whom they belong. In addition, otter or beam trawls would not be immediately available for use while the vessel is on marine waters of the State during the hours between sunset and sunrise except on the Atlantic Ocean at a distance greater than two miles from the coastline. Definitions for trawls not immediately available for use are included in the rule and include nets stowed below deck, nets properly stowed and lashed down on deck, and nets covered and secured on a reel. The Department also proposes to reduce the time to commence retrieval from the water of all gear utilized for fishing to allow for inspection by law enforcement officers from 60 minutes to 15 minutes because past experience indicates that 15 minutes is sufficient to permit positioning of the vessel in preparation for gear retrieval.

The regulation concerning the harvest of weakfish by otter trawl currently located in the weakfish management regulation at N.J.A.C. 7:25-18.12 will be moved to N.J.A.C. 7:25-18.14 in order to consolidate the regulations concerning otter trawling for all species into a single section.

The proposed amendments and new rules described above will reduce fishing pressure on the summer flounder resource, enhance conditions for recovery of the stock, thus assuring its continued viability as a recreational and commercial resource, and allow the Department to better enforce regulations concerning area closures for trawling.

Social Impact

The purpose of the proposed amendments and new rule is to implement a management program for summer flounder consistent with the Summer Flounder Fishery Management Plan approved by the MAFMC and ASMFC. An immediate goal of this management program is to reduce harvest of summer flounder to assure the viability of this resource. For the recreational fishery the proposal requires the imposition of a 14-inch minimum size limit. Since a 13-inch size limit already exists for these fisheries, fishermen should experience little problem adjusting to amended size limit restrictions. In addition, a definition of a directed fishery and a new mesh size are included in the new rule. A directed fishery is defined as harvesting more than 100 pounds of summer flounder per trip and is consistent with the Federal definition of a directed fishery. Commercial otter trawlers are already restricted by a mesh size of 4.5 inches in New Jersey for a directed summer flounder fishery and have been restricted by a 5.5 inch mesh size in Federal waters. Most vessels fishing State waters also fish in Federal waters and are, therefore, familiar with mesh restrictions and should not experience any additional social impact as a result of this provision.

Due to the proposed commercial quota system and recreational season and bag limit, some social impacts will occur. Summer flounder will no longer be subject to a totally open fishery. Commercial fishermen who do not have a recent history (1985-1992) in a directed summer flounder fishery and are not eligible for a New Jersey Summer Flounder Permit will be excluded from a directed fishery. The quota system, however, will provide some protection to those fishermen eligible for a New Jersey Summer Flounder Permit who have made substantial investments in terms of time, effort and vessel and fishing gear expenses in the fishery by assuring them of the opportunity to harvest summer flounder. The most significant social impacts in the commercial fishery would thus be felt by those individuals who are not eligible for a New Jersey Summer Flounder Permit. These fishermen, however, will still be able to participate in the by-catch fishery, landing not more than 100 pounds of summer flounder per trip.

Recreational fishermen will also experience some social impacts due to the proposed fishing season and bag limit. Fishermen will be prohibited from possessing summer flounder except from May 15 to September 30 and a possession limit of six summer flounder per day will be instituted during the fishing season. Bag limits and seasonal closures already exist for a few marine species and for many fresh water species, therefore, many fishermen are familiar with these types of management measures and social impacts for these individuals would be minimized. Although recreational harvest will be restricted, the amendments and new rule do not in any other way restrict a recreational fisherman's opportunity to pursue sportfishing for summer flounder.

Minimal social impacts should occur from requiring that otter and beam trawls be stowed so as not to be immediately available for use. Some minor changes in operations may occur aboard fishing vessels due to the time and effort required to properly stow nets if the vessel is returning from offshore during the hours of darkness. This requirement is only being instituted during the hours of darkness and only in the area of the State where trawling is already illegal. The new rule also decreases the time for initiating retrieval of fishing gear for inspection purposes from the water from 60 minutes to 15 minutes. This change should not create social impacts as the Department, based on past experience, believes that 15 minutes is sufficient time for the boat operator to position the vessel for retrieval of gear. These requirements will enable the Department to better enforce existing regulations prohibiting trawling in internal waters and does not further restrict trawling for summer flounder in areas where it is currently legal.

Economic Impact

Any time the harvest of an important recreational and commercial species is restricted, there is bound to be an economic impact. The purpose of the proposed amendment and new rule is to manage the summer flounder resource, stop the decline of summer flounder and restore the population to prior abundance. Some otter trawl vessels may be required to purchase new nets (approximately \$1,000 each) to comply with minimum mesh sizes. However, Federal regulations have required the use of the 5.5 inch mesh nets in the summer flounder fishery in the past and will mandate the use of larger meshes in the current plan to fish in Federal waters. Most vessels landing summer flounder in New Jersey also fish for this species in Federal waters and have been subject to the 5.5 inch mesh restriction so there will be minimal additional economic impact as a result of this provision. Any short term economic loss resulting from increasing size limits and mesh sizes will be more than offset by improvement in stock conditions in the long term with resultant economic increases in the recreational and commercial fisheries.

Segments of New Jersey's fishing community, especially boat liveries, charter and party boats specializing in summer flounder, and commercial trawlers targeting summer flounder have suffered significant loss of income over the past several years due to the decrease in summer flounder stock size. Although, in the short term, catches will be further restricted by this proposal, the Department believes that these segments of the fishing community will benefit economically from a stabilized summer flounder resource, thus assuring continued viability of their operations. Further, the Department believes that these segments of the fishing community will experience economic gains in the future from a summer flounder resource that is not severely overfished.

Although the Department believes the fishing community will experience economic gains in the future as a result of the proposed amendment and new rule, some economic impact may occur as a result of the commercial quota. Because the quota system does not set individual catch limits, it is impossible to determine the economic impact on individual fishermen. Total landings for the commercial fishery will be restricted to 2,092,992 pounds in 1993; therefore, the fishery as a whole may not harvest more than this amount. Recent history in the fishery suggests that the economic impact may be minimal. Although average commercial landings from 1985 to 1991 were 3,824,117 pounds, landings in 1990 and 1991 were 1,458,281 pounds and 2,340,745 pounds, respectively. The potential 1993 commercial harvest, therefore, will be 634,711 pounds more than was landed in 1990 and only 247,753 pounds less than was landed in 1991. In addition, individuals not eligible for a New Jersey Summer Flounder Permit will experience no significant economic impact. These individuals have never experienced a significant economic gain from the fishery nor have they any significant investment in the fishery which would be lost due to the amendments and new rule.

No economic impacts should occur from requiring that otter and beam trawls be stowed so as not to be immediately available for use during the hours of darkness and within two miles of the coastline. Although some minor changes in operations may occur aboard fishing vessels due to the time and effort required to properly stow nets if a vessel is returning from offshore during the hours of darkness, crew payment is traditionally based upon a percentage of landings value, not on deck work time. These requirements will enable the Department to better enforce existing regulations prohibiting trawling in internal and nearshore waters and will not have any negative economic impact on any legal fishing operation. This provision may economically benefit the recreational fishing industry by reducing the level of illegal harvest and increasing availability of fish in the inshore waters.

Environmental Impact

The proposed amendments and new rule are expected to have a positive environmental impact on the summer flounder resource. Long term trends in abundance and recruitment of summer flounder indicate that summer flounder stocks over the range of the species have been so reduced that current levels of abundance are less than 20 percent of the stock size measured in the late 1970's. In addition, based on current levels of exploitation, spawning stock biomass levels are only two to three percent of the unfished biomass level. In order to allow summer flounder stocks to rebound to previous levels and sustain themselves, spawning stock biomass levels should be at least 20 percent of the unfished level.

The recent decrease in abundance and spawning stock biomass has been attributed to severe overfishing. Increasing size limits and mesh sizes, instituting a commercial quota system, recreational fishing season and bag limits and reducing illegal otter trawling in internal waters through better enforcement will all help to reduce overfishing. Size limits, quotas, fishing seasons and bag limits will reduce the number of fish harvested while increasing mesh sizes will allow greater escapement of small fish and decrease discard mortality from otter and beam trawls. Although the 13 inch size limit for summer flounder taken in otter and beam trawls is less than the 14 inch possession limit for the recreational fishery, similar positive environmental impacts will occur. Trawls with mesh sizes of 5.5 inches are geared toward catching 14 inch fish but will still harvest some 13 inch summer flounder. Because discard mortality is extremely high, these fish would normally be discarded dead under a 14 inch possession limit and not be counted toward the commercial quota. Allowing 13 inch fish to be landed will not increase mortality but will actually decrease the number of summer flounder harvested. These fish will be counted toward the commercial quota instead of being discarded dead on the fishing grounds.

The proposed amendments and new rule are consistent with recommendations of the MAFMC and ASMFC. Their implementation along with similar coastwide regulations should increase the abundance of summer flounder available to both commercial and recreational fishermen and assure the continued viability of this resource as well as the commercial and recreational fishing industries which rely upon it.

Regulatory Flexibility Analysis

The proposed amendments and new rule apply to all commercial, recreational and party and charter boat operators fishing for summer flounder. Most of the commercial fishermen and charter and party boat operators would be considered small business as defined in the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Although these small businesses must comply with the proposed amendments and new rule as described in the Summary above, including some recordkeeping for monitoring the quota, there will be no need for additional professional services or increased capital costs of any significance for compliance. In developing the proposed amendments and new rule, the Department has balanced its environmental responsibilities against the economic impact to small businesses and has determined that to minimize the impact of the amendments and new rule would adversely effect the environment and, therefore, no exemption from coverage is provided.

Full text of the proposal follows (additions indicated in boldface thus; deletions indicated in brackets [thus]):

7:25-18.1 Size and possession limits

(a) (No change.)

(b) A person shall not take from the marine waters in the State or have in his possession any summer flounder, commonly called fluke, under [13]14 inches in length, winter flounder under 10 inches in length, red drum under 14 inches in length or weakfish under 13 inches in length except as provided in N.J.A.C. 7:25-18.12]18.14.

[(c) Special provisions applicable to summer flounder directed fishery are as follows:

1. No person utilizing an otter or beam trawl in a directed fishery for summer flounder, commonly called fluke, shall use a net of not less than four and one-half inches stretched mesh in the cod end.

2. Stretched mesh sizes are measured by a wedge-shaped gauge having a taper of two centimeters in eight centimeters and a thickness of two and three-tenths millimeter, inserted into the meshes under pressure of pull of five kilograms. The mesh size of the cod

end of the net will be the average measurements of any series of 20 consecutive meshes measured at least 10 meshes from the lacings, beginning at the after end, and running parallel to the long axis.

3. No fishing vessel may use any device or method which would have the effect of reducing mesh size; provided, however, that chafing gear which does not obstruct the meshes of the cod end may be attached and net strengtheners may be attached to the cod end of trawl nets if such net strengtheners consist of mesh material similar to the material of the cod end and have a mesh size of at least twice the authorized minimum mesh size.

4. The possession of summer flounder weighing more than 20 percent of the total catch upon otter or beam trawl vessel shall constitute having been engaged in a directed fishery for summer flounder.

5. The operator of, or any other person aboard, any fishing vessel subject to this regulation must immediately comply with instructions and signals issued by an authorized law enforcement officer and comply with instructions to facilitate safe boarding and inspection of the vessel, its gear, equipment, and catch, for the purpose of enforcement of this regulation.

6. Any vessel subject to this regulation, while in the act of fishing and upon being boarded and instructed by an authorized law enforcement officer, shall haul back, or retrieve from the waters for inspection, all gear being utilized. After being so instructed, the operator of the vessel, or any other person so instructed, shall have a 60-minute time period to commence haul back or retrieval and shall continue haul back or retrieval at an ordinary rate and without interruption until the gear is on board and available for inspection.]

(c) A person angling with a hand line or with rod and line or spearfishing shall not possess any summer flounder or summer flounder parts beginning October 1 through May 14 nor shall any person angling with a hand line or with rod and line or spearfishing possess more than six summer flounder at any time during the period beginning May 15 through September 30.

(d) (No change.)

(e) Any person violating the provisions of (a), (b), (c) or (d) above shall be liable to a penalty of \$20.00 for each fish taken or possessed. Each fish taken or possessed shall constitute an additional separate and distinct offense.

(f)-(o) (No change.)

7:25-18.12 Weakfish management

[(a) A person shall not possess any weakfish less than 13 inches in length; provided, however, a person may possess a weakfish that was harvested by otter trawl and that measures not less than 11 inches in length from September 1 through December 31.]

Recodify existing (b)-(h) as (a)-(g) (No change in text.)

[(i) The following provisions shall apply to the use of otter or beam trawls for the taking of weakfish;

1. The possession of at least 100 pounds of weakfish on board a vessel or landed from a vessel shall constitute a directed fishery for weakfish.

2. A person utilizing an otter or beam trawl in a directed fishery for weakfish shall not use a net of less than 3.0 inches stretched mesh inside measurement applied throughout the cod end for at least 75 continuous meshes forward of the terminus of the net. After advertisement and public distribution of the Council meeting agenda and consultation with the Marine Fisheries Council, the Commissioner may modify the mesh size, by notice as specified in (e) above, if more current scientific data indicate a more appropriate size. The possession of any nets less than the minimum mesh specified above in this paragraph, or as modified by the Commissioner, on board a vessel in a directed fishery for weakfish is prohibited.

3. The procedures for determining compliance with the minimum mesh size and enforcement of this subsection shall be consistent with procedures prescribed pursuant to N.J.A.C. 7:25-18.1(c)2, 3, 5, and 6.]

7:25-18.14 Otter and beam trawls

(a) All trawl net doors possessed on the waters of the State of New Jersey must contain the official documentation number or the

state registration number of the vessel to whom they belong indelibly branded or stamped in block letters no less than two inches in height on the surface of each door.

1. Trawl doors shall be used only by the vessel which corresponds to the branded or stamped numbers.

(b) No vessel may have available for immediate use any otter or beam trawl while on the marine waters of this State during the hours between sunset and sunrise except on the Atlantic Ocean, at a distance of greater than two miles from the coast line. An otter or beam trawl that conforms to one of the following is considered not "available for immediate use":

1. A net stowed below deck, provided:

i. It is located below the main working deck from which the net is deployed and retrieved;

ii. The towing wires, including the "leg" wires are detached from the net; and

iii. It is fan-folded (flaked) and bound around its circumference;

2. A net stowed and lashed down on deck, provided;

i. It is securely fastened to the deck of the vessel;

ii. The towing wires, including the leg wires are detached from the net; and

iii. It is fan-folded (flaked) and bound around its circumference;

or

3. A net is on a reel and is covered and secured; provided:

i. The entire surface of the net is covered with canvas or other similar material that is securely bound;

ii. The towing wires, including the leg wires, are detached from the net; and

iii. The cod end is removed from the net and stored below deck or lashed down on deck.

(c) To determine compliance with any established minimum mesh requirement for an otter or beam trawl, the following procedures shall be employed. Stretched mesh sizes are measured by a wedge-shaped gauge having a taper of two centimeters in eight centimeters and a thickness of two and three-tenths millimeters, inserted into the meshes under pressure or pull of five kilograms. The mesh size of the cod end of the net will be the average measurement of any series of 20 consecutive meshes measured at least 10 meshes from the lacings, beginning at the after end and running parallel to the long axis.

(d) No person shall use any device or method which would have the effect of reducing an established minimum mesh size; provided, however, that chafing gear which does not obstruct the meshes of the top half of the cod end may be attached and net strengtheners may be attached to the cod end of the trawl net if such net strengtheners consist of mesh material similar to the material of the cod end and have a mesh size of at least twice the authorized minimum mesh size.

(e) The operator of, or any other person aboard, any fishing vessel shall immediately comply with instructions and signals issued by an authorized law enforcement officer and comply with instructions to facilitate safe boarding and inspection of the vessel, its gear, equipment, and catch, for the purpose of enforcement of this section.

(f) Any vessel in the act of fishing, upon being boarded and instructed by an authorized law enforcement officer, shall haul back, or retrieve from the waters for inspection, all gear being utilized. After being so instructed, the operator of the vessel, or any other person so instructed, shall have a 15 minute time period to commence haul back and shall continue haul back or retrieval at an ordinary rate and without interruption until the gear is on board and available for inspection.

(g) Possession of an otter trawl and doors shall subject said vessel to inspection for compliance with this section by authorized enforcement personnel. Any nets or doors possessed or used in violation of this section shall be subject to forfeiture under authority of N.J.S.A. 23:10-21.

(h) Violation of any section of this subchapter, or any license or order issued pursuant to it, shall subject the violator to the penalties prescribed in N.J.S.A. 23:2B-14. Penalties consist of \$100.00 to \$3,000 for the first offense and \$200.00 to \$5,000 for any subsequent offense.

(i) Special provisions applicable to the commercial harvest of summer flounder are as follows:

1. The possession of more than 100 pounds of summer flounder on board a vessel or landed from a vessel shall constitute a directed fishery for summer flounder.

2. A person shall not possess any summer flounder less than 13 inches in length which have been harvested by vessels in a commercial fishery for summer flounder.

3. A person utilizing an otter or beam trawl in a directed fishery for summer flounder shall not use a net of less than 5.5 inches stretched diamond mesh or 6.0 inches minimum stretched square mesh, inside measurement applied throughout the cod end for at least 75 continuous meshes forward of the terminus of the net. The possession of any net less than the minimum specified above in this paragraph on board a vessel in a directed fishery for summer flounder is prohibited unless it is not available for immediate use as defined in (b) above or is one of the following:

i. Vessels fishing in the fly net fishery are exempt from the minimum mesh size requirement. A fly net is a two seam otter trawl with the following configuration:

(1) The net has large mesh webbing in the wings with a stretch mesh measure of eight inches to 64 inches;

(2) The first body (belly) section of the net consists of 35 meshes or more of eight inch stretch mesh webbing or larger; and

(3) In the body section of the net the stretch mesh decreases in size relative to the wings and continues to decrease throughout the extensions to the cod end, which generally has a webbing of two inch stretch mesh.

4. A vessel shall not land more than 100 pounds of summer flounder in New Jersey on any one trip, after 45 days following the effective date of this regulation, unless said vessel is in possession of its valid New Jersey Summer Flounder Permit to participate in a directed fishery for summer flounder.

i. Applicants for a New Jersey Summer Flounder Permit shall complete an application provided by the Department and submit the application so it is received by the Department no later than June 30, 1993. Applications for a New Jersey Summer Flounder Permit received after June 30, 1993 shall be denied.

ii. To be eligible for a New Jersey Summer Flounder Permit the vessel's owner shall meet the following criteria:

(1) The vessel shall have landed at least 1,000 pounds of summer flounder in each of two years during the period of 1985-1992;

(2) The vessel shall have possessed a valid New Jersey otter trawl license or a valid Federal summer flounder permit during each of the two years it qualified based upon the pounds of summer flounder landed in (i)4i(1) above. Vessels providing documentation regarding the amount of summer flounder landed for two years between January 1, 1985 and November 2, 1988 are exempt from this requirement; and

(3) Applicants shall provide weigh out slips to document the amount of summer flounder landed and copies of their New Jersey otter trawl license or Federal summer flounder permit for the respective years.

iii. The New Jersey Summer Flounder Permit shall be on board the vessel to which it is issued at all times. The permit is valid in 1993 and subsequent years unless revoked as part of a penalty action. The New Jersey Summer Flounder Permit is not transferable and shall remain with the vessel in the name of the owner. The owner may transfer his or her permit to his or her replacement vessel upon application to the Department.

iv. A vessel that does not qualify for a New Jersey Summer Flounder Permit shall be permitted to land not more than 100 pounds of summer flounder on any trip.

5. The annual summer flounder harvest quota for New Jersey shall be determined by the Mid-Atlantic Fishery Management Council as implemented by the National Marine Fisheries Service. All landings of summer flounder in New Jersey shall be applied to the New Jersey annual summer flounder quota.

i. The New Jersey annual quota for the summer flounder fishery shall be divided into three seasons as follows:

(1) January-April: 39.28 percent of the annual quota.

- (2) May-August: 16.83 percent of the annual quota.
- (3) September-December: 43.89 percent of the annual quota.
- ii. The Commissioner, or his or her designee, shall close the season for the commercial summer flounder fishery upon seven days public notice of the projected date the season quota shall be caught. Public notice shall include letters by first class mail to all Federally licensed summer flounder dealers in New Jersey and New Jersey Summer Flounder Permit holders.
- iii. Once the season has been closed for the commercial summer flounder fishery no vessel shall land any summer flounder and no dealer shall accept any summer flounder landed in New Jersey.
- iv. If the Commissioner, or his or her designee, closes the season prematurely because of unanticipated environmental events resulting in the quota not being landed by the projected date and at least one month remains in the current season, then the Commissioner, or his or her designee, may reopen the season for a specified period of time upon seven days public notice. Public notice shall be made as specified in (i)5ii above.
- v. If the quota for a particular season is not taken, the balance shall be reallocated for the following season, except that any balance existing as of December 31 of any year shall not be reallocated.
- vi. If the quota for a particular season is exceeded, the amount overharvested shall be deducted from the following season.
- vii. If the quota for any year is exceeded, the amount overharvested will be deducted from the following year's annual quota. The remaining annual quota will then be allocated as defined in (i)5i above.
- viii. Beginning in 1994, the Department shall notify the holders of New Jersey Summer Flounder Permits of the season allocations no later than January 31 of the year to which the allocation applies. Notification shall be accomplished by first class mail to permit holders.
- ix. All New Jersey Summer Flounder Permit holders shall be required to complete monthly reports supplied by the Department. The monthly report shall be signed by the permittee attesting to the validity of the information and be submitted so it is received by the Department no later than five working days following the end of the reported month at the following address:

Summer Flounder Program
 Nacote Creek Research Station
 P.O. Box 418
 Port Republic, NJ 08241

(1) The monthly report shall include but not be limited to the following information: name, New Jersey Summer Flounder Permit number of the vessel, total amount (in pounds) of each species taken, dates caught, time at sea, duration of fishing time, number of tows, area fished, crew size, landing port, date sold and buyer. This information shall be provided for any trip in which summer flounder are landed.

(2) If no trips for summer flounder were taken and no summer flounder were landed during the month, a report to that effect shall be required.

6. Any person violating the provisions of this section shall be subject to the penalties prescribed in N.J.S.A. 23:2B-14 in addition to the following:

- i. Failure to submit the application by June 30, 1993 or to attach the required documentation to the application shall result in the denial of the permit.
- ii. Falsification or misrepresentation of any information on the application including documentation provided to verify the amount of summer flounder landed as specified in (i)4 above shall result in the denial or revocation of the permit in addition to any civil or criminal penalties prescribed by law.
- iii. Failure to comply with the provisions of (i)5iii above, landing summer flounder after the season has been closed, shall result in the suspension or revocation of the vessel's New Jersey Summer Flounder Permit according to the following schedule:
 - (1) First offense: 60 days suspension
 - (2) Second offense: 120 days suspension
 - (3) Third offense: permanent revocation

iv. Prior to revocation of the permit, the permittee shall have the opportunity to request a hearing pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and 52:14F-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

(j) Special provisions applicable to a directed weakfish fishery are as follows:

1. The possession of more than 100 pounds of weakfish on board a vessel or landed from a vessel shall constitute a directed fishery for weakfish.

2. A person shall not possess any weakfish less than 11 inches in length that have been harvested by otter or beam trawl during the period from September 1 through December 31. During the period of January 1 through August 31 the minimum size limit for weakfish harvested by otter or beam trawl is 13 inches in length pursuant to N.J.A.C. 7:25-18.1(b).

3. A person utilizing an otter or beam trawl in a directed fishery for weakfish shall not use a net of less than 3.0 inches stretched mesh inside measurement applied throughout the cod end for at least 75 continuous meshes forward of the terminus of the net. After advertisement and public distribution of the Council meeting agenda and consultation with the Marine Fisheries Council, the Commissioner may modify the mesh size upon notice if more current scientific data indicate a more appropriate mesh size is equivalent to the 11 inch minimum size limit for weakfish specified in (j)2 above. The Department shall provide notice of any change by filing and publishing in the New Jersey Register. All such notices shall be effective when the Department files notice with the Office of Administrative Law or as specified otherwise in the notice. The possession of any net less than the minimum mesh specified above in this paragraph, or as modified by the Commissioner, on board a vessel in a directed fishery for weakfish is prohibited.

(a)

HAZARDOUS WASTE REGULATION

Interim Status Facilities

Proposed Amendment: N.J.A.C. 7:26-12.3

Authorized By: Scott A. Weiner, Commissioner, Department of Environmental Protection and Energy.

Authority: N.J.S.A. 13:1E-1 et seq., particularly 13:1E-6.

DEPE Docket Number: 47-92-10.

Proposal Number: PRN 1992-483.

Submit written comments, identified by the Docket Number given above, by January 15, 1993 to:

Richard J. McManus, Director
 Office of Legal Affairs
 New Jersey Department of Environmental Protection and Energy
 CN 402
 Trenton, New Jersey 08625

The agency proposal follows:

Summary

The Department of Environmental Protection and Energy ("Department") proposes to amend N.J.A.C. 7:26-12.3(j). This provision affects facilities which become required to obtain a hazardous waste facility permit to continue operation solely because of a change to a State statute or rule, such as a change which results in the regulation of a previously unregulated waste handled by the facility.

The proposed amendment will render the State rule equivalent to the corresponding Federal rule at 40 CFR 270.10(e)1. New Jersey's regulations must be at least as stringent as the Federal regulations promulgated by the United States Environmental Protection Agency under the Federal Resource Conservation and Recovery Act, 42 USC 6901 et seq., in order for New Jersey to maintain Federal authorization to implement the RCRA hazardous waste management program for the State.

N.J.A.C. 7:26-12.3(j) currently provides that the owner or operator of a newly regulated facility may continue to operate the facility as an "existing hazardous waste facility" (as defined in N.J.A.C. 7:26-1.4), if the owner or operator takes certain actions (including the filing of a

Part A application) in accordance with N.J.A.C. 7:26-12.3(j)i through iii within 180 days after the facility becomes subject to regulation. This provision is less stringent than the corresponding provision of the Federal regulations at 40 CFR 270.10(e)1, upon which the proposed State amendment is based. Under the current New Jersey provision, the time limit may exceed 180 days after the date of publication, since the effective date may be delayed.

Under the proposed amendment, to obtain status as an "existing facility," the owner or operator must take the actions required under N.J.A.C. 7:26-12.3(j) by the earlier of the following:

1. Thirty days after the facility becomes subject to regulation; or
2. Six months after the date of publication of notice of the adoption of a rule which first subjects the facility to regulation.

For example, if a rule change which subjects a facility to regulation becomes operative one year after publication, the owner or operator of the facility would have to take the actions required under N.J.A.C. 7:26-12.3(j) within six months after the date of publication. If the rule change has become operative immediately, the owner or operator would have had 30 days from the date of publication to take the required actions.

Social Impact

There will be a positive social impact from this amendment. This amendment will clarify which facilities may handle certain wastes, by shortening the delay between when a material becomes regulated and when the facilities that handle it must obtain existing facility status if they desire to continue operating. Minimizing this gap will provide greater protection for human health and the environment.

Economic Impact

There will be no significant economic impact from this amendment. This amendment does not impose a new requirement, but merely changes the schedule for compliance. The shorter, 30 day compliance period should not have a negative economic impact, as the substantive compliance requirements will continue unchanged, and costs should not increase due to the shorter, 30 day time period. There may be a minimal negative economic impact associated with the requirement to obtain existing facility status earlier than was previously required since facilities may in some cases incur compliance costs for that period of time when they would not have been required to have existing facility status under the earlier rule. There is no filing or permitting fee for the attainment of existing facility status nor is there an operating fee for existing status facilities.

Environmental Impact

There will be a positive environmental impact from the proposed amendment. The amendment will shorten and in some cases eliminate any gap between when a material becomes regulated and when facilities that handle it must obtain existing facility status if they intend to continue to handle the newly regulated material. Since the facility then becomes subject to all the regulations governing existing facilities, the general public is more promptly protected from the dangers associated with the improper handling of hazardous waste.

Regulatory Flexibility Statement

As is set forth in the Summary above, the amendment will apply to all newly regulated facilities. It is estimated that most of those businesses impacted by the amendment are "small businesses" as defined in the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. In

order to comply with the amendment, the small businesses will have to comply with the requirements set forth in the Summary above. Compliance costs attributable to the proposed amendment are discussed under the Economic Impact above. It is not anticipated that professional services will be needed to comply. In developing the proposed amendment, the Department has balanced the need to protect human health and the environment against the economic impact of the proposed amendment and has determined that to minimize the impact of the rule would endanger public health and safety and the environment; therefore, no exemption from coverage is provided.

Full text of the proposal follows (additions indicated in boldface thus; deletions indicated in brackets [thus]):

7:26-12.3 Existing facilities

(a)-(i) (No change.)

(j) A facility that is required to obtain a hazardous waste facility permit pursuant to this subchapter solely because of a State statutory or rule amendment effective after the facility initially commenced operation may be eligible for existing facility status provided the owner or operator of the facility complies, and thereafter remains in compliance, with all existing facility requirements under this section by the **earlier date of:** [within 180 days of the facility's becoming subject to this subchapter. This provision shall not apply to any facility that has been denied a hazardous waste treatment, storage, or disposal facility permit, whose existing facility status has been terminated, or a facility subject to (i) above. To be eligible for existing facility status, an owner or operator of a newly regulated hazardous waste facility shall, within 180 days after becoming subject to this subchapter:

- i. Notify the United States Environmental Protection Agency as required by Section 3010 of the Federal Conservation and Recovery Act (42 USC §6901 et seq.);
- ii. File a Part A application for the facility in accordance with N.J.A.C. 7:26-12.2(d); and
- iii. Operate the facility in accordance with N.J.A.C. 7:26-9 and 11.]

1. Six months after the date of publication of the notice of adoption of the rule which first requires the facility to comply with this chapter; or

2. Thirty days after the date the facility first becomes subject to the standards of this chapter.

(k) The provisions of (j) above shall not apply to any facility that has been denied a hazardous waste treatment, storage, or disposal facility permit, whose existing facility status has been terminated, or to a facility subject to (i) above. To be eligible for existing facility status, an owner or operator of a newly regulated hazardous waste facility shall, within the applicable time period under (j) above:

- i. Notify the United States Environmental Protection Agency as required by Section 3010 of the Federal Resource Conservation and Recovery Act (42 USC §6901 et seq.);
- ii. File a Part A application for the facility in accordance with (d) above; and
- iii. Operate the facility in accordance with N.J.A.C. 7:26-9 and 11.

RULE ADOPTIONS

COMMUNITY AFFAIRS

(a)

DIVISION OF LOCAL GOVERNMENT SERVICES

Tax Collection Administration

Tenant Property Tax Rebate Program Administration

Adopted Amendments: N.J.A.C. 5:33-3.2, 3.3 and 3.6

Adopted New Rules: N.J.A.C. 5:33-3.8 through 3.11

Proposed: September 21, 1992 at 24 N.J.R. 3205(a).

Adopted: October 21, 1992 by Barry Skokowski, Sr., Director,
Division of Local Government Services, Department of
Community Affairs.

Filed: October 27, 1992 as R.1992 d.469 with substantive and
technical changes not requiring additional public notice and
comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 54:4-6.10.

Effective Date: November 16, 1992.

Expiration Date: August 6, 1995.

Summary of Public Comments and Agency Responses:

Comments were received from Judith Thornton of the New Jersey Manufactured Housing Association, Richard Schumm of Schumm Management Associates, and Matthew Shapiro of the New Jersey Tenants Association.

COMMENT: Opposition was noted to the definition of transient tenant being less than 90 days, due to the costs of providing such a tenant a rebate if they have moved. It was also noted that the requirement of a transient having a principal residence elsewhere is difficult to determine. The comment recommended that transient tenancy be defined as less than one year.

RESPONSE: The Division concurs with the difficulty in proving that principal residence exists somewhere else, and this requirement has been eliminated in the adoption. Existing State law sets a definition of transient at 90 days (N.J.S.A. 55:13-3) which has been utilized for this purpose. The law and rules provide a landlord sufficient flexibility to fulfill the responsibility to locate a tenant at a minimal cost and permits the rebate to be retained if the tenant is not located within one year.

COMMENT: It was proposed that a landlord should be permitted to retain a portion of the tax rebate to provide an incentive to appeal property tax assessments that could lower rents. This practice of rebating all tax reductions obtained through tax appeals also appears to be a mechanism to reduce the amount of tax appeals by removing the incentives to appeal. Further, the commenter noted that rebates due to tenants who have left the premises who are due \$100.00 or less should be retained by the landlord.

RESPONSE: These comments are matters of law. The Division has no authority to permit a landlord to retain a portion of the rebate or set a threshold or circumstances under which a landlord does not have to provide a rebate. The handling of tax appeals was set through a court decision and can only be changed through legislation.

COMMENT: The rule appears unclear regarding the eligibility of tenants who live in manufactured or mobile home parks. The rule should be explicit in light of the statutory history which removed them from qualification as rental property. A similar clarification that mobile home parks involved in the "Section 8" housing subsidy program would not have to provide a rebate (N.J.A.C. 5:33-3.9) to the administrative agencies is also requested.

RESPONSE: P.L. 1991, c.65 eliminated mobile homes in mobile home parks from the definition of qualified real rental property. The adoption includes a contemporary definition of mobile and manufactured housing as being an exception under the definition of qualified real rental property. This exclusion eliminates them from the subsidized housing rebate requirement.

COMMENT: The State's acknowledgement that no rebate is required if the annual rebate is less than \$6.00 a year is supported.

RESPONSE: The Division acknowledges the support.

COMMENT: Opposition was noted to the State policy that permits tenants to receive a homestead rebate and a tenant property tax rebate.

RESPONSE: This matter is one of legislative policy which should be addressed to the Legislature.

COMMENT: The enactment of a revised State Homestead Rebate Act (N.J.S.A. 54:4-8.57, et seq.) in 1991, that is reflected in an amendment to N.J.A.C. 5:33-3.2 would prohibit tenants in cooperative housing units from receiving property tax rebates. As there is no legislative intent to exclude this group from receiving a rebate, a clarification should be made.

RESPONSE: N.J.S.A. 54:4-6.3 contains the definition of qualified rental property, which when adopted in 1976, prohibited residents of cooperatives that received homestead rebates from receiving tenant property tax rebates. This was to insure that owners who lived in cooperatives did not receive a rebate, but the tenants of any owner would. At that time, the Homestead Rebate Act (N.J.S.A. 55:4-3.80) did not allow tenants to receive homestead rebates.

In P.L. 1990, c.61, the Legislature repealed that statute, and enacted new provisions which permitted all tenants to receive a homestead rebate. It did not amend the Tenant Property Tax Rebate Law (N.J.S.A. 54:4-6.2 et seq.), thus expressing no intent to alter the right of cooperative tenants to receive a tenant property tax rebate. The Division had no intention to exclude cooperative unit tenants from the program as the amendment to the rule was an administrative one to reflect the new citation. The Division concurs with assessment that there was no legislative intent to eliminate the rebate. The definition has been reworded to continue this practice.

COMMENT: Clarifications were requested to show that: (1) the second definition of base year (N.J.A.C. 5:33-3.2) excluded the current year; (2) that a tenant as well as a landlord could request the tax assessor to recalculate the property value excluding improvements made since the base year for rebate purposes (N.J.A.C. 5:33-3.8(c)); and (3) that conflicts with the rules and local ordinances (N.J.A.C. 5:33-3.11) are limited to provisions that provide rent reductions or rebates.

RESPONSE: The Division concurs with the proposed changes and has included them in the adoption. The clarification of base year is necessary to ensure it cannot be considered to be the rebate year; to afford a tenant the opportunity to obtain information about property improvements, the tenant as well as the landlord should be entitled to make a request of local officials; and the restriction on conflicts with local ordinances is necessary to prevent an overly broad application of these rules to other local rent leveling practices.

Summary of Agency-Initiated Changes:

N.J.A.C. 5:33-3.8 has been amended to replace the term "ordered" with "entered" as the means in which property tax appeal judgements take effect, to properly reflect the legal terminology used in the proceedings.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks *thus*; deletions from proposal indicated in brackets with asterisks *[thus]*).

5:33-3.2 Definitions

The words and terms used in this subchapter shall have the following meanings, unless the context clearly indicates otherwise:

...

"Base year" means, as appropriate:

1. Calendar 1990, for real rental property qualified on March 15, 1991, the effective date of the Act;
2. Any year after 1990*, except the current year,* in which property taxes exceed the amount paid in 1990.

...

"Property tax reduction" means the difference between property taxes paid in the base year, and the lower taxes paid or payable in the current year, excluding taxes on improvements added since the base year. A negative number or zero does not produce a property tax reduction. See N.J.A.C. 5:33-3.8 for special circumstances concerning property tax reductions.

"Qualified property" or "qualified real rental property" means any building or structure, or complex of buildings and structures, in which dwelling units are rented or offered for rent, except:

1. Hotels, motels, and other guesthouses serving transient or seasonal guests;

2. *[Units in]* ***Shareholders or owners of shares or units in a cooperative housing corporation,* or *residents of* mutual housing corporations*, or residents of continuing care retirement communities,*** *[whose occupants]* ***who*** are eligible for homestead rebates pursuant to P.L.1990, c.62 (N.J.S.A. 54:4-8.57 et seq.);

3. A complex of three units or less on a single parcel when one is owner occupied; *[and]*

4. Group residencies, when the rent, paid by an individual or agency on behalf of a tenant, includes various social or personal services and requires tenant participation in rehabilitative, medical, or related programs*[*]*; **and***

5. Mobile or manufactured homes taxed or licensed as vehicles, wherever sited, and manufactured or mobile homes installed in mobile home parks and therefore exempt from taxation as real property pursuant to N.J.S.A. 54:4-1.5b.

“Transient” or “transient guests” means individuals whose residence at a rooming or boarding house is on a temporary basis for a period lasting no more than 90 days *[and who has a principal residence elsewhere]*.

5:33-3.3 Tax collector responsibilities

(a) Each collector shall, within 30 days after tax bills are mailed, send a Notice of Tax Reduction to each owner of qualified property on which property taxes are reduced, with a copy to the local agency to retain for at least one year.

(b) Each tax collector shall make a notation in the MOD IV or other local system to identify, as qualified properties, all MOD IV Qualification Code 2 (Residential), 3A (Farm Regular), and 4A (Commercial) properties for which a Notice of Tax Reduction is returned. In addition, throughout the year, each tax collector shall use all locally available information and records to identify non-qualified or new properties that become qualified during the year.

(c) When third and fourth quarter property tax bills are prepared in any year in which a revaluation takes effect, the collector shall mail a Notice of Tax Reduction to all owners of properties identified in MOD IV Qualification Codes 2 (Residential), 3A (Farm Regular), 4A (Commercial), and 4C, (Apartments, five-family or more) on which property taxes are reduced with respect to the base year.

(d) Beginning in 1992, or the year following a revaluation, collectors shall send Notices to all owners of qualified property on which property taxes are reduced with respect to the base year, which shall include all owners of newly qualified properties, and all others identified as qualified under the program.

5:33-3.6 Rebate calculation and payments

(a)-(b) (No change.)

(c) The first rebate of any year shall include payment or credit retroactive to January 1 for each current tenant resident for any part of that time, and for former tenants similarly resident and paid up. Thereafter, pro-rata rebate payments or credits shall be given whenever rents are due and paid.

1. Rebate amounts shall be completely paid or credited by the end of the calendar year for all tenants whose rent payments are current; provided that, rebates for delinquent tenants or cases in dispute about rent payments shall be held in escrow pending resolution.

2. A landlord who receives a Notice of Tax Reduction after November 1 of any year shall complete the rebate payment process no later than July 1 of the following calendar year.

(d) (No change.)

(e) All rebate payments and credits shall be rounded to the nearest dollar. No rebate shall be required if the total rebate for a unit is less than \$6.00. If credited rather than paid, rebates shall be treated as immediate rent reductions.

(f) (No change.)

(g) Boards of directors of residential cooperatives and mutual housing corporations shall allocate the rebate liability to each shareholder in accordance with existing corporation practices and shall provide the owner of each share a separate Notice of Tax Reduction indicating the rebate liability for that share. If the share represents qualified rental property, the shareholder shall notify and provide the rebate to any tenants.

5:33-3.8 Special circumstances—property tax reductions

(a) The property tax reduction shall take into account judgments *[ordered]* ***entered*** by a county tax board, the State tax court, or any other court of competent jurisdiction that take effect on or before the date on which the extended tax duplicate is closed for the tax year. (See *Cold Indian Springs Corp. v. Township of Ocean*, 81 N.J. 502 (1980).)

(b) Tax appeals from any prior year pending on or before the date on which the extended tax duplicate is closed for the tax year, shall be excluded from the calculation for the tax year. (See *Cold Indian Springs, supra.*)

(c) When the MOD IV system cannot exclude the value of improvements added since the base year, each collector shall, upon written request of the property owner ***or tenant*** and with the assistance of the tax assessor, recalculate the Notice of Tax Reduction to exclude the value of the improvements. Issuance of the revised Notice of Tax Reduction shall restart the time requirement for notice to the tenant.

(d) Changes in property value resulting from a revaluation or reassessment shall not receive special consideration. There is no change in base year taxes, and current year taxes are calculated on the basis of the new assessment. (*Cold Indian Springs, supra.*)

5:33-3.9 Rebates for tenants who receive rent subsidies

If directed to do so by the sponsoring agency, landlords participating in the Federal “Section 8” housing voucher or other subsidized rental housing program who receive a Notice of Tax Reduction shall divide the property tax rebate between the tenant and the sponsoring agency, based on the percentage of the total rent each party pays, and rebate to the parties as appropriate. The sponsoring agency shall notify the landlord of the responsibilities and procedures to be followed under this section. If no direction is provided to the landlord, the entire rebate shall be provided to the tenant.

5:33-3.10 Enforcement by local agency

A municipal governing body may, by ordinance, grant a local rent control agency, serving as the local agency, authority to represent the municipality or tenants in legal action against a landlord under the statute and rules.

5:33-3.11 Consistency with municipal ordinances

The provisions of the act and this chapter herein shall supersede any conflicting municipal ordinance or provision thereof ***which provides rent reductions or rebates when property taxes are reduced***.

ENVIRONMENTAL PROTECTION AND ENERGY

(a)

DIVISION OF FISH, GAME AND WILDLIFE

Marine Fisheries

General Net Regulations

Adopted Amendment: N.J.A.C. 7:25-18.5

Proposed: January 21, 1992 at 24 N.J.R. 207(a).

Adopted: October 13, 1992 by Scott A. Weiner, Commissioner,

Department of Environmental Protection & Energy.

Filed: October 14, 1992 as R.1992 d.449, **with technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 23:2B-6.

DEPE Docket Number: 050-91-12.

Effective Date: November 16, 1992.

Expiration Date: February 15, 1996.

The New Jersey Department of Environmental Protection and Energy (Department) is adopting the amendment of N.J.A.C. 7:25-18.5. The amendment was proposed on January 21, 1992 at 24 N.J.R. 207(a). The

ADOPTIONS

ENVIRONMENTAL PROTECTION

comment period closed on February 20, 1992. Seven individuals submitted written comments. Commenters were commercial fishermen and one assemblyman.

The following is a list of those persons and organizations that submitted written comments directly related to the proposal.

Individual	Organization
Allen Bogdan	
Robert Munson	
Brick Wenzel	
John Bradford	
Alex Ogdan	Delaware Bay Waterman's Association
Charles Givens	
Jack Collins	Assemblyman

Summary of Public Comments and Agency Responses:

The following is a summary of comments received on the Department's proposal and the Department's response to the comments.

General

1. COMMENT: The recommended minimum mesh size of 2.5 inches is too large and will eliminate the catch of eels and perch. These species contribute to a fisherman's income when winter flounder prices are low due to the influx of flounder from other states. In addition, the recommended minimum mesh size of 2.5 inches will increase mortality due to gilling.

RESPONSE: The New Jersey Marine Fisheries Council Fyke Net Committee, comprised of council members, recreational fishermen and commercial fyke netters, specifically recommended a minimum mesh size of 2.5 inches stretched mesh to allow small fish to escape. This recommendation was proposed by the commercial fyke netters on the Committee. In addition, eels do not appear to constitute a large catch from the fyke net fishery. According to commercial landings data for 1988, 1989 and 1990 from the National Marine Fisheries Service, New Jersey commercial landings of American eels averaged 173,323 pounds valued at \$260,820. None of these landings or values were recorded as being taken by fyke nets. N.J.S.A. 23:5-24.1 and N.J.A.C. 7:25-18.5 specifically provide for the use of miniature fykes, a more appropriate gear for the taking of eels. According to the Atlantic States Marine Fisheries Commission's Fishery Management Plan for Winter Flounder, winter flounder stocks and commercial landings in other states are severely depressed. The influx of flounder from other states that are currently experiencing a collapse of the fishery should not be significant enough to regulate prices in New Jersey.

The Department carefully considered comments regarding increased gilling due to increasing minimum mesh to 2.5 inches. Although the Department believes that the proposed minimum mesh size most likely would not increase gilling, there is currently no data available regarding mesh selectivity and gilling for fyke nets. The Department, therefore, has decided to postpone implementation of a 2.5 inches minimum mesh size for fyke nets pending the availability of sufficient data to better support minimum mesh sizes.

2. COMMENT: There are no conflicts between fyke netters and sportfishermen because fyke netting occurs in the winter when there is no sport fishery.

RESPONSE: The Department disagrees with the commenter's statement. An active sportfishery occurs in some areas for winter flounder and white perch at the same time fyke netting is taking place. The Department and Marine Fisheries Council have received complaints from both recreational and commercial fishermen regarding conflicts during the fyke netting season. In fact, the Marine Fisheries Council Fyke Net Committee was established primarily to address and resolve these conflicts. Adoption of the proposed amendment will help alleviate these conflicts by eliminating fyke netting in certain small bodies of water.

3. COMMENT: The proposal will destroy fyke netting and haul seining.

RESPONSE: The Department disagrees with the commenter's statement. The purposes of the proposed amendment are to reduce user conflicts by eliminating fyke netting and haul seining from a few small bodies of water, and eliminate the use of monofilament in fyke nets. Fyke netting and haul seining will continue to be legal in numerous areas in the state. In addition, banning monofilament will not reduce the effectiveness of fyke nets for targeted species.

4. COMMENT: Fyke nets are not set where there are untargetable fish. All fish caught are eatable, therefore they are all targetable fish.

RESPONSE: The Department disagrees with the commenter's statement. The purpose of establishing gear restrictions such as disallowing monofilament in fyke nets is to reduce their effectiveness in acting as gill nets and catching small untargeted and unmarketable fish. There is no commercial market for many species of fish such as sea robins, toadfish and small sharks. In addition, small fish may not be marketable and size limits or restrictions on the sale of other species make them illegal to sell. The Department believes that any fish that are unmarketable commercially should not be targeted in a commercial fishery.

5. COMMENT: Monofilament should be allowed in the wings of fyke nets.

RESPONSE: The Department disagrees with the commenter's statement. The purpose of wings and leaders in fyke nets is to direct fish into the hoops or fyke of the net, not to gill fish. Monofilament is extremely effective in gilling fish and using large amounts in a fyke net could effectively change the net into a gill net. The use of gill nets is prohibited in many areas where fyke nets are permitted. The prohibition on monofilament in fyke nets will prevent individuals from circumventing the regulation on gill nets.

6. COMMENT: All fyke netters and haul seiners should be notified by mail regarding this amendment and a public hearing should be held.

RESPONSE: The Department mailed the proposal to all licensed fyke netters, haul seiners and gill netters, as well as commercial docks and a number of recreational fishing clubs. The proposed amendment was also published in the New Jersey Register at 24 N.J.R. 207(a). Public comment was solicited both by mail and in the New Jersey Register. The Department recognizes the importance of public hearings to access public comment and generally holds public hearings on controversial issues or when dealing with large constituent groups. A public hearing, however, is not a requirement of the Administrative Procedures Act at N.J.S.A. 52:14B-4.

N.J.A.C. 7:25-18.5(g)

7. COMMENT: The language "Persons" is inaccurate in N.J.A.C. 7:25-18.5(g).

RESPONSE: The Department inadvertently used old language which had been amended since the publication of the proposed amendment (see 24 N.J.R. 1113(a)). The correct word in place of "persons" should have been "individuals", and the text of the adoption as published herein so reads.

N.J.A.C. 7:25-18.5(g)1ii and 2ii

8. COMMENT: Comments were received indicating that the sections prohibiting fyke netting and haul seining in any bodies of water with a total area of less than 175 acres could be interpreted to eliminate many coves and small creeks. Those bodies of water which are to be eliminated should be listed.

RESPONSE: The Department agrees that the definition of area closures was too open to individual interpretation to be effective. The adoption has been changed to eliminate the 175 acre definition; it now specifically lists all bodies of water closed to fyke netting and haul seining.

Summary of Agency-Initiated Changes:

At N.J.A.C. 7:25-18.5(g)2ii, latitude, longitude and line bearings defining the Collins Cove area off the Mullica River are incorrect due to typing and charting errors. The line has been redefined in the adoption to accurately reflect the recommendations of the Marine Fisheries Council Fyke Net Committee.

It should also be noted that the text of N.J.A.C. 7:25-18.5(g) published herein corresponds to that text adopted effective March 16, 1992 at 24 N.J.R. 1113(a).

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks *thus*, deletions from proposal indicated in brackets with asterisks *[thus]*).

7:25-18.5 General net regulations

(a)-(f) (No change.)

(g) Individuals intending to take fish with a net in the marine waters of this State pursuant to N.J.S.A. 23:5-24.2 shall, as required, apply to the Commissioner for a license and/or permit. To be eligible to purchase a 1992 license for a drifting, staked or anchored gill net the applicant shall have purchased a gill net license during 1990, 1991 or a 1992 license prior to May 1, 1992 or provide documented proof of active military service within one year of application. An applicant who does not meet the above requirements must file an

application, in person with the Department in each of two consecutive years during the month of January. Such an applicant shall be eligible for gill net licenses in the following calendar year. Beginning in the license year (January 1-December 31) 1993, an applicant for a gill net license must have possessed a gill net license in one of the two previous years. Failure to purchase a gill net license in one of the prior two years shall subject the applicant to the two year waiting period described above. Availability of Delaware Bay Gill Net Permits shall be determined pursuant to N.J.A.C. 7:25-18.6 through 18.11. Upon receipt of the application and the prescribed license fee, the Commissioner may, in his or her discretion, issue single season licenses and/or permits as specified for each net type for the taking of fish with nets only as follows:

1. Haul seines shall have a mesh not smaller than 2.75 inches stretched and shall not exceed 70 fathoms in length, whether used singly or in a series. Haul seines may be used for all species except those specifically protected.

i. (No change.)

ii. A person shall not use or attempt to use a haul seine for any species in Lake Takanassee, Spring Lake, Wreck Pond and Deal Lake*, or in any other body of water in the State with a total area of less than 175 acres]*;

Recodify existing ii as iii (No change.)

2. Fykes shall have a length, including leaders, which shall not exceed 30 fathoms and no part of the net or leaders shall be constructed of monofilament or have a mesh *[smaller than two and one-half inches stretched or]* larger than five inches stretched. Fyke nets may be used for all species except those specifically protected.

i. (No change.)

ii. A person shall not use or attempt to use a fyke net for any species in Lake Takanassee, Spring Lake, Wreck Pond and Deal Lake, or in the area commonly known as Collins Cove off the Mullica River between a line starting at *[Rocky Point (latitude 39°33.29'N, longitude 74°28.48'W)]* ***aid to navigation channel marker flashing red number 8 (latitude 39°33.36'N, longitude 74°28.39'W)***, bearing approximately *[265°T]* ***229°T*** to a point on the western shore of Collins Cove at latitude *[30°33.19'N]* ***39°33.09'N***, longitude *[74°28.48'W]* ***74°28.72'W*** and the Garden State Parkway where it crosses the Mullica River*, or in any other body of water in the State with a total area of less than 175 acres]*;

iii. All stakes used for the setting of fyke nets must be removed within 30 days of the close of the season;

iv. Submerged anchored fyke nets shall be marked at each end with a fluorescent orange float at least 12 inches in diameter or a fluorescent orange flag at least 12 inches by 12 inches and suspended at least three feet above the water, measured from the surface of the water to the bottom of the flag. No less than 24 square inches of any reflective material shall be attached and maintained on each marker.

v. The fyke resident fee shall be \$12.00 per net. Each licensee shall notify the Department in their license application of the specific estuary in which they intend to fish the fyke net(s). Licensees shall notify the Department as to any change in the specific estuary within which the fyke net is located no later than seven days following the change in estuary. Such notice shall be in writing to:

Division of Fish, Game & Wildlife
Marine Fisheries Administration
CN 400

Trenton, New Jersey 08625.

3.-12. (No change.)

(h) (No change.)

(a)

ENVIRONMENTAL REGULATION

Hazardous Waste; Exclusions of Certain Used Chlorofluorocarbons

Adopted Amendment: N.J.A.C. 7:26-8.2

Proposed: December 16, 1991 at N.J.R. 3692(a).

Adopted: October 13, 1992 by Scott A. Weiner, Commissioner, Department of Environmental Protection & Energy.

Filed: October 14, 1992 as R.1992 d.448, **without change**.

Authority: N.J.S.A. 13:1E-1 et seq., particularly 13:1E-6.

DEPE Docket Number: 045-91-11.

Effective Date: November 16, 1992.

Expiration Date: October 25, 1995.

Summary of Public Comments and Agency Responses:

The amendment was proposed on December 16, 1991. The public comment period closed February 14, 1992. The following three comments from the United States Environmental Protection Agency (USEPA) by Deborah Craig, Air Conditioning Contractors of America (ACCA) by Gary Salvano, Penzoil Company by Sarosh Manekshaw, and National Refrigerants, Inc., by Joseph R. Davison, Esq. were received:

1. COMMENT: USEPA questions a statement in the Summary portion of the proposal. In the Summary, the Department stated that 1991 amendments to N.J.A.C. 7:26-8 replaced the Extraction Procedure (EP) toxicity test with the Toxicity Characteristic Leaching Procedure (TCLP), and "thereby included additional compounds." The commenter questioned what the Department meant by the clause "thereby included additional compounds." Additionally, the last sentence of that paragraph needs to be clarified because it implies that the compounds which leach out using the TCLP procedure must be managed as a hazardous waste. It is the waste from which the compounds/constituents are leached that is regulated as a hazardous waste, not just the leachate or the constituents.

RESPONSE: The Department agrees that the clause "thereby included additional compounds" needs clarification. As a result of replacing the EP toxicity test with TCLP, some additional wastes were included within the scope of the term "hazardous waste." TCLP is an improved and more rigorous extraction procedure which includes additional constituents; as a result, wastes containing those additional constituents would be considered hazardous. Consequently, these additional wastes, as well as the original compounds captured by the EP toxicity test, are regulated as hazardous wastes.

The Department also agrees with the commenter that the waste from which the compounds or constituents are leached is regulated as a hazardous waste, not just the leachate or the constituents.

2. COMMENT: Both Penzoil Company and the ACCA supported the proposed amendment. The ACCA noted that it was concerned about the dangers which chlorofluorocarbons pose to the environment and has been working to educate persons repairing or replacing heat transfer equipment. The ACCA viewed the amendment as a reasonable and positive step which will bolster the continued recycling of these substances. Penzoil expressed the opinion that industry should have little trouble in taking advantage of the exemption since CFC technology is advanced.

RESPONSE: The Department appreciates the commenters' support, and their proposed efforts to utilize this rule to achieve its maximum environmental benefit.

3. COMMENT: National Refrigerants, Inc. fully supported the proposed amendment, because it promotes and permits greater recycling and reclamation of used CFCs. In addition, the commenter asked that the Department also consider making application of the proposed amendment to the regulations retroactive to July 28, 1989. It was on that date that the EPA, pursuant to the Resource Conservation and Recovery Act, 42 U.S.C. Section 6900 et seq. ("RCRA"), clarified the regulatory status of CFCs used as refrigerants. Federal Register, Vol. 54, No. 144, July 28, 1989 at 31335. According to the commenter, EPA indicated at that time that CFC refrigerants are not likely to exhibit a characteristic of a hazardous waste. Based in substantial part on that premise, the EPA provided that generators of CFC refrigerants that are reclaimed are not required to test their wastes to determine if the CFCs are not hazardous wastes (though a generator is still required to know

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if the CFC is hazardous waste) (see 54 FR 31336). The commenter stated that EPA also recognized that any confusion over the classification of CFCs when used as refrigerants under Subtitle C of RCRA was only hindering efforts to implement recycling programs designed to mitigate the adverse environmental impacts of CFCs (see 54 FR 31335).

RESPONSE: The Department appreciates the commenter's support of the adopted amendment. However, the Department has not incorporated the commenter's suggestion that the exclusion of used CFCs from regulation as a hazardous waste should be retroactive to July 28, 1989. While the 1989 EPA clarification in regard to CFCs (54 FR 31335) recognized the negative impact RCRA regulation might have on recycling efforts, that announcement of data availability was not a rulemaking. It did not exempt those CFCs which demonstrated a hazardous waste characteristic and were being recycled from being subject to handling as a hazardous waste. The EPA only created such an exemption in 1991 when it adopted an interim final rule which suspended the Toxicity Characteristic rule for used refrigerants which are recycled. Federal Register, Vol. 56, No. 30, February 13, 1991 at 5910.

New Jersey's regulations must be at least as stringent as the regulations promulgated by EPA under the Federal Resource Conservation and Recovery Act, 42 U.S.C. 6901 et seq. in order for New Jersey to maintain Federal authorization to implement the RCRA hazardous waste management program for the State. If New Jersey made this CFC exemption regulation retroactive to 1989, it could have the effect of making New Jersey less strict than the Federal government from 1989 to 1991 since the EPA did not promulgate a retroactive adoption.

Additionally, such a retroactive application would be disruptive to Department's enforcement policies. Finally, there would be no environmental benefit to such a retroactive adoption. For all these reasons the Department is making the adopted amendment effective upon publication in the New Jersey Register.

Full text of the adoption follows.

7:26-8.2 Exclusions

(a) The following materials are not regulated as hazardous wastes for the purposes of this chapter:

1.-26. (No change.)

27. Used chlorofluorocarbon refrigerants from totally enclosed heat transfer equipment, including mobile air conditioning systems, mobile refrigeration, and commercial and industrial air conditioning and refrigeration systems that use chlorofluorocarbons as the heat transfer fluid in a refrigeration cycle, provided the refrigerant is recycled for further use.

(b) (No change.)

HEALTH

(a)

HEALTH FACILITIES RATE SETTING

Standard Hospital Accounting and Rate Evaluation

(SHARE) Manual

Rehabilitation and Specialized Hospitals

Adopted New Rules: N.J.A.C. 8:31A-1.5 and

Appendix D

Adopted Amendments: N.J.A.C. 8:31A-7.4 and 7.5

Proposed: August 17, 1992 at 24 N.J.R. 2810(a).

Adopted: October 8, 1992 by Frances J. Dunston, M.D., M.P.H., Commissioner, Department of Health (with approval of the Health Care Administration Board).

Filed: October 15, 1992 as R.1992 d.450, **without change**.

Authority: N.J.S.A. 26:2H-1 et seq.

Effective Date: November 16, 1992.

Expiration Date: February 20, 1995.

Summary of Public Comments and Agency Responses:

COMMENTER: Blue Cross and Blue Shield of New Jersey

COMMENT: The commenter opposes the retroactive effect of the date of July 1, 1992 upon which a charge per patient day will be added.

Their position is that it should be effective the first day of the month following the approval from the Health Care Administration Board.

RESPONSE: The add-on fee is for the Department of Health staff involved in the SHARE Hospital rate setting function. These administrative costs are calculated on a State Fiscal Year which runs from July 1st through June 30th. Therefore, the date of July 1, 1992, is appropriate for this rule.

COMMENTER: Blue Cross and Blue Shield of New Jersey

COMMENT: It is the commenter's understanding that the approved prospective per diem will not contain an "add-on fee" exceeding the proposed \$5.00 per day cap.

RESPONSE: The Department agrees with this understanding.

COMMENTER: Blue Cross and Blue Shield of New Jersey

COMMENT: Blue Cross and Blue Shield of New Jersey disagrees with the Economic Impact statement that there will be no direct or immediate economic impact on consumers.

RESPONSE: The Department maintains the position, as stated in the proposal, that it is possible that the general public may bear the costs, if the payor passes these costs on to the consumer through rate increases. These costs are currently paid by the Department of Health. The Department has elected to cover these costs via an assessment of the payers, Blue Cross and Medicaid. The fee is based on patient days, which is the most appropriate measure of a payer's benefit from a cost containment system for these types of facilities.

COMMENTER: John E. Runnells' Specialized Hospital

COMMENT: The SHARE system should be completely abolished. Medicaid will not utilize the system as of January 1, 1993; Blue Cross pays the SHARE rate on an interim basis; the SHARE system requires projected and final cost reports which create an unnecessary administrative burden on providers; the system does not adequately reflect differences in level of care and intensity of treatment programs; the system does not account for variances in unit size or average length of stay since it uses admissions as a basis for comparison; peer groupings that exist have no regard for differences between providers and the delivery of care; there is no provision for uncompensated care; the system does not recognize unique situations on appeal; and the system has not met its goal in providing reasonable reimbursement rates.

RESPONSE: Neither the continuation nor the elimination of the SHARE Hospital Reimbursement System was addressed in the proposal. Therefore, it is inappropriate to address the substance of these comments in this forum. Informationally, the Department of Health has the responsibility, under the 1971 Health Care Facilities Planning Act, to establish hospital reimbursement rates for Blue Cross. The Department has prepared several proposed changes to the SHARE System, which are being forwarded to the Hospital Association, the Public Advocate and Blue Cross. These changes are the result of meetings with the above parties, and they are responsive to several of the concerns expressed by the commenter.

Full text of the adoption follows.

8:31A-1.5 Per diem charge

(a) A charge per patient day, based on the latest available data, from July 1, 1992 onward, shall be assessed each hospital for which the Department of Health establishes prospective per diem rates.

1. The per diem charge will be calculated by dividing the total Facilities Rate Setting program administrative expenses by the latest available Blue Cross and Medicaid inpatient days, to a maximum of \$5.00.

i. The per diem charge, as calculated, will be added to the hospital's effective rate.

2. The provider will remit a check to the State Treasury covering the add-on amount in accordance with the process illustrated in Appendix D, incorporated herein by reference. The check may be monthly, quarterly, semi-annually or annually.

8:31A-7.4 Methodology for calculating Global Rates

(a) (No change.)

(b) An administrative add-on, calculated in accordance with N.J.A.C. 8:31A-1.5 will be added to the reimbursement rates.

8:31A-7.5 Methodology for Alternate Rates

(a)-(b) (No change.)

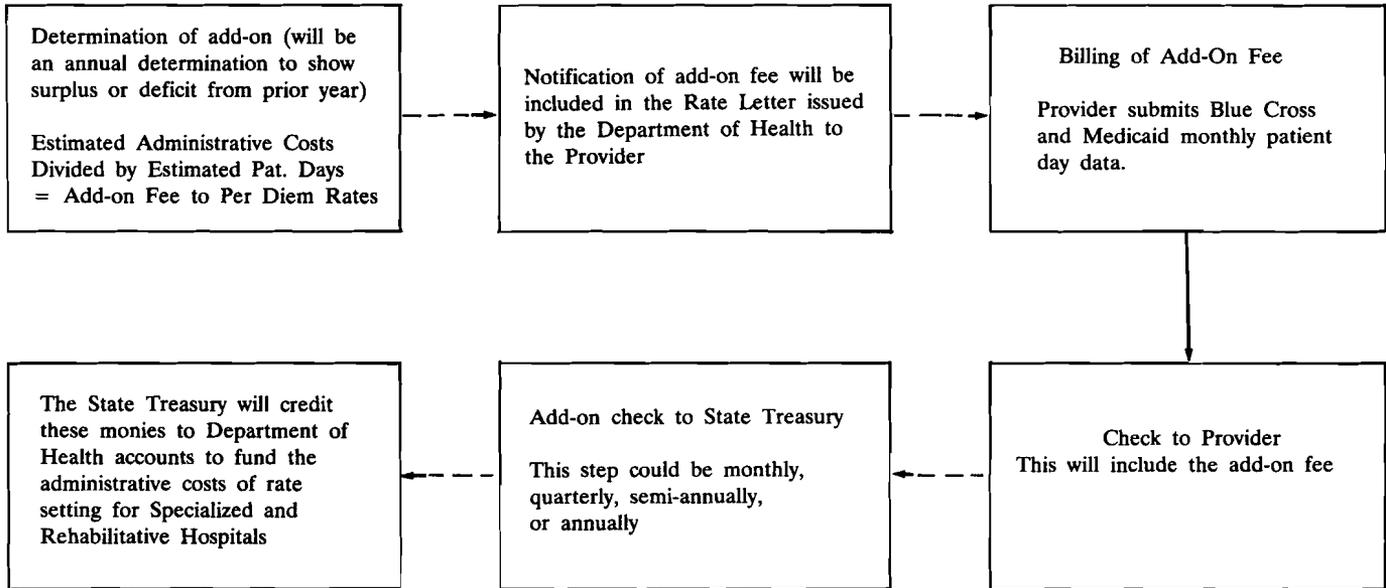
(c) An administrative add-on, calculated in accordance with N.J.A.C. 8:31A-1.5, will be added to the reimbursement rates.

(d) (No change in text.)

Appendix D

FEE STRUCTURE SHARE

ASSUME: Administrative Costs \$309,554
 Patient Days 65,000
 Add-On Fee \$4.77



(a)

DRUG UTILIZATION REVIEW COUNCIL

List of Interchangeable Drug Products

Adopted Amendments: N.J.A.C. 8:71

Proposed: January 6, 1992 at 24 N.J.R. 61(a).
 Adopted: October 13, 1992 by the Drug Utilization Review Council, Robert Kowalski, Chairman.
 Filed: October 22, 1992 as R.1992 d.461, with portions of the proposal not adopted but still pending.

Authority: N.J.S.A. 24:6E-6(b).
 Effective Date: November 16, 1992.
 Expiration Date: February 17, 1994.

Summary of Public Comments and Agency Responses:
 No comments were received regarding the adopted product.

Summary of Hearing Officer's Recommendations and Agency Responses:

A public hearing on the proposed additions to the list of interchangeable drug products was held on January 27, 1992. Mark A. Strollo, R.Ph., M.S., served as hearing officer. Five persons attended the hearing. Seven comments were offered, as summarized in a previous Register (see 24 N.J.R. 947(b)). The hearing officer recommended that the decisions made be based upon available biodata. The Council adopted the products specified as "adopted," and referred the products identified as "pending" for further study.

The following product and its manufacturer was adopted:

Amoxapine tabs 25mg, 50mg, 100mg, 150mg Danbury

The following drugs were not adopted but are still pending:

Bromocriptine mesylate tabs 2.5mg Danbury
 Chlorzoxazone tabs 250mg, 500mg Ohm
 Clorazepate tabs 3.75mg, 7.5mg, 15mg Danbury
 Desipramine HCl tabs 10mg, 25mg, 50mg Danbury
 Desipramine HCl tabs 75mg, 100mg, 150mg Danbury

Fiorinal tabs substitute	Danbury
Fluphenazine HCl Oral Soln 5mg/ml	Copley
Fluphenazine HCl tabs 1mg, 2.5mg, 5mg, 10mg	Danbury
Gemfibrozil caps 300mg	Danbury
Guaifenesin tabs 600mg	DURA
Ibuprofen tabs 300mg	Danbury
Isosorbide Dinitrate tabs 20mg, 30mg, 40mg	Danbury
Loperamide HCl caps 2mg	Danbury
Loxapine succinate caps 5mg, 10mg, 25mg, 50mg	Danbury
Methylprednisolone tabs 4mg, 16mg	Danbury
Metoclopramide HCl tabs 5mg	Danbury
Minocycline HCl tabs 50mg, 100mg	Danbury
Nadolol tabs 40mg, 80mg, 120mg	Danbury
Nitrofurantoin caps 25mg, 50mg, 100mg	Danbury
Nortriptyline HCl caps 10mg, 25mg, 50mg, 75mg	Danbury
Propoxyphene naps/APAP tabs 100/650	Danbury
Spirolactone tabs 25mg, 50mg, 100mg	Danbury
Spirolactone/HCTZ tabs 50/50	Danbury
Temazepam caps 15mg, 30mg	Danbury
Tolmetin sodium caps 400mg	Danbury
Tolmetin sodium tabs 200mg	Danbury
Trazodone HCl tabs 150mg	Danbury

OFFICE OF ADMINISTRATIVE LAW NOTE: See related notices of adoption at 24 N.J.R. 947(b), 1897(a), 2560(a) and 3173(b).

(b)

DRUG UTILIZATION REVIEW COUNCIL

List of Interchangeable Drug Products

Adopted Amendments: N.J.A.C. 8:71

Proposed: May 4, 1992 at 24 N.J.R. 1674(a).
 Adopted: October 13, 1992 by the Drug Utilization Review Council, Robert Kowalski, Chairman.
 Filed: October 22, 1992 as R.1992 d.462, with portions of the proposal not adopted and portions not adopted but still pending.

Authority: N.J.S.A. 24:6E-6(b).
 Effective Date: November 16, 1992.
 Expiration Date: February 17, 1994.

Summary of Public Comments and Agency Responses:

The Drug Utilization Review Council received the following comment pertaining to the products affected by this adoption.

COMMENT: From Searle, in opposition to Baker Cummins Pharmaceuticals' verapamil extended release 240 mg tablets:

Searle contended that the product is bioequivalent, based on the single dose study under fed conditions. Searle pointed out that the log-transformed 90 percent confidence interval exceeds the acceptable range and that plasma concentration time curves reflect dissimilar plasma levels with the test and reference product. In addition, Searle suggested that specific enantiomer concentrations should be measured to determine bioequivalency of verapamil SR products. Searle requested that the Council reject Baker's verapamil SR product.

RESPONSE: The Council reviewed the results of a single dose and multiple dose comparison of Baker's product to the reference product in fasting subjects and a single dose comparison in subjects following a high fat breakfast. The Council determined that the fasting studies met all of its criteria for bioequivalence. The Council recognized that the food study was conducted to test for dose dumping and not bioequivalency. The Council concluded that the amount of verapamil absorbed was comparable for both products. The rate of absorption was different in the food study but this would likely disappear on multiple dosing at steady-state. Searle's point that the individual ratios of test to reference C-max values suggested bioinequivalency was dismissed as a reflection of inter and intrasubject variability and not product difference.

The Council confirmed that stereospecific assay is not a requirement for the determination of bioequivalency at this time. In addition, Searle did not present data that concluded that there were any product-related differences in individual enantiomers.

The Council approved Baker's verapamil SR 240 mg tablets as a generic equivalent to the brands Calan SR and Isoptin SR based on the acceptable comparative values of the AUC, T-max and C-max, as well as, acceptable ranges of the 90 percent confidence intervals.

Summary of Hearing Officer's Recommendations and Agency Responses:

A public hearing on the proposed additions to the list of interchangeable drug products was held on May 26, 1992. Mark A. Strollo, R.Ph., M.S., served as hearing officer. Ten persons attended the hearing. Four comments were offered, as summarized in previous notices of adoption (see 24 N.J.R. 2557(b) and 3173(a)). The hearing officer recommended that the decisions made be based upon available biodata. The Council adopted the products specified as "adopted," declined to adopt the products specified as "not adopted," and referred the products identified as "pending" for further study.

The following products and their manufacturers were **adopted**:

Cephalexin caps 250, 500mg	Atral
Diltiazem tabs 30mg, 60mg, 90mg, 120mg	Lederle
Tetracycline caps 250, 500mg	Atral
Verapamil tabs 240mg extended release	Baker Cummins

The following product was **not adopted**:

Valproic acid caps 250mg	R.P. Scherer
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The following products were **not adopted but are still pending**:

Amoxicillin caps 250, 500mg	Atral
Berocca tabs substitute	Pioneer
Ketoprofen caps 25mg, 50mg, 75mg	Lederle
Lactulose soln 10g/15ml	Technilab
Metoclopramide HCl syrup 5mg/5ml	Lemmon
Metoprolol tartrate tabs 100mg	Geneva
Metoprolol tartrate tabs 50mg	Geneva
Piroxicam caps 10mg, 20mg	Royce
Sucralfate tabs 1g	Blue Ridge Labs
Vancomycin HCl oral soln powder 1g, 2g, 5g	Lederle

OFFICE OF ADMINISTRATIVE LAW NOTE: See related notices of adoption at 24 N.J.R. 2557(b) and 3173(a).

(a)

DRUG UTILIZATION REVIEW COUNCIL

List of Interchangeable Drug Products

Adopted Amendments: N.J.A.C. 8:71

Proposed: September 8, 1992 at 24 N.J.R. 2997(a).

Adopted: October 13, 1992 by the Drug Utilization Review Council, Robert Kowalski, Chairman.

Filed: October 22, 1992 as R.1992 d.463, **with portions of the proposal not adopted and with other portions not adopted but still pending.**

Authority: N.J.S.A. 24:6E-6(b).

Effective Date: November 16, 1992.

Expiration Date: February 17, 1994.

Summary of Public Comments and Agency Responses:

The Drug Utilization Review Council received the following comments pertaining to the proposed products affected by this adoption.

COMMENT: From Procter & Gamble Pharmaceuticals in opposition to Zenith Laboratories' nitrofurantoin 50mg and 100mg capsules. Procter & Gamble informed the Council that Zenith has not received FDA approval for its generic version of Macrochantin and, therefore, no action can or should be taken on this product.

RESPONSE: The Council deferred action until FDA approval is obtained.

COMMENT: From Lemmon Company in support of TEVA/Lemmon tolmetin sodium 400mg capsules. Lemmon pointed out that biodata for its product is similar to that of other manufacturers' tolmetin products that have been approved by the Council. In addition, Lemmon provided further analysis to explain that the test to reference C-max differences appear to be caused by reference product variability.

RESPONSE: The Council accepted this product into the Formulary based on the supporting biodata and precedents.

COMMENT: From Dupont Pharmaceuticals in opposition to TEVA/Lemmon Company's carbidopa/levodopa 10/100, 25/100 and 25/250 tablets. Dupont pointed out that biodata has not been submitted for the 10/100 and 25/100 tablets to establish bioequivalency. Dupont contended that a waiver based on proportionally similar ingredients would not be appropriate since the excipients and active ingredients are not proportional to the 25/250 tablets.

Dupont informed the Council of the importance of the bioavailability of levodopa in the clinical management of Parkinson's disease. Dupont asserts that differences in peak plasma concentrations between the brand and generic could cause significant adverse reactions in patients in advanced stages of disease and necessitate reevaluation.

It is Dupont's position that a metabolite of levodopa, 3-0-methyldopa should have been measured in TEVA/Lemmon's biostudy since it effects the bioavailability.

Dupont suggested that the TEVA/Lemmon's biostudy design for establishing bioequivalency should have been a multiple dose study in more appropriate subjects such as elderly Parkinson's patients. Dupont contended that the pharmacokinetics properties of levodopa differs between young healthy subjects and elderly Parkinson patients.

RESPONSE: The Council deferred taking action on this product in order to review additional information.

COMMENT: From Lemmon Company in support of the TEVA/Lemmon Company's carbidopa/levodopa 10/100, 25/100 and 25/250 tablets. Additional biodata for the carbidopa/levodopa 25/100 tablets was submitted, as well as a comparative dissolution profile for the 10/100 strength tablet. Lemmon noted that a waiver was granted for in vivo biodata on the carbidopa/levodopa 10/100 tablets based on the dissolution data.

Lemmon confirmed that it has met all FDA bioequivalency requirements for this product which addresses any concern of its bioavailability in treating Parkinson disease.

Lemmon noted that the FDA did not find the measurement of 3-0-methyldopa to be significant. Lemmon questioned the relevance of measuring this metabolite since bioavailability of its parent compound, levodopa, is measured.

Lemmon concluded that there are no requirements for biostudies to be conducted in targeted populations and noted that the Council has never required protocols over and above those used by the FDA.

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RESPONSE: The Council deferred taking action on this product in order to review additional information.

Summary of Hearing Officer's Recommendations and Agency Responses:

A public hearing on the proposed additions to the list of interchangeable drug products was held on October 5, 1992. Mark A. Stollo, R.Ph., M.S., served as hearing officer. Two persons attended the hearing. Four comments were submitted. The hearing officer recommended that the decisions made be based upon available biodata. The Council adopted the products specified as "adopted," declined to adopt the products specified as "not adopted," and referred the products identified as "pending" for further study.

The following products and their manufacturers were **adopted**:

Betamethasone dipropionate cream 0.05%	Taro
Carbamazepine chewable tabs 100mg	TEVA
Desonide Cream 0.05%	Taro
Diflunisal tabs 250mg, 500mg	TEVA
Diltiazem tabs 30mg, 60mg, 90mg, 120mg	Copley
Doxycycline hyclate caps 100 mg	Sidmak
Griseofulvin tabs 165mg, 330mg	Sidmak
Ibuprofen tabs 400mg, 600mg, 800mg	TEVA
Methotrexate tabs 2.5mg	Mylan
Midrin caps substitute	Nutripharm
Naphcon A ophthalmic sol. substitute	Optopics
Pilocarpine 6% ophthalmic sol.	Optopics
Piroxicam caps 10mg, 20mg	Mylan
Rondec tablet substitute	Nutripharm
Tolmetin caps 400mg	TEVA
Valproic Acid syrup 250mg/5ml	Copley

The following products were **not adopted**:

Rondec TR tablet substitute	Nutripharm
Phenylephrine 2.5% ophthalmic sol.	Optopics
Deconamine tabs substitute	Nutripharm

The following products were **not adopted but are still pending**:

Albuterol sulfate inh. soln. 0.083%	Copley
Amiloride/HCTZ 5/50 tabs	Danbury
Atenolol tabs 50mg, 100mg	W-C
Betamethasone dipropionate cream 0.05%	ICN
Carbidopa/levodopa tabs 10/100, 25/100, 25/250	TEVA
Cephalexin caps 250mg, 500mg	Yoshitomi
Clofibrate caps 500mg	Pharmacaps
Deconamine SR caps substitute	Nutripharm
Fluocinonide cream 0.05%	ICN
Granulex spray substitute	Topi-cana
Hydrocortisone cream 2.5%	ICN
Naproxen sodium tabs 275mg, 550mg	Danbury
Naproxen tabs 250mg, 375mg, 500mg	Danbury
Nitrofurantoin caps 50mg, 100mg	Zenith
Piroxicam caps 10mg, 20mg	Copley
Singlet caplet substitute	Nutripharm
Singlet LA caplet substitute	Nutripharm
Triamterene/HCTZ 37.5/25 tabs	Danbury

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DRUG UTILIZATION REVIEW COUNCIL

List of Interchangeable Drug Products

Adopted Amendments: N.J.A.C. 8:71

Proposed: July 6, 1992 at 24 N.J.R. 2414(b).

Adopted: October 13, 1992 by the Drug Utilization Review Council, Robert Kowalski, Chairman.

Filed: October 22, 1992 as R.1992 d.464, with portions of the proposal not adopted but still pending.

Authority: N.J.S.A. 24:6E-6(b).

Effective Date: November 16, 1992.

Expiration Date: February 17, 1994.

Summary of Public Comments and Agency Responses:

There were **no comments** submitted pertaining to the proposed products affected by this adoption.

Summary of Hearing Officer's Recommendations and Agency Responses:

A public hearing on the proposed additions to the list of interchangeable drug products was held on August 3, 1992. Mark A. Stollo, R.Ph., M.S., served as hearing officer. Two persons attended the hearing. No comments were submitted. The hearing officer recommended that the decisions made be based upon available biodata. The Council adopted the products specified as "adopted" and referred the products identified as "pending" for further study.

The following products and their manufacturers were **adopted**:

Darvon Compound-65 caps substitute	ALRA
Meprobamate tabs 200mg, 400mg	ALRA
Potassium chloride ER tabs 8mEq	Upsher-Smith
Propoxyphene HCl caps 65mg	ALRA
Sulfisoxazole tabs 500mg	ALRA
Tolmetin sodium tabs 200mg	Geneva
Verapamil tabs 40mg	Geneva

The following products were **not adopted but are still pending**:

Acetazolamide tabs 250mg	ALRA
Atenolol tabs 25mg	Geneva
Atenolol tabs 50mg, 100mg	Novopharm
Clemastine fumarate tabs 1.34mg, 4.68mg	Geneva
Clonidine HCl/chlorthalidone tabs 0.1/15mg	Geneva
Clonidine HCl/chlorthalidone tabs 0.2/15mg	Geneva
Clonidine HCl/chlorthalidone tabs 0.3/15mg	Geneva
Clorazepate tabs 3.75mg, 7.5mg, 15mg	ALRA
Diltiazem tabs 30mg, 60mg, 90mg, 120mg	Mutual
Fenoprofen caps 300mg	W-C
Fenoprofen tabs 600mg	W-C
Ibuprofen tabs 400mg, 600mg, 800mg	ALRA
Imipramine tabs 10mg, 25mg, 50mg	ALRA
Ketoprofen caps 25mg, 50mg, 75mg	Biocraft
Lactulose syrup 10g/15ml	ALRA
Loperamide HCl caps 2mg	Geneva
Loxapine caps 5mg, 10mg, 25mg, 50mg	Geneva
Metoclopramide tabs 5mg	Biocraft
Naproxen sodium tabs 275mg, 550mg	Mutual
Naproxen tabs 250mg, 375mg	Mutual
Nucofed expectorant substitute	LuChem
Pediazole suspension substitute	ALRA
Potassium bicarbonate effervescent tabs 25mEq	ALRA
Sucralfate tabs 1gm	Biocraft
Tolbutamide tabs 500mg	ALRA
Tolmetin sodium caps 400mg	Geneva
Tolmetin sodium caps 400mg	Geneva
Triamterene/HCTZ tabs 37.5/25mg	Lemma

OFFICE OF ADMINISTRATIVE LAW NOTE: See related notices of adoption at 24 N.J.R. 3174(c) and 3728(a).

(b)

OFFICE OF HEALTH POLICY AND RESEARCH

State Health Plan

Hospital Inpatient Services

Full Rate Review; Specific Recommendations

Adopted Amendments: N.J.A.C. 8:100-14.8 and 14.13

Proposed: August 3, 1992 at 24 N.J.R. 2704(a).

Adopted: October 14, 1992 by Frances J. Dunston, M.D., M.P.H., Commissioner of Health, with the approval of the Health Care Administration Board.

Filed: October 16, 1992, as R.1992 d.451, with substantive and technical changes not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 26:2H-1 et seq., specifically N.J.S.A. 26:2H-5.

ADOPTIONS**HEALTH**

Effective Date: November 16, 1992.

Expiration Date: July 20, 1997.

Summary of Public Comments and Agency Responses:

The following commented on the reproposal: Edward M. Lewis, Chief Executive Officer, Bergen Pines County Hospital; and Harold S. Sherman, Senior Vice President Corporate Development, St. Francis Medical Center.

N.J.A.C. 8:100-14 Hospital inpatient services**General Comments**

COMMENT 1: Bergen Pines County Hospital stated that the use of occupancy rates as the "single, significant planning variable" is inaccurate.

RESPONSE 1: The Department acknowledges this comment and refers the commenter to the adoption notice of N.J.A.C. 8:100-14 at 24 N.J.R. 2561(a), in which this comment was addressed. This comment is outside the realm of the proposed amendments.

N.J.A.C. 8:100-14.13 Specific recommendations

COMMENT 2: Bergen Pines County Hospital requests that the hospital not be singled out to participate in Local Advisory Board II's bed need study, but rather proposes that all hospitals within all Local Advisory Boards should participate in bed need studies.

RESPONSE 2: There has been no change in the recommendation for Bergen Pines Hospital to participate in a M/S bed need study since the original proposal of N.J.A.C. 8:100-14 at 24 N.J.R. 1164(a) and adoption at 24 N.J.R. 2561(a). Therefore the Department's prior response to this comment holds, that is, that the:

"Plan calls only for a study of Bergen Pines Hospital's role in acute care, and does not reflect any pre-determined decision. The future of Bergen Pines Hospital has been the subject of many discussions between the Department and the hospital's administration and will clearly remain such a subject in the future."

Additionally, N.J.A.C. 8:100-14.13(c) already requires all hospitals in a Local Advisory Board area to participate in bed need studies.

Hospitals selected to participate in initial bed need studies are those in which efficiency, distribution, and need for a particular service are most in question at this time. Additional bed need studies for all hospitals in all LABs will be called for on a periodic basis to monitor these and other issues, such as quality, over time. No change in the rule will be made as a result of this comment.

COMMENT 3: St. Francis Medical Center of Trenton expressed concern that concessions were made to another hospital in the county without input from other Mercer County hospitals providing similar services.

RESPONSE 3: This comment refers to the language change whereby both Helene Fuld Hospital and St. Francis Medical Center will participate in the LAB pediatric and OB/GYN bed need study to determine if either hospital should eliminate its unit, reduce the number of licensed beds or consolidate pediatric and/or OB/GYN services at one site. This is a revision to the original recommendation that Helene Fuld eliminate its pediatric unit, which was made following a meeting of Department staff with Helene Fuld Hospital to discuss the performance of the facility's pediatric unit in terms of utilization, access, practice patterns, and quality, among other issues. Based on additional information presented at this session, the Department determined that further investigation of Helene Fuld's role as a community pediatric center in relation to St. Francis Medical Center is warranted. The requirement that a bed need study be conducted is to assure that input is obtained from other Mercer County hospitals providing similar services. This is to be accomplished by a LAB bed need study of all acute care services in all hospitals in Mercer County, with specific recommendations for consolidation of pediatric and OB/GYN services at Helene Fuld Hospital and St. Francis Medical Center.

COMMENT 4: St. Francis Medical Center gave a two-part rationale for needing to remain a full service hospital. This includes (1) that as a Catholic hospital, it is philosophically, morally, and ethically bound to provide alternatives in care to the community, particularly in its efforts to serve the medically indigent; and (2) that the hospital has obtained several managed care contracts that were successfully negotiated because the hospital offered a complete range of primary care services with evidence of quality and reasonable cost. This commenter contended that to eliminate services at a given hospital on a service-by-service basis will

weaken the facility and will create a State hospital network of many diminished institutions instead of a complement of strong and vigorous hospitals.

RESPONSE 4: While the Department acknowledges the position held by St. Francis Medical Center that it must stay a full service facility, neither reason presents evidence that access to a full range of services could not be achieved by working collaboratively with other facilities to accomplish this. Rules promulgated by the Department supersede those of religious authorities in the State. Further, managed care contracts are of a time limited nature and must be renegotiated on a periodic basis. Many facilities provide high quality, efficiently delivered services without offering a full range of services and fill needs of members of the communities through alternative arrangements and referrals. Therefore, there will be no change in this rule as a result of this comment.

Summary of Agency-Initiated Change:

At 24 N.J.R. 2704 there was an inadvertent omission of a proposed change in Salem County's specific recommendations at 8:100-14.13(b)5v(1) and (2). The rule should state that all Salem County hospitals are required to participate in bed need studies within their LAB. N.J.A.C. 8:100-14.13(c) already requires all hospitals to participate in bed need studies conducted by their LABs.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks ***[thus]***).

8:100-14.8 Limitations on hospitals and areas with excess bed capacity

(a)-(c) (No change.)

(d) The Department of Health may initiate a full rate review under N.J.A.C. 8:31B-3.52 for a hospital which has been recommended for phase out of all acute care services in the following circumstances:

1. Patient volume falls below an average daily census of 50, or to a level which the Department determines will result in adverse patient care outcomes or risk to patient safety; or
2. The hospital is financially insolvent.

8:100-14.13 Specific recommendations

(a) (No change.)

(b) Based upon the criteria contained in N.J.A.C. 8:100-4 and N.J.A.C. 8:100-14.3, 14.5, 14.7 and 14.8, certificate of need applications shall be consistent with the following list of responsibilities and provisions:

1. Local Advisory Board I—shall submit to the State Health Planning Board and the Department of Health: a M/S bed need study for each county, an OB/GYN bed need study for Warren County which addresses consolidation of programs at one site, and a pediatric bed need study for Morris County and the city of Passaic. The LAB shall also submit a bed need study that addresses the conversion of St. Mary's and the need to continue the psychiatric outpatient programs currently provided at St. Mary's. The specific responsibilities of the hospitals in LAB I are listed by county, as follows:

i.-iii. (No change.)

iv. Warren County:

(1) (No change.)

(2) Hackettstown Community Hospital shall participate in the LAB OB/GYN bed need study.

(3) Warren Hospital shall participate in the LAB OB/GYN bed need study. It may apply for designation as a community pediatric center.

2. Local Advisory Board II shall submit to the State Health Planning Board and the Department of Health a M/S bed need study that addresses the feasibility of maintaining M/S beds at Bergen Pines County Hospital. The specific responsibilities of the hospitals in LAB II are listed by county as follows:

i. Bergen County:

(1)-(5) (No change.)

(6) Pascack Valley Hospital shall reduce its number of licensed pediatric beds to 14 and may apply for designation as a community pediatric center, following the bed reduction.

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(7) (No change.)
 ii. Hudson County:
 (1)-(5) (No change.)
 (6) St. Francis Hospital shall consolidate its licensed pediatric beds at one site with St. Mary Hospital. The consolidation shall include a reduction in the total number of licensed pediatric beds. St. Francis Hospital or St. Mary Hospital may apply for designation as a community pediatric center at the single site, following the pediatric bed consolidation.

(7) St. Mary Hospital shall eliminate its licensed OB/GYN unit or reduce its number of OB/GYN beds. St. Mary shall consolidate its licensed pediatric beds at one site with St. Francis Hospital. The consolidation shall include a reduction in the total number of licensed pediatric beds, St. Mary Hospital or St. Francis Hospital may apply for designation as a community pediatric center at the single site, following the pediatric bed consolidation.

3. Local Advisory Board III shall submit to the State Health Planning Board and the Department of Health M/S bed need studies for Essex and Union Counties. The specific responsibilities of the hospitals in LAB III are listed by county as follows:

i. Essex County:

(1) Clara Maass Medical Center shall reduce its number of licensed pediatric beds or consolidate its pediatric service with an area hospital. Any consolidation shall include a reduction in the total number of licensed pediatric beds. If pediatric beds are maintained at Clara Maass, Clara Maass may apply for designation as a community pediatric center, following the pediatric bed reduction or consolidation. Clara Maass Medical Center shall participate in a LAB bed need study to determine if further acute care bed reductions are warranted.

(2)-(12) (No change.)

ii. Union County:

(1)-(3) (No change.)

(4) Rahway Hospital shall reduce its number of licensed OB/GYN beds. Rahway Hospital shall reduce its number of licensed pediatric beds to 17 and may apply for designation as a community pediatric center, following the pediatric bed reduction.

(5) (No change.)

4. Local Advisory Board IV shall submit to the State Health Planning Board and the Department of Health M/S bed need studies for Mercer and Middlesex Counties. The LAB shall develop a strategy for acute care bed reductions in Mercer County, including consideration of converting one existing facility to another needed service. The LAB shall submit a study recommending a plan to consolidate to one site pediatric and OB/GYN services at Helene Fuld Medical Center and St. Francis Medical Center. Also, it shall submit a study of Raritan Bay Medical Center and South Amboy Memorial Hospital to determine the appropriateness and feasibility of joint ventures, particularly to retain South Amboy's inpatient psychiatric programs in the county as South Amboy transitions from general acute care services. The specific responsibilities of the hospitals in LAB IV are listed by county as follows:

i. (No change.)

ii. Mercer County:

(1)-(2) (No change.)

(3) Helene Fuld Medical Center shall participate in the LAB pediatric and OB/GYN bed need study to determine if it should eliminate its units, reduce the number of licensed beds or consolidate pediatric and OB/GYN services at one site with St. Francis Medical Center. Any consolidation shall include a reduction in the total number of licensed pediatric and OB/GYN beds. If pediatric services are consolidated at Helene Fuld, Helene Fuld may apply for designation as a community pediatric center following the pediatric bed consolidation.

(4) St. Francis Medical Center shall participate in the LAB pediatric and OB/GYN bed need study to determine if it should eliminate its units, reduce the number of licensed beds or consolidate pediatric and OB/GYN services at one site with Helene Fuld Medical Center. Any consolidation shall include a reduction in the total number of licensed pediatric and OB/GYN beds. If pediatric services

are consolidated at St. Francis, St. Francis may apply for designation as a community pediatric center following the bed consolidation.

(5)-(6) (No change.)

iii.-iv. (No change.)

5. Local Advisory Board V shall submit to the State Health Planning Board and the Department of Health M/S bed need studies for Camden, Cumberland and Salem Counties. The LAB shall submit a plan to maintain access to the psychiatric and substance abuse services currently being provided by Zurbrugg's Riverside Division as the hospital transitions from general acute care services. The specific responsibilities of the hospitals in LAB V are listed by county as follows:

i. Burlington County:

(1) (No change.)

(2) Rancocas Hospital shall reduce its number of licensed pediatric beds to 10 and may apply for designation as a community pediatric center following the pediatric bed reduction.

(3) (No change.)

ii. Camden County:

(1) (No change.)

(2) Kennedy Memorial Hospitals (Stratford Division) shall reduce its number of licensed pediatric beds to 10 and may apply for designation as a community pediatric center following the bed reduction.

(3)-(5) (No change.)

iii. Cumberland County:

(1)-(3) (No change.)

(4) South Jersey Hospital System (Bridgeton Division) shall reduce its number of licensed OB/GYN beds, eliminate the unit or consolidate at one site with Newcomb Medical Center. South Jersey Hospital System (Bridgeton Division) shall reduce its number of licensed pediatric beds to 10 and may apply for designation as a community pediatric center following the pediatric bed reduction.

iv. Gloucester County:

(1) (No change.)

(2) Underwood-Memorial Hospital shall reduce its number of licensed OB/GYN beds. Underwood-Memorial shall also reduce its number of licensed pediatric beds to 10 and may apply for designation as a community pediatric center following the pediatric bed reduction.

v. Salem County:

(1) *[Reserved]* ***All Salem County hospitals shall participate in a LAB M/S bed need study.***

(2) (No change.)

6. (No change.)

(c) All hospitals shall participate in bed need studies conducted by their LABs.

Recodify (c)-(e) as (d)-(f) (No change in text.)

HUMAN SERVICES**(a)****DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES****Transportation Services Manual, Livery Services, Including Reimbursement; Invalid Coach Services****Adopted Amendments: N.J.A.C. 10:50-1.1, 1.2, 1.3, 1.4, 1.6, 1.7 and 2.1****Adopted Repeal and New Rule: N.J.A.C. 10:50-2.2**

Proposed: July 20, 1992 at 24 N.J.R. 2517(a).

Adopted: October 8, 1992 by Alan J. Gibbs, Commissioner, Department of Human Services.

Filed: October 14, 1992 as R.1992 d.447, **without change.**

Authority: N.J.S.A. 30:4D-6b(15); 30:4D-7, 7a, b and c; 30:4D-12, 42 CFR 440.170(a).

Effective Date: November 16, 1992.

Expiration Date: February 27, 1996.

Summary of Public Comments and Agency Responses:

The Division of Medical Assistance and Health Services (the Agency) received six letters containing comments from livery service providers enrolled in the New Jersey Medicaid program. All six commenters objected to the agency's proposal to revise the livery service reimbursement rate structure. Because the commenters expressed the same concern, the agency is making one response to the issue presented.

COMMENT: Agnes A. Smith, President of New Jersey Medical Livery Service, Inc. argued that livery service is beneficial to the State and results in a substantial savings when compared to the cost of invalid coach service. Ms. Smith indicated that operating costs for livery service are rising each day, especially in the area of insurance. Ms. Smith indicated that the proposal, if implemented, might force many livery service companies into bankruptcy, adding to the unemployment, welfare, and Medicaid ranks.

COMMENT: Edward Bennett, President of Bennett's Transportation, Inc., indicated that the proposal would not allow small companies, like his, to maintain an efficient level of business operations.

COMMENT: Mark T. Williams, President of Smith & Williams Transportation, indicated that his company would not make enough money to stay in business if this proposal is implemented.

COMMENT: Kantilal I. Patel, Parivan Corporation, objected to the proposal because of the rising costs of insurance, including workers' compensation insurance, the minimum wage rate, unrestricted law suits, and vehicular maintenance and repair.

COMMENT: Harold Katz, President of Van Go, Inc., objected to the proposal by asserting that a study was not made of the costs involved in providing the services. Mr. Katz indicated that his company, and others, will be forced to discontinue the provision of livery service if the new rates go into effect.

Mr. Katz also contended that those persons who are unable to receive livery service will have to be approved for invalid coach service, or denied service, if livery providers go out of business because of the implementation of the new rates.

COMMENT: Dr. Errol L. Lennard, President of Lennard & Associates, Inc., protested the proposed amendments "because of the adverse economic and social impacts that will result." Dr. Lennard indicated that the proposed rate change will greatly reduce the number of providers and, possibly, will eliminate the livery mode altogether. Dr. Lennard speculated that providers may take passengers to their destination but may not pick them up for the return trip (if the proposal is implemented), resulting in service delays, missed appointments, and barriers to medical care for the Medicaid population.

Dr. Lennard supported the provision which requires workers' compensation insurance. Dr. Lennard disagreed with the eight year vehicle age limit but indicated that it is an improvement over the (current) six year age limit.

RESPONSE: The agency is sensitive to the plight of transportation providers and other deserving provider groups who are coping with rising operating costs. Medical transportation expenses are rising steadily, especially in the areas of insurance, personnel, vehicular replacement, and maintenance of equipment and supplies.

The agency's "operating costs" are also on the rise, in New Jersey as well as nationwide. The agency reimbursed providers of ambulance and invalid coach service approximately \$8 million in calendar year 1987. By calendar year 1991, this amount increased to over \$16 million. Medicaid reimbursement for the provision of livery service totaled approximately \$1.1 million in calendar year 1989. This reimbursement amount rose to over \$3.5 million in calendar year 1991.

The current livery service reimbursement structure, that includes a loading charge, is inappropriate for the provision of service to individuals who are ambulatory and capable of entering and exiting a vehicle unassisted. The proposed per-mile reimbursement structure is similar to the structure used by taxicab companies, which also transport ambulatory individuals.

The proposed rate structure is also similar to the rate structure used by several county welfare agencies which arrange transportation services for ambulatory individuals. These counties, through a competitive bid process, use a similar rate structure and similar rates of reimbursement.

The agency's position with regard to the proposed rate revision is that the economic impact on livery service providers will vary, depending on the number of recipients transported and the length of the trip. The revised methodology will result in lower Medicaid payments for shorter trips and higher Medicaid payments for longer trips.

Providers of livery service will benefit by the increased age requirement for livery service vehicles. By revising the age requirement from a six-year-old vehicle to an eight-year-old vehicle, the costs of vehicular replacement may be postponed.

Providers of livery service will also benefit by avoiding administrative costs in the use of transportation certification form. Providers are no longer required to attach the certification form to the claim form when submitting a claim to the fiscal agent.

It is the agency's position that the proposed rate structure and revised rates for livery service reimbursement are both equitable and realistic. It is anticipated that Medicaid recipients will continue to receive livery service when needed for the purpose of obtaining Medicaid-covered services.

Full text of the adoption follows.

10:50-1.1 Scope

This chapter describes the policies and procedures of the New Jersey Medicaid Program for reimbursement of approved providers of transportation services. Questions about this chapter may be directed to any Medicaid District Office (MDO) listed in N.J.A.C. 10:49 Appendix or to the Division of Medical Assistance and Health Services, CN-712, Trenton, New Jersey 08625-0712.

10:50-1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

...

"Loaded mile" means mileage accrued when a vehicle is actually carrying a Medicaid recipient.

...

"Transportation reimbursement allowance" means that claims are paid on a fee-for-service basis, as indicated in N.J.A.C. 10:50-2, HCFA Common Procedure Coding System (HCPCS).

"Waiting Time" means that period of actual time, in increments of 15 minutes, beginning 30 minutes following delivery of the recipient to his or her destination, for ground ambulance and invalid coach service.

10:50-1.3 General policies for participation

(a) The approval process for becoming a transportation service provider is as follows:

1. Each transportation provider must be individually approved for each type of service provided. The Division of Medical Assistance and Health Services, Department of Human Services, in conjunction with the Fiscal Agent for the New Jersey Medicaid Program, must approve each provider before reimbursement can be made to that provider for a transportation service.

2. Medicaid Provider Application (Form FD-20), Provider Agreement (Form FD-62), and Ownership and Control Interest Disclosure Statement (HCFA-1513) may be obtained from the Fiscal Agent for the New Jersey Medicaid Program.

3. (No change.)

4. A potential provider seeking approval to provide livery service shall attach to the Medicaid Provider Application (Form FD-20) the following documents, each of which shall bear the name and address of the livery company or the company's principal owner(s), for each vehicle in the provider's fleet:

i.-ii. (No change.)

iii. A photocopy of the vehicle registration bearing the classification "Livery", issued by the New Jersey Division of Motor Vehicles. A potential provider shall also indicate on the photocopy of the vehicle registration the respective vehicle fleet number;

iv. A Certificate of Insurance, including a 10-day notice of cancellation, listing as Certificate Holder: State of New Jersey, Division of Medical Assistance and Health Services, CN-712, Trenton, New Jersey 08625-0712. The Certificate of Insurance shall indicate coverage for Workers' Compensation and Employers' Liability Insurance; and Automobile Liability Insurance; and

v. A photocopy of an Operator License for each driver, issued by the New Jersey Division of Motor Vehicles.

5. An approved provider of livery service shall forward to the Fiscal Agent for the New Jersey Medicaid Program photocopies of

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the above-mentioned documents (license, registration and insurance) when the documents are renewed on an annual basis, and when additional livery service vehicles are added to a provider's fleet. A provider shall also forward written notification to the Fiscal Agent when a livery service vehicle is taken out of service.

6-7. (No change.)

8. The completed provider agreement, disclosure statement, and/or provider application shall be submitted to the Fiscal Agent.

9. Once approved, the applicant will receive the following from the Fiscal Agent: a Medicaid provider number; a Transportation Services Manual; an initial supply of claim forms; and, if applicable, an initial supply of prior authorization forms.

(b) (No change.)

10:50-1.4 Services covered by the New Jersey Medicaid Program

(a) Ground ambulance service is a covered service under the following conditions:

1-2. (No change.)

3. When the use of any other method of transportation is medically contraindicated and the service is provided as specified in New Jersey State Department of Health rules N.J.A.C. 8:40-5 and 6.

4. The ambulance crew shall comply with the duties of staff as specified in New Jersey State Department of Health rules N.J.A.C. 8:40-6.27.

5-6. (No change.)

(b) Invalid coach service is a covered service under the following conditions:

1-2. (No change.)

3. In accordance with New Jersey State Department of Health rules, as indicated in N.J.A.C. 8:40-4.1(b) invalid coach service shall not be provided to a patient who requires (based upon current medical condition or past medical history):

i-iv. (No change.)

v. An automatic ventilator or whose breathing is ventilator-assisted;

Recodify existing v.-viii. as vi.-ix. (No change in text.)

4-5. (No change.)

(c) Livery service is a covered service under the following conditions:

1-2. (No change.)

3. Vehicle requirements are as follows:

i. A vehicle used to provide livery service shall not be more than eight model years old at the time the service is provided and shall have a seating capacity of not less than five nor more than 10 persons, inclusive of the driver. Each vehicle used to provide livery service shall be licensed, registered, and insured as indicated in N.J.A.C. 10:50-1.3(a)4.

ii-iv. (No change.)

4-5. (No change.)

10:50-1.6 Reimbursement policy

(a) The least expensive mode of transportation suitable to the recipient's needs is to be used.

(b) Mileage for ground ambulance, invalid coach, and livery service is measured by odometer from the point at which the recipient enters the vehicle to the point at which the recipient exits the vehicle.

(c) In a multiple-load situation for ground ambulance service and invalid coach service, the amount reimbursable for loaded mileage accrued is only applicable to one recipient. Total mileage is equivalent to the total distance traveled by the recipient from point of departure to point of destination. No allowance is reimbursable for any mileage accrued by additional recipients in the multiple-load situation.

(d) For livery service, the amount reimbursable for loaded mileage accrued is only allowed on a per-person basis when the points of departure or destination for the additional recipients transported are different from those of the first recipient. When two or more recipients are transported in the same vehicle at the same time from a common point of departure to a common point of destination, mileage shall only be reimbursed for one recipient.

1. Only the flat rate of \$3.00 is reimbursable for each additional recipient transported in a multiple-load situation. The flat rate is only applicable when all recipients are transported in a multiple-load situation from a common point of departure to a common point of destination. This rate is only reimbursable once per person/per trip, either on a one way or round trip basis.

(e) For trips by ground ambulance and invalid coach in excess of 15 miles one way, loaded mileage is reimbursable beginning with the first mile, at a higher rate as indicated in N.J.A.C. 10:50-2, HCFA Common Procedure Coding System (HCPCS). The higher rate of reimbursement is applicable to both the one way trip and to the return/round trip.

(f) There is no reimbursement for waiting time on round trips, and it is limited to a maximum of one hour on one-way trips at the point of destination, not at the point of departure. Waiting time is only applicable to one recipient in a multiple-load situation.

Recodify existing (b)-(h) as (g)-(m) (No change in text.)

Recodify (j)-(l) as (n)-(p) (No change in text.)

10:50-1.7 Transportation certification

(a) The Fiscal Agent Billing Supplement contains a sample transportation certification form and instructions for the form's proper completion. The elements appearing on the sample transportation certification form shall appear on all certification forms furnished and prepared by the transportation provider.

(b) The transportation certification form shall be retained on file at the provider's place of business and shall be made available for review upon request by staff of the Division of Medical Assistance and Health Services or the Division's Fiscal Agent. If a transportation certification form is not on file for each service, Medicaid reimbursement for the service is subject to recoupment, as indicated in N.J.A.C. 10:49-9.6(b).

(c) The vehicle fleet number (livery) or the vehicle recognition number (ground ambulance and invalid coach) that corresponds to the vehicle used to provide the respective transportation service shall be entered on the "Transportation Claim" (Form MC-12) in Item 18 (REMARKS) when submitting hard copy claims to the Division's Fiscal Agent for ground ambulance, invalid coach, and livery service.

10:50-2.1 Introduction

(a) (No change.)

(b) The following modifiers shall accompany the appropriate HCPCS procedure codes when applicable:

1. "22" Mileage, ground ambulance and invalid coach service, in excess of 15 miles one way (see N.J.A.C. 10:50-1.6(e)).
2. "XA" Base allowance, invalid coach service, when a Medicaid recipient is transported to or from a nursing facility (see N.J.A.C. 10:50-1.5(f)).
3. "XE" Non-Medicare-covered service—to indicate that a ground ambulance service provided to a Medicare/Medicaid recipient is NOT reimbursable by Medicare because the place of destination is a physician's office, a clinic, or a dialysis facility, etc. Use modifier "XE" following all applicable HCPCS procedure codes when billing Medicaid for the non-Medicare-reimbursable service; an Explanation of Medicare Benefits statement is not required.
4. "76" Repeat procedure—same day—to indicate that the service duplicates a service previously rendered to the same recipient on the same day. Use modifier "76" following all HCPCS procedure codes when billing for the repeat service. Do NOT use the modifier to bill for the first service. Failure to use modifier "76" to indicate a second service on the same date of service will result in the denial of the second service as a duplicate. Likewise, affixing modifier "76" to both services will cause the claims to deny as duplicates.

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10:50-2.2 HCPCS procedures codes and maximum fee schedule

HCPCS Mod. Code	Description	Maximum Fee Allowance
(a) AMBULANCE SERVICE		
A0010	Ambulance Service, Basic Life Support (BLS) Base Rate, Emergency Transport, One Way	\$30.00
A0020	Ambulance Service, (BLS) Per Mile, Transport, One Way	1.00
A0020 22	Ambulance Service, (BLS) Per Mile, Transport, One Way NOTE: The higher rate is applicable for trips in excess of 15 miles one way, beginning with the first mile. The higher rate is applicable to both the one way and to the return trip.	1.50
A0040	Ambulance Service, Air, Helicopter Service, Transport	B.R.
A0070	Ambulance Service, Oxygen, Administration and supplies, Life sustaining situation	12.00 per occurrence
A0222	Ambulance Service, Return Trip, Transport	30.00
Y0005	Waiting Time—Ambulance Service—One Way Trip Only	
	¼ hour	2.50
	½ hour	5.00
	¾ hour	7.50
	1 hour	10.00
	NOTE: Reimbursable only on one way trips and only after 30 minutes have elapsed. It is reimbursable in ¼ hour increments. Maximum reimbursement for waiting time is \$10.00 (1 hour).	
(b) INVALID COACH SERVICE		
A0130	Non-Emergency Transportation: Wheelchair Van NOTE: Invalid Coach Service, One Way, Per Patient	20.00
Y0002	Invalid Coach Service, Per Mile, One Way and Round Trip	1.00
Y0002 22	Invalid Coach Service, Per Mile, One Way and Round Trip, in excess of 15 miles one way NOTE: The higher rate is applicable for trips in excess of 15 miles one way, beginning with the first mile. The higher rate is applicable to both the one way and to the round trip.	1.50
Y0010	Waiting Time—Invalid Coach Service—One Way Trip Only	
	¼ hour	1.25
	½ hour	2.50
	¾ hour	3.75
	1 hour	5.00
	NOTE: Reimbursable only on one way trips and only after 30 minutes have elapsed. It is reimbursable in ¼ hour increments. Maximum reimbursement for waiting time is \$5.00 (1 hour).	
Y0060	Invalid Coach Service, Round Trip, Per Patient	40.00
Y0065	Extra crew differential, round trip	20.00
Y0070	Extra crew differential, one way	10.00
Y0075	Invalid Coach Oxygen	12.00 per occurrence

(c) LIVERY SERVICE

Y0251	Per loaded mile, only one recipient per trip NOTE: This rate may be applied to additional recipients ONLY when the points of departure or destination are different from those of the first recipient.	1.00
Y0252	Flat rate, each additional recipient NOTE: Only this rate is reimbursable for each additional recipient transported in a multiple-load situation from a common point of departure to a common point of destination. This rate is only reimbursable once per person/ per trip, either on a one way or round trip basis.	3.00

(a)

**DIVISION OF THE DEAF AND HARD OF HEARING
Organizational Rules
Organization of the Division of the Deaf and Hard of Hearing**

Adopted New Rules: N.J.A.C. 10:150

Adopted: October 20, 1992 by Alan J. Gibbs, Commissioner, Department of Human Services.
Filed: October 22, 1992 as R.1992 d.460.
Authority: N.J.S.A. 34:1-69.1 et seq.
Effective Date: October 22, 1992.
Expiration Date: October 22, 1997.

Take notice that the Department of Human Services hereby adopts as new rules, a description of the organizational structure and operation of the Division of the Deaf and Hard of Hearing (DDHH).

These rules are intended to inform the public of the existence of and the basic tasks and responsibilities delegated to DDHH and how it is organized to implement those duties. The rules also provide procedures for obtaining copies of the various officially promulgated literature covering the subject of hearing loss.

These organizational rules are exempt from the notice and hearing requirements of the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and become effective upon filing with the Office of Administrative Law.

Full text of the adoption follows.

**CHAPTER 150
ORGANIZATION OF THE DIVISION OF THE
DEAF AND HARD OF HEARING**

SUBCHAPTER 1. SCOPE

10:150-1.1 Division history and purpose

(a) The New Jersey Division of the Deaf, established by law in 1977, began operations on May 15, 1978 as a division of the New Jersey Department of Labor and Industry. On April 28, 1989, the Division of the Deaf was transferred to the Department of Human Services from the Department of Labor as a result of a reorganization plan. The Division was renamed the Division of the Deaf and Hard of Hearing.

(b) The purpose of the Division of the Deaf and Hard of Hearing is to act as an advocate for New Jersey's deaf and hard of hearing citizens by promoting increased accessibility to programs, services, and information routinely available to the state's general population. Programs and services of the Division are administered by a Director who is appointed by the Commissioner, Department of Human Services.

INSURANCE**ADOPTIONS**

- (c) The Division's services may include, but are not limited to:
1. Information and Referral;
 2. Deaf and Hard of Hearing Awareness Day;
 3. Interpreter Referral Service;
 4. Dial-A-News Bulletin Board;
 5. New Jersey Business and Agency Text Telephone Directory.

10:150-1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings:

"Deaf" means a hearing impairment of such severity that the individual cannot understand speech through hearing alone, even with the use of a hearing aid.

"Hard of hearing" means hearing impaired persons who are able to utilize their residual hearing through amplification to such a degree that they are able to carry on normal oral communication with a minimum of difficulty.

"Telecommunication device for the deaf or TDD" means a device that permits people with hearing and speech impairments to communicate using the standard telephone system without the aid of an interpreter. It generally consists of a keyboard and a display screen.

"TT" means text telephone and is synonymous with telecommunication device for the deaf.

SUBCHAPTER 2. OPERATIONS AND SERVICES**10:150-2.1 Information and referral**

(a) The Division of the Deaf and Hard of Hearing is a clearinghouse for information on hearing loss in New Jersey. The Division distributes, upon request, information concerning assistive listening devices, telecommunication devices for the deaf, sign language and other relevant topics.

(b) The Division serves as an advocate for deaf and hard of hearing persons seeking services from public and private agencies such as schools, courts, hospitals, employers and government.

(c) The Division makes available to the general public brochures and pamphlets which describe interpreting services, tips on communicating with the deaf, and information on how to use a TDD.

(d) The Division publishes the "Monthly Communicator" newsletter, which is distributed to more than 3,500 deaf and hard of hearing individuals as well as professionals serving the deaf. The newsletter is a major source of information for the deaf community involving cultural, social, educational and employment activities.

10:150-2.2 Deaf and Hard of Hearing Awareness Day

The Division of the Deaf and Hard of Hearing annually sponsors Deaf and Hard of Hearing Awareness Day in New Jersey. The event was initiated by the Division in 1985 to promote a better understanding by the general public of the deaf and hard of hearing. Many exhibits and information on hearing loss are available during the event. Also featured are performances by deaf and hard of hearing performers.

10:150-2.3 Interpreter Referral Service

The Division operates an Interpreter Referral Service which is staffed by coordinators who process requests for qualified sign language interpreters. The coordinators will match the appropriate interpreter with the specific needs of the client.

10:150-2.4 Dial-A-News Bulletin Board

The Division of the Deaf and Hard of Hearing maintains a dedicated telephone line for its Dial-A-News Bulletin Board. The telephone number is (609) 633-9831—TT or PC with modem set at 300 Baud ASCII. The bulletin board enables TT users to access information visually 24 hours a day.

10:150-2.5 New Jersey Business and Agency Text Telephone Directory

(a) The Division of the Deaf and Hard of Hearing annually publishes a comprehensive New Jersey Business and Agency TT Directory for use by deaf citizens and agencies serving deaf clients throughout the State.

(b) The Directory provides listings of New Jersey and national "800" numbers, services for the deaf-blind, libraries, police, medical centers, deaf contact centers, interpreters, schools/colleges, referral agencies, State and Federal government, businesses, legal services, mental health services, religious and organizations of and for the deaf. Each entry in the Directory has a TT number accessible to deaf persons.

SUBCHAPTER 3. ADVISORY COUNCIL ON THE DEAF AND HARD OF HEARING**10:150-3.1 Advisory Council; membership**

Pursuant to N.J.S.A. 34:1-69.1a, the New Jersey Division of the Deaf and Hard of Hearing has a 14 member advisory council which supports and guides the work of the Division. The members of the council are unsalaried. Seven public members are appointed by the Governor for staggered terms of three years. Seven representatives, one from each of the following, are ex officio members: the Departments of Education, Higher Education, Health, Human Services, Labor, and Community Affairs, and the Marie Katzenbach School for the Deaf. Committee chairs appointed covered the following areas: Education, Community Services, Inter-Agency Coordination, Legislative, and Interpreter Advisory Committee.

INSURANCE**(a)****DIVISION OF REAL ESTATE COMMISSION****Fee Cap for Mortgage Services Without Banking License****Adopted Amendment: N.J.A.C. 11:5-1.38**

Proposed: June 1, 1992 at 24 N.J.R. 1957(a) (see also 24 N.J.R. 2129(a)).

Adopted: September 22, 1992 by the New Jersey Real Estate Commission, Micki Greco Shillito, Executive Director.

Filed: October 26, 1992 as R.1992 d.468, **with technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3), and with N.J.A.C. 11:5-1.9(d) not adopted at this time.

Authority: N.J.S.A. 45:15-6, 17; *Mortgage Bankers Assoc. of N.J. v. N.J. Real Estate Comm'n, et al.*, 102 N.J. 176 (1976) (on remand OAL Docket No. BRE-228-87); N.J.S.A. 17:11B-1 et seq.; N.J.A.C. 3:38-5.2.

Effective Date: November 16, 1992.

Operative Date: January 1, 1993.

Expiration Date: October 28, 1993.

Summary of Public Comments and Agency Responses:

The New Jersey Real Estate Commission ("Commission") received six written comments submitted by the following interested organizations or individuals: New Jersey Council of Savings Institutions, New Jersey Association of Realtors, Anthony Dandola of Adamcorp, Coldwell Banker Schlott and Sears Mortgage Corporation, the New Jersey Savings League, and Mortgage Bankers Association of New Jersey. The Commission continues to review the proposed amendment to N.J.A.C. 11:5-1.9 and comments thereon, but is not adopting the amendment at this time.

COMMENT: Commenters opposed the concept of permitting real estate licensees to receive up to \$250.00 in reimbursement for providing mortgage financing services and suggested that computer linked mortgage originations may not be beneficial to consumers.

RESPONSE: After extensive hearings, the Commission concluded that the Real Estate License Act does not prohibit real estate licensees from providing mortgage services for a fee. The Banking Department has adopted the \$250.00 maximum expense reimbursement as its threshold for determining when a real estate licensee is engaged in the business of residential mortgage brokerage and, thus, must be licensed by the Banking Department under the Mortgage Bankers and Brokers Act. The Commission determined to adopt this rule amendment to foster com-

ADOPTIONS

LABOR

pliance by real estate licensees with the Department of Banking's licensing requirements. The hearing record suggested that computerized mortgage origination may be beneficial to consumers.

COMMENT: One commenter objected to disclosing to his employing broker and to consumers his dual employment as a real estate salesperson and as mortgage solicitor for a lender. He requested that salesperson/solicitors be exempt from disclosing their dual role.

RESPONSE: The Commission considers that when a real estate licensee undertakes to aid a borrower to obtain mortgage financing, even without compensation, disclosure of any financial affiliation between the licensee and the lender is necessary to fully inform the consumer. Buyers frequently rely upon real estate licensees for advice and assistance in obtaining mortgage financing. Consumers need to be informed when the licensee's advice may not be completely objective, or disinterested, because the licensee has a financial affiliation with a mortgage lender. Dual employment of the salesperson by the lender is certainly a clear example of a situation requiring these disclosures, both to the real estate broker who is responsible for supervising the salesperson's real estate transaction, and to the consumer who may otherwise be unaware that the salesperson is expecting to obtain significant compensation from the related mortgage transaction. The Commission firmly believes that such dual employment should not be exempted from the disclosure requirements.

COMMENT: Commenters objected to the regulation of fees to be received by real estate licensees for providing mortgage financing services.

RESPONSE: The Commission is not regulating fees received by real estate licensees by means of this amendment. The Commission is merely alerting licensees to the need to comply with the newly adopted Department of Banking rule, N.J.A.C. 13:38-5.2, which requires real estate licensees who charge fees greater than their actual expenses, to a maximum of \$250.00, for providing residential mortgage financing services, to be licensed by the Department under the Mortgage Bankers and Brokers Act.

COMMENT: One commenter suggested that the Commission delete the reference to the \$250.00 dollar figure, since this dollar figure established by the Department of Banking may be changed from time to time and, thus, the Commission rule could become inconsistent with the Banking rule.

RESPONSE: The Commission agrees with this suggestion and has modified the rule text to refer generally to the "expense amount" in the Department of Banking regulation so that the two rules will remain consistent regardless of any future changes to the maximum dollar figure permitted by the Department of Banking. This is a technical change which does not expand or contract the rule's coverage or change its substantive effect.

COMMENT: Several commenters continue to oppose the Commission's determination that real estate licensees are permitted to receive compensation for providing mortgage financing services, and, thus, oppose the entire regulatory approach adopted by both the Commission and the Department of Banking.

RESPONSE: The Commission's regulatory approach to this complex issue is founded upon the interpretation of the Real Estate License Act, N.J.S.A. 45:15-17(i), recommended by Administrative Law Judge ("ALJ") Arnold Samuels after extensive hearings and legal briefing. This legal interpretation has been appealed and will be reviewed by the appellate courts. The Commission's regulations follow the legal interpretation and, in conjunction with the Department of Banking, implement those of the ALJ's regulatory recommendations which were deemed consistent with existing law and with the hearing record. The Commission recognizes that given the rapid technological changes which are impacting existing mortgage origination practices nationwide, further regulation or even statutory change may prove desirable to better protect New Jersey consumers. The Commission, however, considers that the rules currently adopted by the Department of Banking and the Commission represent a balanced regulatory response which will protect consumers while permitting lenders and the real estate industry in New Jersey to fully test and explore innovative ways to use "one-stop-shopping" through computer technology in the real estate office to improve and expand mortgage financing services to borrowers.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks ***[thus]***):

11:5-1.9 Funds of others: safeguards; funds of lenders
(a)-(c) (No change.)

11:5-1.38 Prohibition against licensees receiving dual compensation for dual representation in the sale or rental transaction
(a)-(e) (No change.)

(f) Except as provided in (g) below, when providing mortgage financing services related to the purchase or sale of a one to six family residential dwelling, a portion of which may be used for non-residential purposes, located in New Jersey:

1. A real estate broker shall not solicit or receive compensation or reimbursement pursuant to ***[subsection]*** (e) ***above*** ***[of this rule other than the \$250.00 maximum expense reimbursement]*** ***greater than the expense amount*** permitted at closing by N.J.A.C. 3:38-5.2(a)4 unless licensed as a mortgage broker or mortgage banker by the Department of Banking pursuant to the Mortgage Bankers and Brokers Act, N.J.S.A. 17:11B-1 et seq.; and

2. A real estate salesperson or broker-salesperson shall not solicit or receive any compensation or reimbursement pursuant to (e) above from any person other than his or her employing real estate broker unless licensed as a mortgage broker or mortgage banker by the Department of Banking pursuant to the Mortgage Bankers and Brokers Act, N.J.S.A. 17:11B-1 et seq.

(g) Any real estate licensee who is individually employed as a mortgage solicitor by a licensed mortgage banker or mortgage broker and registered in compliance with N.J.A.C. 3:38-5.3 may solicit and accept compensation from his or her licensed mortgage employer for providing mortgage services in residential mortgage transactions.

LABOR

(a)

DIVISION OF UNEMPLOYMENT AND TEMPORARY
DISABILITY INSURANCE

1993 Maximum Weekly Benefit Rates

1993 Taxable Wage Base Under the Unemployment
Compensation Law1993 Contribution Rate of Governmental Entities and
Instrumentalities

1993 Base Week

1993 Alternative Earnings Test

Adopted Amendments: N.J.A.C. 12:15-1.3, 1.4, 1.5,
1.6 and 1.7

Proposed: September 8, 1992 at 24 N.J.R. 3014(a).

Adopted: October 19, 1992 by Raymond L. Bramucci,
Commissioner, Department of Labor.

Filed: October 20, 1992 as R.1992 d.454, **without change**.

Authority: N.J.S.A. 34:1-5, 34:1-20, 34:1A-3(e), 43:21-3(c),
43:21-4(e), 43:21-7(b)(3), 43:21-7.3(e), 43:21-19(t), 43:21-27,
43:21-40 and 43:21-41.

Effective Date: November 16, 1992.

Expiration Date: July 30, 1995.

Summary of Public Comments and Agency Responses:

No comments received.

Full text of the adoption follows.

12:15-1.3 Maximum weekly benefit rates

(a) In accordance with the provisions of the Unemployment Compensation Law, the maximum weekly benefit rate for benefits under the Unemployment Compensation Law is hereby promulgated as being \$325.00 per week.

(b) The maximum weekly benefit rate for State Plan benefits under the Temporary Disability Benefits Law is hereby promulgated as being \$304.00 per week.

(c) These maximum benefits shall be effective for the calendar year 1993 on benefit years and periods of disability commencing on or after January 1, 1993.

12:15-1.4 Taxable wage base under the Unemployment Compensation Law

In accordance with the provisions of N.J.S.A. 43:21-7(b)(3), the "wages" of any individual with respect to any one employer for the purpose of contributions under the Unemployment Compensation Law shall include the first \$16,100 during the calendar year 1993.

12:15-1.5 Contribution rate of governmental entities and instrumentalities

(a) In accordance with the provisions of N.J.S.A. 43:21-7.3(e), the contribution rate for all governmental entities and instrumentalities electing to pay contributions under the Unemployment Compensation Law is hereby promulgated as being four-tenths of one percent (0.4 percent) for the entire calendar year.

(b) This contribution rate shall be effective on taxable wages paid in the calendar year 1993.

12:15-1.6 Base week

In accordance with the provisions of N.J.S.A. 43:21-19(t), the base week amount is hereby promulgated as being \$115.00 per week for benefit years and periods of disability commencing on or after January 1, 1993.

12:15-1.7 Alternative earnings test

In accordance with the provisions of N.J.S.A. 43:21-4(e) and 43:21-41, in those instances in which the individual has not established 20 base weeks, the alternative earnings amount for establishing eligibility is hereby promulgated as being \$6,900 for benefit years and periods of disability commencing on or after January 1, 1993.

(a)

DIVISION OF WORKERS' COMPENSATION
1993 Maximum Workers' Compensation Benefit Rate
Adopted Amendment: N.J.A.C. 12:235-1.6

Proposed: September 8, 1992 at 24 N.J.R. 3015(a).

Adopted: October 20, 1992 by Raymond L. Bramucci,
Commissioner, Department of Labor.

Filed: October 22, 1992 as R.1992 d.467, **without change**.

Authority: N.J.S.A. 34:1-5; 34:1-20; 34:1A-3(e) and 34:15-12(a).

Effective Date: November 16, 1992.

Expiration Date: May 3, 1996.

Summary of Public Comments and Agency Responses:

No comments received.

Full text of the adoption follows.

12:235-1.6 Maximum workers' compensation benefit rates

(a) In accordance with the provisions of N.J.S.A. 34:15-12(a), the maximum workers' compensation benefit rate for temporary disability, permanent total disability, permanent partial disability, and dependency is hereby promulgated as being \$431.00 per week.

(b) This maximum compensation shall be effective as to injuries occurring in the calendar year 1993.

LAW AND PUBLIC SAFETY

(b)

DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF EXAMINERS OF MASTER
PLUMBERS

State Board of Examiners of Master Plumbers Rules
Readoption with Amendments: N.J.A.C. 13:32

Proposed: July 6, 1992 at 24 N.J.R. 2334(a).

Adopted: October 15, 1992 by the Board of Examiners of Master Plumbers, Thomas Biondi, Chairman.

Filed: October 21, 1992 as R.1992 d.457, **with substantive and technical changes** not requiring additional public notice and comment (N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 45:14C-7 and 45:1-3.2.

Effective Date: October 21, 1992, Readoption;
November 16, 1992, Amendments.

Expiration Date: October 21, 1997.

The Board of Examiners of Master Plumbers afforded all interested parties an opportunity to comment on the proposed readoption of N.J.A.C. 13:32, with amendments. The official comment period ended on August 5, 1992. Announcement of the opportunity to respond to the Board appeared in the New Jersey Register on July 6, 1992, at 24 N.J.R. 2334(a). Announcements were also forwarded to the Star Ledger, the Trenton Times, the New Jersey Association of Plumbing-Heating-Cooling Contractors, the New Jersey State League of Master Plumbers and other interested parties.

A full record of this opportunity to be heard can be inspected by contacting the Board of Examiners of Master Plumbers, Post Office Box 45008, Newark, New Jersey 07101.

Summary of Public Comments and Agency Responses:

One letter commenting upon the proposed readoption with amendments was received during the 30-day comment period from Frank Maddalon, Chairman of the Legislative Committee of the New Jersey Association of Plumbing-Heating-Cooling Contractors, Inc. Mr. Maddalon expressed the Association's strong opposition to the revisions to N.J.A.C. 13:32-1.7, which require that the name of the licensee and the words "plumbing license number" appear on all trucks, stationery and advertising.

The commenter stated more specifically that requiring this information on commercial vehicles is of questionable value to the consumer because (1) the regulations presently require that the license number appear, and a call to Board offices will provide the licensee's name; and (2) the company name does not necessarily reflect who the licensee is. The commenter also expressed the concern that licensees will be forced to repaint their trucks, reorder stationery, advertising, business cards, etc. and requested that present licensees not be mandated to comply until they purchase a new truck or order new stationery or business cards.

In response, the Board states that disclosure of the licensee's name, license number and type of license held provides important information which may enable the public to accurately identify the vehicle owner and which also allows the public to clearly link a licensee to the business entity providing the plumbing services. If a commercial vehicle is marked with only a license number and no other information, the public's ability to identify the Board's licensee, who must as a matter of law be associated with the plumbing contractor (see N.J.S.A. 45:14C-12.3), is limited. The disclosure of a name may also act as a deterrent to the unlicensed practice of master plumbing, as vehicles bearing no name may form the basis for public inquiry and Board investigation into such unlawful practice. In the Board's opinion, the appearance of this information—both on vehicles and on business correspondence and stationery—also enhances the professionalism of the licensee. The Board agrees that the company name may not reflect who the licensee is and points out that the regulation requires the licensee's name, not the company's name, thus affording the consumer the information noted above. The commenter's suggestion that licensees not be mandated to comply immediately was considered, and the Board agrees that a delayed effective date is necessary to give licensees not currently in compliance time to meet these requirements. Accordingly, a new subsection has been added upon

adoption at N.J.A.C. 13:32-1.7(d) to give licensees one year from the effective date of these amended rules to include the name of the licensed master plumber and the words "licensed master plumber" on all commercial vehicles, business correspondence and stationery and in all advertising.

Summary of Changes Between Proposal and Adoption:

1. Upon adoption, the Board is amending N.J.A.C. 13:32-1.2(c) and 1.3(a) to make editorial changes only.
2. In response to the concerns raised by the Association of Plumbing-Heating-Cooling Contractors, Inc., the Board is adding a new subsection (d) to N.J.A.C. 13:32-1.7. This new subsection gives licensees one year to comply with the requirement to include their name and the words "plumbing license number" on commercial vehicles, business correspondence and stationery and in all advertising.

Full text of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 13:32.

Full text of the adopted amendments follows (additions to proposal indicated in boldface with asterisks *thus*; deletions from proposal indicated in brackets with asterisks *[thus]*):

- 13:32-1.2 Application; examination registration form
- (a)-(b) (No change.)
 - (c) *[Approved applicants shall receive from the Board, by mail,]* ***The Board shall mail an examination registration form to approved applicants*** in advance of the time and place of examinations*[, an examination registration form]*.

- 13:32-1.3 Examinations
- (a) Examinations shall be *[conducted]* ***prepared and administered*** by *[the]* ***a*** Board approved testing service *[and overseen by members of the Board so designated by the chairman]* but no license shall be granted except by the Board. ***The Board chairman may designate members of the Board to oversee the administration of the examination.***
 - (b)-(c) (No change.)
 - (d) In order to pass the examination an applicant must receive a minimum grade of 70.
 - (e) An applicant who has failed the examination may review his or her examination upon written request to the Board-approved testing service and payment to the testing service of its review fee.

- 13:32-1.5 Bona fide representative, responsibilities and limitations
- (a) A licensee seeking to act as a bona fide representative for any firm, partnership, corporation or other legal entity contemplated by N.J.S.A. 45:14C-2 shall comply with the following:
 1. Register with the Board, providing the name of the entity, its business address and, if the entity is a corporation, the names of the officers of record; and
 2. (No change.)
 - (b) A bona fide representative registered with the Board pursuant to (a) above shall comply with the following:
 1. Give notice to the Board in writing concerning any change in the name or address of the entity within 10 days of the change.
 - 2.-5. (No change.)
 - (c) (No change.)

- 13:32-1.7 Identification of licensees
- (a) All commercial vehicles used in the practice of state-licensed master plumbing shall be marked, in lettering a minimum of one inch high, with the following information:
 1. Name of the licensed master plumber; and
 2. The words "Plumbing license number" followed by the license number of the owner or qualified bona fide representative.
 - (b) All business correspondence and stationery shall display:
 1. The name of the licensed master plumber; and
 2. The words "Plumbing license number" followed by the license number of the owner or qualified bona fide representative; and
 3. The business address, including the street name and number of the owner or qualified bona fide representative.
 - (c) All advertising shall include:
 1. The name of the licensed master plumber; and

2. The words "Plumbing license number" followed by the license number of the owner or qualified bona fide representative.
- ***(d) A licensed master plumber whose commercial vehicle, business correspondence and stationery or advertising currently does not include the name of the licensed master plumber and the words "plumbing license number," as required pursuant to (a) through (c) above, shall have until November 16, 1993 to comply with these requirements.***
- ***[(d)]*(e)** (No change in text from proposal.)

- 13:32-1.8 Requirement of pressure seal defined
- (a) At the time of the issuance of the license or as soon thereafter as deemed appropriate, the Board of Examiners of Master Plumbers shall furnish a seal to every State-licensed master plumber. The cost of the seal shall be paid for by the State-licensed master plumber to whom it is issued. The seal shall be used exclusively by the State-licensed master plumber in the conduct of his practice including service as a bona fide representative consistent with N.J.A.C. 13:32-1.5. A licensee who willfully or negligently allows an unlicensed and unauthorized person to use his seal shall be subject to such penalties and sanctions as shall be imposed by the Board pursuant to authority granted by N.J.S.A. 45:14C-1 and N.J.S.A. 45:1-14 et seq. The State-licensed Master plumber is required to impress the said seal upon all applications for plumbing permits by the appropriate duly licensed State inspection agency.
 - (b)-(c) (No change.)

SUBCHAPTER 2. FEES

- 13:32-2.1 Fees
- (a) Charges for licensure and other services are as follows:

1. Application fee (non-refundable)	\$100.00
2. Initial license fee:	
i. If paid during the first year of a biennial renewal period	120.00;
ii. If paid during the second year of a biennial renewal period	60.00;
3. License renewal fee, biennial	120.00;
4. Late renewal fee	50.00;
5. Reinstatement fee	150.00;
6. Replacement seal press	40.00;
7. Duplicate license fee	25.00;
8. Replacement wall certificate	40.00;
9. Verification of licensure	25.00.

PUBLIC UTILITIES
(a)

BOARD OF REGULATORY COMMISSIONERS
Fire Protection Service
Adopted Amendments: N.J.A.C. 14:3-3.2 and 7.12

Proposed: July 6, 1992 at 24 N.J.R. 2341(a).
 Adopted: October 15, 1992 by the Board of Regulatory Commissioners, Dr. Edward H. Salmon, Chairman, and Jeremiah F. O'Connor, Commissioner.
 Filed: October 21, 1992 as R.1992 d.456 **without change**.
 Authority: N.J.S.A. 48:2-13.
 BRC Docket Number: AX92030337.
 Effective Date: November 16, 1992.
 Expiration Date: May 6, 1996.

Summary of Public Comments and Agency Responses:
 The proposed amendments were published in the New Jersey Register on July 6, 1992. During the comment period, which closed on August 5, 1992, comments were received from: Dennis G. Sullivan, Esq., Vice-President, on behalf of Middlesex Water Company; Edward F. Cash, Vice-President, on behalf of Elizabethtown Water Company; Frank X. Simpson, Chairman, Gail P. Brady, Regulatory Committee Chairman and Michael P. Walsh, Legislative Committee Chairman, on behalf of the

New Jersey Chapter of the National Association of Water Companies; Robert J. Iacullo, Director-Rate Development, on behalf of Hackensack Water Company; Ray Blacklidge, Policy Manager and Counsel, on behalf of the Alliance of American Insurers; Michael P. Walsh, President, on behalf of Shorelands Water Company; Roger P. Frye, Esq., Regional Counsel, on behalf of New Jersey-American Water Company, Inc.; and Frank X. Simpson, Vice-President, on behalf of Garden State Water Company.

COMMENT: Shorelands Water Company (SWC), New Jersey American Water Company (NJAW), Garden State Water Company (GSW), Elizabethtown Water Company (EWC), Hackensack Water Company (HWC) and National Association of Water Companies (NAWC) expressed concern regarding the number of local and state officials or agencies to receive notice of discontinuance of fire protection service in addition to the customer and owner of the property.

RESPONSE: Because fire protection service is provided to structures that may be wholly or partially used as residences, the Board believes that the notification requirements in the proposed amendments are necessary to ensure the health, safety and welfare of the public.

COMMENT: SWC comments that there should be a seven day notice for both voluntary and involuntary discontinuance.

RESPONSE: The Board feels that a 30 day notice to fire protection customers is necessary for the prevention of loss of life and property. It provides the customer ample time to contact the utility to arrange for payment or, if necessary, it provides an opportunity for a third party to intervene. In addition, the Alliance of American Insurers (AAI) has commented that when lives are at stake, all efforts should be exhausted before discontinuing fire protection service. The Board sees no need for a notice in the case of voluntary discontinuance of service.

COMMENT: SWC, GSW, NAWC and HWC claim that the amendments would require a water utility to do title searches in order to determine the owner of record.

RESPONSE: The utility may contact the local tax assessor to determine the owner of the property should a customer be unable or unwilling to provide this information.

COMMENT: Middlesex Water Company (MWC), NJAW and HWC state that N.J.A.C. 14:3-3.2 does not address the problem of an applicant failing or refusing to supply insurance information.

RESPONSE: It is incumbent upon the applicant for fire protection service to provide the insurance information. The utility should require this information as a precondition for service. Pursuant to N.J.A.C. 14:3-3.5, a utility may refuse to connect service for failure to comply with its standard terms and conditions.

COMMENT: SWC, MWC, EWC and NAWC assert that the amendments are costly, create red tape and increase the liability of a water utility.

RESPONSE: The Board acknowledges that water utilities will incur additional recordkeeping and mailing responsibilities which will increase administrative costs. Since these costs will be incurred in the normal course of business, all reasonable levels of expenses will be considered by the Board in an appropriate rate proceeding and included in customer rates. The Board believes that the notice requirements and extended notice will lessen a utility's liability, not increase it.

COMMENT: NJAW asserts that a utility will have little opportunity to verify the information provided by the applicant. In such cases, NJAW requests that fire protection service be discontinued based upon N.J.A.C. 14:3-3.6(a)3iii, fraudulent representation.

RESPONSE: A utility may refuse to establish fire protection service should it discover fraudulent representation at the time of application. The applicant should then be given an opportunity to provide the necessary information to perfect the application. In cases where fraudulent representation is discovered after fire protection service is established, the utility may discontinue service based on N.J.A.C. 14:3-3.6(a)3iii. However, the utility must follow the notice requirements of amended N.J.A.C. 14:3-7.12, which will allow the applicant an opportunity to correct the discrepancy in the application.

COMMENT: NJAW states that the extension of the notice time to 30 days for fire protection service customers will have an indeterminate economic impact on water companies.

RESPONSE: Utilities may request a deposit of new non-residential customers which can be held for 24 months at which time it will be returned if the customer has established credit satisfactory to the utility. Generally, as the deposit equals two months bills, a utility should have a sufficient deposit to secure payment when giving a 30 day notice. Also, fire protection service is a standby service with consumption used only

in the case of fire or in periodic testing. Other than the service charge, customers can not increase "consumption" or otherwise take advantage of the increased notice of discontinuance. Any adverse economic effect will be analyzed by the Board in an appropriate rate proceeding.

COMMENT: ETW, NJAW, MWC and HWC cite to the administrative burden as well as to the cost associated with reconfirming the insurance information semiannually and request the reconfirmation be done annually. It was also stated that many customers are tenants and it is the owners who hold the insurance. It was requested that a utility make a "reasonable effort" to obtain the insurance information.

RESPONSE: In order to ensure that the insurance information is accurate and as up-to-date as possible, the Board will retain the semiannual requirement. While owners have insurance on the structure, tenants have insurance for their contents, in addition to liability. A tenant who has fire protection service will also have insurance.

COMMENT: ETW suggests that utilities notify the Insurance Service Office prior to discontinuance stating this would eliminate the need of the utility to solicit and maintain the records of a customer's insurance company.

RESPONSE: The Board believes that by contacting the customer's insurance company there will be a meaningful and direct exchange of information and dialogue between the affected parties and local and State officials. The Board stresses that the need to safeguard the public's welfare necessitates the involvement of all the parties included in the notification requirement.

COMMENT: GSW requests that "limited sprinkler service" be exempted from the notice requirements. GSW notes that building codes allow limited sprinkler services to be served off of domestic service for fire protection. GSW advises those customers that it is not providing fire protection service and is not liable for failure of that type of system.

RESPONSE: The amendments designate fire protection service as the only rate classification for which the utility should solicit the insurance information and follow the specific notification procedures.

COMMENT: GSW suggests that the notification of social service agencies apply only to nursing homes and other similar institutions.

RESPONSE: The Board had considered this option in drafting the proposal but found that it is not possible to reasonably ascertain in all cases whether a particular fire protection service customer is in a multi-use structure which include residential units. Therefore, the Board considers it prudent to retain the notification requirement.

COMMENT: MWC states that it should be the responsibility of the customer to notify the insurance carrier when fire protection service is about to be discontinued.

RESPONSE: The Board believes that it is unlikely that a fire protection service customer would notify the insurance carrier of a pending discontinuance of service. The customer would probably prefer that the insurance carrier did not know that fire protection service may be discontinued. The fact that a customer knows that the water utility will notify the insurance carrier acts as an incentive to keep the fire protection service account current.

COMMENT: The NAWC requests a meeting of all interested parties to modify the proposal in order to balance the safety and welfare of the public with the obligation of a utility to collect unpaid bills.

RESPONSE: The purpose of publishing this proposal was to provide the affected utilities with a forum in which to express their opinions, suggestions and reservations. The Board has received comments from eight parties regarding this proposal and sees no need for a meeting in addition to the comment period afforded all parties.

COMMENT: AAI supports the extension of discontinuance notice time to 30 days as well as the utility sending notice to the customer's insurance carrier.

RESPONSE: The Board agrees with AAI's assessment that notifying as many interested parties as possible better serves the health, safety and welfare of the public.

Full text of the adoption follows.

14:3-3.2 Applications

(a)-(b) (No change.)

(c) All applications to water utilities for fire protection service must request that the applicant supply the name and address of the insurance company that provides the applicant with fire protection insurance for the property listed on the application as well as the number of the policy itself.

Recodify existing (c) and (d) as (d) and (e) (No change in text.)

ADOPTIONS**TRANSPORTATION**

14:3-7.12 Notice of discontinuance

(a) At least 10 days' time for payment shall be allowed after sending a bill. A public utility may discontinue service for nonpayment of bills provided it gives the customer, except for a fire protection service customer as set out in (f) below, at least seven days' written notice of its intention to discontinue. The notice of discontinuance shall not be served until the expiration of the said 10 day period. However, in case of fraud, illegal use, or when it is clearly indicated that the customer is preparing to leave, immediate payment of accounts may be required.

1.-3. (No change.)

(b)-(e) (No change.)

(f) Each water utility shall, on a semiannual basis, solicit information from its fire protection service customers in order to determine the name of the insurance company currently providing insurance protection to the customer and the policy number under which said protection is being provided.

1. At least 30 days prior to the discontinuance of fire protection service, the water utility providing that service shall give notice via certified mail to the following:

- i. The fire protection service customer of record;
- ii. The property owner, if different than the customer of record;
- iii. The mayor of the municipality in which the service is provided;
- iv. The fire chief of the municipality in which the service is provided;
- v. The enforcing housing code official of the municipality in which the service is provided;
- vi. The enforcing uniform fire code official of the municipality in which the service is provided;
- vii. The welfare officer of the municipality in which the service is provided;
- viii. The Director of County Welfare in the county in which the service is provided;
- ix. The District Director of the Division of Youth and Family Services;
- x. The District Office Manager of the Division of Youth and Family Services;
- xi. The insurance company providing fire protection coverage; and
- xii. The Board of Regulatory Commissioners.

2. In the event that fire protection service is ultimately discontinued, the servicing water utility shall immediately notify, via certified mail, the parties listed in (f)1 above and the:

Customer Service Division
Insurance Service Office
Commercial Risk Services
2 Sylvan Way
Parsippany, New Jersey 07054

TRANSPORTATION**(a)****DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID****BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS****Restricted Parking and Stopping**

Routes N.J. 4 and N.J. 5 in Bergen County; N.J. 7 in Hudson and Essex Counties; U.S. 22 in Hunterdon County; and N.J. 44 in Gloucester County.

Adopted Amendment: N.J.A.C. 16:28A-1.4, 1.5, 1.6, 1.13 and 1.30

Proposed: September 8, 1992 at 24 N.J.R. 3024(a).

Adopted: October 9, 1992 by Richard C. Dube, Director,
Division of Traffic Engineering and Local Aid.

Filed: October 20, 1992 as R.1992 d.455, **without change.**

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 39:4-138.1 and 39:4-198.

Effective Date: November 16, 1992.

Expiration Date: June 1, 1993.

Summary of Public Comments and Agency Responses:

No comments received.

Full text of the adoption follows.

16:28A-1.4 Route 4

(a) The certain parts of State highway Route 4 described in this subsection shall be designated and established as "no stopping or standing" zones where stopping or standing is prohibited at all times except as provided in N.J.S.A. 39:4-139. In accordance with the provisions of N.J.S.A. 39:4-198, proper signs shall be erected.

1. No stopping or standing along both sides for the entire length within the corporate limits, including all ramps and connections thereto which are under the jurisdiction of the Commissioner of Transportation; except in areas covered by other parking requirements, adopted in accordance with the Administrative Procedure Act and N.J.A.C. 1:30, in the following municipalities in Bergen County:

- i. The Borough of Elmwood Park;
- ii. The Borough of Paramus;
- iii. The Borough of River Edge;
- iv. The City of Hackensack;
- v. The Township of Teaneck;
- vi. The City of Englewood; and
- vii. The Borough of Fort Lee.

3. (No change.)

(b)-(c) (No change.)

16:28A-1.5 Route 5

(a) The certain parts of State highway Route 5 described in this subsection shall be designated and established as "no stopping or standing" zones where stopping or standing is prohibited at all times except as provided in N.J.S.A. 39:4-139. In accordance with the provisions of N.J.S.A. 39:4-198, proper signs shall be erected.

1. No stopping or standing along both sides for the entire length within the corporate limits, including all ramps and connections thereto, which are under the jurisdiction of the Commissioner of Transportation; except in areas covered by other parking requirements adopted in accordance with the Administrative Procedure Act and N.J.A.C. 1:30, in the following municipalities in Bergen County:

- i. The Borough of Fort Lee;
- ii. The Borough of Ridgefield;
- iii. The Borough of Palisades Park; and
- iv. The Borough of Edgewater.

(b) (No change.)

16:28A-1.6 Route 7

(a) The certain parts of State highway Route 7 described in this subsection shall be designated and established as "no stopping or standing" zones where stopping or standing is prohibited at all times except as provided in N.J.S.A. 39:4-139. In accordance with the provisions of N.J.S.A. 39:4-198, proper signs shall be erected.

1. No stopping or standing along both sides for the entire length within the corporate limits, including all ramps and connections thereto, which are under the jurisdiction of the Commissioner of Transportation; except in areas covered by other parking restrictions adopted in accordance with the Administrative Procedure Act and N.J.A.C. 1:30, in the following municipalities in Hudson County:

- i. The Town of Kearney; and
- ii. The City of Jersey City.

2. No stopping or standing along both sides for the entire length within the corporate limits, including all ramps and connections thereto, which are under the jurisdiction of the Commissioner of Transportation; except in areas covered by other parking restrictions adopted in accordance with the Administrative Procedure Act and N.J.A.C. 1:30, in the following municipalities in Essex County:

- i. The Town of Nutley; and
- ii. The Town of Belleville.

(b)-(c) (No change.)

16:28A-1.13 Route U.S. 22

(a) The certain parts of State highway Route U.S. 22 described in this subsection shall be designated and established as "no stopping or standing" zones where stopping or standing is prohibited at all times except as provided in N.J.S.A. 39:4-139. In accordance with provisions of N.J.S.A. 39:4-189, proper signs will be erected.

1. No stopping or standing along both sides;

i. (No change.)

ii. In Hunterdon County:

(1)-(2) (No change.)

(3) In the Township of Readington:

(A) For the entire length within the corporate limits, including all ramps and connections thereto, which are under the jurisdiction of the Commissioner of Transportation; except in areas covered by parking restrictions adopted in accordance with the Administrative Procedure Act and N.J.A.C. 1:30.

iii. (No change.)

2.-3. (No change.)

(b) (No change.)

16:28A-1.30 Route 44

(a) The certain parts of State highway Route 44 described in this subsection shall be designated and established as "no stopping or standing" zones where stopping or standing is prohibited at all times except as provided in N.J.S.A. 39:4-139. In accordance with the provisions of N.J.S.A. 39:4-198, proper signs shall be erected.

1. No stopping or standing in Gloucester County:

i. Along both sides:

(1) In West Deptford Township:

(A) From the center line of Woodbury Terrace to a point 100 feet west of the westerly curb line of Delaware Avenue.

(2) In the Township of Greenwich:

(A) For the entire length within the corporate limits, including all ramps and connections thereto, which are under the jurisdiction of the Commissioner of Transportation; except in areas covered by parking restrictions adopted in accordance with the Administrative Procedure Act and N.J.A.C. 1:30.

(b) (No change.)

OTHER AGENCIES

(a)

ELECTION LAW ENFORCEMENT COMMISSION

Pre-Candidate Activity; "Testing the Waters" Reporting of Expenditures: Independent Expenditures

Public Financing of Primary Election for Governor

Adopted Amendments: N.J.A.C. 19:25-3.1, 12.7, 16.3, 16.5, 16.18, 16.24, 16.25, 16.27, 16.28, 16.29, 16.39 and 16.43

Adopted Repeal: N.J.A.C. 19:25-16.16

Adopted New Rule: N.J.A.C. 19:25-16.48

Adopted Repeal and New Rule: N.J.A.C. 19:25-16.30

Proposed: September 8, 1992 at 24 N.J.R. 3026(a).

Adopted: October 21, 1992 by the Election Law Enforcement Commission, Frederick M. Herrmann, Ph.D., Executive Director.

Filed: October 22, 1992 as R.1992 d.458, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 19:44A-6 and 19:44A-38.

Effective Date: November 16, 1992.

Expiration Date: October 1, 1995.

Summary of Public Comment and Agency Responses:

The proposed amendments were published on September 8, 1992, and a public hearing was held on September 16, 1992. Notice of the hearing

was circulated to the public and the press on August 19, 1992, and the text of the proposal and notice of the hearing were mailed on August 21, 1992, to interested persons. The hearing was held before the Commission on September 16, 1992. The hearing record may be examined by contacting Gregory Nagy, at the Commission, 28 West State Street, 12th Floor, Trenton, New Jersey, ((609) 292-8700). The comment period expired on October 8, 1992. Written comments were received by the Commission from Peter Verniero, Esq., and Angelo J. Genova, Esq.

COMMENT: One commenter noted that the proposed text of N.J.A.C. 19:25-16.28(c) (Travel expenses) made reference to campaign expenditures for use of a "State-owned" vehicle when requiring reporting and reimbursement of those expenditures. The commenter suggested that the phrase "government-owned" vehicle be substituted for the phrase "State-owned" vehicle to clarify that all government-owned vehicles, not just those owned by the State of New Jersey, are subject to the requirements of the rule.

RESPONSE: The Commission agrees that the suggested modification is warranted to clarify that any transportation service which is owned by a government entity and used by a gubernatorial campaign is subject to the travel expenses reporting and reimbursement requirements. Further, the Commission has clarified that use of a vehicle leased by a government entity also comes within the reach of the rules.

COMMENT: One commenter questioned the standard in N.J.A.C. 19:25-16.30(c)1, Coordinated expenditures, used to evaluate "direct mail" literature paid for by a non-gubernatorial candidate or political party committee to determine whether the cost of the literature is to be allocated against the expenditure limit of the gubernatorial candidate. The commenter suggested that the language at N.J.A.C. 19:25-16.30(c)1, which permitted "no more than a single use of the gubernatorial candidate's name in the text, a single use of the gubernatorial candidate's name within a slate or listing of the names of gubernatorial and non-gubernatorial candidates, and a single photograph or depiction of the gubernatorial candidate" was unclear. A reader might not know from that language whether three references to a gubernatorial candidate were permitted or only one reference was permitted by the language of the rule.

RESPONSE: Prior to its emergency adoption of the rule concerning coordinated expenditures for the 1989 general election, at its June 16, 1989 meeting, the Commission specifically discussed the issue raised by the commenter. The Commission indicated on June 16, 1989, that the "direct mail" literature may contain both a mention of the name of the gubernatorial candidate in the text of the literature and "again within a listing of the gubernatorial and non-gubernatorial candidates." See Public Session Minutes, June 16, 1989, page 6. The Commission then clarified that, in addition, one photograph of the gubernatorial candidate may also be included without causing the cost of the "direct mail" literature to be charged against the expenditure limit of the gubernatorial candidate. See Public Session Minutes, June 16, 1989, page 8. Therefore, to clarify its intention that all three references to a gubernatorial candidate within a piece of "direct mail" literature paid for by a non-gubernatorial candidate or political party committee are permitted without causing the expenditure for that literature to become an expenditure of the gubernatorial candidate, the Commission has inserted the coordinate conjunction "and" into the text of N.J.A.C. 19:25-16.30(c)1.

COMMENT: In expressing his support of the purpose of the proposed new rule at N.J.A.C. 19:25-16.48, Complaint alleging violation of primary election expenditure limit, one commenter suggested that language be added to the rule to clarify that a gubernatorial candidate or official of the candidate's campaign must verify the expenditure limit complaint. The commenter further suggested that the Commission make a pre-printed complaint form available for complainants.

RESPONSE: While customarily an expenditure limit complaint would be initiated by an opposing candidate, it is feasible that a complaint alleging violation of the primary election expenditure limit may be brought by an individual or entity other than a gubernatorial candidate. The Commission therefore believes that the requirement in the amendment that the complaint be in writing and verified is sufficient without requiring which specific party or parties verify such complaints. The Commission also does not wish to suggest that a complaint is required to be made in a specific form in order to be acceptable. The Commission believes that suggesting use of a specific form might discourage a non-candidate complainant. To assist a complainant unfamiliar with drafting of a complaint, the Commission has added text to the rule, specifying that the name and address of the complainant and the respondent be specifically identified in the expenditure limit complaint.

COMMENT: One commenter suggested that N.J.A.C. 19:25-16.48, Complaint alleging violation of primary election expenditure limit, be expanded to clarify the role to be played by the Commission once it has received a complaint alleging violation of the primary election expenditure limit. The commenter believes that the rule should specify whether the Commission functions as investigator, prosecutor, trier of fact, or some blend of all three. It was also noted that the rule might deal with issues such as availability of discovery to the complainant and whether there is a need for a threshold determination by the Commission of probability of a violation before the complaint advances.

RESPONSE: While the Commission envisions that a preelection complaint for violation of the expenditure limit will most often be brought by a gubernatorial candidate, it does not wish to preclude the participation of the Commission as a party, or in any other role which might become necessary in the unique setting of a publicly-financed gubernatorial primary election. In response to the comment, the Commission has clarified that the New Jersey Uniform Administrative Procedure Rules, N.J.A.C. 1:1, and the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., apply in the event that a hearing is conducted by the Commission upon a complaint alleging violation of the primary election expenditure limit. This text parallels the existing Commission rule governing a hearing on a complaint for failure to participate in a gubernatorial primary election debate. The Commission believes that the rule as proposed and as modified above on adoption provides an adequate procedural framework for an expenditure limit complaint without restricting the functions which the Commission might be called upon to perform.

Summary of Agency-Initiated Change:

A technical change has been made to correct a printing error in proposed N.J.A.C. 19:25-3.1(a) where the word "for" has been changed to the word "or."

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks *thus*; deletions from proposal indicated in brackets with asterisks *[thus]*):

19:25-3.1 Exemption for activities conducted solely for the purpose of determining whether an individual will become a candidate; "Testing the Waters"

(a) Funds or other benefits received and payments made solely for the purpose of determining whether an individual should become a candidate are not contributions or expenditures. Activities contemplated under this exemption include, but are not limited to, expenses incurred for: conducting a poll, telephone calls and travel, to determine whether an individual should become a candidate. An individual or a committee acting on that individual's behalf shall keep written records of all such funds received and payments made for a period of not less than four years after the transaction to which they relate occurred *[for]* *or* four years after the date of the election to which they are relevant, whichever is longer.

(b) (No change.)

19:25-12.7 Independent expenditures

(a) Independent expenditures shall be subject to all of the reporting and disclosure requirements of the act. Every person, political committee, or continuing political committee making an independent expenditure and required to report under the act shall include in the reports required under the act a sworn statement on a form provided by the Commission that such independent expenditure was not made with the cooperation or prior consent of, or in consultation with or at the request or suggestion of, the candidate or any person or committee acting on behalf of the candidate.

(b) (No change.)

19:25-16.3 Definitions for this subchapter

The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise.

... "Principal campaign committee" means the political committee designated by the candidate to receive contributions and make expenditures on behalf of his or her candidacy.

...

19:25-16.5 Pre-candidacy activity

(a) All funds or other benefits received and payments made pursuant to N.J.A.C. 19:25-3.1 by an individual, or a committee in his or her behalf, solely for the purpose of determining whether that individual should become a candidate (for example, "testing the waters") are not contributions or expenditures. All funds so received shall be deposited in a separate depository established solely for that purpose. The individual or committee shall keep written records of all such funds received and payments made for a period of not less than four years after the transaction to which they relate occurred or four years after the date of the election to which they are relevant, whichever is longer.

(b) (No change.)

(c) In the event the individual on whose behalf funds are received and payments made solely for the purpose of determining whether the individual should become a candidate does in fact become a candidate, the funds received and payments made are contributions subject to the contribution limit contained in N.J.A.C. 19:25-16.10 and expenditures subject to the expenditure limit contained in N.J.A.C. 19:25-16.9(a)3 and shall be reported with the first report filed by the candidate or the campaign committee of the candidate, regardless of the date the funds were received or the payments made. This exemption does not apply to funds received or payments made for general public political advertising; nor does this exemption apply to funds received or payments made for activities designed to amass campaign funds that would be spent after the individual becomes a candidate. In no instance shall permissible activities conducted solely for the purpose of determining whether an individual will become a candidate be confined or limited on the basis of total funds received or payments made for such purpose.

(d) The separate depository established pursuant to (a) above may be designated by that individual as the matching fund account under N.J.A.C. 19:25-16.18(b), provided that the account and all the contributions deposited in it meet all of the requirements of N.J.A.C. 19:25-16.18(b).

19:25-16.16 (Reserved)

19:25-16.18 Matching of funds

(a) (No change.)

(b) The campaign treasurer or deputy campaign treasurer of the candidate shall open a matching fund account in a national or a State bank pursuant to N.J.S.A. 19:44A-32 which shall be designated "Matching Fund Account of (name of candidate)" and in which only contributions eligible for match may be deposited. The campaign treasurer or deputy campaign treasurer of such candidate shall deposit in such matching fund account, funds to be matched in aid of the candidacy of or in behalf of such candidate. Such deposit shall be made within 10 days of receipt and shall include only moneys received in accordance with this subchapter and section 5 of P.L. 1980, c.74 (N.J.S.A. 19:44A-29) and sections 11 and 12 of the act (N.J.S.A. 19:44A-11; 19:44A-12).

(c) (No change.)

(d) The statement referred to in (c) above shall include an original and two photocopies of a typed or printed list of contributors showing each contributor's full name and full mailing address (number, street, city, state, zip code), the date of receipt of each contribution by the candidate and of the deposit into the matching fund account, the dollar amount of each contribution submitted for match, the type of contributor of each contribution from a list of contributor types to be provided by the Commission, and the total amount of all contributions submitted for match. The list of contributors shall be segregated by deposit. The statement shall also include an original and two photocopies of a typed or printed list of contributors of contributions not eligible or submitted for match and any other receipt (for example, in-kind contributions, contributions intended to be repaid, or interest on invested funds), showing each contributor's full name and full mailing address (number, street, city, state, zip code), the date of receipt of each such contribution by the candidate, the dollar amount of each such contribution, and the type of contributor of each contribution from a list of contributor types to be provided by the Commission. The statement shall also

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include an original and two photocopies of a list of repayment by the candidate of any contribution, including any loan described under N.J.A.C. 19:25-16.31 (Borrowing of funds; repayment).

(e) (No change.)

(f) The certification shall include three photocopies of the face of each check or other written instrument as described in N.J.A.C. 19:25-16.11 (Contributions eligible for match; generally) for each contribution which the candidate submits to receive matching funds. Where a check is endorsed by some person other than the principal campaign committee, the face and back must be photocopied. The photocopies shall be segregated by deposit, sorted in the order in which the contributors are listed pursuant to (d) above and accompanied by copies of the relevant receipted deposit slips.

(g) The initial certification shall include three photocopies of checks, receipted bills, contracts or the like, as proof of the expenditure of at least \$150,000.

(h)-(j) (No change.)

(k) Each submission for public matching fund payments shall include an original and two photocopies of a cumulative list of all contributions received by a candidate from the beginning of his or her candidacy which list shall contain for each contribution the full name and full mailing address (number, street, city, state, zip code) of the contributor, the date or dates of receipt of contributions by the candidate, the aggregate total amount contributed by each contributor, and the type of contributor from a list of contributor types to be provided by the Commission, and which list shall:

1. Be arranged alphabetically by contributor name and which shall contain written authorization by the candidate for public disclosure of all contributions to the candidate; or

2. Be separated into an alphabetical list of all contributors whose contributions in the aggregate exceed \$100.00 and an alphabetical list of all contributors whose contributions are in the aggregate \$100.00 or less and which shall contain authorization by the candidate for public disclosure only of contributors whose contributions in the aggregate exceed \$100.00.

19:25-16.24 Disclosure of information

The statements and certifications submitted by a candidate in accordance with N.J.A.C. 19:25-16.18 (Matching of funds) shall not be public records and shall not be available for public inspection; provided, however, the Commission shall from time to time publish a listing which shall contain the information included in the statements and certifications for each contribution, except that it shall not include the name, address or amount of contribution of any contributor whose contributions in the aggregate are \$100.00 or less unless the candidate authorizes such disclosure in writing.

19:25-16.25 Use of public funds

(a)-(b) (No change.)

(c) Any disbursement made from a candidate's public fund account which results in the purchase of time on radio and television stations pursuant to (a) above shall be documented by signed media affidavits of the radio or television station, to be obtained by the candidate, his or her campaign treasurer, or deputy campaign treasurer within fourteen days following the actual use of such media time. Such media affidavits shall be maintained pursuant to N.J.A.C. 19:25-16.32.

(d) Any disbursement made from a candidate's public fund account shall be identified on campaign reports and submissions for public matching funds to include the check number, date of payment, full name of payee, full payee mailing address, amount of payment, and a complete statement of the purpose of the disbursement which includes the applicable permitted use of public funds contained in (a) above.

(e) A reimbursement made to the depository or matching fund account of a candidate from the public fund account of that candidate for an expenditure or expenditures permitted under (a) above shall:

1. Be made by individual check from the public fund account in the exact amount of the expenditure or expenditures being reimbursed;

2. Be specifically identified as a reimbursement on the report required pursuant to N.J.A.C. 19:25-16.20(b) and on campaign reports required by the Act; and

3. Contain a list of the previously paid expenditure or expenditures permissible under (a) above for which the reimbursement is being made.

(f) (No change in text.)

19:25-16.27 Expenses not subject to expenditure limits

(a) The following expenditures by a qualified candidate shall not be subject to the expenditure limit described in N.J.A.C. 19:25-16.9(a)3 (Limitations on participating candidates):

1.-3. (No change.)

4. Election night celebration or event expenses incurred pursuant to N.J.A.C. 19:25-16.34(c).

19:25-16.28 Travel expenses

(a)-(b) (No change.)

(c) If any individual, including a candidate, uses a government *[conveyance or a State]*-owned *or government-leased* vehicle for transportation to aid or promote a campaign for nomination for election to the Office of Governor, such use shall:

1. Be reported as a travel expense pursuant to (b) above;

2. Be valued for purposes of reports required to be filed under the Act and for purposes of the expenditure limit contained in the Act (N.J.S.A. 19:44A-7) by the reasonable commercial value of the transportation services to the candidate pursuant to N.J.A.C. 19:25-16.35; and

3. Be reimbursed immediately from campaign funds to the appropriate government entity providing the conveyance or vehicle.

19:25-16.29 Independent expenditures

(a) Independent expenditures shall not be deemed to be expenditures within the meaning of section 7 of the act (N.J.S.A. 19:44A-7), but all such expenditures shall be subject to all of the reporting and disclosure requirements of the act. Each person, political committee, or continuing political committee making independent expenditures who is required to file reports pursuant to N.J.A.C. 19:25-12.7 or 12.8 shall include in the reports required under the act a sworn statement on a form provided by the Commission that such independent expenditure was not made with the cooperation or prior consent of, or in consultation with or at the request or suggestion of, the candidate or any person or committee acting on behalf of the candidate.

(b) (No change.)

19:25-16.30 Coordinated expenditures

(a) A communication expenditure by any person or entity, other than a gubernatorial candidate or his or her principal campaign committee, as defined in N.J.A.C. 19:25-16.3, is a contribution by such person or entity subject to the limit on a contribution to a gubernatorial candidate in N.J.S.A. 19:44A-29 and is a coordinated expenditure of the gubernatorial candidate properly allocable against the expenditure limit of the gubernatorial candidate in N.J.S.A. 19:44A-7 if:

1. The communication makes an unambiguous reference to the gubernatorial candidate in an audio, visual or printed format; and

2. The gubernatorial candidate or his or her campaign committee has consented to, authorized, or exercised control over the production or circulation of the communication.

(b) A reference to a gubernatorial candidate appearing in materials paid for by non-gubernatorial candidates, as hereinafter defined, or political party committees, as defined in N.J.A.C. 19:25-1.7, will be deemed insubstantial and not subject to (a) above provided that:

1. The reference consists of the name or picture of the gubernatorial candidate in equal or less than equal prominence to the prominence given the names or pictures of non-gubernatorial candidates;

2. The names or pictures of the gubernatorial and non-gubernatorial candidates appear on printed campaign materials used in connection with volunteer activities on behalf of the named or pictured non-gubernatorial candidates, such as materials consisting

of buttons, pins, bumper stickers, handbills, brochures, posters, yard signs or palm cards; and

3. The materials in (b)2 above are not used in connection with any broadcasting, newspaper, magazine, billboard, or similar type of general public communication or political advertising.

(c) A reference to a gubernatorial candidate appearing in campaign literature or material circulated to voters by direct mail and paid for by non-gubernatorial candidates, as hereinafter defined, or by political party committees, as defined in N.J.A.C. 19:25-1.7, shall be deemed insubstantial and not subject to (a) above provided that:

1. The reference consists of no more than a single use of the gubernatorial candidate's name in the text, ***and*** a single use of the gubernatorial candidate's name within a slate or listing of the names of gubernatorial and non-gubernatorial candidates, and a single photograph or depiction of the gubernatorial candidate*,* provided that a photograph or depiction of each non-gubernatorial candidate larger or of equal size to the gubernatorial candidate's photograph or depiction is included;

2. The size of the print used to reproduce the name of the gubernatorial candidate is the same or smaller than the size of the print used for the names of the non-gubernatorial candidates; and

3. The predominant theme of the text promotes the candidacy or candidacies of the non-gubernatorial candidate or candidates and not that of the gubernatorial candidate.

(d) A reference to a gubernatorial candidate made in a telephone communication to a voter shall be deemed insubstantial and not subject to (a) above provided that:

1. The telephone communication is part of a get-out-the-vote effort of the non-gubernatorial candidate, as hereinafter defined, or of a political party committee, as defined in N.J.A.C. 19:25-1.7, conducted seven or fewer days before the gubernatorial general election; and

2. The reference to the gubernatorial candidate is limited to stating the name of the gubernatorial candidate as part of a slate or together with the names of non-gubernatorial candidates.

(e) A gubernatorial candidate or campaign committee receiving a coordinated communication pursuant to (a) above must determine:

1. The cost of preparation and circulation of the communication; and

2. The reasonable value of the coordinated communication to the gubernatorial candidate.

(f) The reasonable value of a coordinated communication to a gubernatorial candidate may be determined at less than 100 percent of the total cost of preparation and circulation if the coordinated communication referred to one or more non-gubernatorial candidates in the same election, and the percentage of the cost to be allocated to the gubernatorial candidate shall be determined based upon the following:

1. The number of non-gubernatorial candidates identified or otherwise referred to; and

2. The relative prominence of the reference to the gubernatorial candidate in relation to references to non-gubernatorial candidates. For example, if a printed pamphlet is prepared and circulated at a cost of \$1,000 and features equally one page for a non-gubernatorial candidate and one page for a gubernatorial candidate, the reasonable value is 50 percent of the total cost of \$1,000 or \$500.00.

(g) A gubernatorial candidate determining the reasonable value to his or her candidacy of a coordinated communication pursuant to (f) above shall establish that value to the nearest five percent of the total cost of preparation and circulation. In no case shall the reasonable value be determined to be less than five percent of the total cost.

(h) For the purposes of this section, the term "non-gubernatorial candidate" shall mean any candidate, other than a gubernatorial candidate, acting alone under a single campaign committee or jointly with other candidates under a multi-candidate joint campaign committee designated pursuant to N.J.S.A. 19:44A-16(h), but shall not mean any political committee, as defined in N.J.S.A. 19:44A-3(i), or shall not mean any continuing political committee, as defined in N.J.S.A. 19:44A-3(n)(2), which is not a political party committee, as defined in N.J.A.C. 19:25-1.7, or shall not mean any other corpor-

ation, partnership, incorporated or unincorporated association or part thereof.

19:25-16.39 Application to sponsor debates

(a) To be eligible for selection by the Commission to sponsor one or more of the interactive gubernatorial primary election debates, an organization:

1. (No change.)

2. Must not have endorsed any candidate in the pending primary election for the office of Governor and must agree not to make any such endorsement until the completion of any debate sponsored by the organization; and

3. (No change.)

(b) Any association of two or more separately owned news publications or broadcasting outlets, including newspapers, radio stations or networks, and television stations or networks, having between or among them a substantial readership or audience in this State, and any association of print or broadcast news or press service correspondents having among them a substantial readership or audience in this State, shall be eligible to sponsor any such gubernatorial primary election debate, without regard to whether that association or any of its members shall previously have sponsored any debate among candidates for Statewide office.

(c) (No change in text.)

19:25-16.43 Complaint alleging failure to participate in debate

(a) (No change.)

(b) Service of a complaint alleging failure to participate in a primary election debate shall be made by the complainant by personal service or by certified mail, return receipt requested, upon the respondent candidate, the Commission, the debate sponsor, and any person named in the complaint.

19:25-16.48 Complaint alleging violation of primary election expenditure limit

(a) Any complaint filed with the Commission alleging violation by a primary election candidate receiving public matching funds of the primary election expenditure limit in N.J.A.C. 19:25-16.9(a)3 shall:

1. Be in writing and be verified; ***[and]***

2. Specifically identify the name and address of the complainant and the name and address of the respondent; and

[2.]*3. Contain a detailed statement alleging with specificity all facts known to the complainant pertinent to the alleged violation of the primary election expenditure limit.

(b) Service of a complaint alleging violation of the primary election expenditure limit shall be made by the complainant by personal service or by certified mail, return receipt requested, upon the respondent candidate, the Commission, and any person named in the complaint.

*** (c) Any hearing conducted by the Commission arising from a complaint filed pursuant to this subsection shall be governed by the New Jersey Uniform Administrative Procedure Rules, N.J.A.C. 1:1, and the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.***

(a)

**ELECTION LAW ENFORCEMENT COMMISSION
Lobbyists and Legislative Agents
Reporting of Identity of State Officials Receiving
Benefits**

**Adopted Amendments: N.J.A.C. 19:25-20.11 and
20.13**

Proposed: September 8, 1992 at 24 N.J.R. 3031(a).

Adopted: October 21, 1992 by the Election Law Enforcement Commission, Frederick M. Herrmann, Ph.D., Executive Director.

Filed: October 22, 1992 as R.1992 d.459, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 52:13C-23.2.

Effective Date: November 16, 1992.

Operative Date: January 1, 1993.

Expiration Date: October 1, 1995.

Summary of Public Comments and Agency Responses:

On August 11, 1992, the Commission circulated a press advisory announcing that a public hearing on these proposed amendments would be conducted on September 16, 1992. A copy of the press advisory was mailed on August 28, 1992 to legislative agents registered with the Commission. The proposed amendments were published in the New Jersey Register on September 8, 1992. At the September 16, 1992 public hearing before the Commission, comments were received from Robert A. Woodford, Vice President and Secretary, New Jersey Business and Industry Association. The record of the hearing before the Commission may be reviewed by contacting Gregory Nagy, at the Commission, 28 West State Street, 12th Floor, Trenton, New Jersey, (609) 292-8700. Written comments were received from Linda M. Czipo, Director of Communications and Advocacy Services, Center for Non-Profit Corporations.

The operative date of the amendments will be January 1, 1993, so that they will affect annual reports for calendar year 1993, and annual reports thereafter. They are not intended to affect annual reports for calendar year 1992, which are due for filing no later than February 15, 1993.

COMMENT: One commenter objected to any requirement that would compel a lobbyist organization conducting a reception or similar event to make and maintain records identifying any State official who attended and received benefits in the form of food or beverage at such a reception if the value of the benefits were \$25.00 or less per official. Specifically, the commenter cited the statutory requirement that a lobbyist organization must report the identity of a State official receiving benefits from a lobbyist organization in excess of \$25.00 per day, or \$200.00 per calendar year; see N.J.S.A. 52:13C-22.1. The commenter contended that unless the lobbyist organization passes benefits valued at \$25.00 or more per day to a State official attending a reception or similar event, the lobbyist organization should not be under an obligation to make and keep records for the purpose of determining at the conclusion of a calendar year whether the \$200.00 per year threshold had been exceeded for that State official.

RESPONSE: The Commission does not agree that a lobbyist organization conducting or otherwise paying the costs for a reception has no obligation to make and keep records of the identity of a State official receiving benefits at a reception unless the benefits provided to the State official exceed \$25.00 per day. The Legislative Activities Disclosure Act, specifically N.J.S.A. 52:13-22.1, requires a lobbyist organization to report the identity of any State official who has received benefits in excess of \$25.00 per day, or in excess of \$200.00 per calendar year. Under the approach suggested by the commenter, only the \$25.00 per day standard would be applied to expenditures for receptions. The \$200.00 per calendar year standard could not be calculated because no records would be made of any reception-related benefits of \$25.00 or less per day that when combined with other benefits of \$25.00 or less given to an official over the course of a calendar year exceeded \$200.00.

The Commission agrees that a lobbyist organization sponsoring a reception necessarily will bear some recordkeeping burden, and careful planning to satisfy recordkeeping requirements may be needed. To lessen that burden, the Commission has changed the text of N.J.A.C. 19:25-20.13(b) so that if the value of the benefits provided by a lobbyist organization to a State official at a reception or other similar event do not exceed \$5.00, no recordkeeping or benefit-passing reporting will be required. The Commission believes this change is in conformity with the recordkeeping exemption already established in the existing text of subsection (b) of N.J.A.C. 19:25-20.14, Audit by Commission; recordkeeping. Further, since the commenter testified that the average reception expense is probably less than \$5.00 per person, this change may substantially address the commenter's concerns.

COMMENT: One commenter objected to the text of subsection (b) of N.J.A.C. 19:25-20.13 on the grounds that it appeared to preclude the allocation of the costs of a reception or similar event among all the attendees, not just State officials.

RESPONSE: The Commission notes that costs of conducting a reception or similar event that are related to overhead, such as room rental, are subject to different reporting treatment than are those costs that provide benefits to State officials, such as food and beverage. The intent

of the Commission in proposing subsection (b) was to require reporting of the identity of State officials who receive benefits at such events, but not to require that costs, such as overhead, that do not result in any benefit being received by a State official, be subject to allocation. Therefore, if a lobbyist organization rents a hotel suite for a reception, that cost need not be considered in calculating whether any attending State official must be identified because the rental did not confer any benefit on the official. However, if a catering cost was incurred, the per person cost for the catering service which provided food or beverage to an attending State official must be calculated to determine whether benefits exceeding a value of \$25.00 per day, or \$200.00 per year, were provided by the sponsoring lobbyist organization.

The Commission agrees that the text of subsection (b) of N.J.A.C. 19:25-20.13, as proposed, was not restricted to only those costs that provide benefits, and therefore was overbroad. Consequently, the text as adopted provides that only those expenditures that provide benefits to State officials, specifically those expenditures that are described in subsection (b) of N.J.A.C. 19:25-20.11, are subject to inclusion in the calculation of whether the identity of a State official must be reported because benefits in excess of \$25.00 per day, or \$200.00 per calendar year, were provided to that State official.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks *thus*; deletions from proposal indicated in brackets with asterisks *[thus]*).

19:25-20.11 Expenditures

(a) (No change.)

(b) The following expenditures of a lobbyist or legislative agent which relate to communication with, or providing benefits to, any member of the Legislature, legislative staff, the Governor, the Governor's staff, or an officer or staff member of the Executive Branch shall be reported in the Annual Report and shall be listed in the aggregate by category, except that if the aggregate expenditures on behalf of any member of the Legislature, legislative staff, the Governor, the Governor's staff, or an officer or staff member of the Executive Branch exceed \$25.00 per day, or exceed \$200.00 per calendar year, the expenditures, together with the name of the intended recipient of the benefit, shall be stated in detail and shall include the date and type of each expenditure, amount of each expenditure and the name of the person to whom it was paid.

1. Entertainment, including, but not limited to, disbursements for sporting, theatrical and musical events provided to any member of the Legislature, legislative staff, the Governor, the Governor's staff, or an officer or staff member of the Executive Branch, and paid for by a lobbyist or legislative agent.

2. Food and beverages provided to any member of the Legislature, legislative staff, the Governor, the Governor's staff, or an officer or staff member of the Executive Branch, paid for by a lobbyist or legislative agent. Also included are payments by lobbyists or legislative agents for food or beverages for any member of the Legislature, legislative staff, the Governor, the Governor's staff, or an officer or staff member of the Executive Branch at conferences, conventions, banquets or other similar functions.

3.-6. (No change.)

(c) For purposes of reporting under the Act or this subchapter, when an expenditure included in (b) above is made to a member of the immediate family of any member of the Legislature, legislative staff, the Governor, the Governor's staff, or an officer or staff member of the Executive Branch, such expenditure shall be deemed to be made on behalf of the member of the Legislature, legislative staff, the Governor, the Governor's staff, or the officer or staff member of the Executive Branch whose family member received it. A member of the immediate family shall mean a spouse residing in the same domicile, or any dependent children.

19:25-20.13 Contents of annual report

(a) (No change.)

(b) With respect to any specific event, such as a reception, where expenditures required to be reported pursuant to N.J.A.C. 19:25-20.11(b) in the aggregate exceed \$100.00, the report shall include the date, type of expenditure, amount of expenditure and to whom paid. *[The costs of any specific event shall be allocated among the members of the Legislature, legislative staff, the Gov-

error, members of the Governor's staff, or officers or staff members of the Executive Branch present, attending or participating in the event with the actual or constructive knowledge of the lobbyist or legislative agent for inclusion in the daily or annual calculations under N.J.A.C. 19:25-20.11(b).] * **Any expenditure in excess of \$5.00 made to provide a benefit pursuant to N.J.A.C. 19:25-20.11(b) to a member of the Legislature, legislative staff, the Governor, member of the Governor's staff, or offices or staff members of the Executive Branch present, attending or participating in the event with the actual or constructive knowledge of the lobbyist or legislative agent shall be included in the calculation of the per day, or per calendar year, thresholds contained in N.J.A.C. 19:25-20.11(b).***

(c)-(d) (No change.)

(a)

CASINO CONTROL COMMISSION

Gaming Equipment

Rules of the Game

Roulette Table; Physical Characteristics; Double Zero Roulette Wheel Used as a Single Zero Roulette Wheel

Roulette; Inspection Procedures; Security Procedures

Roulette; Payout Odds

Adopted Amendments: N.J.A.C. 19:46-1.7 and 1.9; 19:47-5.2

Proposed: September 8, 1992 at 24 N.J.R. 3033(a).

Adopted: October 15, 1992 by the Casino Control Commission, Steven P. Perskie, Chairman.

Filed: October 19, 1992 as R.1992 d.452, **with a technical change** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 5:12-69(a), 70(f) and 100(e).

Effective Date: November 16, 1992.

Expiration Date: April 28, 1993, N.J.A.C. 19:46 and 19:47.

Summary of Public Comments and Agency Responses:

COMMENT: The Sands Hotel and Casino, Tropworld Casino and Entertainment Resort, and the Division of Gaming Enforcement all indicated that they supported adoption of the proposal.

RESPONSE: Accepted.

Full text of the adoption follows (addition to proposal indicated in boldface with asterisks *thus*; deletion from proposal indicated in brackets with asterisks *[thus]*).

19:46-1.7 Roulette table; physical characteristics; double zero roulette wheel used as a single zero roulette wheel

(a)-(b) (No change.)

(c) A double zero roulette wheel may be used as a single zero roulette wheel, provided that:

1. If a double zero table layout is used, the "00" wager above on the layout is obscured with a cover or other approved device which clearly indicates that such a wager is not available; and

2. Appropriate signage is posted at the roulette table to notify players that:

i. A double zero roulette wheel is being used as a single zero roulette wheel, and that double zero (00) is not an available wager;

ii. If the roulette ball comes to rest around the wheel in a compartment marked double zero (00), the spin will be declared void and the wheel will be respun; and

iii. Wagers on red, black, odd, even, 1 to 18 and 19 to 36 shall be lost if the roulette ball comes to rest in a compartment marked zero (0).

(d) Unless otherwise approved by the Commission, the layout of each roulette table shall have the name of the casino imprinted

thereon and appear as depicted in the following diagrams according to whether the roulette wheel at such table is a single-zero or double-zero wheel:

Editor's Note: Graphics concerning the single and double roulette wheel and table layouts were adopted with these rules but are not reproduced herein. Further information on these graphics may be obtained from the Casino Control Commission,*[Building 5, 3131 Princeton Pike Office Park, Trenton, New Jersey 08625]* *Arcade Building, Tennessee Avenue and the Boardwalk, Atlantic City, New Jersey 08401*.

19:46-1.9 Roulette; inspection procedures; security procedures

(a) Prior to opening a roulette table for gaming activity, a casino supervisor or member of the casino security department shall:

1.-2. (No change.)

3. Inspect the roulette wheel to assure that all parts are secure and free from movement;

4. Inspect the roulette ball by passing it over a magnet or compass to assure its non-magnetic quality; and

5. Conform that the layout and signage comply with N.J.A.C. 19:46-1.7(c), if a double zero roulette wheel is being used as a single zero roulette wheel.

(b)-(f) (No change.)

19:47-5.2 Roulette; payout odds

(a)-(c) (No change.)

(d) When roulette is played on a double zero wheel being used as a single zero roulette wheel, as provided in N.J.A.C. 19:46-1.7(c):

1. Notice shall be provided, in accordance with N.J.A.C. 19:47-8.3;

2. The dealer shall announce "no spin," declare the spin void and respin the wheel if the roulette ball comes to rest around the wheel in a compartment marked double zero (00); and

3. Wagers on red, black, odd, even, 1 to 18 and 19 to 36 shall be lost if the roulette ball comes to rest in a compartment marked zero (0).

(b)

CASINO CONTROL COMMISSION

Pokette

Rules of the Game

Gaming Equipment

Accounting and Internal Controls

Adopted Amendments: N.J.A.C. 19:45-1.19,

19:46-1.1, 1.17, 1.18, 1.20; and 19:47-8.2

Adopted New Rules: N.J.A.C. 19:46-1.13D; 19:47-12.1 through 12.10

Proposed: June 15, 1992 at 24 N.J.R. 2140(a).

Adopted: October 15, 1992 by the Casino Control Commission, Steven P. Perskie, Chairman.

Filed: October 19, 1992 as R.1992 d.453 **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 5:12-63(c), 69 and 100.

Effective Date: November 16, 1992.

Expiration Date: March 24, 1993, N.J.A.C. 19:45.

April 28, 1993, N.J.A.C. 19:46.

April 28, 1993, N.J.A.C. 19:47.

AGENCY NOTE: The Commission adopted a number of amendments to N.J.A.C. 19:46-1.18 in conjunction with the rules governing the game of pai gow poker, which were published in the October 19, 1992 New Jersey Register, at 24 N.J.R. 3742(a). These same amendments were included in the proposal governing the game of pokette. Since the amendments were previously adopted, the Commission did not need to address them in conjunction with the pokette adoption. For this reason, the proposed amendments to N.J.A.C. 19:46-1.18(a) through (d), (f) through (m) and (o) through (p) are not adopted herein. The proposed amendments to N.J.A.C. 19:46-1.18(e) and (n), which deal specifically with the game of pokette, are adopted.

Summary of Public Comment and Agency Responses:

COMMENT: The Division of Gaming Enforcement commented that the cards used in pokette should be included in the approved stratification plan pursuant to which the casino licensee's security department inspects a sample of the decks of cards that were utilized during the gaming day.

RESPONSE: Rejected. Adding the pokette cards to the sample will dilute the sample of cards that need to be checked for markings, that is, blackjack and baccarat cards, because any markings on those cards will impact on the integrity of the game. Rather, the Commission has adopted a minor change to N.J.A.C. 19:46-1.18(n)2 by adding subparagraph (n)2iv which requires that all pokette cards (three decks for each table) be checked to insure that no cards are missing at the end of the gaming day. This change addresses the substance of the Division's concern.

Summary of Agency-Initiated Changes:

A minor change was made to N.J.A.C. 19:46-1.13D(c) and 19:47-12.2 to provide that a device approved by the Commission may be used to indicate the winning card, in lieu of using cards and a card stand. The location of such a device must be approved by the Commission.

Minor changes were made to N.J.A.C. 19:46-1.18(e) and 19:47-12.3(b) to correct the section number of cross references.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks ***[thus]***):

19:45-1.19 Acceptance of tips or gratuities from patrons

(a) (No change.)

(b) All tips and gratuities allowed dealers shall be:

1. Immediately deposited in a transparent locked box reserved for that purpose. If non-value chips are received at a roulette or pokette table, the marker button indicating their specific value shall not be removed until after a dealer, in the presence of a casino supervisor, has expeditiously converted them into value chips which shall then be immediately deposited in a transparent locked box reserved for that purpose;

2.-3. (No change.)

(c) (No change.)

19:46-1.1 Gaming chips; value and non-value; physical characteristics

(a)-(g) (No change.)

(h) Nothing in this section shall preclude a casino licensee from using non-value chips approved for use in roulette at the game of pokette.

(i) Non-value chips issued at a roulette or pokette table shall only be used for gaming at that table and shall not be used for gaming at any other table in the casino nor shall any casino licensee or its employees allow any casino patron to remove non-value chips from the table from which they were issued.

(j) No person at a roulette or pokette table shall be issued or permitted to game with non-value chips that are identical in color and design to value chips to non-value chips being used by another person at the same table. When a patron purchases non-value chips, a chip of the same color shall be placed in a slot or receptacle attached to the outer rim of the roulette wheel or, for pokette, in such other device as approved by the Commission. At that time, a marker button denoting the value of a stack of 20 chips of that color shall also be placed in the slot, receptacle or other device.

(k) (No change in text.)

(l) Each casino licensee shall have the discretion to permit, limit or prohibit the use of value chips in gaming at roulette and pokette provided, however, that it shall be the responsibility of the casino licensee and its employees to keep accurate account of the wagers being made at roulette and pokette with value chips so that the wagers made by one player are not confused with those made by another player at the table.

Recodify existing (l)-(p) as (m)-(q) (No change in text.)

19:46-1.13D Pokette table; pokette wheel; physical characteristics

(a) Each pokette table shall have the name of the casino licensee imprinted on the cloth covering it and shall have a drop box and

a tip box attached to it on the same side of the gaming table as, but on opposite sides of, the dealer in a location as approved by the Commission.

(b) The cloth covering each pokette table shall be approved by the Commission and shall be marked with:

1. Depictions of each of the 52 playing cards contained within a deck as depicted on the pokette wheel;

2. Two jokers as depicted on the pokette wheel;

3. The following poker hand wagers:

i. Pair in two;

ii. Pair in three;

iii. Three of a kind;

iv. Straight;

v. Flush; and

vi. Straight Flush; and

4. The following non-poker hand wagers:

i. Black;

ii. Red;

iii. Ace-King-Queen rank;

iv. Jack-10-9 rank;

v. 8-7-6 rank;

vi. 5-4-3 rank; and

vii. Each suit.

(c) Pokette shall be played with a card stand and a container to house the cards to be placed in the card stand. The location of the card stand and card container at the pokette table shall be approved by the Commission. ***Notwithstanding these requirements, a device approved by the Commission may be used to indicate the winning card determined by each spin of the pokette wheel in lieu of cards and a card stand. The location of such a device shall be approved by the Commission.***

(d) Pokette shall be played with a wheel to be known as a "pokette wheel" which shall be circular in shape and no less than 48 inches in diameter. The rim of the pokette wheel shall be divided into 54 equally spaced sections with 52 sections containing a depiction of each of the 52 playing cards contained within a deck and two sections each containing a depiction of a joker that is different from the other joker. The background of each joker shall be of a different color from each other, so as to be distinguishable from each other, and shall not be red or black. All 54 sections shall be covered with glass or some other transparent covering. The sections shall be arranged around the rim of the pokette wheel as follows: joker, 7 of diamonds, 4 of spades, 9 of hearts, queen of clubs, 5 of diamonds, 8 of spades, ace of hearts, 10 of clubs, 3 of diamonds, king of spades, 6 of hearts, 2 of clubs, jack of diamonds, 7 of spades, 4 of hearts, 9 of clubs, queen of diamonds, 5 of spades, 8 of hearts, ace of clubs, 10 of diamonds, 3 of spades, king of hearts, 6 of clubs, 2 of diamonds, jack of spades, joker, 7 of hearts, 4 of clubs, 9 of diamonds, queen of spades, 5 of hearts, 8 of clubs, ace of diamonds, 10 of spades, 3 of hearts, king of clubs, 6 of diamonds, 2 of spades, jack of hearts, 7 of clubs, 4 of diamonds, 9 of spades, queen of hearts, 5 of clubs, 8 of diamonds, ace of spades, 10 of hearts, 3 of clubs, king of diamonds, 6 of spades, 2 of hearts and jack of clubs.

(e) The location and the necessary security measures over the non-value and value gaming chips at a pokette table shall be approved by the Commission.

19:46-1.17 Cards; physical characteristics

(a) Cards used to play blackjack, baccarat, minibaccarat, pai gow poker, pokette and red dog shall be in decks of 52 cards each with each card identical in size and shape to every other card in such deck.

(b)-(h) (No change.)

19:46-1.18 Cards; receipt, storage, inspections and removal from use

(a)-(d) (No change.)

(e) With the exception of cards used to game at pokette, which are governed by the requirements of N.J.A.C. 19:47-*[12.4]**12.3*, prior to their use at a table all decks shall be inspected by the dealer, and the inspection verified by a floorperson. Card inspection at the gaming table shall require each pack to be

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used to be sorted into sequence and into suit to assure that all cards are in the deck. The dealer shall also check the back of each card to assure that it is not flawed, scratched or marked in any way.

1. If, after checking the cards, the dealer finds that a card is unsuitable for use, a casino supervisor shall bring a substitute card from the card reserve in the pit stand.

2. The unsuitable card shall be placed in a sealed envelope or container, identified by table number, date and time and shall be signed by the dealer and casino supervisor. The casino supervisor shall maintain the envelope or container in a secure place within the pit until collection by a casino security officer.

(f)-(m) (No change.)

(n) When the envelopes or containers of used cards and reserve cards with broken seals are returned to the casino security department, they shall be inspected for tampering, marks, alterations, missing or additional cards or anything that might indicate unfair play.

1. For cards used in blackjack, red dog, baccarat or minibaccarat, the casino licensee shall cause to be inspected either:

i. (No change.)

ii. A sample of decks selected at random or in accordance with an approved stratification plan provided that the procedures for selecting the sample size and for assuring a proper selection of the sample are submitted to and approved by the Commission;

2. The casino licensee shall also inspect:

i. (No change from proposal.)

ii. Any cards the casino licensee removed for indication of tampering; ***[and]***

iii. All cards used for pai gow poker; ***and***

iv. All cards used for pokette, which must be inspected by sorting the cards sequentially by suit.

3. The procedures for inspecting all decks required to be inspected under this subsection*, with the exception of pokette cards,* shall, at a minimum, include:

i. (No change.)

ii. The inspection of the backs with an ultra-violet light; and

iii. (No change.)

4. The individuals performing said inspection shall complete a work order form which shall detail the procedures performed and list the tables from which the cards were removed and the results of the inspection. The individual shall sign the form upon completion of the inspection procedures.

5. (No change.)

6. Evidence of tampering, marks, alterations, missing or additional cards or anything that might indicate unfair play discovered at this time, or at any other time, shall be immediately reported to the Commission and Division by the completion and delivery of a three-part Card Discrepancy Report.

i-ii. (No change.)

iii. The Commission inspector receiving the cards shall sign the original, duplicate and triplicate copy of the Card Discrepancy Report and retain the original at the Commission Booth. The duplicate copy shall be delivered to the Division office located within the casino hotel facility. The triplicate copy shall be retained by the casino licensee.

(o)-(p) (No change.)

19:46-1.20 Approval of gaming equipment; retention by Commission and Division; evidence of tampering

(a) The Commission shall have the discretion to review and approve all gaming equipment and other devices used in a casino as to quality, design, integrity, fairness, honesty and suitability including, without limitation, gaming tables, layouts, roulette wheels, pokette wheels, roulette balls, drop boxes, big six wheels, sic bo shakers, sic bo electrical devices, pai gow shakers, chip holders, racks and containers, scales, counting devices, trolleys, slip dispensers, dealing shoes, dice, cards, pai gow tiles, locking devices and data processing equipment.

(b) (No change.)

(c) Any evidence that gaming equipment or other devices used in a casino including, without limitation, gaming tables, layouts, roulette wheels, pokette wheels, roulette balls, drop boxes, big six

wheels, sic bo shakers, sic bo electrical devices, pai gow shakers, gaming chips, plaques, chip holders, racks and containers, scales, counting devices, trolleys, slip dispensers, dealing shoes, locking devices, data processing equipment, tokens and slot machines have been tampered with or altered in any way which would affect the integrity, fairness, honesty or suitability of the gaming equipment or other device for use in a casino shall be immediately reported to an agent of the Commission and the Division. A member of the casino licensee's security department shall be required to insure that the gaming equipment or other device and any evidence required to be reported pursuant to this subsection is maintained in a secure manner until the arrival of an agent of the Division. Rules concerning evidence of tampering with dice, cards and pai gow tiles may be found at N.J.A.C. 19:46-1.16, 19:46-1.18, and 19:46-1.19B respectively.

19:47-8.2 Minimum and maximum wagers

(a) (No change.)

(b) The spread between the minimum wager and the maximum wager at table games shall be as follows:

1-10. (No change.)

***[9.]*11.* Pokette:** If the minimum wager at a table is \$5.00 or less, the maximum wager shall be at least \$40.00. Nothing in this chapter shall preclude a casino licensee from establishing different maximum wagers for each permissible wager at the game of pokette; provided, however, that such limitations are posted at the table.

(c) (No change.)

SUBCHAPTER 12. POKETTE

19:47-12.1 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise.

"Rank" shall mean the four cards of identical value within a single deck of cards. For example, the 5 rank consists of the 5 of diamonds, 5 of spades, 5 of clubs and 5 of hearts.

"Suit" shall mean one of the four categories of cards, that is, diamond, spade, club or heart.

"Pair" shall mean two cards of identical value, regardless of suit.

"Non-poker hand wager" shall mean any of the wagers listed in N.J.A.C. 19:47-12.5(a).

"Poker hand wager" shall mean any of the wagers listed in N.J.A.C. 19:47-12.5(b).

"Winning card" shall mean the card which is depicted in the section of the pokette wheel where the clapper comes to rest after a valid spin of the pokette wheel.

19:47-12.2 Cards; number of decks; value of cards depicted on the pokette wheel

(a) Three decks of cards shall be used in the game of pokette. The cards shall be used to indicate, through placement on the card stand, the winning card determined by each spin of the pokette wheel. Cards used at pokette shall meet the requirements of N.J.A.C. 19:46-1.17. ***Notwithstanding these requirements, a device approved by the Commission may be used to indicate the winning card determined by each spin of the pokette wheel, in lieu of cards and a card stand.***

(b) For purposes of settling a poker hand wager, the relative value of the cards depicted on the pokette wheel, in order of highest to lowest value, shall be: ace, king, queen, jack, 10, nine, eight, seven, six, five, four, three, and two. Neither of the jokers shall have any value for purposes of forming a poker hand. For purposes of completing a "straight" or a "straight flush" poker hand, an ace may be combined with a king and a queen or a 2 and a 3 but may not be combined with a king and a 2.

19:47-12.3 Opening of the table for gaming

(a) After receiving three decks of cards at the table in accordance with N.J.A.C. 19:46-1.18, the dealer or the floorperson assigned to the table shall inspect the three decks by sorting each deck into sequence and into suit to ensure that all cards are in each deck.

(b) Following the inspection of the cards by the dealer or floorperson assigned to the table, each deck shall be placed in the

container used to house the cards pursuant to N.J.A.C. 19:46-*[1.13C]**1.13D*.

19:47-12.4 Wagers; supervision

(a) All wagers at pokette shall be made by placing gaming chips or plaques on the appropriate areas of the pokette layout except that verbal wagers accompanied by cash may be accepted provided that they are confirmed by the dealer and that such cash is expeditiously converted into gaming chips or plaques in accordance with the regulations governing the acceptance and conversion of such instruments.

(b) No person at a pokette table shall be issued or permitted to game with non-value chips that are identical in color and design to value chips or to non-value chips being used by another person at the same table.

(c) Each player shall be responsible for the correct positioning of his or her wager on the pokette layout regardless of whether he or she is assisted by the dealer. Each player must ensure that any instructions given to the dealer regarding the placement of his or her wager is correctly carried out.

(d) The wagers identified in N.J.A.C. 19:47-12.5(a) (non-poker hand wagers) may be made by a player on each spin of the pokette wheel. The wagers identified in N.J.A.C. 19:47-12.5(b) (poker hand wagers) may only be made on a subsequent spin of the pokette wheel when, in accordance with N.J.A.C. 19:47-12.8, one or two winning cards are posted on the card stand.

(e) For purposes of complying with the organization and supervision requirements contained in N.J.A.C. 19:45-1.11 and 1.12, each pokette table shall be considered the same as one roulette table.

19:47-12.5 Permissible wagers

(a) The following shall constitute the permissible non-poker hand wagers at the game of pokette:

1. "Single card straight up" is a wager that the winning card shall be the same card as the single card selected by the player.

2. "Two cards or split" is a wager that the winning card shall be the same card as either of the two adjoining cards selected by the player.

3. "Four cards or corner" is a wager that the winning card shall be the same card as any of the four adjoining cards selected by the player.

4. "Single rank" is a wager that the winning card shall be one of the four cards contained in the single rank selected by the player.

5. "Double rank" is a wager that the winning card shall be one of the eight cards contained in the two adjacent ranks selected by the player.

6. "Ace-king-queen rank" is a wager that the winning card shall be one of the 12 cards contained in the ace, king and queen ranks or the two of spades.

7. "Jack-10-9 rank" is a wager that the winning card shall be one of the 12 cards contained in the jack, 10 and 9 ranks or the two of clubs.

8. "8-7-6 rank" is a wager that the winning card shall be one of the 12 cards contained in the 8, 7 and 6 ranks or the two of diamonds.

9. "5-4-3 rank" is a wager that the winning card shall be one of the 12 cards contained in the 5, 4 and 3 ranks or the two of hearts.

10. "Red" is a wager that the winning card shall be a diamond or a heart.

11. "Black" is a wager that the winning card shall be a spade or a club.

12. "Suit or column" is a wager that the winning card shall be one of the 13 cards contained in the suit selected by the player.

13. "Jacer" is a wager that the winning card shall be the ace of clubs, the ace of diamonds or either of the two jokers.

(b) The following shall constitute the permissible poker hand wagers at the game of pokette:

1. "Pair in two" is a wager that the winning cards on two consecutive spins of the pokette wheel shall be of identical value, regardless of suit.

2. "Pair in three" is a wager that at least two of the three winning cards on three consecutive spins of the pokette wheel shall be of identical value, regardless of suit.

3. "Three of a kind" is a wager that the winning cards on three consecutive spins of the pokette wheel shall be of identical value, regardless of suit.

4. "Straight" is a wager that the winning cards on three consecutive spins of the pokette wheel shall be of consecutive value, regardless of suit or the order in which the winning cards are determined.

5. "Straight flush" is a wager that the winning cards on three consecutive spins of the pokette wheel shall be of consecutive value and of the same suit, regardless of the order in which the winning cards are determined.

6. "Flush" is a wager that the winning cards on three consecutive spins of the pokette wheel shall be of the same suit.

19:47-12.6 Payout odds

(a) The payout odds for pokette printed on any layout or in any brochure or other publication distributed by a casino licensee shall be stated through the use of the word "to" or "win" and no odds shall be stated through the use of the word "for."

(b) Each casino licensee shall pay off winning wagers at the game of pokette at no less than the odds listed below:

Wager	Payout Odds
Single card straight up	51 to 1
Two cards or split bet	25 to 1
Four cards or corner bet	12 to 1
Single rank	12 to 1
Double rank	5 to 1
Ace-king-queen rank	3 to 1
Jack-10-9 rank	3 to 1
8-7-6 rank	3 to 1
5-4-3 rank	3 to 1
Red	1 to 1
Black	1 to 1
Suit or column	3 to 1
Jacer	12 to 1
Pair in two	11 to 1
Pair in three	5 to 1
Three of a kind	11 to 1
Flush	3 to 1
Straight:	
Open	5 to 1
Inside	11 to 1
Straight flush:	
Open	24 to 1
Inside	49 to 1

19:47-12.7 Procedures for dealing the game

(a) Prior to spinning the pokette wheel, the dealer shall announce "No more bets."

(b) The pokette wheel shall be spun by the dealer in either direction and shall complete at least three revolutions to constitute a valid spin.

(c) Each wager shall be settled strictly in accordance with its position on the layout.

(d) Upon completion of each spin, the dealer shall announce the winning card, including its suit, and shall place a marker on the corresponding card on the pokette layout. The dealer shall then select the winning card from the decks of cards maintained at the pokette table and place the winning card in a card stand located at the pokette table. After placing the marker on the layout and the card in the card stand, the dealer shall first collect all losing wagers and then pay off all winning wagers at the odds currently being offered pursuant to N.J.A.C. 19:47-12.6.

(e) When the pokette wheel clapper comes to rest on a joker:

1. All non-poker hand wagers, except wagers on that single joker straight up, a two card or split wager that includes that joker, or a jacer wager, shall be lost;

2. The dealer shall collect all losing and pay off all winning non-poker hand wagers at the odds currently being offered pursuant to N.J.A.C. 19:47-12.6; and

ADOPTIONS

3. That spin of the pokette wheel shall have no bearing on the settling of any poker hand wagers which have not been completed in accordance with N.J.A.C. 19:47-12.8.

19:47-12.8 Procedures for placing and determining the outcome of poker hand wagers

(a) After the first winning card that is not a joker has been placed in the first space of the card stand and all non-poker hand wagers relevant to that winning card have been settled, the dealer shall announce that wagers may also be placed for a "pair in 2."

(b) Once all wagers have been placed by the players, the dealer shall spin the pokette wheel in accordance with N.J.A.C. 19:47-12.7(a) and (b). Upon completion of the spin, the dealer shall announce the winning card, including its suit, place a marker on the corresponding card on the pokette layout, select the winning card from the decks of cards maintained at the pokette table and place it in the second space of the card stand. The dealer shall first settle all non-poker hand wagers relevant to that winning card. If the second winning card does not form a pair with the first winning card, all wagers on a "pair in 2" shall lose and shall be immediately collected by the dealer. If the second winning card forms a pair with the first winning card, all wagers on a "pair in 2" shall win and shall be paid at the odds currently being offered pursuant to N.J.A.C. 19:47-12.6.

(c) If the second winning card does not form a pair, once all wagers relevant to the second winning card have been settled, the dealer shall announce, in accordance with (d) below, that wagers may also be placed for a "pair in 3" and on the other possible poker hand wagers.

(d) Additional poker hand wagers which may be made once all wagers relevant to the second winning card have been settled are as follows:

1. If the first and second winning cards in the card stand are of the same suit, the dealer shall announce that wagers may be placed for a "flush."

2. If the third winning card could complete a "straight" with the first and second winning cards pursuant to N.J.A.C. 19:47-12.2 and 12.5, the dealer shall:

i. If the values of the first and second winning cards in the card stand are consecutive, announce that wagers may be placed on an "open straight"; or

ii. If there is only one winning card that could complete a "straight" with the first and second winning cards in the card stand, announce that wagers may be placed on an "inside straight."

3. If the third winning card could complete a "straight flush" with the first and second winning cards in the card stand pursuant to N.J.A.C. 19:47-12.2 and 12.5, the dealer shall:

i. If the values of the first and second winning cards in the card stand are consecutive, announce that wagers may be placed on an "open straight flush"; or

ii. If there is only one winning card that could complete a "straight flush" with the first and second winning cards in the card stand, announce that wagers may be placed on an "inside straight flush."

4. If the first and second winning cards in the card stand are a pair, the dealer shall announce that wagers may be made on "three of a kind."

(e) After the third winning card is placed in the card stand, all poker hand wagers shall be settled as follows:

1. A wager on a "pair in three" shall only win if the third winning card forms a pair with either the first or second winning card;

2. A wager on a "flush" shall only win if the third winning card is of the same suit as the first and second winning cards;

3. A wager on an "open straight" or "inside straight" shall only win if the third winning card is consecutive in value with the first and second winning cards;

4. A wager on an "open straight flush" or "inside straight flush" shall only win if the third winning card is consecutive in value with and of the same suit as the first and second winning cards; and

OTHER AGENCIES

5. A wager on a "three of a kind" shall only win if the third winning card is of identical value with the first and second winning cards.

(f) All losing poker hand wagers shall be collected immediately by the dealer. The dealer shall then pay off all winning poker hand wagers in accordance with the odds currently being offered pursuant to N.J.A.C. 19:47-12.6.

(g) After all poker hand wagers are settled, the dealer shall remove the three cards from the card stand. The next spin of the pokette wheel which results in a winning card other than a joker shall determine the first winning card for the formation of new poker hand wagers.

19:47-12.9 Irregularities

(a) If the clapper comes to rest between two depictions of cards upon completion of the spin of the pokette wheel, the casino licensee has the option to do one of the following:

1. Declare the winning card to be the depiction of the card previously passed; or

2. Declare the spin void and re-spin the wheel.

(b) Upon a casino licensee choosing one of the options as outlined in (a) above, it shall conspicuously post a sign at each table stating which option is in effect.

(c) If the pokette wheel does not complete at least three revolutions, the dealer shall announce "No spin" and re-spin the pokette wheel.

19:47-12.10 Minimum and maximum wagers

(a) Each casino licensee shall submit to the Commission for review and approval, in accordance with N.J.A.C. 19:47-8.2, the minimum wagers permitted at each pokette table.

(b) Each casino licensee shall provide notice in accordance with N.J.A.C. 19:47-8.3 of the minimum and maximum wagers in effect at each pokette table.

(a)

**CASINO CONTROL COMMISSION
Temporary Adoption of Amendments
Gaming Equipment; Rules of the Games
Pai Gow Poker**

Authority: N.J.S.A. 5:12-69(e), 70(f) and 100(e).

Take notice that the Casino Control Commission shall, pursuant to N.J.S.A. 5:12-69(e), conduct an experiment for the purpose of determining whether various temporary amendments, which would give casino licensees the option of dealing the game of pai gow poker from the dealer's hand, should be adopted on a permanent basis. The experiment shall be conducted in accordance with temporary rules which will be posted in each casino participating in the experiment and will also be available from the Commission upon request.

Specifically this test would permit any casino which provides the necessary training and receives the necessary approvals to deal pai gow poker from the dealer's hand on a limited number of pai gow poker tables, subject to the terms and conditions of the experiment established by the Commission. The test will begin on or after November 24, 1992, on a specific date to be determined by the Commission, which date will be posted in each casino participating in the experiment and which will also be available from the Commission upon request. This experiment would continue for the maximum period of time permissible under N.J.S.A. 5:12-69(e), unless otherwise terminated by the Commission or any of the participating licensees prior to that time, pursuant to the terms and conditions of the experiment.

Should the temporary amendments prove successful in the judgment of the Commission, the Commission will adopt them in accordance with the public notice and comment requirements of the Administrative Procedure Act and N.J.A.C. 1:30. See the proposed amendments and new rule published in this issue of the New Jersey Register.

PUBLIC NOTICES

ENVIRONMENTAL PROTECTION AND ENERGY

(a)

ENVIRONMENTAL REGULATION

Notice of Public Hearings

Requests for Modification of Thermal Effluent Limitations by Exxon Company, U.S.A. (Bayway Facility) for its Discharge to the Tidal Portion of Morses Creek in Linden, pursuant to N.J.S.A. 58:10A-8 and N.J.A.C. 7:9-4.9

Take notice that the New Jersey Department of Environmental Protection and Energy ("Department") will be holding two public hearings and is soliciting public comments regarding two requests by Exxon Company, U.S.A. ("Exxon") and other petitioners, pursuant to N.J.S.A. 58:10A-8 and N.J.A.C. 7:9-4.9, for a modification of Exxon's anticipated thermal effluent discharge limitations. These limitations will eventually be included in Exxon's New Jersey Pollutant Discharge Elimination System ("NJPDES") permit to discharge to the tidal portion of Morses Creek. The hearings will also allow Exxon and the public to present testimony regarding the Department's use of a "no visible sheen" limitation and the issue of whether the Department may give Exxon credit, using "net" limitations, for the discharge of pollutants present in Exxon's intake water from the Arthur Kill.

Exxon discharges once-through cooling water and treated wastewater into the tidal portion of Morses Creek from its Bayway Refinery. The once-through cooling water is taken from the Arthur Kill and is discharged between two dams on Morses Creek. Exxon's existing NJPDES permit includes a thermal effluent limitation of 95° F measured at Exxon's lower dam (No. 1 dam). On January 1, 1991 Exxon submitted a request for a public hearing pursuant to N.J.S.A. 58:10A-8. In this request, Exxon maintained that the Department had announced its intention, in a December 3, 1990 decision denying a reclassification request for the tidal portion of Morses Creek, to issue a draft renewal NJPDES permit to Exxon with water quality-based effluent limitations that would be more stringent than federally required technology-based limitations. On June 24, 1991, the Department issued a draft renewal NJPDES permit to Exxon which included the same thermal limitations contained in the existing permit (95° F) and required Exxon to submit certain thermal studies and information which would allow the Department to establish appropriate thermal effluent limitations when the NJPDES permit was reopened. The Department stated that these appropriate thermal limitations may include water quality-based and/or best available technology economically achievable ("BAT") based effluent limitations.

In June of 1991, after discussions with the Department regarding the thermal limitations, Exxon expressed interest in an expedited determination on the appropriate thermal effluent limitations. In order to address Exxon's concerns, the Department established an alternative procedure in which Exxon would submit thermal discharge information and the Department would thereafter issue a notice of intent to establish the appropriate thermal effluent limitations. Having received a submittal of information from Exxon, the Department will publish its notice of intent to establish numerical effluent limitations on or before December 1, 1992. The notice of intent will contain the following: (1) a description of the Exxon Bayway facility and of its discharge to Morses Creek; (2) an analysis of the water quality in Morses Creek, and of the Bayway facility's effect upon it; (3) an analysis and description of the available alternatives that the Department could place within the NJPDES permit to improve the water quality; (4) a description and schedule of the remaining steps in the permit process; and (5) a proposed set of thermal effluent limitations for Exxon's discharge which may include water quality-based limitations, BAT-based limitations, or a combination of these two types of limitations for the various discharge points. Two public hearings on this issue have been scheduled for December 2nd and 7th, 1992 in Linden.

Exxon has requested two types of modifications to the anticipated thermal effluent limitations. First, Exxon requests relief under Section

8 of the Water Pollution Control Act, N.J.S.A. 58:10A-8. Section 8 provides the Department with the authority to establish effluent limitations which are more stringent than BAT limitations as required by the Clean Water Act, 33 U.S.C.A. § 1251 et seq., when a discharge in compliance with BAT limitations would interfere with the attainment and maintenance of the applicable water quality standards. Section 8 also requires the Department to publish a notice of intent when it plans to establish these more stringent effluent limitations. The thermal water quality standards in the tidal portion of Morses Creek, which is classified as SE3 in N.J.A.C. 7:9-4.15(e) Table 3, includes a numerical criterion of 85°F, as a maximum temperature, and limits the deviation from the ambient temperature to 4°F from September through May and to 1.5°F from June through August. N.J.A.C. 7:9-4.14(c)12i(1)(iv).

Section 8 requires the Department to hold a public hearing, when requested, to determine "if there is a reasonable relationship between the economic and social costs of achieving" the more stringent limitations, "including any economic or social dislocation in the affected community or communities, and the social and environmental benefits to be obtained, including the objective of restoring and maintaining the water quality of the State, and to determine whether such effluent limitations can be implemented with available technology or with other control strategies." Section 8 also provides that "[i]f a person affected by any such limitations demonstrates at the hearing that there is no reasonable relationship between the economic and social costs of compliance and the benefits to be obtained, the commissioner shall modify any such limitations as they may apply to that person."

In addition to its request for relief under Section 8, Exxon has requested a modification of its anticipated thermal water quality-based effluent limitations in accordance with N.J.A.C. 7:9-4.9. This modification procedure is consistent with the Federal limitations on allowing variances from water quality standards in 40 C.F.R. § 131.13. In order to obtain any relief, Exxon must demonstrate that:

1. The thermal water quality criteria are not attainable because of natural background; or
2. The thermal water quality criteria are not attainable because of irretrievable man-induced conditions; or
3. Natural, ephemeral, intermittent, or low flow conditions or water levels prevent the attainment of the thermal water quality criteria, unless these conditions may be compensated for by the discharge of sufficient volume of effluent discharges without violating State water conservation requirements to enable uses to be met; or
4. Controls more stringent than those required by Sections 301(b) and 306 of the Federal Clean Water Act would result in substantial and widespread adverse social and economic impact. [N.J.A.C. 7:9-4.9(a)2].

The purpose of this notice is to solicit public comment on Exxon's requests for modification. It should be noted that Exxon's submittals to date are based upon an assumption that the notice of intent will include water quality-based effluent limitations which will assure compliance with the thermal criteria for Morses Creek. Since the notice of intent will include the actual limitations Exxon seeks relief from, the notice of intent will be sent to all interested parties on or about December 1, 1992. In addition, additional copies will also be available at the public hearing. **All persons interested in receiving the Department's notice of intent** should send a letter to Jeanne A. Mroczko, at the address below, requesting a copy of the notice. After the issuance of the notice of intent, Exxon may supplement their submittals with additional arguments in support of the requested relief. Copies of the existing submittals and any additional submittals will be made available as a public record at the locations listed below. Due to the fact that the notice of intent will be published within two weeks of the public hearings and Exxon may submit additional material in support of their requests, the **comment period** will be open until January 15, 1993.

Public comments are encouraged on the following issues:

1. Whether the limitations in the Department's notice of intent are appropriate for Exxon's thermal discharge;
2. Whether Exxon has adequately demonstrated that it should be granted relief under Section 8 of the Water Pollution Control Act and, if relief is appropriate, what thermal effluent limitation should be imposed on Exxon's discharge;
3. Whether Exxon has adequately demonstrated that it should be granted relief under N.J.A.C. 7:9-4.9 and, if relief is appropriate, what

PUBLIC NOTICES

ENVIRONMENTAL PROTECTION

thermal water quality criteria and/or effluent limitation should be imposed on Exxon's discharge;

4. Whether the relief under Section 8 is limited or precluded by Federal law or regulations, including the limitations on variances from water quality standards under 40 C.F.R. § 131.13; and

5. Whether the Department should grant any relief to Exxon regarding the "no visible sheen" and "net" limitations as discussed below.

In addition to Exxon's request for relief from the anticipated thermal effluent limitations, the hearing will include Exxon's concerns regarding "no visible sheen" and "net" limitations. Exxon has asked that the "no visible sheen" limitation on its cooling water discharge be removed from its NJPDES permit. Exxon's arguments, that the limit is inconsistent with N.J.A.C. 7:14A-14.4 and 14.5(f) and 40 C.F.R. § 419.22(d) and that the presence of a sheen is also due to sources other than the fugitive leaks into the once-through cooling water system, may be found in Exxon's submittal. The two issues for public comment on the "net" limitations issue are: 1) whether "net" limits may be granted when the intake is from the Arthur Kill and the discharge is to the tidal portion of Morses Creek; and 2) whether "net" limitations may be allowed for water quality-based effluent limitations.

Two public hearings on Exxon's requests for modification will be held: Wednesday, December 2 and Monday, December 7, 1992 from 2:00 P.M. until 6:00 P.M. and from 7:00 P.M. until the end of testimony (but in no case later than 11:00 P.M.)

Linden Municipal Building
Public Hearing Room
Linden, New Jersey

The public hearings will begin with Exxon's testimony regarding the modification requests and other issues. Most of the time of the first hearing is likely to be devoted to the testimony by Exxon and its co-petitioners; they have estimated that this testimony may take up to eight hours. Other members of the public will be encouraged to present relevant testimony for any time remaining on December 2nd, and for the entire hearing on December 7th. All persons planning to testify at the hearings are strongly encouraged to pre-file any testimony with Jeanne A. Mroczko at the address below.

Interested persons may ask to be placed on a mailing list for the Department's notice of intent or submit written comments, by January 15, 1993, on Exxon's requests by writing to:

Jeanne A. Mroczko, Assistant Administrator
Office of Permit Information and Assistance
Environmental Regulation
Department of Environmental Protection and Energy
CN-423
Trenton, New Jersey 08625

Copies of the submittal in support of the requests for modification and the Department's notice of intent may be examined at the following locations:

Linden Public Library, Main Branch, Linden, NJ;
New Jersey State Library, Trenton, NJ;
Library of Science and Medicine, Rutgers University,
Piscataway, NJ;
Elizabeth Public Library, Elizabeth, NJ;
Newark Public Library, Newark, NJ; and
Public Access Center, Department of Environmental Protection
and Energy, 1st Floor, 401 East State Street,
Trenton, NJ

(a)

OFFICE OF LEGAL AFFAIRS

**Notice of Receipt of Petition for Rulemaking
N.J.A.C. 7:26-9.4, 9.8 and 9.10**

Petitioner: Exxon Company, U.S.A., Linden, New Jersey.

Take notice that the Department of Environmental Protection and Energy (Department) received a petition for rulemaking from Exxon Company, U.S.A. (petitioner) concerning N.J.A.C. 7:26-9.4, General facility standards, 9.8, General closure requirements, and 9.10, Financial requirements for facility closure.

Petitioner requests that the Department amend N.J.A.C. 7:26-9.4, 9.8 and 9.10 to conform them with counterpart provisions adopted on August 14, 1989 by the United States Environmental Protection Agency. The Federal regulations were adopted pursuant to the Resource Conservation

and Recovery Act, 42 U.S.C. 6901 et seq. See 54 FR 33376, "Delay of Closure Period for Hazardous Waste Management Facilities"; 40 C.F.R. Parts 264, 265 and 270. Specifically, petitioner asks the Department to adopt "delay of closure" regulations, which would allow, under limited circumstances, a landfill, surface impoundment, or land treatment unit to remain open after the final receipt of hazardous wastes in order to receive non-hazardous wastes in that unit.

In accordance with the provisions of N.J.A.C. 1:30-3.6, the Department shall subsequently mail to petitioner, and file with the Office of Administrative Law, a notice of action on the petition.

(b)

DIVISION OF PARKS AND FORESTRY

**Notice of Public Hearing
Proposed Granting of Access Easement
Comprising Part of Delaware and Raritan Canal State
Park**

Take notice that the State of New Jersey, Department of Environmental Protection and Energy by the Division of Parks and Forestry, will hold a public hearing to seek comments on the proposed easement of the following State-owned Delaware and Raritan Canal State Park lands to allow access to an adjacent residence.

Easement Description

All that certain land at Delaware and Raritan Canal State Park containing approximately 1500 square feet designated as a portion of Block 1043, Lot 6 on the current Tax Map of the city of Lambertville, county of Hunterdon, State of New Jersey. This easement is required to provide for vehicular access to an existing residence adjacent to the Delaware and Raritan Canal State Park. This access easement shall be granted to Jennifer Kitchen Ennis and Robert P. Ennis, current owners of 62-64 Canal Street, Lambertville, NJ.

The easement documents will be available for review Monday through Friday between the hours of 9:00 A.M. to 4:00 P.M. at the Delaware and Raritan Canal State Park Office located on Canal Road, Somerset, New Jersey.

The proposed easement land and adjacent State-owned lands serve as recreational lands for active and passive public use. The granting of this easement will not interfere with or affect the use of State-owned lands for this stated purpose.

The public hearing will be held on:

Thursday, December 17, 1992 at 2:00 P.M.
at the Delaware and Raritan Canal Commission Office
Route 29, Stockton, NJ 08559.

Persons wishing to make oral presentations are asked to limit their comments to a three to five minute time period. Presenters should bring a copy of their comments to the hearing for use by the Department. The hearing record will be kept open for a period of seven days following the date of the public hearing so that additional written comments can be received.

Anyone in need of special assistance to participate in the public hearing should please contact Superintendent Paul Stern at (908) 873-3050.

Interested persons may submit written comments until December 24, 1992 to:

Gregory A. Marshall, Director
Division of Parks and Forestry
Department of Environmental Protection and Energy
CN 404
Trenton, New Jersey 08625

(c)

DIVISION OF PARKS AND FORESTRY

**Notice of Availability of Grants
Open Lands Management Program**

Take notice that in compliance with N.J.S.A. 52:14-34.4 et seq., the Department of Environmental Protection and Energy hereby announces the availability of the following State grant funds:

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A. Name of program: Open Lands Management Program. Authority: Open Lands Management Act, P.L. 1983, c. 560 (N.J.S.A. 13:1B-15.133 et seq.), and Open Lands Management rules, N.J.A.C. 7:2-12.

B. Purpose: The purpose of the Open Lands Management Program is to provide financial assistance and in-kind services for the development and maintenance of privately owned land for public recreational purposes. If an application for funding is approved, the landowner and the State sign an agreement known as an access covenant, which guarantees public access for a specified period of time, for specified recreational purposes, to a specific parcel of private land.

C. Amount of money in the program: The Department anticipates that \$55,000 will be available for funding Open Lands Management projects in FY 1993 which ends on June 30, 1993.

D. Individuals or organizations who may apply for funding under this program: Any person, including, but not necessarily limited to, individuals, corporations, clubs, associations and non-profit organizations, who owns real property in fee simple, may apply for financial assistance under this program.

E. Qualifications needed by an applicant to be considered for the program: To be eligible for financial assistance under this program, the applicant must meet the following criteria in accordance with the provisions of N.J.A.C. 7:2-12.4:

1. The applicant must have a fee simple interest in real property; the property must include open space which is not dominated by buildings, structures or other manmade facilities; the property must be free of any known public health hazards; and the property must be free of liens or other clouds against title which would tend to interfere with the use and enjoyment of the property.

2. The applicant must specify a project to be funded. Eligible projects include:

- a. Installation, repair or replacement of protective structures, such as fencing, water bars, berms or stiles.
- b. Installation, repair or replacement of any facility which provides or improves public recreational access to privately-owned land, such as parking area, access roads, trails, interpretive signs, picnic areas, rest areas, portable sanitary facilities, boat or canoe launch areas, and signs stating ownership, and use;
- c. Planting, restoration or maintenance of trees or shrubs for the purpose of screening or increasing the value of scenic areas;
- d. Repair or restoration of any vandalized crops or improvements located on, or adjacent to agricultural and which is subject to an access covenant provided that the damage occurred as a result of the public use;
- e. Installation, repair, replacement and maintenance of litter and trash control facilities;
- f. Installation, repair or replacement of facilities which provide or improve recreational access for the handicapped;
- g. Stocking of fish and wildlife to provide recreational fishing and hunting;
- h. Purchase of additional liability insurance made necessary because of use of the property by the public;
- i. Filing fees for access covenant and associated legal fees; and
- j. Professional fees for design, survey and construction of project in accordance with the approved application.

3. The applicant must make the eligible real property available to the public for passive recreational activities. Such activities may include: trail use, water related activities, and other outdoor recreational use.

F. Procedure for application and review: The landowner or landowner's agent designated by a properly executed Power of Attorney, shall submit an application for financial assistance on a form provided by the Department. During its review, the Department may meet with the applicant to discuss the proposed project, inspect the property and recommend any changes it deems necessary. Within 30 days of receipt of the application the Department will either deny the application citing the reasons for denial or grant preliminary approval.

Final approval shall be contingent primarily upon receipt of all permits required to implement the proposed project; execution of an agreement which states the terms and conditions by which financial assistance will be disbursed; and execution of an access covenant in accordance with the provisions of N.J.A.C. 7:2-12.10 which assures public access for a specified time period.

G. Address of the division, office or official receiving the application: Applications for Open Lands Management grants may be requested from, and completed and submitted to:

Celeste Tracy
 Open Lands Management Program
 Office of Natural Lands Management
 Division of Parks and Forestry
 New Jersey Department of Environmental
 Protection and Energy
 CN 404
 Trenton, New Jersey 08625-0404
 (609) 984-1339

H. Dates applications will be accepted: Applications or funding during FY 1992 must be submitted between February 22, 1993 and February 26, 1993.

I. Date by which applicant shall be notified for preliminary approval or disapproval: Within 30 days of receipt, the Department shall evaluate applications for funding under this program and either disapprove or grant preliminary approval of the application.

(a)

**OFFICE OF REGULATORY POLICY
 Amendment to the Cape May County Water Quality
 Management Plan
 Public Notice**

Take notice that as a result of a lawsuit filed in the Superior Court, Chancery Division, *Senico, et al. v. Township of Middle, et al.*, (Docket No. CPM-C-35-91), the New Jersey Department of Environmental Protection and Energy ("NJDEPE") will reopen its October 12, 1990 decision adopting a Middle Township Wastewater Management Plan as an amendment to the Cape May County Water Quality Management ("WQM") Plan. Pursuant to the court's order, the NJDEPE will make a *de novo* determination, but only with respect to that part of its decision that affected property located at Block 415.01, Lot 1; Block 432, Lots 1-5; and Block 433, Lots 11-13 located on the Delaware Bay in the Del Haven area of the Township of Middle, County of Cape May.

This notice is being given to inform the public that the NJDEPE is seeking public comment as to whether the Cape May County WQM Plan should be amended to eliminate the property described above from the Del Haven sewer service area. This will also serve as notice that the NJDEPE will hold a **nonadversarial public hearing** with regard to this issue. The hearing will be held on Thursday, December 17, 1992 at 10:00 A.M. in the Courtroom of the Middle Township Municipal Building, 2 South Boyd Street, Cape May Court House, New Jersey. All information dealing with the aforesaid WQM Plan and the proposed amendment is located at the Cape May County Planning Department, CN 309, Central Mail Room, 4 Moore Road, Cape May Court House, New Jersey 08210 and the NJDEPE, Office of Regulatory Policy, 401 East State Street, 3rd Floor, CN 423, Trenton, New Jersey 08625. It is available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appointment may be made by calling the Cape May County Planning Department at (609) 465-1083 or the Office of Regulatory Policy at (609) 633-7021.

Interested persons may also submit written comments on the amendment to Mr. Barry Chalofsky at the NJDEPE address cited above with a copy sent to Mr. Grover Webber of the Cape May County Planning Department at the Cape May Court House address cited above. All comments must be submitted by January 4, 1993. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by NJDEPE with respect to the amendment request.

(b)

**OFFICE OF REGULATORY POLICY
 Amendment to the Upper Raritan Water Quality
 Management Plan
 Public Notice**

Take notice that the New Jersey Department of Environmental Protection and Energy (NJDEPE) is seeking public comment on an amendment to the Upper Raritan Water Quality Management (WQM) Plan. This amendment, requested by the Borough of Peapack and Gladstone, would

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adopt a Wastewater Management Plan (WMP) for the Borough of Peapack and Gladstone. The WMP proposes abandonment of the Peapack Sewage Treatment Plant (STP) with flows being conveyed to the Environmental Disposal Corporation (EDC) STP in Bedminster Township. The EDC STP sewer service area and a groundwater discharge area for facilities with design flows of less than 2,000 gallons per day are identified.

This notice is being given to inform the public that a plan amendment has been proposed for the Upper Raritan WQM Plan. All information related to the WQM Plan and the proposed amendment is located at the New Jersey Department of Environmental Protection and Energy (NJDEPE), Office of Regulatory Policy, CN-029, 401 East State Street, Third Floor, Trenton, New Jersey 08625. It is available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appointment to inspect the documents may be arranged by calling the Office of Regulatory Policy at (609) 633-7021.

Interested persons may submit written comments on the proposed amendment to Mr. Edward Frankel, at the NJDEPE address cited above with a copy sent to Margaret Gould, Peapack and Gladstone Borough Administrator, 1 School Street, Peapack, New Jersey 07977. All comments must be submitted within 30 days of the date of this notice. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by NJDEPE with respect to the amendment request.

Any interested persons may request in writing that NJDEPE hold a nonadversarial public hearing on the amendment or extend the public comment period in this notice up to 30 additional days. These requests must state the nature of the issues to be raised at the proposed hearing or state the reasons why the proposed extension is necessary. These requests must be submitted within 30 days of this notice to Mr. Frankel at the NJDEPE address cited above. If a public hearing for the amendment is held, the public comment period in this notice shall be extended to close 15 days after the public hearing.

(a)**DIVISION OF SOLID WASTE MANAGEMENT****Notice of Legislative Requirements****Toxic Packaging Reduction Act****Public Law 1991, Chapter 520****N.J.S.A. 13:1E-99.44 through 99.58**

Effective January 20, 1992

Take notice that on or after January 1, 1993, no person shall sell, offer for sale or offer for promotional purposes in New Jersey any package or packaging component which includes, in the package itself or in any packaging component, inks, dyes, pigments, adhesives, or any other additives containing any lead, cadmium, mercury or hexavalent chromium which has been intentionally introduced as a chemical element during manufacturing or distribution as opposed to the incidental or natural background presence of any of these elements. In addition, no person shall sell, offer for sale or offer for promotional purposes in New Jersey any product contained in a package which includes, in the package itself or any packaging component, inks, dyes, pigments, adhesives, stabilizers or any other additives containing any lead, cadmium, mercury or hexavalent chromium which has been intentionally introduced as a chemical element during manufacturing or distribution as opposed to the incidental or natural background presence of any of these elements.

On or after January 1, 1993, the sum concentration levels of lead, cadmium, mercury or hexavalent chromium present in any packaging or packaging component shall not exceed 600 parts per million (ppm), or 0.06 percent by weight. This sum concentration in the packaging or packaging component shall not exceed 250 ppm or 0.025 percent by weight on or after January 1, 1994, and shall not exceed 100 ppm or 0.01 percent by weight on or after January 1, 1995.

A "package" is defined as a container specifically manufactured for the purpose of marketing, protecting or handling a product and shall include a unit package, an intermediate package and a shipping container as defined by the American Society for Testing and Materials (ASTM) in ASTM D996. In addition, a package also means and includes such unsealed receptacles as carrying cases, crates, cups, pails, rigid foil and other trays, wrappers and wrapping films, bags and tubs. A "packaging component" is defined as any individually assembled part of a package

including, but not limited to, any interior or exterior blocking, bracing, cushioning, weather proofing, exterior strapping, coating, closure, ink, label, dye, pigment, adhesive, stabilizer or any other additive; except that a coating shall not include a thin tin layer applied to base steel or sheet steel during manufacturing of the steel or package.

In addition to the above exemption, the following exemptions to the Toxic Packaging Reduction Act may be claimed by a packaging manufacturer, product manufacturer or distributor in accordance with rules and regulations to be adopted by the Department of Environmental Protection and Energy (hereinafter Department) pursuant to the Administrative Procedures Act as set forth at N.J.S.A. 52:14B-1 et seq.:

1. The package or packaging components were manufactured prior to January 1, 1993, provided the package or packaging component is labeled with a code indicating a date of manufacture prior to January 1, 1993. The labeling requirement may be waived by the Department in those cases where it is not feasible or practical to label individual packages or packaging components, provided that suitable alternative evidence of a date of manufacture, prior to January 1, 1993, is provided to the Department;

2. Packages or packaging components used to contain alcoholic beverages, including liquor, wine, vermouth and sparkling wine, bottled prior to January 1, 1993;

3. Packages or packaging components which are glass containers with ceramic labeling used to contain pharmaceutical preparations. This exemption expires on January 1, 1995;

4. Packages or packaging components which are glass containers with ceramic labeling used to contain cosmetics. This exemption expires on January 1, 1995;

5. Packages or packaging components to which lead, cadmium, mercury or hexavalent chromium have been added in the manufacturing, forming, printing or distribution process in order to comply with health or safety requirements of Federal law;

6. Packaging or packaging components to which lead, cadmium, mercury or hexavalent chromium have been added in the manufacturing, forming, printing or distribution process and for which there is no feasible or practical alternative or substitute. This exemption expires on January 1, 1995. This exemption may be renewed by the Department for a period not to exceed two years provided evidence is furnished to the Department that there is no feasible or practical alternative or substitute;

7. Packaging or packaging components that would not exceed the maximum contaminant level except for the addition of post-consumer waste material. This exemption expires on January 1, 1997;

8. Packaging or packaging components composed of metal and commonly referred to as "tin cans" that are used to contain food or food products intended for human consumption and that may exceed the maximum contaminant levels due to incidental presence of lead as a naturally occurring chemical element in the metal that is unrelated to the manufacturing process; or

9. Packaging or packaging components composed of metal and commonly referred to as "tin cans" that are used to contain paints, chemicals or other non-food products to which lead has been added in the manufacturing process for the purposes of forming, soldering, or sealing the can, or that may exceed the maximum contaminant levels due to the incidental presence of lead as a naturally occurring element in the metal that is unrelated to the manufacturing process.

The exemptions in 8 and 9 above shall expire on January 1, 1997, except that the exemption may be renewed by the Department after this date for a period not to exceed two years, provided evidence is furnished to the Department that there is no feasible method to reduce the concentration levels of lead for the specified package or packaging component.

The term "no feasible or practical alternative or substitute" is defined as one in which the use of lead, cadmium, mercury or hexavalent chromium is essential to the protection, safe handling, or function of the contents of the package.

A "distributor" is defined as any person who distributes packaged products intended for retail sale in packages or packaging components. A "package manufacturer" is defined as any person who manufactures packages or packaging components. A "product manufacturer" is defined as any person who purchases packages or packaging components from a package manufacturer for the purposes of marketing, protecting or handling the contents of the package or packaging component, including a product intended for retail sale. A "retailer" is defined as any person

who engages in the sale within New Jersey of packaged products intended for retail sale in packages or packaging components to a consumer for off-premises use or consumption.

Any product contained in a package or packaging component for which an exemption is claimed may be sold by a retailer provided that a declaration of exemption claimed by the product manufacturer, package manufacturer or distributor, is valid and in accordance with the provisions of the exemption noted in 1 through 9 above, and as may be verified by the Department.

Any package manufacturer, product manufacturer or distributor claiming an exemption shall maintain on file a written declaration of exemption for each specified package or packaging component for which an exemption is claimed. The written declaration shall contain the following:

1. A statement setting forth the specific basics upon which the exemption is claimed;
2. The full name, business address, telephone number and signature of the person claiming the exemption; and
3. The full name, business address, telephone number of the authorized local representative of the person claiming the exemption.

No later than January 1, 1993, a written certification of compliance stating that a package or packaging component is in compliance with the requirements of the Act shall be furnished by the package manufacturer to the product manufacturer or distributor of the product packaged in that specified package or packaging component. The certification shall be signed by an authorized representative of the package manufacturer. The product manufacturer or distributor shall retain the certification of compliance for as long as the package or packaging component is in use, a copy of which shall be kept on file by the package manufacturer. In the event that the package manufacturer reformulates or creates a new package or packaging component, a new or amended certification of compliance shall be furnished by the packaging manufacturer to the product manufacturer or distributor.

Copies of the certification of compliance and its declaration of exemption shall be furnished to the Department and to members of the public upon request. The Department may request, by certified mail, that any package manufacturer, product manufacturer or distributor transmit to the Department a written certification or declaration of exemption that a specified package or packaging component is in compliance with the provisions of this Act. The package manufacturer, product manufacturer or distributor, as the case may be, shall submit copies of each declaration of exemption or certification of compliance to the Department within 45 days of receipt of the request. Upon receipt by the Department of the information requested from the package manufacturer, product manufacturer or distributor, the Department shall review this information and shall verify that all certifications of compliance are complete and that all declarations of exemptions claimed are valid. Requests for copies of the certification of compliance from the public shall be made in writing with a copy provided to the Department at the following address:

New Jersey Department of Environmental
Protection and Energy
Division of Solid Waste Management
Bureau of Source Reduction and Market Development
CN 414
Trenton, New Jersey 08625-0414

The package manufacturer, product manufacturer or distributor shall respond, in writing, within 60 days of receipt of the request and shall provide a copy of this response to the Department at the above address.

The Department shall have the right to enter the premises of a package manufacturer, product manufacturer, distributor or retailer at which packages or packaging components are manufactured or stored or at which products packaged in packages or packaging components are sold or offered for sale or for promotional purposes, in order to determine compliance with the requirements of this Act. The Department may, at any time during normal business hours and upon presentation of appropriate credentials, conduct inspections which may include the taking of samples of products packaged in a package or packaging component for the purpose of testing the package or packaging component. The Department may be required to purchase any product packaged in a package or packaging component for which a sample is sought at a retail establishment, if requested to do so by the retailer.

Whenever a package or packaging component is found by the Commissioner of the Department to fail to comply with the provisions of the Act, the Commissioner may issue an order requiring the distributor or retailer, as the Department deems appropriate, to remove or arrange

for the removal of the entire allotment of the product packaged in the noncomplying package or packaging component from the premises and directing that the distributor or retailer return the entire allotment of the product packaged in the noncomplying package or packaging component to the product manufacturer for credit or reimbursement.

Whenever the Commissioner finds that a package manufacturer, product manufacturer or distributor has failed to respond to a request for certification or declaration of exemption made by the Department, the Commissioner may issue an order requiring the package manufacturer or product manufacturer, as the Department deems appropriate, to submit a specified package or packaging component to laboratory analyses, conducted at the ordered person's expense by a laboratory certified by the Department, in order to certify that the package or packaging component is in compliance with the provisions of this Act.

Whenever the Commissioner finds that a person has violated any provision of this Act, the Commissioner may:

1. Issue an order requiring the person found to be in violation to comply. The order shall specify the provisions which the person is in violation, cite the action that constituted the violation, order abatement of the violation, and give notice to the person of the person's right to a hearing. The person receiving the order shall have 20 calendar days from receipt of the order to request a hearing. A request for hearing shall not automatically stay the effect of the order;

2. Bring a civil action. The Commissioner may institute an action or proceeding in the Superior Court for injunctive and other relief to enforce the provisions of this Act, and to prohibit and prevent a violation of this Act and the court may proceed in the action in a summary manner. In any such proceeding the court may grant temporary or interlocutory relief. Such relief may include singly or in combination the following:

- a. A temporary or permanent injunction; and
- b. Assessment of the violator for reasonable costs of any inspection, including the costs of any sampling or testing of packages or packaging components that led to the establishment of the violation and for the reasonable costs of preparing and litigating the case;

3. Levy a civil administrative penalty. The Commissioner may assess a civil administrative penalty of not more than \$7,500 for a first offense, not more than \$10,000 for a second offense and not more than \$25,000 for a third and every subsequent offense. Each day that a violation continues shall constitute an additional, separate and distinct offense. No assessment may be levied until after the violator has been notified by certified mail or personal service. The notice shall include the violation, a concise statement of the facts, the amount of the penalties and the right to a hearing. Payment of the assessment is due when a final order is issued. The authority to levy a civil administrative penalty is in addition to all other enforcement provisions of the Act;

4. Bring an action for a civil penalty. A person who violates this Act shall be liable for a penalty of not more than \$7,500 per day to be collected in a civil action commenced by the Commissioner; and

5. Petition the Attorney General to bring a criminal action. Any person who purposely or knowingly sells, offers for sale or offers for promotional purposes any package or packaging component in violation of the Act; sells, offers for sale or offers for promotional purposes any product in violation of the Act; or sells, offers for sale or offers for promotional purposes any package or packaging component that exceeds the maximum contaminant levels of the Act, upon conviction, shall be guilty of a crime of the third degree and shall be subject to a fine of not less than \$7,500 for a first offense, not more than \$10,000 for a second offense and not more than \$25,000 for a third and every subsequent offense. Each day during which the violation continues constitutes an additional separate and distinct offense. A prosecution for a violation of this provision shall be commenced within five years of the date of discovery of the violation.

No retailer shall be deemed to have violated the provisions of the Act if the Commissioner finds that the retailer can demonstrate that, in the purchase of a specified package or packaging component, the retailer relied in good faith on the written assurance of the product manufacturer or distributor that the package or packaging component complied with the Act. The written assurance shall state that a specified package or packaging component is in compliance with the provisions of the Act and shall be signed by or authorized by a representative of the package manufacturer or distributor. If an exemption is claimed for a package or packaging component, the written assurance shall state the specific basis upon which the exemption is claimed.

The Department, in consultation with the Source Reduction Council of the Coalition of Northeastern Governors (CONEG), shall review the

effectiveness of the Act no later than 42 months after its effective date (July 20, 1996), and shall provide to the Governor and the Legislature a written report based upon that review. The report shall include the following:

1. A recommendation whether to continue exemptions 7, 8 and 9 referenced above;
2. A description of the nature of the substitute elements used in lieu of lead, cadmium, mercury and hexavalent chromium during the manufacturing or distribution of a package or packaging components; and
3. May contain recommendations to include additional toxic substances contained in packages or packaging components in order to further reduce the toxicity of packaging waste.

The effective date of the Act was January 20, 1992.

(a)

DIVISION OF SOLID WASTE MANAGEMENT
Notice of Receipt of Battery Management Plans
Public Law 1991, Chapter 520
N.J.S.A. 13:1E-99.59 et seq.

Take notice that pursuant to N.J.S.A. 13:1E-99.66, the Department is publishing notice of receipt of the Consumer Mercuric Oxide, Institutional Mercuric Oxide and Nickel-Cadmium and Sealed Lead Rechargeable Battery Management Plans. In addition to the Battery Management Plans, the Department is publishing notice of receipt of the Battery Collection Plans for all other dry cell batteries.

The dry cell batteries covered by the Consumer Mercuric Oxide Battery Management Plan are only for consumer mercuric oxide batteries, typically referred to as button batteries, sold for use in hearing aids. Pursuant to N.J.S.A. 13:1E-99.61, a "consumer mercuric oxide battery" is defined as any battery which is purchased at retail by a consumer for personal or household use. The dry cell batteries covered by the Institutional Mercuric Oxide Battery Management Plan are for mercuric oxide batteries designed or sold for commercial, industrial, medical or institutional use. Pursuant to N.J.S.A. 13:1E-99.61, an "institutional generator" is defined as the owner or operator of any public or private, commercial or industrial establishment or facility, including any establishment owned or operated on behalf of, a governmental agency, health care facility or hospital, licensed or other authorized hearing aid dispenser, research laboratory or facility, who routinely uses large quantities of mercuric oxide batteries or nickel-cadmium or sealed lead rechargeable batteries; or the owner or operator of any public or private facility identified by the Department that generates at least 220 pounds of these types of dry cell batteries per month, or the owner or operator of any public or private facility that accumulates 220 pounds of these of used dry cell batteries at any time. The dry cell batteries covered by the Nickel-Cadmium and Sealed Lead Rechargeable Battery Management Plan are for all rechargeable nickel-cadmium and sealed lead acid batteries including both consumer and institutional users.

Pursuant to N.J.S.A. 13:1E-99.66, Alexander Manufacturing Company submitted the Institutional Mercuric Oxide Battery Management Plan for its institutional mercuric oxide batteries.

Pursuant to N.J.S.A. 13:1E-99.66, the National Electrical Manufacturers Association (NEMA) submitted the Consumer Mercuric Oxide Battery Management Plan on behalf of the following consumer mercuric oxide battery manufacturers:

Duracell, Inc.;
 Eveready Battery Company, Inc.;
 Panasonic Industrial Company, for the batteries produced by its overseas affiliated companies; and
 Rayovac Corporation

Pursuant to N.J.S.A. 13:1E-99.66, the Portable Rechargeable Battery Association (PRBA) submitted the Rechargeable Battery Management Plan on behalf of the following consumer and institutional nickel-cadmium and sealed lead acid battery manufacturers:

AER Energy Resources, Inc.;
 Alexander Manufacturing, Co.;
 BRK Electronics (A Pittway Division);
 Duracell;
 ELPOWER Corp.;
 Eveready Battery Company, Inc.;
 Gates Energy Products, Inc.;

GP Batteries International, Ltd.;
 GS Battery U.S.A., Inc.;
 JaBro Batteries, Inc.;
 Panasonic Industrial Company;
 Rayovac Corporation;
 SAFT America, Inc.;
 Sanyo Energy (USA) Corp.;
 Shin-Kobe Electric Machinery Co.;
 The Furukawa Battery Co., Ltd.;
 VARTA Batteries, Inc.; and
 Yuasa Battery Company, Ltd.

Pursuant to N.J.S.A. 13:1E-99.67, NEMA submitted the Battery Collection Plan on behalf of the following dry cell battery manufacturers:

Alexander Manufacturing Company;
 Bright Star Industries, Inc.;
 Duracell, Inc.;
 Eveready Battery Company, Inc.;
 Fuji Electrochemical;
 Gates Energy Products;
 Marathon Power Technologies;
 Matsushita;
 Mutec;
 Polaroid Corp.;
 Rayovac Corp.;
 Sanyo Electric;
 Sony Energy-Tech;
 Toshiba Battery; and
 Toyo Takasago.

Pursuant to N.J.S.A. 13:1E-99.63a, no person shall sell, offer for sale, or offer for promotional purposes in this State any consumer mercuric oxide batteries which exceed a mercury concentration level of more than 250 parts per million by weight (0.025 percent) for all batteries manufactured on or after January 1, 1992. This provision, in effect, bans consumer mercuric oxide batteries from sale in New Jersey unless they can meet the 250 ppm level. N.J.S.A. 13:1E-99.63b grants an exemption to this ban for consumer mercuric oxide batteries which are sold by hearing aid dispensers licensed pursuant to the provisions of N.J.S.A. 45:9A-1 et seq. or by other specialized hearing aid dispensers authorized by the Commissioner to sell these batteries. The reason for this exemption is that there are a small and decreasing universe of hearing aids which require a consumer mercuric oxide battery to function properly. The Consumer Mercuric Oxide Battery Management Plan addresses only that decreasing universe of consumer mercuric oxide batteries. This exemption expires on January 1, 1994.

Pursuant to N.J.S.A. 13:1E-99.65, no person shall sell, offer for sale or offer for promotional purposes in this State any mercuric oxide battery or any nickel-cadmium or sealed lead rechargeable battery, unless the manufacturer has obtained the prior written approval of the Department of a plan for the collection, transportation, recycling or proper disposal of that used dry cell battery. Every manufacturer shall be liable, at his own expense, for the environmentally sound collection, transportation, recycling or proper disposal of every used mercuric oxide battery or used nickel-cadmium or sealed lead rechargeable battery produced by him and sold or offered for promotional purposes in this State.

As of October 20, 1992 (nine months from the effective date of the Dry Cell Battery Management Act), every manufacturer of mercuric oxide batteries, nickel-cadmium rechargeable batteries or sealed lead rechargeable batteries sold or offered for promotional purposes in this State was to prepare and submit a battery management plan, in writing to the Department for the environmentally sound collection, transportation, recycling or proper disposal of each specified used dry cell battery produced by that manufacturer.

This plan must include, but need not be limited to:

1. The designation of the collector, transporter, processor or collection system to be utilized by the manufacturer, or by the county or municipality, institutional generator, retailer or small quantity generator on behalf of the manufacturer, for the collection, transportation, recycling or proper disposal of used mercuric oxide batteries or used rechargeable batteries in each county including, as appropriate, evidence of contracts or agreements entered into;
2. Designation of the funding source or mechanism to be utilized by the manufacturer to defray the costs of implementing the battery management plan;
3. A strategy for informing consumers, on any store display promoting the sale or use of the rechargeable batteries he manufactures, that these

types of used dry cell batteries may not enter the solid waste stream, and that a convenient mechanism for collection, transportation, recycling or proper disposal of used rechargeable batteries is available to the consumer;

4. A Statewide consumer education program to assure the widespread dissemination of information concerning the environmental impact of the improper disposal of used mercuric oxide batteries or rechargeable batteries, and to inform consumers that manufacturers of these types of dry cell batteries are liable for their environmentally sound disposal; and

5. A strategy for establishing and implementing, as deemed necessary by the Department, an industry-wide uniform coding system for the identification and labeling of all mercuric oxide batteries or rechargeable batteries.

In addition to the Battery Management Plans as required pursuant to N.J.S.A. 13:1E-99.66 for all mercuric oxide and rechargeable batteries, as of October 20, 1992 (nine months from the effective date of the Dry Cell Battery Management Act), all other dry cell battery manufacturers, including, but not limited to, alkaline, carbon zinc, lithium, silver oxide, and zinc-air battery manufacturers, who sell or offer for sale their batteries in this State, were to submit Battery Collection Plans. The Battery Collection Plans were to include, but not be limited to:

1. A strategy for expanding and increasing the collection, recycling or proper disposal of all used dry cell batteries in each county including, but not limited to, alkaline manganese, consumer mercuric oxide or zinc-carbon batteries manufactured prior to January 20, 1992; and

2. A strategy for establishing and implementing, as deemed necessary by the Department, an industry-wide uniform coding system for the identification and labeling of all dry cell batteries.

Take notice that all other mercuric oxide battery manufacturers, nickel-cadmium and sealed lead rechargeable battery manufacturers not cited above for submission of their Battery Management Plans and all other battery manufacturers are in violation of the N.J.S.A. 13:1E-99.59 et seq. Pursuant to N.J.S.A. 13:1E-99.78, any person convicted of a violation of the Dry Cell Battery Management Act shall be subject to a penalty of not less than \$500.00 nor more than \$1,000 for each offense. If the violation is of a continuing nature, each day during which it continues constitutes an additional, separate and distinct offense.

Copies of the Plans are available for review at the offices of the Division of Solid Waste Management, Bureau of State and County Planning. Appointments to review the plans can be made by writing or calling the following:

New Jersey Department of Environmental
Protection and Energy
Division of Solid Waste Management
Chief, Bureau of State and County Planning
CN 414
840 Bear Tavern Road
Trenton, New Jersey 08625-0414
(609) 530-8203

Information concerning the NEMA Battery Management Plan or NEMA Battery Collection Plan may be obtained by contacting:

Lisa Silverstone
National Electrical Manufacturers Association
2101 L Street, NW
Suite 300
Washington, DC 20037
(202) 457-8424

Information concerning the PRBA Battery Management Plan may be obtained by contacting:

Norm England
Portable Rechargeable Battery Association
1000 Parkwood Circle
Suite 430
Atlanta, Georgia 30339
(404) 612-8826

Pursuant to N.J.S.A. 13:1E-99.66c(1), the Department has 30 days from receipt of the plan to deem the application complete or request that the manufacturer submit additional information to assist in its review. Pursuant to N.J.S.A. 13:1E-99.66c(2), the Department shall, within 45 days of receipt of a complete plan, approve or deny the plan.

HEALTH

(a)

DIVISION OF HEALTH FACILITIES EVALUATION AND LICENSING

Notice of Action on Petition for Rulemaking

Licensing Standards for Hospitals

Patient Rights; Administrative and Hospital-Wide Rules

N.J.A.C. 8:43G

Hospital Reimbursement: Hospital Rate Setting

N.J.A.C. 8:31B

Petitioner: Frank R. Ciesla, Esq., representing the New Jersey Hospital Association.

Authority: N.J.S.A. 26:2H-5(b).

Take notice that on September 16, 1992, the New Jersey Department of Health received a petition for rulemaking from the New Jersey Hospital Association (NJHA). The petition was filed by Frank R. Ciesla, Esq., of Giordana, Halleran and Ciesla, counsel to NJHA.

Public notice of receipt of this petition was published in the November 2, 1992 New Jersey Register. The petition requests the Department to promulgate amendments to current hospital licensure standards which require each New Jersey hospital to accept all patients for treatment, irrespective of their ability to pay. In addition, the petitioner requested that new hospital rate setting rules be proposed to provide reimbursement to hospitals providing care to indigent and bad debt non-residents who were not suffering from life-threatening conditions. NJHA has submitted the proposed amendments in response to enactment of P.L. 1992, c.68 (N.J.S.A. 26:2H-18.29) on July 29, 1992. This legislation amended the statutory provisions establishing the New Jersey Health Care Trust Fund, by prohibiting reimbursement to hospitals for uncompensated care for health care services provided to patients who are residents of another state, other than emergency care for life-threatening conditions.

In accordance with N.J.A.C. 1:30-3.6, and after thorough review of the petition, the Department has determined that the matter needs further deliberation. The Department has not yet received any comment on this petition from individual facilities or from the public at large. In order to gather public comment on the issues presented in the petition, the Department will consider scheduling a public hearing.

Upon the conclusion of the Department's deliberations on January 15, 1993, the decision will be mailed to the petitioners and published in a future New Jersey Register.

A copy of this notice has been mailed to the petitioner, as required by N.J.A.C. 1:30-3.6.

HUMAN SERVICES

(b)

OFFICE OF THE ASSOCIATE COMMISSIONER

Notice of Availability of Grant Funds

Community Challenge Grants Under the Department of Human Services' Minority Males Initiative

Take notice that, in compliance with N.J.S.A. 52:14-34.4 et seq., the New Jersey Department of Human Services hereby announces the availability of the following grant program funds:

A. Name of program: Community Challenge Grant Program for Minority Males.

B. Purpose: The purpose for which these grants are issued is to fund new projects which address the multitude of health and human services problems afflicting minority males in New Jersey. Specifically, grant funds must be used as start-up money to develop and support activities meeting one of the following goals: family unity; prevent or remedy health

conditions in minority males; encourage young men to stay in school and to reach their full potential; prepare the workforce for the technical skills that will be needed in the future; and/or reduce the likelihood that young men will become involved in the criminal justice system. Projects should seek opportunities to empower communities and local organizations to be active participants in creating solutions to the health and human services problems afflicting minority males in New Jersey. Grant funds may be used for personnel, equipment, supplies, domestic travel, and other costs directly related to the project described in the approved application. Funds may not be used for construction of facilities, including additions and extensions, or for the acquisition of land. In addition, funds may not be used to expand existing programs and/or support an existing activity.

C. Amount of available funding for each project: Current funds available equal \$100,000. Grants of up to a maximum of \$20,000 will be awarded to eligible agencies and organizations for the period February 1, 1993 to June 30, 1993.

D. Organizations which may apply for funding under this program: Agencies must be New Jersey based not-for-profit organizations. Eligible applicants may be community coalitions. The applicant is responsible for the management of the project and will serve as the fiscal agent for funds awarded by the State.

E. Qualifications which may apply for funding under this program: Through written proposals, agencies must demonstrate the capacity to carry out the purposes of the grant, and evaluate the success of their program or activity. Applicants must demonstrate their ability to develop and implement a new innovative project in the community that can provide support to high risk minority males, or foster community solutions to the complex range of problems facing minority males.

F. Procedure for eligible organizations to apply: Agencies may request a copy of the Community Challenge Grant Application in writing from the Office of the Associate Commissioner, New Jersey Department of Human Services, CN 700, Trenton, New Jersey 08625 or via telephone by calling the Office at (609) 984-7262.

G. Address to which applications must be submitted:

Larry J. Lockhart
Office of the Associate Commissioner
New Jersey Department of Human Services
Capital Place One, 5th Floor
CN 700
Trenton, NJ 08625
ATTN: Vivian Martin

H. Deadline by which applications must be submitted: December 16, 1992.

A technical assistance session will be held Monday, November 30, 1992 at 9:30 A.M. at the New Jersey Department of Human Services, 3rd Floor Conference Room, 222 South Warren Street, Trenton, New Jersey.

I. Date the applicant is to be notified of acceptance or rejection: No later than January 15, 1993.

(a)

DIVISION OF MENTAL HEALTH AND HOSPITALS

Notice of Availability of Grant Funds Adolescent Partial Care Program

Take notice that, in compliance with N.J.S.A. 52:14-34.4 et seq., the Department of Human Services hereby announces the availability of the following grant program funds:

Name of program: Division of Mental Health and Hospitals—Adolescent Partial Care Program.

Purpose: The purpose of the funding is to establish an after school partial care program in order to provide seriously emotionally disturbed Morris County youths with a highly structured day treatment program. This program is intended to prevent unnecessary institutionalization by providing intensive day treatment to adolescents previously or currently residing in Arthur Brisbane Child Treatment Center, a Children's Crisis Intervention Services (CCIS) unit, a residential treatment center, a private hospital or other extended out-of-home placement.

The program will serve 10 Morris County males and females between 12 and 17 years of age.

Services should include individual and group counselling support, therapeutic activities to address daily living (ADL) skills and recreation or socialization needs, medication management, family support services, psychiatric assessment, case coordination, therapeutic milieu activities such as community meetings, behavior management programs and related programming.

Modification of existing partial care programs as well as the development of new programs will be considered for funding.

Applicants should demonstrate how the program will be integrated with their own administrative structure and services as well as the community system of care for children.

Applicants should contact the Department of Health prior to submission to determine if a Certificate of Need is required for the service.

Amount of available funding under this program: The Division anticipates that the State share of program funding will not exceed \$80,000. This amount is net of Medicaid fees and third party income which are also expected to offset program operational costs. Medicaid providers and non-Medicaid providers are encouraged to apply. Non-Medicaid providers should include a clear statement of their intent to seek or not seek Medicaid approval for the service. Applicants' proposed budgets should indicate projected revenue amounts.

Organizations which may apply for funding under this program: Any nonprofit agency or hospital which meets the qualifications of the Department of Human Services as specified in the Contract Policy and Information Manual and currently provides mental health or related services, or is capable of providing mental health services needed by those clients may apply.

Procedure for eligible organizations to apply: Interested applicants may request an application package from the Division of Mental Health and Hospitals/Northern Region Office, 100 Hamilton Plaza, 8th floor, Paterson, NJ 07505 or by calling Leslie Myers, Regional Children's Services Coordinator at (201) 977-4397. All applicants will be required to attend a technical assistance meeting to be held on November 30th, at 10:00 A.M. at the Division of Mental Health and Hospitals, 8th floor office. Please contact Leslie Myers for registration details and further information. Completed applications (six copies) must be submitted to Anne DeMuro, Assistant Director for the Northern Region, by close of business Monday, December 28, 1992. Fax submissions will not be accepted.

Copies of completed applications also must be submitted to the Morris County Mental Health Administrator and the Morris County Interagency Coordinating Council (CIACC) convener.

Deadline by which applications must be submitted: December 28, 1992.

Date the applicant is to be notified of acceptance or rejection: January 29, 1993.

(b)

NEW JERSEY DEVELOPMENTAL DISABILITIES COUNCIL

Notice of Availability of Grants Charity Racing Days for the Developmentally Disabled Program

Take notice that, in compliance with N.J.S.A. 52:14-34.4 et seq., the New Jersey Developmental Disabilities Council hereby announces the availability of the following grant program:

A. Name of program: Charity Racing Days for the Developmentally Disabled Program, P.L. 1977, c.200.

B. Purpose: To distribute funds received by the New Jersey Racing Commission to nonprofit organizations in New Jersey which expend funds for direct services in full-time programs to individuals who are developmentally disabled.

C. Amount of monies in program: The amount of monies available is based on money collected on designated racing days by the New Jersey Racing Commission in compliance with N.J.S.A. 5:5-44.2, and distributed proportionally among eligible organizations on the basis of an incidence and service formula as defined in N.J.A.C. 10:141.

D. Organizations which may apply for funding under this program: Agencies which may apply for Charity Racing Days monies must be nonprofit organizations located in New Jersey and expend funds for

direct services in full time programs to residents who are developmentally disabled. Agencies must be affiliated with a national organization of the same type and purpose.

E. Qualifications needed by an applicant to be considered for the program: An eligible organization shall be a full time service provider to individuals who are developmentally disabled which expends funds for direct services and has as its main purpose either:

1. The provision of services; or
2. The raising of funds on behalf of a single other organization whose sole purpose is the provision of eligible services.
 - All funds raised shall be contributed to the provision of eligible services (except minimal costs for administration and fund raising).
 - At least 75 percent of the recipients of eligible services provided by the organization must be developmentally disabled.

F. Procedure for eligible organizations to apply: Application can be requested from:

Dennis Rizzo
NJ Developmental Disabilities Council
CN 700
Trenton, New Jersey 08625
(609) 292-3745

G. Address for applications to be submitted: Same as F above.

H. Deadline by which applications must be submitted: Completed applications must be submitted by January 31, 1993.

I. Date by which applicant shall be notified of approval or disapproval: Applicants shall receive notice of approval or disapproval within 60 days after deadline.

STATE

(a)

NEW JERSEY STATE COUNCIL ON THE ARTS Notice of Grants Application Process and Deadlines Fellowship Support Fiscal Year 1994 (July 1, 1993-June 30, 1994)

Take notice that the New Jersey State Council on the Arts, acting under the authority of P.L. 1966, c.214, hereby announces, in accordance with N.J.S.A. 52:14-34.4 et seq., the availability of the following grant program.

Name of program: Fellowship Support, Fiscal Year 1994.

Purpose: In recognition of outstanding artistic work, Fellowships are awarded to New Jersey artists to enable them to pursue their artistic goals. Fellowships are awarded in choreography, music composition, opera/music theatre composition, theatre (mime), experimental art, graphics, painting, sculpture, design arts, crafts, photography, media arts (film/video), prose, playwriting, poetry, and interdisciplinary.

Eligible applicants: Artists who are residents of the State of New Jersey (all awards are subject to verification of New Jersey residency); artists who have not received a fellowship since Fiscal Year 1990-91; artists who are not students matriculating in an undergraduate program at the time of application. (Fellowships do not provide funding for scholarships or academic study in pursuit of a college degree). **NOTE:** Artists may apply in one discipline only and only in one category of a single discipline.

Ineligible applicants: Artists who are residents in another state, are students matriculating in an undergraduate program at the time of application, or who received an NJSCA Fellowship during Fiscal Years 1991-92 or 1992-93.

Amount of Awards: Contingent upon the availability of funds and Council action. For Fiscal Year 93, 73 awards ranging from \$5,000 to \$12,000 were made from among the 993 applicants.

Match: This is a non-matching award.

Deadline for submission: Complete applications, including all support materials, must be postmarked or delivered to Council Offices no later than February 4, 1993 (5:00 P.M. if delivered in person to office).

Decision-making process: All complete applications by eligible applicants are evaluated by an independent panel of experts in the applicant's discipline for evidence of artistic excellence and promise, which is the sole criteria. The Council reviews the evaluations of all applicants as well as Council funding priorities and issues. Its final recommendations

are voted upon by the full Council at its annual meeting, tentatively scheduled for July 27, 1993. Applicants are notified in writing of the Council's decision within six weeks following the annual meeting.

To receive a set of guidelines and application forms, call (609) 292-6130 or write FELLOWSHIPS 94, New Jersey State Council on the Arts, CN-306, Trenton, NJ 08625.

(b)

NEW JERSEY STATE COUNCIL ON THE ARTS Notice of Grants Application Process and Deadlines Organizational Grants in Aid to the Arts Fiscal Year 1994 (July 1, 1993-June 30, 1994)

Take notice that the New Jersey State Council on the Arts, acting under the authority of P.L. 1966, c.214, hereby announces the availability of the following grant program.

Name of program: Organizational Grants in Aid to the Arts, Fiscal Year 1994.

General Operating Support (for arts organizations)
Special Project Support (for arts projects)
Arts Basic to Education Expansion Project Support (for arts organizations)

Purpose: To stimulate and encourage the production and presentation of the arts in New Jersey, and to foster public interest in and support of the arts in New Jersey through the award of matching grants to eligible organizations.

Eligible Applicants: Must be a New Jersey incorporated, nonprofit organization that is tax exempt as 501(c)(3) or (4) by determination of the Internal Revenue Service, or a unit of government; must have been in existence and active in presenting, producing or servicing the fine, performance or literary arts for at least two years prior to making application; must have a board of trustees empowered to formulate policies and be responsible for the administration of the organization, its programs and its finance; and must comply with all existing State and Federal regulations and laws as described in the Guidelines and Application.

Ineligible Applicants: Organizations that are unincorporated, incorporated in another state or incorporated as profit-making entities.

Grant size: Grants will range in size, but generally will not exceed 20 percent of projected general operating expenses or 50 percent of project expenses.

Amount of available funding for the program: Will depend on the finalization of the Council's legislative appropriation for Fiscal Year (FY) 94.

Match: All grants offered under this program must be matched at least dollar-for-dollar. In-kind contributions and indirect costs are not allowed as any part of the match. All grants offered through this program must be matched with cash. General Operating Support applicants must be able to project a 4:1 match of applicant cash to NJSCA dollars; Special Project applicants who are arts organizations, a 1:1 match of applicant cash to NJSCA dollars and Special Project applicants who are not arts organizations, a 3:1 match of applicant cash to NJSCA dollars.

Projected deadline for submission: Complete applications, including all support materials, must be postmarked or delivered to Council Offices no later than January 29, 1993 (5:00 P.M. if delivered in person to office). All prospective applicants that are not direct recipients of FY 93 NJSCA Grants must submit a Letter of Intent. **PROJECTED DEADLINE FOR LETTERS OF INTENT IS DECEMBER 21, 1992 (5:00 P.M. Receipt).** These deadlines are subject to change that would place them later in the year. The NJSCA urges all organizations interested in applying for FY 94 support to call the Grants Office immediately to discuss issues related to deadlines and eligibility.

Decisions: All complete applications by eligible applicants will be evaluated by an independent panel of experts and by the NJSCA according to the published criteria for evaluation. The Council reviews the evaluations of all applications as well as Council funding priorities and issues. Its final recommendations are voted upon by the full Council at its annual meeting, tentatively scheduled for July 27, 1993. Applicants are notified in writing of the Council's decision within six weeks following the annual meeting.

To receive a set of guidelines and application forms, call (609) 292-6130 or write GRANTS 94, New Jersey State Council on the Arts, CN-306, Trenton, NJ 08625.

OTHER AGENCIES

(a)

HACKENSACK MEADOWLANDS DEVELOPMENT COMMISSION

Permit Extension Act Notice

Take notice that, pursuant to the Permit Extension Act (Act), P.L. 1992, c.82, any approval as defined in the Act, issued by the Hackensack Meadowlands Development Commission, as authorized under the "Hackensack Meadowlands Reclamation Development Act", P.L. 1968, c.404 (N.J.S.A. 13:17-1 et seq.), which expires during the period of January 1, 1989 through December 31, 1994, is hereby extended through December 31, 1994.

Any person wishing a written confirmation of the extension of a specific permit may write to the Office of the Chief Engineer. The applicant's request must include the name and number of the file under which the permit was issued and the location of the site.

Any questions regarding the applicability of this law should be submitted in writing to:

Hackensack Meadowlands Development Commission
Office of the Chief Engineer
One DeKorte Park Plaza
Lyndhurst, New Jersey 07071

(b)

CASINO CONTROL COMMISSION

Notice of Receipt of Petition for Rulemaking Electronic Wagering on Slot Machines

N.J.A.C. 19:45-1.1, 1.33, 1.37, 1.39, 1.43 and 1.44

Petitioner: Grete Bay Hotel and Casino, Inc.

Authority: N.J.S.A. 5:12-69.

Take notice that on October 5, 1992, Grete Bay Hotel and Casino, Inc. filed a rulemaking petition with the Casino Control Commission requesting amendments to N.J.A.C. 19:45-1.1, 1.33, 1.37, 1.39, 1.43 and 1.44.

The petitioner's proposed amendments will provide for and permit "electronic drop" in slot machines; for purposes of this rulemaking petition, the term "electronic drop" has been defined as "funds which are transferred electronically between a patron's account and a slot machine and played on a slot machine."

The petitioner contends that by permitting the electronic transfer of funds between a patron's account established with the petitioner and

the slot machine on which the patron is then playing, the provision of "electronic drop" will permit the petitioner to more efficiently service its slot patrons, while enhancing and greatly simplifying the slot patron's gaming experience.

After due notice, the petition will be considered by the Casino Control Commission in accordance with the provisions of N.J.S.A. 5:12-69(c).

(c)

CASINO CONTROL COMMISSION

Notice of Receipt of Petition for Rulemaking Procedure for Dealing Cards in Blackjack

N.J.A.C. 19:47-2.6

Petitioner: Stanley W. Greenfield.

Authority: N.J.S.A. 5:12-69.

Take notice that on October 8, 1992, Stanley W. Greenfield filed a rulemaking petition with the Casino Control Commission requesting an amendment to N.J.A.C. 19:47-2.6.

The petitioner proposes that N.J.A.C. 19:47-2.6(c) be amended so that when a blackjack shoe is started to be dealt, no card should be burned other than the first one, regardless of how many changes in dealers there are during that shoe.

After due notice, the petition will be considered by the Casino Control Commission in accordance with the provisions of N.J.S.A. 5:12-69(c).

(d)

CASINO CONTROL COMMISSION

Notice of Receipt of Petition for Rulemaking Permissible Additional Wager in Blackjack

N.J.A.C. 19:47-2.17

Petitioner: Trump Plaza Associates,

d/b/a Trump Plaza Hotel and Casino.

Authority: N.J.S.A. 5:12-69.

Take notice that on October 15, 1992, Trump Plaza Associates, d/b/a Trump Plaza Hotel and Casino filed a rulemaking petition with the Casino Control Commission requesting an amendment to N.J.A.C. 19:47-2.17.

The petitioner proposes that a casino licensee be permitted to establish a maximum limit on the amount of the optional wager which is independent of the underlying blackjack wager.

After due notice, the petition will be considered by the Casino Control Commission in accordance with the provisions of N.J.S.A. 5:12-69(c).

REGISTER INDEX OF RULE PROPOSALS AND ADOPTIONS

The research supplement to the New Jersey Administrative Code

A CUMULATIVE LISTING OF CURRENT PROPOSALS AND ADOPTIONS

The **Register Index of Rule Proposals and Adoptions** is a complete listing of all active rule proposals (with the exception of rule changes proposed in this Register) and all new rules and amendments promulgated since the most recent update to the Administrative Code. Rule proposals in this issue will be entered in the Index of the next issue of the Register. **Adoptions promulgated in this Register have already been noted in the Index by the addition of the Document Number and Adoption Notice N.J.R. Citation next to the appropriate proposal listing.**

Generally, the key to locating a particular rule change is to find, under the appropriate Administrative Code Title, the N.J.A.C. citation of the rule you are researching. If you do not know the exact citation, scan the column of rule descriptions for the subject of your research. To be sure that you have found all of the changes, either proposed or adopted, to a given rule, scan the citations above and below that rule to find any related entries.

At the bottom of the index listing for each Administrative Code Title is the Transmittal number and date of the latest looseleaf update to that Title. Updates are issued monthly and include the previous month's adoptions, which are subsequently deleted from the Index. To be certain that you have a copy of all recent promulgations not yet issued in a Code update, retain each Register beginning with the October 5, 1992 issue.

If you need to retain a copy of all currently proposed rules, you must save the last 12 months of Registers. A proposal may be adopted up to one year after its initial publication in the Register. Failure to adopt a proposed rule on a timely basis requires the proposing agency to resubmit the proposal and to comply with the notice and opportunity-to-be-heard requirements of the Administrative Procedure Act (N.J.S.A. 52:14B-1 et seq.), as implemented by the Rules for Agency Rulemaking (N.J.A.C. 1:30) of the Office of Administrative Law. If an agency allows a proposed rule to lapse, "Expired" will be inserted to the right of the Proposal Notice N.J.R. Citation in the next Register following expiration. Subsequently, the entire proposal entry will be deleted from the Index. See: N.J.A.C. 1:30-4.2(c).

Terms and abbreviations used in this Index:

N.J.A.C. Citation. The New Jersey Administrative Code numerical designation for each proposed or adopted rule entry.

Proposal Notice (N.J.R. Citation). The New Jersey Register page number and item identification for the publication notice and text of a proposed amendment or new rule.

Document Number. The Registry number for each adopted amendment or new rule on file at the Office of Administrative Law, designating the year of adoption of the rule and its chronological ranking in the Registry. As an example, R.1992 d.1 means the first rule adopted in 1992.

Adoption Notice (N.J.R. Citation). The New Jersey Register page number and item identification for the publication notice and text of an adopted amendment or new rule.

Transmittal. A series number and supplement date certifying the currency of rules found in each Title of the New Jersey Administrative Code: Rule adoptions published in the Register after the Transmittal date indicated do not yet appear in the loose-leaf volumes of the Code.

N.J.R. Citation Locator. An issue-by-issue listing of first and last pages of the previous 12 months of Registers. Use the locator to find the issue of publication of a rule proposal or adoption.

MOST RECENT UPDATE TO THE ADMINISTRATIVE CODE: SUPPLEMENT SEPTEMBER 21, 1992

NEXT UPDATE: SUPPLEMENT OCTOBER 19, 1992

Note: If no changes have occurred in a Title during the previous month, no update will be issued for that Title.

N.J.R. CITATION LOCATOR

If the N.J.R. citation is between:	Then the rule proposal or adoption appears in this issue of the Register	If the N.J.R. citation is between:	Then the rule proposal or adoption appears in this issue of the Register
23 N.J.R. 3403 and 3548	November 18, 1991	24 N.J.R. 1933 and 2102	June 1, 1992
23 N.J.R. 3549 and 3678	December 2, 1991	24 N.J.R. 2103 and 2314	June 15, 1992
23 N.J.R. 3679 and 3840	December 16, 1991	24 N.J.R. 2315 and 2486	July 6, 1992
24 N.J.R. 1 and 164	January 6, 1992	24 N.J.R. 2487 and 2650	July 20, 1992
24 N.J.R. 165 and 318	January 21, 1992	24 N.J.R. 2651 and 2752	August 3, 1992
24 N.J.R. 319 and 508	February 3, 1992	24 N.J.R. 2753 and 2970	August 17, 1992
24 N.J.R. 509 and 672	February 18, 1992	24 N.J.R. 2971 and 3202	September 8, 1992
24 N.J.R. 673 and 888	March 2, 1992	24 N.J.R. 3203 and 3454	September 21, 1992
24 N.J.R. 889 and 1138	March 16, 1992	24 N.J.R. 3455 and 3578	October 5, 1992
24 N.J.R. 1139 and 1416	April 6, 1992	24 N.J.R. 3579 and 3784	October 19, 1992
24 N.J.R. 1417 and 1658	April 20, 1992	24 N.J.R. 3785 and 4144	November 2, 1992
24 N.J.R. 1659 and 1840	May 4, 1992	24 N.J.R. 4145 and 4306	November 16, 1992
24 N.J.R. 1841 and 1932	May 18, 1992		

**N.J.A.C.
CITATION**

ADMINISTRATIVE LAW—TITLE 1

1:1-1.5, App. A	Conduct of administrative law judges
1:13A-1.2, 18.1, 18.2	Lemon Law hearings: exceptions to initial decision
1:31-3.1	Conduct of administrative law judges

**PROPOSAL NOTICE
(N.J.R. CITATION)**

24 N.J.R. 2755(a)
24 N.J.R. 1843(a)
24 N.J.R. 2755(a)

**DOCUMENT
NUMBER**

R.1992 d.430
R.1992 d.430

**ADOPTION NOTICE
(N.J.R. CITATION)**

24 N.J.R. 4028(a)
24 N.J.R. 4028(a)

Most recent update to Title 1: TRANSMITTAL 1992-4 (supplement September 21, 1992)

AGRICULTURE—TITLE 2

2:6	Animal health: biological products for diagnostic or therapeutic purposes	24 N.J.R. 2974(a)		
2:6	Animal health: extension of comment period regarding biological products for diagnostic or therapeutic purposes	24 N.J.R. 3981(a)		
2:32-2.4	Sire Stakes Program: stallion standing full season	24 N.J.R. 3981(b)		
2:69-1.11	Commercial values of primary plant nutrients	24 N.J.R. 2318(a)	R.1992 d.373	24 N.J.R. 3511(a)
2:71-2.2, 2.4, 2.5, 2.6	Jersey Fresh Quality Grading Program	24 N.J.R. 2318(b)	R.1992 d.374	24 N.J.R. 3511(b)
2:71-2.28, 2.29	Inspection and grading charges for fruits and vegetables	24 N.J.R. 2321(a)	R.1992 d.375	24 N.J.R. 3513(a)
2:76-3.12, 4.11	Farmland Preservation Program: pre-existing uses of enrolled lands	24 N.J.R. 2831(a)		
2:76-6.15	Farmland Preservation Program: pre-existing uses on lands permanently deed restricted	24 N.J.R. 2833(a)		
2:90-1.4, 1.5	Certification of soil erosion and sediment control plans	24 N.J.R. 3587(a)		

Most recent update to Title 2: TRANSMITTAL 1992-4 (supplement August 17, 1992)

BANKING—TITLE 3

3:1-2.1-2.9, 2.18, 2.20, 2.21	Branch and charter application procedures for banks, savings banks, and savings and loan associations	24 N.J.R. 3034(a)		
3:18	Secondary Mortgage Loan Act rules	24 N.J.R. 3982(a)		
3:18-1, 2.1, 3, 4.1, 4.2, 5.1, 5.2, 5.3, 7.4, 7.5, 8.1, 8.2, 9, 10.5, 10.7, 10.8, 11	Secondary Mortgage Loan Act rules	24 N.J.R. 2760(a)		
3:38	Mortgage bankers and brokers	24 N.J.R. 2653(a)	R.1992 d.378	24 N.J.R. 3514(a)
3:38-1.6	Mortgage bankers and brokers: administrative correction regarding surety bonds			24 N.J.R. 3514(b)
3:38-1.9, 5.2, 5.3	Branch offices; mortgage services licensure exemption; solicitor registration	24 N.J.R. 1937(a)	R.1992 d.431	24 N.J.R. 4032(a)

Most recent update to Title 3: TRANSMITTAL 1992-6 (supplement August 17, 1992)

CIVIL SERVICE—TITLE 4

Most recent update to Title 4: TRANSMITTAL 1992-1 (supplement September 21, 1992)

PERSONNEL—TITLE 4A

4A:1	General rules and Department organization	24 N.J.R. 2490(a)	R.1992 d.416	24 N.J.R. 3715(a)
4A:2	Appeals, discipline, separations	24 N.J.R. 2491(a)	R.1992 d.414	24 N.J.R. 3716(a)
4A:3-5.3, 5.6, 5.9	Comparable time off restrictions	24 N.J.R. 3588(a)		
4A:4-2.6, 2.15	Promotional examinations	24 N.J.R. 3589(a)		
4A:4-6.5	Medical and psychological examinations as condition of employment	24 N.J.R. 3596(a)		
4A:4-7.11	Transfers and retention of employee rights in a consolidation	24 N.J.R. 2494(a)	R.1992 d.419	24 N.J.R. 3718(a)

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4A:5	Veterans and disabled veterans preference	24 N.J.R. 2495(a)	R.1992 d.415	24 N.J.R. 3719(a)
4A:6	Leaves, hours of work, employee development, and awards program	24 N.J.R. 3590(a)		
4A:6-1.6	Sick leave injury (SLI) benefits: carpal tunnel syndrome and asbestosis	24 N.J.R. 2108(a)	R.1992 d.413	24 N.J.R. 3720(a)
4A:7	Equal employment opportunity and affirmative action	24 N.J.R. 2496(c)	R.1992 d.420	24 N.J.R. 3721(a)
4A:9-1	Political subdivisions	24 N.J.R. 2498(a)	R.1992 d.418	24 N.J.R. 3722(a)
4A:10	Violations and penalties	24 N.J.R. 2499(a)	R.1992 d.417	24 N.J.R. 3723(a)

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5:4-2	Debarment and suspension from Department contracting	24 N.J.R. 2322(a)	R.1992 d.389	24 N.J.R. 3515(a)
5:10-25	Indirect apportionment of heating costs in multiple dwellings: methods, devices, and systems	24 N.J.R. 1844(a)	R.1992 d.390	24 N.J.R. 3515(b)
5:10-25.2	Indirect apportionment of heating costs in multiple dwellings	24 N.J.R. 3597(a)		
5:12-2.1	Homelessness Prevention Program: eligibility	23 N.J.R. 3439(a)	R.1992 d.433	24 N.J.R. 4035(a)
5:14-1.6, 2.2, 3.1, 4.1, 4.5, 4.6, 4.7	Neighborhood Preservation Balanced Housing Program: per unit developer fees and costs; other revisions	24 N.J.R. 1144(a)		
5:18-1.5, 2.4A, 2.4B, 2.7, 2.8	Uniform Fire Code: life hazard uses and permits	24 N.J.R. 2654(a)	R.1992 d.385	24 N.J.R. 3519(a)
5:18-1.5, 4.7	Uniform Fire Code: eating and drinking establishments; exemption from fire suppression system requirement	24 N.J.R. 1938(a)	R.1992 d.405	24 N.J.R. 3723(b)
5:19	Continuing care retirement communities	24 N.J.R. 1146(a)		
5:23	Uniform Construction Code	24 N.J.R. 1420(b)		
5:23-2.1, 2.15	Uniform Construction Code: licensing disputes	24 N.J.R. 4(a)		
5:23-2.5	UCC: increase in building size	24 N.J.R. 1421(a)		
5:23-2.17, 8	Asbestos Hazard Abatement Subcode	24 N.J.R. 1422(a)		
5:23-3.4, 4.4, 4.18, 4.20, 5.3, 5.5, 5.19A, 5.21, 5.22, 5.23, 5.25	Uniform Construction Code: mechanical inspector license and mechanical inspections	24 N.J.R. 3457(a)		
5:23-3.7, 3.8, 4.20	Indirect apportionment of heating costs in multiple dwellings: methods, devices, and systems	24 N.J.R. 1844(a)	R.1992 d.390	24 N.J.R. 3515(b)
5:23-3.14	Uniform Construction Code: tent permits	24 N.J.R. 2656(a)	R.1992 d.391	24 N.J.R. 3521(a)
5:23-3.21	UCC: one and two family dwelling subcode	23 N.J.R. 3444(b)		
5:23-4.5, 4.19-4.22, 4A.12, 5.21, 5.22, 8.6, 8.10, 8.18, 8.19, 12.5, 12.6	UCC: State Training Fee Report; fees	24 N.J.R. 2657(a)	R.1992 d.392	24 N.J.R. 3521(b)
5:23-4.18, 4.20	UCC enforcing agencies: minimum fees	24 N.J.R. 169(b)		
5:23-5.7	UCC: subcode official requirements	24 N.J.R. 2661(a)	R.1992 d.393	24 N.J.R. 3525(a)
5:23-5.19	UCC: elevator inspector H.H.S. requirements	24 N.J.R. 2662(a)	R.1992 d.394	24 N.J.R. 3525(b)
5:23-9.7	Uniform Construction Code: manufacturing, production and process equipment exemption	24 N.J.R. 3458(a)		
5:25-5.4	State new home warranty plan contributions	24 N.J.R. 2663(a)	R.1992 d.395	24 N.J.R. 3525(c)
5:26-2.3, 2.4	Planned real estate development full disclosure: fees	24 N.J.R. 2657(a)	R.1992 d.392	24 N.J.R. 3521(b)
5:30-8.2	Unbudgeted school aid	24 N.J.R. 2766(a)	R.1992 d.426	24 N.J.R. 3723(c)
5:33-1.2, 1.3, 1.5-1.8	Municipal tax collection procedures	24 N.J.R. 2766(a)	R.1992 d.426	24 N.J.R. 3723(c)
5:33-3.2, 3.3, 3.6, 3.8-3.11	Tenant Property Tax Rebate Program	24 N.J.R. 3205(a)	R.1992 d.469	24 N.J.R. 4255(a)
5:33-4	Property tax and mortgage escrow account transactions	24 N.J.R. 2664(a)	R.1992 d.400	24 N.J.R. 3527(a)
5:34-7	Cooperative purchasing by local contracting units	24 N.J.R. 2667(a)	R.1992 d.401	24 N.J.R. 3529(a)
5:80-32	Housing and Mortgage Finance Agency: project cost certification	24 N.J.R. 2208(a)		
5:91	Council on Affordable Housing: procedural rules	24 N.J.R. 2671(a)		

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MILITARY AND VETERANS' AFFAIRS—TITLE 5A

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6:3-2.6	Conditions for access to pupil records	24 N.J.R. 3038(a)		
6:8	Thorough and efficient system of public schools	24 N.J.R. 3039(a)		
6:8-6	Programs and services for pupils at risk	24 N.J.R. 3494(a)		
6:8-9	Educational improvement plans in special needs districts	24 N.J.R. 2323(a)	R.1992 d.396	24 N.J.R. 3535(b)
6:12-1.2, 1.7-1.10, 1.14	Governor's Teaching Scholars Program	24 N.J.R. 3050(a)		
6:21-5, 6, 6A, 6B, 6C, 8, 9	Pupil transportation: school bus and small vehicle standards	24 N.J.R. 2109(a)	R.1992 d.397	24 N.J.R. 4069(a)
6:21-6A.6	Pupil transportation: administrative correction to N.J.A.C. 6:21-6A.6 regarding school bus color	24 N.J.R. 2325(a)		

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6:29-2.4	Attendance at school by pupils or adults infected by HIV	24 N.J.R. 2124(a)	R.1992 d.398	24 N.J.R. 3538(a)
6:29-8	Nonpublic school nursing services	24 N.J.R. 3495(a)		
6:31-1.1-1.7, 1.9-1.16	Multiple indicators for exit from bilingual programs	24 N.J.R. 3497(a)		
6:64	Public, school, and college libraries	24 N.J.R. 2126(a)	R.1992 d.399	24 N.J.R. 3538(b)

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7:0	Well construction and sealing: request for public comment regarding comprehensive rules	24 N.J.R. 3286(a)		
7:1-1	Organization of Department	Exempt	R.1992 d.441	24 N.J.R. 4085(a)
7:1-1.3, 1.4	Delegations of authority within the Department	23 N.J.R. 3276(a)		
7:1-2	Third-party appeals of permit decisions	23 N.J.R. 3278(a)		
7:1C-1.5, 1.6, 1.7	Ninety-day construction permit fees	24 N.J.R. 2768(a)		
7:1J	Spill Compensation and Control Act: processing of damage claims (repeal 17:26)	24 N.J.R. 1255(a)		
7:1K	Pollution Prevention Program	24 N.J.R. 3609(a)		
7:6-1.24, 9.2	Boating rules: rotating lights; "personal watercraft"	24 N.J.R. 1694(a)		
7:7-1.7	Coastal Permit Program fees	24 N.J.R. 2768(a)		
7:7-4.5, 4.6	Coastal Permit Program: public hearings; final review of applications	23 N.J.R. 3280(a)		
7:7A-1.4, 2.7, 8.10	Freshwater wetlands protection: project permit exemptions; hearings on contested letters of interpretation	24 N.J.R. 912(b)		
7:7A-16.1	Freshwater wetlands permit fees	24 N.J.R. 2768(a)		
7:7E-7.5	Alternative traffic reduction programs in Atlantic City	24 N.J.R. 1986(a)		
7:9-4	Surface water quality standards: request for public comment on draft Practical Quantitation Levels	24 N.J.R. 4008(a)		
7:9-4 (7:9B-1), 6.3	Surface water quality standards	24 N.J.R. 3983(a)		
7:9-4.14 (7:9B-1.14)	NJPDES program and surface water quality standards: request for public comment regarding total phosphorous limitations and criteria	24 N.J.R. 4008(b)		
7:9-6	Ground water quality standards	24 N.J.R. 181(a)		
7:9A-1.1, 1.2, 1.6, 1.7, 2.1, 3.3, 3.4, 3.5, 3.7, 3.9, 3.10, 3.12, 3.14, 3.15, 5.8, 6.1, 8.2, 9.2, 9.3, 9.5, 9.6, 9.7, 10.2, 12.2-12.6, App. A, B	Individual subsurface sewage disposal systems	24 N.J.R. 1987(a)		
7:12	Shellfish-growing water classifications	24 N.J.R. 3657(a)		
7:14A-1, 2, 3, 5-14, App. F	NJPDES program and Clean Water Enforcement Act requirements	24 N.J.R. 344(b)		
7:14A-1.2, 1.7-1.10, 2.1, 2.4, 2.5, 2.12, 2.13, 3.8, 3.9, 3.11, 3.12, 3.13, 3.17, App. A, B, 7.8, 9.1, 10.3, 14.8, App. H	Statewide Stormwater Permitting Program	24 N.J.R. 2352(a)	R.1992 d.434	24 N.J.R. 4088(a)
7:14A-1.9, 3.14	Surface water quality standards	24 N.J.R. 3983(a)		
7:14B	Underground storage tanks	24 N.J.R. 2975(a)		
7:14B	Underground storage tanks: public hearing	24 N.J.R. 3286(b)		
7:15-1.5, 3.4, 3.6, 4.1, 5.22	Statewide water quality management planning	24 N.J.R. 344(b)		
7:19-3.9	Water supply allocation permits: fee schedule			24 N.J.R. 4121(a)
7:25-5.13	1992-93 Game Code: hunting prohibition in Monmouth County	24 N.J.R. 2773(a)	R.1992 d.423	24 N.J.R. 3725(a)
7:25-6	1993-94 Fish Code	24 N.J.R. 2539(a)	R.1992 d.439	24 N.J.R. 4122(a)
7:25-11	Introduction of imported or non-native shellfish or finfish into State's marine waters	24 N.J.R. 3660(a)		
7:25-16.1	Defining freshwater fishing lines	24 N.J.R. 204(a)		
7:25-16.1	Freshwater fishing line for Rahway River in Union County	24 N.J.R. 2977(a)		
7:25-18.1	Filleting of flatfish at sea	24 N.J.R. 1456(a)		
7:25-18.1, 18.5	Atlantic sturgeon management	24 N.J.R. 205(a)		
7:25-18.5	Haul seining and fyke netting regulation	24 N.J.R. 207(a)	R.1992 d.449	24 N.J.R. 4256(a)
7:25-18.16	Taking of horseshoe crabs	24 N.J.R. 2978(a)		
7:26-1.4, 2.13, 6.3, 6.8	Solid waste management: scrap metal shredding residue, animal manure, interdistrict and intradistrict flow	24 N.J.R. 1995(a)		
7:26-2.11, 2.13, 2B.9, 2B.10, 6.2, 6.8	Solid waste flow through transfer stations and materials recovery facilities	24 N.J.R. 3286(c)		

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7:26-4.3	Thermal destruction facilities: compliance monitoring fees and postponed operative date	24 N.J.R. 1999(a)		
7:26-4.3	Thermal destruction facilities: extension of comment period regarding compliance monitoring fees	24 N.J.R. 2687(a)		
7:26-4A.6	Hazardous waste program fees: annual adjustment	24 N.J.R. 2001(a)		
7:26-5.4, 7.4, 7.6, 9.4, 12.4	Hazardous waste manifest discrepancies	23 N.J.R. 3607(a)		
7:26-6.5, 6.6	Interdistrict and intradistrict solid waste flow	24 N.J.R. 3291(a)		
7:26-5.4, 7.4, 7.6, 9.4, 12.4	Hazardous waste manifest discrepancies: reopening of comment period	24 N.J.R. 2002(a)		
7:26-8.2	Hazardous waste exclusions: household waste	23 N.J.R. 3410(a)		
7:26-8.2	Hazardous waste exclusions: used chlorofluorocarbon refrigerants	23 N.J.R. 3692(a)	R.1992 d.448	24 N.J.R. 4258(a)
7:26-8.16	Hazardous constituents in waste streams	23 N.J.R. 3093(b)	R.1992 d.440	24 N.J.R. 4126(a)
7:26-8.16	Hazardous constituents in waste streams: reopening of comment period	24 N.J.R. 2003(a)		
7:26-8.20	Used motor oil recycling	24 N.J.R. 2383(a)		
7:26A-6	Used motor oil recycling	24 N.J.R. 2383(a)		
7:26B	Environmental Cleanup Responsibility Act rules	24 N.J.R. 2773(b)		
7:26B-1.3, 1.5, 1.6, 1.8, 1.9, 1.10, 1.13, 5.4, 13.1, App. A	Environmental Cleanup Responsibility Act rules	24 N.J.R. 720(a)		
7:26B-1.3, 1.5, 1.6, 1.8, 1.9, 1.10, 1.13, 5.4, 13.1, App. 1	ECRA rules: extension of comment period	24 N.J.R. 1281(a)		
7:26B-7, 9.3	Remediation of contaminated sites: Department oversight	24 N.J.R. 1281(b)		
7:26C	Remediation of contaminated sites: Department oversight	24 N.J.R. 1281(b)		
7:26D	Cleanup standards for contaminated sites	24 N.J.R. 373(a)		
7:26D	Cleanup standards for contaminated sites: additional public hearing and extension of comment period	24 N.J.R. 1458(b)		
7:26D	Cleanup standards for contaminated sites: additional public hearing and extension of comment period	24 N.J.R. 2003(b)		
7:26E	Technical requirements for contaminated site remediation	24 N.J.R. 1695(a)		
7:27-1.4, 1.6-1.30, 8.4, 8.14-8.24, 16.9, 21	Air contaminant emission statements from stationary sources	24 N.J.R. 2979(a)		
7:27-1.4, 1.36, 1.37, 1.38, 8.1, 8.3, 8.4, 8.24, 18	Control and prohibition of air pollution from new or altered sources: emission offsets	24 N.J.R. 3459(a)		
7:27-25	Control and prohibition of air pollution by vehicular fuels: public meeting and hearing on oxygenated fuels program	24 N.J.R. 2128(a)		
7:27-25.1-25.4, 25.7-25.12	Control and prohibition of air pollution by vehicular fuels	24 N.J.R. 2386(a)	R.1992 d.382	24 N.J.R. 3539(a)
7:27-26	Low Emissions Vehicle Program	24 N.J.R. 1315(a)		
7:27-26	Low Emissions Vehicle Program: correction to proposal	24 N.J.R. 1458(c)		
7:27A-3.10	Civil administrative penalties for violations of Air Pollution Control Act	24 N.J.R. 2386(a)	R.1992 d.382	24 N.J.R. 3539(a)
7:27A-3.10	Civil administrative penalties for violations of emission statement requirements	24 N.J.R. 2979(a)		
7:30	Pesticide Control Code	24 N.J.R. 2776(a)		
7:36-9	Green Acres Program: nonprofit land acquisition	24 N.J.R. 2405(a)		
7:61	Commissioners of Pilotage: licensure of Sandy Hook pilots	24 N.J.R. 3477(a)		

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8:13	Shellfish handling and shipping; hard and soft shell clam depuration	24 N.J.R. 2504(a)	R.1992 d.384	24 N.J.R. 3532(a)
8:21-3.13	Repeal (see 8:21-3A)	24 N.J.R. 3100(a)		
8:21-3A	Registration of manufacturers and wholesale distributors of non-prescription drugs, and manufacturers and wholesale distributors of devices	24 N.J.R. 3100(a)		
8:31A-1.5, 7.4, 7.5, App. D	SHARE Manual: per diem add-on fee assessment	24 N.J.R. 2810(a)	R.1992 d.450	24 N.J.R. 4259(a)
8:31B-4.40	Uncompensated care collection procedures	24 N.J.R. 1124(c)		
8:33-3.11	Certificate of Need process for demonstration and research projects	24 N.J.R. 3104(a)		
8:33C-2.7, 7.2	Regionalized perinatal services: administrative corrections	_____	_____	24 N.J.R. 3727(a)
8:33R	Psychiatric health care facilities and services: policy manual for planning and certificate of need reviews	24 N.J.R. 3598(a)		

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8:41	Mobile intensive care programs	24 N.J.R. 3255(b)		
8:43	Residential health care facilities: standards for licensure	24 N.J.R. 2506(a)		
8:43A	Ambulatory care facilities: public meeting and request for comments regarding Manual of Standards for Licensure	24 N.J.R. 3603(a)		
8:43E	Recodification (see 8:33R)	24 N.J.R. 3598(a)		
8:43I	Hospital Policy Manual	24 N.J.R. 3280(a)		
8:45-1.3, 2.1	Blood bank licensure fees and Department laboratory services charges	24 N.J.R. 2508(a)	R.1992 d.427	24 N.J.R. 3725(c)
8:65-2.5	Controlled dangerous substances: physical security controls	24 N.J.R. 174(a)		
8:71	Interchangeable drug products (see 24 N.J.R. 145(b))	23 N.J.R. 3258(a)	R.1992 d.136	24 N.J.R. 948(b)
8:71	Interchangeable drug products	24 N.J.R. 59(b)	R.1992 d.137	24 N.J.R. 949(a)
8:71	Interchangeable drug products (see 24 N.J.R. 947(b), 1897(a), 2560(a), 3173(b))	24 N.J.R. 61(a)	R.1992 d.461	24 N.J.R. 4260(a)
8:71	Interchangeable drug products (see 24 N.J.R. 1896(a), 2560(b))	24 N.J.R. 735(a)	R.1992 d.350	24 N.J.R. 3174(a)
8:71	Interchangeable drug products	24 N.J.R. 1673(a)	R.1992 d.296	24 N.J.R. 2559(a)
8:71	Interchangeable drug products (see 24 N.J.R. 2557(b), 3173(a))	24 N.J.R. 1674(a)	R.1992 d.462	24 N.J.R. 4260(b)
8:71	Interchangeable drug products (see 24 N.J.R. 3174(c), 3728(a))	24 N.J.R. 2414(b)	R.1992 d.464	24 N.J.R. 4262(a)
8:71	Interchangeable drug products	24 N.J.R. 2997(a)	R.1992 d.463	24 N.J.R. 4261(a)
8:71	Interchangeable drug products	24 N.J.R. 4009(a)		
8:100	State Health Planning Board: public hearings on draft chapters of State Health Plan	24 N.J.R. 3788(a)		
8:100	State Health Plan: draft chapters	24 N.J.R. 3789(a)		
8:100-14.8, 14.13	State Health Plan: hospital inpatient services	24 N.J.R. 2704(a)	R.1992 d.451	24 N.J.R. 4262(b)
8:100-16	State Health Plan: correction to Economic Impact statement regarding Long-Term Care Services	24 N.J.R. 1675(a)		

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9:1-1.2, 3.1, 3.2, 3.4, 3.5	Teaching university	24 N.J.R. 1464(a)		
9:1-5.11	Regional accreditation of degree-granting proprietary institutions	24 N.J.R. 3207(a)		
9:6A	State college personnel system	24 N.J.R. 3052(a)		
9:7	Student Assistance Programs	24 N.J.R. 2510(a)		
9:9-7.6	NJCLASS Program: loan interest rate	24 N.J.R. 2687(b)	R.1992 d.436	24 N.J.R. 4035(b)
9:16-1	Primary Care Physician and Dentist Loan Redemption Program	24 N.J.R. 1192(a)		

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10:8	Administration of State-provided Personal Needs Allowance	24 N.J.R. 681(a)		
10:16	Child Death and Critical Incident Review Board concerning children under DYFS supervision	24 N.J.R. 3506(a)		
10:46-1.3, 2.1, 3.2, 4.1, 5	Developmental Disabilities: determination of eligibility for division services	24 N.J.R. 211(a)		
10:50-1.1-1.4, 1.6, 1.7, 2.1, 2.2	Livery services: Medicaid reimbursement, age of vehicles, workers' compensation coverage; invalid coach services	24 N.J.R. 2517(a)	R.1992 d.447	24 N.J.R. 4264(a)
10:51	Pharmaceutical Services Manual	24 N.J.R. 3053(a)		
10:53A	Hospice Services Manual	24 N.J.R. 2778(a)	R.1992 d.442	24 N.J.R. 4036(a)
10:60-2.3, 3.15, 4.2	Home Care Services: personal care assistant services; eligibility for Home Care Expansion Program	24 N.J.R. 2687(c)	R.1992 d.438	24 N.J.R. 4054(a)
10:63-1	Long-Term Care Services Manual: administrative changes	_____	_____	24 N.J.R. 3728(b)
10:71-5.6	Medicaid Only income eligibility standards for hospice care	24 N.J.R. 2778(a)	R.1992 d.442	24 N.J.R. 4036(a)
10:72-1.1, 3.4, 4.1	New Jersey Care: Medicaid eligibility of children	24 N.J.R. 1860(a)		
10:80 et al.	Designation of Division of Economic Assistance as Division of Family Development	_____	_____	24 N.J.R. 3729(a)
10:81-11.4, 11.9	Public Assistance Manual: provision of information regarding services to AFDC clients; legal representation in child support matters	24 N.J.R. 2327(a)		
10:81-11.5, 11.7, 11.9, 11.20, 11.21	Public Assistance Manual: child support and paternity services	24 N.J.R. 2328(a)		
10:83	Service Programs for Aged, Blind or Disabled Persons	24 N.J.R. 3074(a)		
10:83-1.2	Emergency Assistance benefits for SSI recipients	24 N.J.R. 326(a)		
10:83-1.2	Emergency Assistance benefits for SSI recipients: public hearing and extension of comment period	24 N.J.R. 1204(a)		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
10:85-1.1, 2.1, 3.1-3.5, 4.1, 4.2, 5.1-5.8, 6.8, 7.2, App. D	General Assistance program: time-limited eligibility for employable persons; alien eligibility; payment of hospital medical services	24 N.J.R. 3075(a)		
10:87-2.4, 2.6, 2.31, 2.39, 3.8, 3.14, 4.1, 4.8, 5.1, 5.9, 5.10, 6.9, 6.20, 10.3, 10.6, 10.18, 11.26, 11.29, 12.1	Food Stamp Program revisions	24 N.J.R. 3207(b)		
10:87-12	Food Stamp Program: income eligibility, deduction, and coupon allotment standards	_____	_____	24 N.J.R. 3769(b)
10:97-1.3, 7.3	Business Enterprise Program for the blind and visually impaired: promotion and transfer	24 N.J.R. 2798(a)		
10:120-1.2	Youth and Family Services: scope of responsibilities and services	23 N.J.R. 3420(b)		
10:121A	Manual of Requirements for Adoption Agencies	24 N.J.R. 3500(a)		
10:122B	Division of Youth and Family Services: requirements for foster care	23 N.J.R. 3693(a)		
10:122C	DYFS: approval of foster homes	23 N.J.R. 3696(a)		
10:122D	DYFS: foster care services	23 N.J.R. 3703(a)		
10:122E	DYFS: removal of foster children and closure of foster homes	23 N.J.R. 3708(a)		
10:123-3.4	Personal needs allowance for eligible residents of residential health care facilities and boarding houses	24 N.J.R. 3088(a)		
10:124	Children's Shelter Facilities and Homes: manual of standards	24 N.J.R. 3089(a)		
10:131	DYFS: Adoption Assistance and Child Welfare Act of 1980 requirements	24 N.J.R. 2522(a)	R.1992 d.437	24 N.J.R. 4055(a)
10:133	DYFS: initial response and service delivery	23 N.J.R. 3714(a)		
10:133A	DYFS: initial response and screening	23 N.J.R. 3717(a)		
10:133B	DYFS: information and referral	23 N.J.R. 3720(a)		
10:133C-3	DYFS: assessment of family service needs	24 N.J.R. 217(a)		
10:150	Organization of Division of the Deaf and Hard of Hearing	Exempt	R.1992 d.460	24 N.J.R. 4267(a)

Most recent update to Title 10: TRANSMITTAL 1992-9 (supplement September 21, 1992)

CORRECTIONS—TITLE 10A

10A:6	Inmate access to courts	24 N.J.R. 2799(a)		
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Most recent update to Title 10A: TRANSMITTAL 1992-6 (supplement September 21, 1992)

INSURANCE—TITLE 11

11:1-31	Surplus lines insurer eligibility	24 N.J.R. 9(a)		
11:1-32.4	Automobile insurance: limited assignment distribution servicing carriers	24 N.J.R. 519(a)		
11:1-32.4	Workers' compensation self-insurance	24 N.J.R. 1944(a)		
11:1-32.4	Workers' compensation self-insurance: extension of comment period	24 N.J.R. 2708(b)		
11:1-33	Public Advocate reimbursement disputes	24 N.J.R. 2706(a)		
11:2-17.7	Payment of health insurance claims	23 N.J.R. 3196(c)		
11:2-17.11	Payment of third-party claims: written notice to claimant	24 N.J.R. 522(a)		
11:2-26	Insurer's annual audited financial report	24 N.J.R. 1940(a)		
11:2-26	Insurer's annual audited financial report: extension of comment period	24 N.J.R. 2708(a)		
11:2-33	Workers' compensation self-insurance	24 N.J.R. 1944(a)		
11:2-33	Workers' compensation self-insurance: extension of comment period	24 N.J.R. 2708(b)		
11:2-35.1-35.6	Insurer relief from FAIR Act obligations	24 N.J.R. 3212(a)		
11:3-2A	New Jersey Automobile Full Insurance Underwriting Association claims payment deferral for residual bodily injury	24 N.J.R. 3480(a)		
11:3-16.7	Automobile insurance: rating programs for physical damage coverages	24 N.J.R. 3604(a)		
11:3-19.3, 34.3	Automobile insurance eligibility rating plans: incorporation of merit rating surcharge	24 N.J.R. 2332(a)		
11:3-28.8	Reimbursement of excess medical expense benefits paid by insurers	24 N.J.R. 3215(a)		
11:3-29.1, 29.2, 29.4	Motor bus medical expense benefits coverage	24 N.J.R. 3605(a)		
11:3-29.6	Automobile PIP coverage: physical therapy services	24 N.J.R. 2998(a)		
11:3-33.2	Appeals from denial of automobile insurance: failure to act timely on written application for coverage	24 N.J.R. 2128(b)		
11:3-34.4	Automobile insurance coverage: eligible person qualifications	Emergency (expired R.1992 d.380 11-3-92)		24 N.J.R. 3420(a)

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
11:3-35.5	Automobile insurance rating: eligibility points of principal driver	24 N.J.R. 2331(a)		
11:3-36.12	Automobile physical damage photo inspection	24 N.J.R. 2708(c)	R.1992 d.424	24 N.J.R. 3729(b)
11:3-42	Producer Assignment Program	Emergency (expired 11-3-92)	R.1992 d.381	24 N.J.R. 3421(a)
11:3-43	Private passenger automobile insurance: personal lines rating plans	23 N.J.R. 3221(a)		
11:4-14.1, 15.1, 16.2, 19.2, 28.3, 36	BASIC health care coverage	24 N.J.R. 1205(a)		
11:4-16.5	Individual health insurance: disability income benefits riders	24 N.J.R. 338(a)		
11:4-16.8, 23, 25	Medicare supplement coverage: minimum standards	24 N.J.R. 12(a)		
11:5-1.8	Real Estate Commission: deposit of monies paid to broker	24 N.J.R. 3483(a)		
11:5-1.9, 1.38	Real Estate Commission: fee cap for mortgage services; transmittal of funds to lenders	24 N.J.R. 1957(a)	R.1992 d.468	24 N.J.R. 4268(a)
11:5-1.9, 1.38	Real Estate Commission: extension of comment period regarding fee cap for mortgage services; transmittal of funds to lenders	24 N.J.R. 2129(a)		
11:5-1.15	Real Estate Commission: advertising by brokers and licensees	24 N.J.R. 3484(a)		
11:5-1.16	Real Estate Commission: documentation of offers and counter-offers	24 N.J.R. 3485(a)		
11:5-1.23	Real Estate Commission: transmittal by licensees of written offers on property	24 N.J.R. 3486(a)		
11:5-1.28	Real Estate Commission: surety bond posting by prelicensure schools	24 N.J.R. 3488(a)		
11:5-1.38	Real Estate Commission: pre-proposal regarding buyer-brokers	24 N.J.R. 3488(b)		
11:7	Insurance of municipal bonds	24 N.J.R. 1958(a)	R.1992 d.425	24 N.J.R. 3729(c)
11:13	Commercial lines insurance	24 N.J.R. 2830(a)		
11:16-2	Reports to National Insurance Crime Bureau regarding motor vehicle theft or salvage	24 N.J.R. 3606(a)		
11:17-1.2, 2.3-2.15, 5.1-5.6	Insurance producer licensing	24 N.J.R. 3216(a)		
11:17A-1.2, 1.7	Appeals from denial of automobile insurance: failure to act timely on written application for coverage; premium quotation	24 N.J.R. 2128(b)		
11:17A-1.3	Licensure as insurance producer or registration as limited insurance representative: compliance deadline	24 N.J.R. 3220(a)		
11:19-2	Financial Examination Monitoring System: data submission by domestic insurers	24 N.J.R. 2999(a)		
11:19-3	Financial Examination Monitoring System: data submission by surplus lines producers and insurers	24 N.J.R. 3003(a)		

Most recent update to Title 11: TRANSMITTAL 1992-8 (supplement September 21, 1992)

LABOR—TITLE 12

12:15-1.3-1.7	Unemployment Compensation and Temporary Disability: 1993 maximum benefit rates, taxable wage base, government entity contribution rate, base week, and alternative earnings test	24 N.J.R. 3014(a)	R.1992 d.454	24 N.J.R. 4269(a)
12:16-4.8	Board and room, meals and lodging in lieu of wages: 1993 rates	_____	_____	24 N.J.R. 3182(a)
12:60-3.2, 4.2	Prevailing wages on public works contracts: telecommunications worker	24 N.J.R. 2689(a)		
12:60-3.2, 4.2	Prevailing wages on public works contracts: extension of comment period	24 N.J.R. 3015(b)		
12:60-3.2, 4.2	Prevailing wages for public works: extension of comment period	24 N.J.R. 3607(a)		
12:100-4.2	Public employee safety and health: occupational exposure to bloodborne pathogens	24 N.J.R. 3607(b)		
12:100-4.2, 10, 17.1, 17.3	Safety standards for firefighters	24 N.J.R. 73(a)		
12:235-1.6	Workers' Compensation: 1993 maximum benefit rate	24 N.J.R. 3015(a)	R.1992 d.467	24 N.J.R. 4270(a)
12:235-9.4	Workers' Compensation: appeal procedures regarding discrimination complaint decisions	24 N.J.R. 1684(a)		
12:235-9.4	Workers' Compensation appeal procedures regarding discrimination complaint decisions: extension of comment period	24 N.J.R. 3090(a)		

Most recent update to Title 12: TRANSMITTAL 1992-3 (supplement August 17, 1992)

COMMERCE AND ECONOMIC DEVELOPMENT—TITLE 12A

Most recent update to Title 12A: TRANSMITTAL 1992-2 (supplement September 21, 1992)

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
LAW AND PUBLIC SAFETY—TITLE 13				
13:2-22	Alcoholic Beverage Control: licensee training and certification	24 N.J.R. 1958(b)	R.1992 d.445	24 N.J.R. 4055(b)
13:20-37	Motor vehicles with modified chassis height	24 N.J.R. 3662(a)		
13:21-19.9	Motor Vehicle Franchise Committee: administrative hearing costs	24 N.J.R. 3015(c)		
13:28-5.1, 6.35	Schools of cosmetology and hairstyling: use of annex classrooms	24 N.J.R. 2333(a)	R.1992 d.444	24 N.J.R. 4057(a)
13:30-8.5	Board of Dentistry: complaint review procedures	24 N.J.R. 2800(a)		
13:30-8.6	Board of Dentistry: professional advertising	24 N.J.R. 2801(a)		
13:31-1.11, 1.17	Electrical contractor's business permit: telecommunications wiring exemption	24 N.J.R. 339(a)		
13:32	Rules of Board of Examiners of Master Plumbers	24 N.J.R. 2334(a)	R.1992 d.457	24 N.J.R. 4270(b)
13:33-1.35, 1.36	Ophthalmic dispensers and technicians: referrals; space rental agreements	24 N.J.R. 4010(a)		
13:34-1.1	Board of Marriage Counselor Examiners: annual license fees and charges	24 N.J.R. 2522(b)	R.1992 d.386	24 N.J.R. 3533(a)
13:35-6.5	Medical practice: preparation of patient records	24 N.J.R. 50(a)	R.1992 d.429	24 N.J.R. 3729(d)
13:35-6.13	Bio-analytical laboratory directorships: license fees	24 N.J.R. 4011(a)		
13:35-6.13, 9	Acupuncture Examining Board: practice of acupuncture	24 N.J.R. 4013(a)		
13:35-6.18	Board of Medical Examiners: control of anabolic steroids	24 N.J.R. 4012(a)		
13:36-5.12, 5.20	Mortuary Science: licensee advertising; referral fee prohibition	24 N.J.R. 3016(a)		
13:37	Certification of homemaker-home health aides: open public forum	24 N.J.R. 1861(a)		
13:37-13.1, 13.2	Nurse anesthetist: conditions for practice	24 N.J.R. 4020(a)		
13:38-2.4, 4, 5.1	Board of Optometrists: issuing prescriptions; certification by examination; fees	24 N.J.R. 2802(a)	R.1992 d.443	24 N.J.R. 4058(a)
13:40-5.1	Land surveys: setting of corner markers	24 N.J.R. 51(a)		
13:40-5.1	Land surveys: extension of comment period regarding setting of corner markers	24 N.J.R. 554(a)		
13:40A-1, 2, 2A, 3.6, 6.1, 6.2, 6.3	Board of Real Estate Appraisers: certified residential classification; general appraiser; temporary visiting license; fees and designations	24 N.J.R. 3489(a)		
13:41-2.1	Board of Professional Planners: professional misconduct	24 N.J.R. 3221(a)		
13:44-2.5, 2.7, 2.11	Veterinary Medical Examiners: referral fee prohibition; product endorsements; licensee advertising	24 N.J.R. 3017(a)		
13:44B	Per diem compensation for members of professional and occupational licensing boards	24 N.J.R. 3019(a)		
13:44E-2.7	Chiropractic practice: referral fees	24 N.J.R. 1470(a)		
13:44F	Rules of State Board of Respiratory Care	24 N.J.R. 2336(a)		
13:44G-14.1	Board of Social Work Examiners: fees for licensure, certification, and services	24 N.J.R. 2523(a)		
13:45A-9.2, 9.3, 9.4	Advertising of merchandise by manufacturer	24 N.J.R. 684(a)		
13:45A-24	Toy and bicycle safety	24 N.J.R. 3019(b)		
13:45A-24	Toy and bicycle safety: extension of comment period	24 N.J.R. 3666(a)		
13:46-9.17	Boxing inspectors	24 N.J.R. 3492(a)		
13:47A-1-8, 10, 11	Bureau of Securities rules	24 N.J.R. 2524(a)	R.1992 d.435	24 N.J.R. 4060(a)
13:47K-5.2	Weights and measures: magnitude of allowable variations for packaged commodities	24 N.J.R. 1233(a)		
13:54-1.15	Confidentiality of information regarding firearms permits, ID cards, licenses and registration	24 N.J.R. 3022(a)	R.1992 d.446	24 N.J.R. 4068(a)
13:70-4.1, 4.2, 4.15, 9.41, 22.5	Thoroughbred racing: licensure fees; partnership registration	24 N.J.R. 4021(a)		
13:70-12.4	Thoroughbred racing: claimed horse	24 N.J.R. 4022(a)		
13:71-7.1, 7.5, 7.26, 7.35, 24.5	Harness racing: licensure fees; partnership registration	24 N.J.R. 4023(a)		
13:71-10.5	Harness racing: programmed trainer	24 N.J.R. 2340(a)	R.1992 d.388	24 N.J.R. 3533(b)
13:72	Casino simulcasting of horse races	24 N.J.R. 3666(b)		
Most recent update to Title 13: TRANSMITTAL 1992-9 (supplement September 21, 1992)				
PUBLIC UTILITIES (BOARD OF REGULATORY COMMISSIONERS)—TITLE 14				
14:3-3.2, 7.12	Discontinuance of fire protection service by water utility	24 N.J.R. 2341(a)	R.1992 d.456	24 N.J.R. 4271(a)
14:3-5.1	Relocation or closing of utility office	24 N.J.R. 2132(a)		
14:3-6.5	Public records	24 N.J.R. 1966(a)		
14:3-7.15	Discontinuance of services to customers: notification of municipalities and others	24 N.J.R. 3023(a)		
14:3-10.15	Solid waste collection: customer lists	24 N.J.R. 3286(c)		
14:3-11	Solid waste collection regulatory reform	24 N.J.R. 1459(a)		
14:5A	Nuclear generating plant decommissioning: periodic cost review and trust funding reporting	23 N.J.R. 3239(b)		
14:6-5	Natural gas service: preproposal on inspection and operation of master meter systems	24 N.J.R. 1862(b)		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
14:9B	Private domestic wastewater treatment facilities	24 N.J.R. 1863(a)		
14:10-5	Competitive telecommunications services	24 N.J.R. 1868(a)		
14:10-7	Telephone access to adult-oriented information	24 N.J.R. 1238(a)		
14:11	Board of Regulatory Commissioners: administrative orders	24 N.J.R. 1684(b)		
14:11-7.10	Solid waste disposal facilities: initial tariff for special in lieu payment	24 N.J.R. 3286(c)		
14:12-1.2, 3.6, 4.1-4.3, 5.3	Demand side management	24 N.J.R. 2804(a)		

Most recent update to Title 14: TRANSMITTAL 1992-3 (supplement August 17, 1992)

ENERGY—TITLE 14A

14A:11-2	Reporting of energy information by home heating oil suppliers	23 N.J.R. 2830(b)	R.1992 d.403	24 N.J.R. 3725(b)
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Most recent update to Title 14A: TRANSMITTAL 1992-2 (supplement July 20, 1992)

STATE—TITLE 15

15:10-1.5, 7	Distribution of voter registration forms through public agencies	24 N.J.R. 736(a)		
15:10-1.5, 7	Distribution of voter registration forms through public agencies: extension of comment period	24 N.J.R. 1688(a)		
15:10-1.5, 7	Distribution of voter registration forms through public agencies: extension of comment period	24 N.J.R. 2531(a)		

Most recent update to Title 15: TRANSMITTAL 1992-2 (supplement July 20, 1992)

PUBLIC ADVOCATE—TITLE 15A

Most recent update to Title 15A: TRANSMITTAL 1990-3 (supplement August 20, 1990)

TRANSPORTATION—TITLE 16

16:28-1.41	Speed limit zones along Route U.S. 9 in Atlantic County	24 N.J.R. 2806(a)	R.1992 d.408	24 N.J.R. 3731(a)
16:28A-1.1, 1.2, 1.3, 1.7, 1.97, 1.106	Restricted parking and stopping along U.S. 1, U.S. 1 and 9, and Route 3 in northern and central counties, and U.S. 9 in Atlantic County	24 N.J.R. 2807(a)	R.1992 d.407	24 N.J.R. 3732(a)
16:28A-1.4, 1.5, 1.6, 1.13, 1.30	Restricted parking and stopping zones along Routes 4 and 5 in Bergen County; Route 7 in Kearny, Jersey City, Nutley and Belleville; U.S. 22 in Readington; and Route 44 in Greenwich and West Deptford	24 N.J.R. 3024(a)	R.1992 d.455	24 N.J.R. 4273(a)
16:28A-1.5, 1.61, 1.71	Bus stop zones along Route 5, U.S. 9W, and Route 67 in Bergen County	24 N.J.R. 3673(a)		
16:28A-1.27	Restricted parking and stopping along Route 38 in Burlington County	24 N.J.R. 3492(b)		
16:54	Licensing of aeronautical and aerospace facilities	24 N.J.R. 2542(a)		
16:54	Licensing of aeronautical and aerospace facilities: extension of comment period	24 N.J.R. 3026(a)		
16:54	Licensing of aeronautical and aerospace facilities: extension of comment period	24 N.J.R. 4025(a)		
16:83	Conduct and safety of public in use of NJ TRANSIT equipment and facilities	24 N.J.R. 3674(a)		

Most recent update to Title 16: TRANSMITTAL 1992-9 (supplement September 21, 1992)

TREASURY-GENERAL—TITLE 17

17:2-1.4	Public Employees' Retirement System: election of member-trustee	24 N.J.R. 3690(a)		
17:3-4.1	Teachers' Pension and Annuity Fund: creditable salary	23 N.J.R. 3274(a)		
17:9-2.3	State Health Benefits Program: annual enrollment periods	24 N.J.R. 4025(b)		
17:9-2.4	State Health Benefits Program: retirement or COBRA enrollment	24 N.J.R. 4025(c)		
17:9-4.1, 4.5	State Health Benefits Program: "appointive officer" eligibility	24 N.J.R. 3493(a)		
17:9-4.2	State Health Benefits Program: part-time deputy attorneys general	24 N.J.R. 2345(a)		
17:9-5.6	Health maintenance organization charges: administrative correction	_____	_____	24 N.J.R. 4068(b)
17:20-2.1, 4.3, 4.4	Background checks and training of lottery agents and employees	24 N.J.R. 2238(a)	R.1992 d.376	24 N.J.R. 3533(c)
17:20-4.8	Sale of lottery tickets at specific locations licensed	24 N.J.R. 2239(a)	R.1992 d.378	24 N.J.R. 3534(b)
17:20-6.2	Redemption of winning lottery tickets	24 N.J.R. 2239(b)	R.1992 d.377	24 N.J.R. 3534(a)
17:26	Repeal interim rules regarding Spill Compensation and Control Act (see 7:1J)	24 N.J.R. 1255(a)		
17:28-2.8	Applications for State Employee Charitable Fund-Raising Campaign: administrative change	_____	_____	24 N.J.R. 3534(c)

Most recent update to Title 17: TRANSMITTAL 1992-7 (supplement September 21, 1992)

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
TREASURY-TAXATION—TITLE 18				
18:5-2.3, 3.2-3.13, 3.20-3.25, 4.3-4.7, 5.8	Cigarette Tax rate and stamps	24 N.J.R. 2415(a)		
18:7-3.18	Corporation Business Tax: recycling tax credit	24 N.J.R. 2809(a)		
18:7-13.1	Corporation Business Tax: abatements of penalty and interest	23 N.J.R. 3275(a)	R.1992 d.404	24 N.J.R. 3733(a)
18:22-1.3, 3.3, 6.1, 6.2, 6.3, 8.1, 9.2, 9.6, 10.1	Public utility corporations	24 N.J.R. 2531(b)		
18:26-3.2, 6.4, 11.20-11.28	Transfer Inheritance and Estate Tax: State death tax credit; tenancy by the entirety in personal property; release of safe deposit box contents	24 N.J.R. 2533(a)	R.1992 d.402	24 N.J.R. 3734(b)
18:35-1.27	Gross Income Tax: interest on overpayments	24 N.J.R. 2419(a)		
18:35-2.11	Gross income tax refunds and homestead rebates: priorities in claims to setoff	24 N.J.R. 1967(b)		

Most recent update to Title 18: TRANSMITTAL 1992-5 (supplement July 20, 1992)

TITLE 19—OTHER AGENCIES

19:4-6.28	HMDC Official Zoning Map: heavy industrial zoning	24 N.J.R. 1690(b)		
19:4-6.28	Official Zoning Map: redesignation of site in Kearny	24 N.J.R. 2346(a)	R.1992 d.422	24 N.J.R. 3734(b)
19:8-1.2	Garden State Parkway speed limits	24 N.J.R. 3222(a)		
19:9-1.1	Definition of "New Jersey Turnpike"	24 N.J.R. 2692(a)	R.1992 d.379	24 N.J.R. 3534(d)
19:25-3.1, 12.7, 16.3, 16.5, 16.16, 16.18, 16.24, 16.25, 16.27-16.30, 16.39, 16.43, 16.48	ELEC: Pre-candidacy activity; independent expenditures; public financing of gubernatorial primary candidates	24 N.J.R. 3026(b)	R.1992 d.458	24 N.J.R. 4274(a)
19:25-16.3, 16.6, 16.8-16.12, 16.14, 16.18, 16.21, 16.22, 16.31, 16.33, 16.35, 16.37, 16.38	Public financing of primary election candidates for Governor	24 N.J.R. 3690(b)		
19:25-20.11, 20.13	ELEC: Lobbyists and legislative agents: reporting of identity of State officials receiving benefits	24 N.J.R. 3031(a)	R.1992 d.459	24 N.J.R. 4277(a)
19:31-7	EDA: Local Development Financing Fund	24 N.J.R. 2534(a)	R.1992 d.421	24 N.J.R. 3735(a)

Most recent update to Title 19: TRANSMITTAL 1992-5 (supplement June 15, 1992)

TITLE 19 SUBTITLE K—CASINO CONTROL COMMISSION/CASINO REINVESTMENT DEVELOPMENT AUTHORITY

19:40-1.2	Submission and approval of new games	24 N.J.R. 3223(a)		
19:40-1.2	Casino simulcasting of horse races	24 N.J.R. 3695(a)		
19:40-2.1	Organization of Commission	Exempt	R.1992 d.410	24 N.J.R. 3737(a)
19:40-2.5	Delegation of Commission authority	24 N.J.R. 2348(a)		
19:41-1.1, 2, 3.1, 4.2, 13	Casino licensure and financial stability	24 N.J.R. 3225(a)		
19:41-1.2, 3.2, 9.9A, 9.11A, 11.1-11.4	Junkets; casino service industries	24 N.J.R. 2695(b)	R.1992 d.412	24 N.J.R. 3738(a)
19:41-1.3	Casino simulcasting of horse races	24 N.J.R. 3695(a)		
19:41-1.11	Casino licensee-bus company agreements	24 N.J.R. 3694(a)		
19:41-14	Renewal of employee licenses	24 N.J.R. 2133(a)		
19:42-5.9, 5.10	Casino simulcasting of horse races	24 N.J.R. 3695(a)		
19:42-10	Administrative suspension of license or registration, or dismissal of application upon determination of unpaid fees or civil penalties	23 N.J.R. 3249(a)		
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