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NEW JERSEY REGISTER

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MOST RECENT UPDATE TO NEW JERSEY ADMINISTRATIVE CODE: JUNE 15, 1992
See the Register Index for Subsequent Rulemaking Activity.

NEXT UPDATE: SUPPLEMENT JULY 20, 1992

RULEMAKING IN THIS ISSUE

EXECUTIVE ORDER

OFFICE OF THE GOVERNOR
Executive Order No. 63(1992): Establishment of State Agency Coordinating Council on Local Partnerships .... 2973(a)

RULE PROPOSALS

Interested persons comment deadline 2972

AGRICULTURE
Animal health: biological products for diagnostic or therapeutic purposes ..... 2974(a)
BANKING
Branch and charter application procedures for banks, savings banks and savings and loan associations ..... 3034(a)
EDUCATION
Conditions for access to pupil records ..... 3038(a)
Thorough and efficient system of public schools ..... 3039(a)
Governor's Teaching Scholars Program ..... 3050(a)
ENVIRONMENTAL PROTECTION AND ENERGY
Underground storage tanks ..... 2975(a)
Freshwater fishing line for Rahway River in Union County ..... 2977(a)
Taking of horseshoe crabs ..... 2978(a)
Air contaminant emission statements from stationary sources ..... 2979(a)
HEALTH
Interchangeable drug products ..... 2997(a)
HIGHER EDUCATION
State college personnel system ..... 3052(a)
HUMAN SERVICES
Pharmaceutical Services Manual ..... 3053(a)
Service Programs for Aged, Blind or Disabled Persons .. 3074(a)
General Assistance program: time-limited eligibility for employable persons; alien eligibility; payment of hospital medical services ..... 3075(a)
Personal needs allowance for eligible residents of residential health care facilities and boarding houses ..... 3088(a)
Children's Shelter Facilities and Homes: manual of standards ..... 3089(a)
INSURANCE
Automobile PIP coverage: physical therapy services ..... 2998(a)
Financial Examination Monitoring System: data submission by domestic insurers ..... 2999(a)
Financial Examination Monitoring System: data submission by surplus lines producers and insurers ..... 3003(a)
LABOR
Unemployment Compensation and Temporary Disability: 1993 maximum benefit rates, taxable wage base, government entity contribution rate, base week, and alternative earnings test ..... 3014(a)
Workers' Compensation: 1993 maximum benefit rate ..... 3015(a)
Prevailing wages on public works contracts: extension of comment period ..... 3015(b)
Workers' Compensation appeal procedures regarding discrimination complaint decisions: extension of comment period ..... 3090(a)
LAW AND PUBLIC SAFETY
Motor Vehicle Franchise Committee: administrative hearing costs ..... 3015(c)
Mortuary Science: licensee advertising; referral fee prohibition ..... 3016(a)
Veterinary Medical Examiners: referral fee prohibition; product endorsements; licensee advertising ..... 3017(a)
Per diem compensation for members of professional and occupational licensing boards ..... 3019(a)

(Continued on Next Page)

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INTERESTED PERSONS

Interested persons may submit comments, information or arguments concerning any of the rule proposals in this issue until **October 8, 1992.** Submissions and any inquiries about submissions should be addressed to the agency officer specified for a particular proposal.

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.

RULEMAKING IN THIS ISSUE—Continued

Toy and bicycle safety ..... 3019(b)
Confidentiality of information regarding firearms permits, ID cards, licenses and registration ..... 3022(a)

PUBLIC UTILITIES
Discontinuance of services to customers: notification of municipalities and others ..... 3023(a)

TRANSPORTATION
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 ..... 3024(a)
Licensing of aeronautical and aerospace facilities: extension of comment period ..... 3026(a)

ELECTION LAW ENFORCEMENT COMMISSION
Pre-candidacy activity; independent expenditures; public financing of gubernatorial primary candidates ..... 3026(a)
Lobbyists and legislative agents: reporting of identity of State officials receiving benefits ..... 3031(a)

CASINO CONTROL COMMISSION
Single zero roulette ..... 3033(a)

RULE ADOPTIONS

ADMINISTRATIVE LAW
Special Education Program ..... 3091(a)

PERSONNEL
Reinstatement of permanent employee following disability retirement ..... 3091(b)

HEALTH
Registration of wholesale drug distributors and device manufacturers and wholesale distributors ..... 3100(a)
SHARE Manual: administrative correction regarding Cost Center Record ..... 3103(a)
Health care facilities and services: Certificate of Need application and review process ..... 3104(a)
Regionalized perinatal services: Certificate of Need criteria and standards ..... 3131(a)
Long-term care services: Certificate of Need policy manual ..... 3144(a)
Licensure examination fee for nursing home administrator ..... 3161(a)
Maternal and child health consortia: licensing standards ..... 3162(a)
Hospital licensing standards: obstetrics ..... 3165(a)
Interchangeable drug products ..... 3173(a), 3173(b), 3174(a), 3174(b), 3174(c)

HIGHER EDUCATION
Educational Opportunity Fund Program: financial eligibility for undergraduate grants ..... 3091(c)

HUMAN SERVICES
Assistance Standards Handbook: DYFS monthly foster care rates ..... 3092(a)

CORRECTIONS
Office of Interstate Services: administrative correction ..... 3093(a)

COMMERCE AND ECONOMIC DEVELOPMENT
Small businesses, minorities' and women's enterprises: direct loan and loan guarantee programs ..... 3093(b)

LAW AND PUBLIC SAFETY
Certified nurse midwife practice ..... 3094(a)

TRANSPORTATION
Parking along U.S. 206 in Lawrence Township ..... 3097(a)
Permits for work or activities involving State highway rights-of-way ..... 3097(b)
Zone of Rate Freedom for regular route autobus carriers: 1993 percentage maximums ..... 3097(c)

TREASURY-GENERAL
Lottery prize offset against overdue child support and public assistance overpayments ..... 3098(a)

CASINO CONTROL COMMISSION
Gaming school tables ..... 3099(a)
Supervision of table games ..... 3099(c)
Baccarat staffing requirements ..... 3099(b)

PUBLIC NOTICES

COMMUNITY AFFAIRS
Smoke detector requirements in single family dwellings: request for public comment ..... 3176(a)
Uniform Construction Code: notice of permit extensions ..... 3176(b)

ENVIRONMENTAL PROTECTION AND ENERGY
Clean Water Council: annual public hearing ..... 3176(c)
Bakers Basin properties: public hearing on proposed sale of lands for roadway construction ..... 3176(d)
Monmouth County water quality management: Township of Middletown Sewerage Authority WMP ..... 3177(a)
Monmouth County water quality management: Colts Neck ..... 3177(b)
Water Quality Management Planning and Implementation Process Pass-Through Grant Program ..... 3177(c)

(Continued on page 3201)

NEW JERSEY REGISTER

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EXECUTIVE ORDER

(a)

OFFICE OF THE GOVERNOR
Governor Jim Florio
Executive Order No. 63(1992)
Establishment of State Agency Coordinating Council on Local Partnerships

Issued: August 6, 1992.
Effective: August 6, 1992.
Expiration: Indefinite.

WHEREAS, the Governor's Task Force on Local Partnerships has examined the opportunities for, and problems with, local governments joining together to provide certain services; and

WHEREAS, the Task Force concluded that the joint delivery of government services offers opportunities to provide governmental services in a more efficient and cost effective manner; and

WHEREAS, the Task Force recommends that State government support and encourage local efforts to provide joint services by assisting local governments in establishing cooperative service initiatives; and

WHEREAS, there are various State agencies that work with local government on issues of mutual concern and a coordination of efforts is needed to ensure more effective responses to joint local services initiatives.

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 in, but not of, the Department of Community Affairs, a State Agency Coordinating Council on Local Partnerships (Council) which shall be composed of fifteen members including representatives of State agencies which have substantial involvement with units of local government, local agencies, school districts and local authorities and representatives of municipalities and county governments.

2. The Commissioners of the Departments of Community Affairs, Environmental Protection and Energy, Health, Transportation, Personnel, Treasury, Education and the Office of State Planning shall each appoint a representative to the Council. The Attorney General shall appoint a representative from the Department of Law and Public Safety. The Governor shall appoint one additional State representative. The Governor shall also appoint five representatives of municipalities and county government. The Council may recommend to the Governor the addition of other State agency or local representatives. The chair and vice-chair of the Council shall be designated by the Governor from among the Council members.

3. The Council is established for the purpose of:

(a) Increasing responsiveness to initiatives for the provision of joint local services;

(b) Developing outreach to identify and publicize opportunities for the joint provision of local services;

(c) Creating a data base consisting of fiscal, economic, operational and other relevant data to be shared with local governments and to provide a basis for evaluating joint service opportunities;

(d) Compiling and maintaining an inventory of case studies on local partnerships which would serve as a basis for comparing the experience of local joint service arrangements in New Jersey and other states; and

(e) Providing other "clearinghouse" and reference services.

4. The Council shall extend technical assistance to units of local government on interlocal and regional concerns, including, but not limited to: local police services, local health services, county environmental health; public works; fire services; public education services; code enforcement; planning and land use; cooperative purchasing; joint insurance fund; and joint municipal courts.

5. The Council shall arrange for studies of regional approaches to the provision of joint services; develop guidelines for pilot projects as well as full implementation of interlocal services; and sponsor the development, through the State colleges, State universities and the private sector, of models for various local partnerships and privatization options.

6. The Council shall cooperate with Statewide local government organizations in conducting or sponsoring seminars and workshops on interlocal services and attendant concerns.

7. The Council shall evaluate requests for State funds, as are presently or in the future made available, to carry out the objectives of this Order, and recommend actions and priorities to the appropriate administrative agencies.

8. The Division of Local Government Services (Division) in the Department of Community Affairs shall request from all local governments, as part of the annual local budget process, a report on any joint service opportunities considered in the previous year and any prospects for the following year. The Division shall provide such Report to the Council to serve as a basis for its outreach, research and follow-up activities.

9. The Council is authorized to call upon any department, office, division or agency of this State to supply it with data and any other information, personnel or assistance it deems necessary to discharge its duties under this Order. Each department, office, division or agency of this State is hereby required, to the extent not inconsistent with law, to cooperate with the Council and furnish it with such information, personnel and assistance as is necessary to accomplish the purpose of this Order. The Attorney General shall act as legal counsel to the Council.

10. This Order shall take effect immediately.

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RULE PROPOSALS

AGRICULTURE

(a)

DIVISION OF ANIMAL HEALTH

Biological Products for Diagnostic or Therapeutic Purposes

Proposed New Rules: N.J.A.C. 2:6

Authorized By: State Board of Agriculture and Arthur R. Brown, Jr., Secretary, Department of Agriculture.
Authority: N.J.S.A. 4:5-107 et seq.
Proposal Number: PRN 1992-387.

Submit comments by October 8, 1992 to:
Ernest W. Zirkle, DVM, Director
Division of Animal Health
New Jersey Department of Agriculture
CN 330
Trenton, New Jersey 08625
Telephone (609) 292-3965

The agency proposal follows:

Summary

N.J.A.C. 2:6, Biological Products for Diagnostic or Therapeutic Purposes, expired September 3, 1990 pursuant to the requirements and criteria of Executive Order No. 66(1978). The Department proposes to adopt these new rules in an effort to regulate the sale and use of veterinary vaccines in New Jersey.

These rules do not apply to drugs or chemicals, including antibiotic preparations.

Biologics are complex products with variable applications and effects that have the potential for misuse. The probable results of their misuse can maintain or spread disease, complicate the diagnostic process and fail to provide effective disease protection.

In December 1985, the Congress of the United States amended the Federal Virus, Serum, and Toxins Act of 1913 to include Federal control of intrastate and export sales. Following that, Executive Order 12612 of October 26, 1987 stated in its expression of Fundamental Federalism Principles (Sect. e) that "States uniquely possess the constitutional authority, the resources, and the competence to discern the sentiments of the people and to govern accordingly." Furthermore, (Sect. i) stated that "In the absence of clear constitutional or statutory authority, the presumption of sovereignty should rest with the individual states. Uncertainties regarding legitimate authority of the national government should be resolved against regulation at the national level." Therefore, these rules further clarify the relationship of the State statutes to Federal law and regulations.

These proposed new rules exempt individual registration of most Federally licensed manufacturers or products; limit the use of certain products which may introduce disease or diagnostic complications into the State; and limit the use or retail distribution of all biologics, except poultry, to a veterinarian.

With the exception of dairy farmers and some breeding equine farms, the largest group of livestock owners in New Jersey are niche farmers, such as 4-H and FFA members and land owners with occupations which allow for part time livestock farming. The number of owners within these groups remains rather stable; however, individual ownership frequently changes. Consequently, there is a constant potential for new owners who are unfamiliar with the proper health care and management of the livestock they own. These rules assure, to the extent possible, that these owners receive professional guidance prior to administering biologics with the potential to be harmful to livestock, ineffective or a waste of time and money.

Social Impact

The proposed new rules affect veterinarians, livestock owners and poultrymen by protecting these individuals from the ineffective use of vaccines, serums, antigens and diagnostic agents to determine, prevent and treat animal disease. The risks of not promulgating these rules also include the misuse of these biologics, which could result in the maintenance and spread of infection, improper handling, misdiagnosis and mistreatment by laymen. In addition, the rules will protect human health by restricting exposure to virulent organisms.

Economic Impact

Diagnosis, prevention and treatment of animal diseases, to include the proper use of veterinary biologics, prevents the illness and death of horses, livestock and poultry, and as a consequence increases the economic return of animal agriculture products. Healthy animals allow New Jersey farmers the opportunity to compete more effectively in the national and international marketplace for the distribution and sale of animal agricultural products.

A minor degree of economic loss may occur within the animal feedstuff and the pet-animal industry by restricting the sale of biologics. Also, farmers may incur additional expenses related to the need for the professional services of a veterinarian in the treatment of livestock. However, biologics must be applied in a uniform and safe manner in order to effectively control disease for the public welfare.

Regulatory Flexibility Analysis

The restriction of the distribution or use of biologics to veterinarians will have a minimum impact upon the farmers in this State. Most, if not all farmers, are considered small businesses as defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. There are no reporting or recordkeeping requirements created by these rules; however, there are compliance requirements which mandate that biologics be administered or prescribed by a veterinarian. The rules permit non-professional individuals to acquire and use biologics products, if, in the veterinarian's professional opinion, the product is appropriate for that herd under the specific farm setting and practices and the individual is properly trained. Because these rules are concerned with the control of disease and the public welfare, no lessening of or exemption from these requirements is provided.

Full text of the proposed new rules follows:

CHAPTER 6
BIOLOGICAL PRODUCTS FOR DIAGNOSTIC OR THERAPEUTIC PURPOSES

SUBCHAPTER 1. BIOLOGICAL LICENSING

2:6-1.1 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Accredited veterinarian" means any licensed Doctor of Veterinary Medicine who has fulfilled the requirements for Federal and State accreditation, pursuant to 9 C.F.R. sec. 160.1 et seq. in the State of New Jersey.

"Biological product" or "biologic," "biological" and "biological drug" mean any product utilizing virus (whether active or inactive) or any molecular part thereof, bacteria or any genetic equivalent thereof, or toxin as its basic component, or any product derived from the serum of any other animal, in the diagnosis (diagnostic biologic) or prevention (prophylactic biologic) or animal disease. This includes any and all products covered by the Animal Virus, Serum, and Toxin Act, 21 U.S.C.A. secs. 151 et seq., and the regulations issues pursuant thereto, 9 C.F.R. sec. 101.1 et seq.

"Diagnostic biologic" means a preparation of bacterial, viral or parasitic agents, products, factions, serums, or fractions of serums utilized to determine experience with a disease causing agent.

"Director" means the Director, Division of Animal Health, New Jersey Department of Agriculture.

"Distribution" means the preparation, sale, barter, exchange, or giving away of any regulated product.

"Domestic animal" means any and all animals other than humans.

"Licensed veterinarian" means a Doctor of Veterinary Medical Examiners, pursuant to N.J.S.A. 45:16-1 et seq., and the rules issued pursuant thereto, N.J.A.C. 13:44, to practice veterinary medicine, surgery, and dentistry in the State of New Jersey.

"Person" means any individual, corporation, institution or partnership.

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"Prophylactic biologic" means any and all vaccines or toxoids used to initiate immunity against disease in domestic animals.

2:6-1.2 Distribution of biologics

(a) Unless otherwise stated, all United States Department of Agriculture (U.S.D.A.) licensed biologics may be distributed and used according to the terms of this chapter.

(b) No USDA unlicensed or conditionally licensed biologic or diagnostic biologic shall be distributed without a license or the written permission from the Director.

(c) The distribution and use of the following biological products in New Jersey is prohibited:

1. Anthrax Spore Vaccine;
2. Avian Influenza Vaccine;
3. Bluetongue Vaccine;
4. Chlamydia Psittaci Bacterin;
5. Duck Virus Enteritis Vaccine;
6. Duck Virus Hepatitis Vaccine;
7. Mycobacterium Paratuberculosis Bacterin;
8. Mycoplasma Gallisepticum Vaccine;
9. Ovine Ecthyma Vaccine;
10. Pseudorabies Vaccine, except as provided in N.J.A.C. 2:2-4.37; and
11. Salmonella Dublin Bacterin.

(d) The Director may prohibit the distribution of any other diagnostic product or prophylactic biologic, based upon the scientific evidence and/or the usefulness, desirability and value of the biologic product to the overall health and safety of the industry, in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and N.J.A.C. 1:30.

2:6-1.3 Procedure when not fully USDA licensed

(a) License or written permission to distribute, use, sell, or give away a biological product unlicensed or conditionally licensed by the USDA may be granted by the Director upon a showing to the Director's satisfaction in writing of:

1. The purpose, purity, safety, potency and efficacy of the product;
2. The procedures to insure the same;
3. Reporting procedures to track the product; and
4. The credibility and reliability of the person applying for the license, based on their credentials and past performance in handling these materials.

(b) License or written permission to distribute, use, sell, or give away a biologic product may be granted for more than one biologic product upon a showing of the need for scientific research or testing.

2:6-1.4 Use of biologic products, diagnostic biologics and prophylactic biologics

(a) Only USDA licensed and New Jersey permitted biologic products may be used in New Jersey in accordance with N.J.A.C. 2:6-1.2 and 1.3.

(b) All biologic products, including diagnostic biologics, shall be administered only by or on the order of a licensed veterinarian, except:

1. Prophylatic biologics used to immunize poultry;
2. Brucella Abortus and contagious ecthyma vaccines shall be administered only by accredited veterinarians; and
3. Diagnostic biologics for the following diseases are limited to use by the New Jersey Department of Agriculture, Division of Animal Health only, unless specific written permission is granted by the Director, for in vitro diagnosis of:

i. Equine Infectious Anemia;
ii. Brucellosis; and
iii. Paratuberculosis (Johne's Disease).

(c) Exceptions to (b)3 above may be granted by the Director to other government agencies who may be cooperating with the New Jersey Department of Agriculture, or where in the opinion of the Director, there is an emergent situation requiring immediate action.

2:6-1.5 Revocation of license or permission to distribute or use

(a) A license or permission to distribute or use any biologic product may be revoked by the Director when there has been a violation of State or Federal laws or regulations, or where the public health, welfare or safety shall warrant such revocation, subject to notice and opportunity to be heard.

(b) Any hearing to be conducted under this section shall be so conducted pursuant to N.J.A.C. 2:1-3.8 and the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

ENVIRONMENTAL PROTECTION AND ENERGY

(a)

DIVISION OF RESPONSIBLE PARTY SITE REMEDIATION

Underground Storage Tanks

Proposed Readoption: N.J.A.C. 7:14B

Authorized By: Scott A. Weiner, Commissioner, Department of Environmental Protection and Energy.

Authority: N.J.S.A. 13:1D-1 et seq. and 58:10A-21 et seq.

DEPE Docket Number: 36-92-08.

Proposal Number: PRN 1992-402.

Submit written comments by October 8, 1992 to:

Richard J. McManus, Esq. (R)
Administrative Practice Officer
Department of Environmental Protection and Energy
CN 402
Trenton, New Jersey 08625

The agency proposal follows:

Summary

Pursuant to the requirements and criteria of Executive Order No. 66(1978), N.J.A.C. 7:14B expires on December 21, 1992. As required by the Executive Order, the Department of Environmental Protection and Energy (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 Department proposes to readopt these rules without change.

On September 3, 1986, the Underground Storage of Hazardous Substances Act, N.J.S.A. 58:10A-21 to 37, (Act) was signed into law. Subsequent to its enactment, the Department promulgated rules, N.J.A.C. 7:14B, to implement the Act and provide a regulatory program for the prevention and control of unauthorized discharges of hazardous substances caused by releases from underground storage tank (UST) systems. Effective December 21, 1987, the Department adopted rules for the registration and annual certification of regulated UST facilities. The Department adopted subsequent amendments and rules effective September 4, 1990 to establish tank design and construction standards, tank operating and closure requirements, release reporting and discharge remediation requirements, and requirements for the issuance of loans from the UST Improvement Fund.

The Legislature amended the Act in January 1991 (P.L. 1991 c.1) and April 1991 (P.L. 1991, c.123). The first amendment had two major provisions. First, the deadlines for owners or operators of existing underground storage tank systems to upgrade their systems to meet design and performance standards were extended from September 1991 to either December 1993 (for all tank systems except regulated heating oil tank systems) or August 1995 (for all regulated heating oil tank systems). Second, the Department was authorized to modify the registration cycle from an annual cycle to a periodic cycle, as a means of reducing administrative burdens on the regulated community. The Department promulgated regulatory amendments to N.J.A.C. 7:14B-4.5, 9.1, and 13.20 effective March 2, 1992 to incorporate the new requirements pertaining to the upgrade schedule.

The April 1991 statutory amendments established a certification program for individuals and business firms who provide services to owners and operators of underground storage tank systems for the purposes of complying with the requirements of the Act. The certification program is designed to minimize the potential for pollution caused by accidental discharges during installation, removal, repair or upgrade of regulated USTs. It provides that as a condition of certification or recertification,

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a business firm shall be required to provide evidence of financial responsibility for the cleanup or mitigation of a hazardous substance discharge resulting from the performance of services.

The Department intends to propose expansive technical amendments to N.J.A.C. 7:14B in the near future to address these statutory amendments as well as numerous modifications to reflect process improvements. Due to the rules' expiration date of December 21, 1992, there was not enough time to prepare a complete rule amendment proposal incorporating all of these items. The Department will propose these technical amendments in the New Jersey Register in October 1992 and conduct hearings in November 1992. An extended comment period will be provided with adoption anticipated early in 1993.

In addition, the Department has decided to postpone proposing any amendments to the UST rules at this time in order to ensure consistency between the UST rules and the recently proposed rules for Cleanup Standards for Contaminated Sites (Cleanup Standards), N.J.A.C. 7:26D (see 24 N.J.R. 373(a)), Procedures for Department Oversight of the Remediation of Contaminated Sites (Oversight Rules), N.J.A.C. 7:26C (see 24 N.J.R. 1281(b)), and Technical Requirements for Site Remediation (Technical Rules), N.J.A.C. 7:26E (see 24 N.J.R. 1695(a)). Together these three chapters will ensure that sites are investigated in accordance with minimum technical standards and that the same remedial processes and cleanup levels will apply regardless of the party conducting the work or the lead regulatory program overseeing the work. The Cleanup Standards will provide clearly articulated, predictable levels to which contaminated sites must be remediated in order to adequately protect human health and the environment. The Oversight Rules will define when and how a party may participate in remediation activities and the degree of Department oversight of those activities. The Technical Regulations will provide detailed requirements of how investigations and cleanups are to be conducted by establishing the technical requirements for remediation. The Department will be required to amend the UST rules, particularly subchapters 1, 7, 8 and 9, in order to make the UST rules consistent with the Cleanup Standards, Technical Rules and Oversight Rules. However, the Department has determined that, in order to ensure clarity and predictability in the manner in which the UST rules will interact with these new rules, it is necessary to review the public comment to these new rules and formulate appropriate regulatory responses prior to modifying the UST rules.

In sum, although the Department has identified revisions it would like to propose to the UST rules, it is proposing to readopt the chapter without change to allow the Department to continue to implement the Act while the Department completes ongoing related rulemaking which has broad impact to the remediation of all contaminated sites in New Jersey. The Department is developing, and intends to propose, amendments to N.J.A.C. 7:14B in the near future.

Summary of the text of N.J.A.C. 7:14B follows:

Subchapter 1 sets forth general information, including the scope, construction, purpose and applicability of the rules, and the definitions for the chapter.

Subchapter 2 sets forth the registration requirements for underground storage tank owners and operators, including the procedures for initial registration, periodic certification, and modification of existing registrations.

Subchapter 3 sets forth the fee schedule for administering the UST Program.

Subchapter 4 sets forth performance standards and engineering requirements for new and existing underground storage tank systems. All new tank systems have to meet minimum construction standards, including corrosion protection for the tank and piping, and spill and overfill protection for the tank. All owners and operators must also maintain a release monitoring system. New facilities in environmentally sensitive areas need to install secondary containment on the tank system, as well as corrosion, spill and overfill protection and a monitoring system. Existing tank systems storing any hazardous substance except heating oil for on-site consumptive use must be upgraded to meet new tank standards by December 23, 1993. Existing heating oil tanks must be upgraded by August 6, 1994, if the tank is over 20 years old and by August 6, 1995 if the tank is less than 20 years old.

Subchapter 5 sets forth general operating requirements for owners and operators of UST systems. These include testing and maintenance schedules for cathodic protection systems, tank and piping repair requirements, inventory control requirements, and recordkeeping specifications. The requirement for a release response plan is also included.

Subchapter 6 sets forth performance standards and operating requirements for monitoring systems used to detect leaks or discharges from UST systems. The major types of acceptable systems include vapor monitoring, ground water monitoring, in-tank monitoring and interstitial monitoring for secondary containment systems. Various restrictions and conditions apply to the use of each system depending on soil type, depth to ground water, type of hazardous substance, and existing contamination at the site.

Subchapter 7 sets forth the procedure to be followed if a release is suspected or confirmed. Methods to investigate a suspected release including checking inventory records, conducting a visual inspection of all accessible points of the UST system and checking the calibration of the monitoring system. All confirmed discharges must be reported to the Department Hotline and local officials.

Subchapter 8 sets forth the requirements for remediation activities by the owner and/or operator if a discharge to the environment has occurred. The facility must take immediate steps to stop the discharge by ceasing use of the tank, emptying it, and mitigating the effects of the discharge. The owner or operator must undertake remediation activities to identify and remediate the extent of the contamination.

Subchapter 9 sets forth the requirements for the closure of a UST system, including an investigation of the site. Tanks must be removed upon closure except under special circumstances when they may be abandoned in place. Requirements for the temporary closure of tank systems are also included.

Subchapter 10 sets forth the permitting requirements for all new tank installations and substantial modifications to existing tanks. Permits are required prior to the installation of single-walled tanks, monitoring systems, piping, corrosion protection systems and spill and overfill prevention devices.

Subchapter 11 sets forth the criteria under which a municipality may pass a local ordinance which regulates USTs. The municipality must prove that there is an environmental condition in the town which requires additional regulatory protection. All other municipal ordinances are superseded by these rules.

Subchapter 12 sets forth the penalty provisions of the UST Program and the procedures for requesting an adjudicatory hearing.

Subchapter 13 sets forth the program for the issuance of loans from the Underground Storage Tank Improvement Fund, including the application, eligibility, financial hardship and collateral requirements.

Subchapter 14 is reserved. When proposed, it will contain the Financial Responsibility Assurance requirements for facility owners. The United States Environmental Protection Agency (USEPA) has recently promulgated rules for Federally regulated UST facilities. The Department intends to incorporate USEPA's rule and propose this subchapter in the spring of 1993.

Subchapter 15 sets forth the confidentiality provisions, including the procedures for application and storage of materials that are deemed to be confidential.

Social Impact

N.J.A.C. 7:14B has had a beneficial social impact. Releases from underground storage tank systems have the potential to cause severe harm to public health and the environment. Tanks can discharge hazardous substances into the environment, threaten ground water and potable water sources, create vapor hazards which have immediate dangers of explosion and long term health risks. Contamination lowers property values, creates real estate transfer problems and can render land unfit for development and use. The tank installation and design standards, general operating conditions, closure site investigation requirements and the UST Improvement Loan Program all contribute to the elimination or early detection of discharges to prevent these negative impacts.

Economic Impact

The proposed readoption of these rules will not increase or decrease the cost of regulatory compliance. N.J.A.C. 7:14B requires the underground storage tank owner or operator to properly manage the tank system. Proper management of the tank system consists of upgrading the system to meet construction standards for corrosion protection, monitoring systems and spill and overfill prevention; conducting site investigations during closure of the tank system to determine if releases have occurred; operating the system in a manner to prevent releases entirely or to detect releases before they migrate from the excavation area; and conducting remedial activities if a release does occur. The

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proposed readoption will continue to impose economic burdens on the owners and operators of facilities subject to the Act. The cost of compliance with these rules varies depending on the number, condition and age of the tanks, and the extent of the remediation required at the site. These costs can include Department fees, consultant and laboratory technical costs and attorney fees. However, the Legislature intended that the owner or operator of facilities should incur these expenses rather than the citizens and taxpayers of New Jersey at some later date.

Since the original adoption of N.J.A.C. 7:14B, the Department has taken steps to decrease case processing times and thereby alleviate some of the economic burdens imposed by the Act. In addition, as evidenced by the proposed Cleanup Standards, Oversight Rules and Technical Rules, the Department will be able to provide more guidance and predictability to the regulated community for its remediation work. As a result, the Department anticipates that on the average it will take less time for the regulated community to obtain a Closure Plan approval or Discharge Investigation and Corrective Action Report approval from the Department, and less time to remediate.

Environmental Impact

The proposed readoption will have a positive environmental impact by continuing without interruption the regulatory framework necessary to implement the benefits of the Act. The harm caused by discharges from underground storage tank systems can be devastating. One gallon of a hazardous substance released into ground water has the potential of rendering millions of gallons of water unfit for human consumption.

The Department is currently investigating over 1,000 releases from underground storage tanks which have impacted ground water. Since New Jersey depends on ground water for 50 percent of its potable water, noncomplying tank systems cannot be allowed to operate in New Jersey. Upgrading requirements and early detection of releases will significantly decrease new cases reported to the Department. One of the primary goals of the UST Program is to prevent even minimal releases from occurring. Where they do occur, the releases must be detected early and controlled as soon as feasible to prevent the spread of contamination. Releases which are detected early may never reach the ground water supply. Early detection will also prevent the spread of vapors created by the release from a gasoline tank system. Vapors can form an explosive mixture if allowed to accumulate in an enclosed area. In addition, long term inhalation of low levels of hazardous substance vapors can become a chronic health condition.

The rules at N.J.A.C. 7:14B have provided a substantial degree of protection from the environmental threats of discharges from underground storage tanks by requiring the owner or operator to meet certain reasonable standards; to install tanks that do not discharge, to upgrade their existing tanks already in place, and monitor their tanks to insure that no discharge occurs.

Regulatory Flexibility Analysis

The proposed readoption of N.J.A.C. 7:14B would apply to all owners and operators of regulated underground storage tanks that store hazardous substances. The Department estimates that 15,000 tank owners and operators are "small businesses" as defined in the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., and will therefore continue to be affected. Types of small businesses to which the rules apply include independent gasoline service stations, fleet services, and heating oil companies, to name a few. In order to comply with these rules, small businesses will have to comply with the requirements set forth in the Summary above. In so doing, it is likely that small businesses will need to engage the services of consultants and/or professional engineers. It is expected that the capital and operating costs of complying with tank upgrade, operating and monitoring requirements at N.J.A.C. 7:14B-4, 5 and 6 could vary from approximately $3,000 to $100,000 depending upon whether the owner or operator has already installed state of the art equipment and whether any existing equipment can be retrofitted or needs to be replaced. It is expected that the costs of complying with the remediation requirements at N.J.A.C. 7:14B-7, 8 and 9 could vary from $2,000 for a site investigation to over $1,000,000 when ground water must be remediated. In readopting these rules, the Department has balanced the need to protect human health, property and environment against the economic impact of these rules and has determined that to minimize the impact of the rules based upon the size of the business would unacceptably endanger human health, property and the environment.

Therefore, these rules do not establish different compliance, fee or reporting requirements or timetables that take into account resources available to small businesses. However, small businesses may apply to take advantage of the UST Improvement Fund which was established at N.J.A.C. 7:14B-13 to provide funds to owners and operators under financial hardship to upgrade their systems.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 7:14B.

(a)

DIVISION OF FISH, GAME AND WILDLIFE

Defining Fishing Lines
Union County—Rahway River
Proposed Amendment: N.J.A.C. 7:25-16.1

Authorized By: Scott A. Weiner, Commissioner, Department of Environmental Protection and Energy.
Authority: N.J.S.A. 23:1-2, 23:3-1 and 23:9-1.
DEPE Docket Number: 33-92-07.
Proposal Number: PRN 1992-372.

Submit written comments by October 8, 1992 to:
Samuel Wolfe, Esq.
Office of Legal Affairs
Department of Environmental Protection and Energy
CN 402
Trenton, New Jersey 08625

The agency proposal follows:

Summary

N.J.S.A. 23:3-1 states, in part, that no person above the age of 14 may fish in the freshwaters of the State without a fishing license. This provision necessitates that the freshwaters of the State be distinguished from the State's salt waters and that the transition line between the two be defined. These lines of transition for all of the State's coastal waters are listed in N.J.A.C. 7:25-16.1.

The determination of the line of transition is now made on the basis of salinity test results. Inland tidal streams were monitored to establish the freshwater background chemical character and then they were monitored downstream, at high tide, to determine the upstream extent of saltwater influence. Determinations were made under streamflow conditions ranging from 40 to 60 percent of the average freshwater discharge, and therefore, these license lines are conservative in the upstream direction, that is favoring upstream placement of the line. This conservative placement of the license line results in licenses being necessary in a smaller portion of the stream than would be the case if a stricter determination was made which would place the line further downstream. For purposes of reasonable and adequate notice, this transition line is adjusted further upstream to the nearest readily discernible landmark. Many of the transition lines listed in N.J.A.C. 7:25-16.1 predate the establishment of this procedure and there has been a considerable number of line revisions made to the original listing on the basis of the results of subsequent testing.

The proposed amendment will correct a long standing error in the listing of the line of transition for the Rahway River in Union County. N.J.A.C. 7:25-16.1 currently lists the Grand Street Bridge, Rahway as the line of transition. The correct line of transition, as determined in accordance with the procedure identified in the preceding paragraph, is the Lawrence Street (Route 514) Bridge, Rahway. The error resulted from a simple misidentification of the bridge in question. The Grand Street Bridge lies upstream of the confluence of two of the Rahway River's major tributaries (the Robinson's Branch of the Rahway River and the South Branch of the Rahway River), with the Rahway River. Neither of these tributaries has an identified line of transition and both are considered as freshwater throughout their entire drainages. Division of Fish, Game and Wildlife maps defining the lines of transition for all of the State's coastal waters, clearly show the line for the Rahway River to be the Lawrence Street (Route 514) Bridge, which is downstream of the confluences of the two aforementioned tributaries and approximately 500 feet downstream of the Routes 1 and 9 Bridge. The Grand Street Bridge is nearly a mile upstream of the Routes 1 and 9 Bridge, making the error in bridge identification obvious. These maps are available for inspection, Monday through Friday, from 9:00 A.M. to 4:00 P.M. at the Division's office at 501 East State Street, Trenton, New Jersey.

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Social Impact

Adoption of the proposed amendment will require that fishermen possess a freshwater fishing license on an approximate one mile stretch of the Rahway River where they could previously fish without such license. Although N.J.A.C. 7:25-16.1 is footnoted to state that the absence of a stream from the listing does not preclude the requirement to possess a license to fish in the fresh waters thereof, the current listing leaves some doubt as to where that line of transition might be on the Robinson's Branch of the Rahway River and the South Branch of the Rahway River. That portion of the Robinson's Branch of the Rahway River known as Milton Lake is stocked with trout by the Division of Fish, Game and Wildlife. If it were determined that it was legal to fish in this area without a license because the waters were not clearly defined as fresh waters by law, the lake would no longer be stocked. Removal of a popular, local water from the list of trout stocked waters would have a negative social impact reducing the recreational fishing opportunity afforded by the stocking.

Economic Impact

No economic impact is expected as a result of the adoption of the proposed amendment. The portions of the impacted area that are currently fished are already assumed to be fresh waters by those that fish them and the vast majority of these fishermen already possess fishing licenses. The fishermen that currently fish these waters without a license, will be required to purchase one (at a cost which currently is $15.00), if they wish to continue this practice.

Environmental Impact

The proposed amendment will have a positive environmental impact, because the one mile stretch of the Rahway River, and adjacent tributaries, affected by the proposed amendment will be eligible for full consideration for benefits under the State's freshwater fisheries management program. These benefits include fish stocking and protection under the provisions of the Fish Code, N.J.A.C. 7:25-6.

Regulatory Flexibility Statement

In accordance with the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., the Department has determined that this amendment would not impose reporting, recordkeeping, or other compliance requirements on small businesses, because small businesses are not regulated by N.J.A.C. 7:25-16.1. The rule defines lines upstream of which individuals must obtain a license in order to fish with handline, rod and line, or long bow and arrow.

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

7:25-16.1 Defining lines upstream of which license is required to fish with handline, rod and line, or long bow and arrow

(a) The following table defines lines upstream of which a license is required to fish with handline, rod and line, or long bow and arrow:

Name of Water	License required upstream of this location
...	
UNION COUNTY	
...	
Rahway River	[Grand St.] **Lawrence Street (Route 514)** Bridge, Rahway
...	

(b)-(c) (No change.)

(a)

DIVISION OF FISH, GAME AND WILDLIFE

Marine Fisheries

Horseshoe Crab

Proposed New Rule: N.J.A.C. 7:25-18.16

Authorized By: Scott A. Weiner, Commissioner, Department of Environmental Protection and Energy.

Authority: N.J.S.A. 23:2A-5 and 23:2B-6.

DEPE Docket Number: 34-92-08.

Proposal Number: PRN 1992-382.

Submit written comments by October 8, 1992 to:

Samuel A. Wolfe, Esq.
Office of Legal Affairs
Department of Environmental Protection and Energy
CN 402
Trenton, NJ 08625

The agency proposal follows:

Summary

Horseshoe crabs, *Limulus polyphemus,* spawn in late spring and early summer in the mid-Atlantic region during higher lunar tides. Delaware Bay beaches between the Cape May Canal in Cape May County and Stow Creek in Cumberland County are important horseshoe crab spawning areas.

During the horseshoe crab spawning season, these beaches also serve as critical feeding areas for migratory birds. Many species of migratory shorebirds heavily rely on a diet of horseshoe crab eggs to replenish their energy supply prior to completing extensive migrations. Unrestricted harvesting of horseshoe crabs along these Delaware Bay beaches disrupts the natural, daytime feeding of migratory shorebirds at a critical point and time during their migration.

The proposed new rule restricts the harvest of horseshoe crabs along Delaware Bay beaches between the Cape May Canal in Cape May County and Stow Creek in Cumberland County to non-daylight hours only during the period from May 1 through June 7 for the protection of shorebirds. These restrictions keep the harvesters off shorebird feeding beaches at times of daily feeding allowing the migratory shorebirds to feed on the abundant horseshoe crab eggs without disruption by the horseshoe crab harvesters. Permitting the limited harvest of horseshoe crabs during the hours of darkness (three nights a week) should provide for the traditional harvest of horseshoe crabs while minimizing disturbance of shorebirds. The allowance to harvest horseshoe crabs three nights per week represents a compromise to minimize disturbance to shorebirds that actively feed at night while allowing adequate access to the horseshoe crab resource to maintain a fresh product to utilize as bait. This compromise was developed in coordination with the Endangered and Non Game Species Advisory Committee, commercial fishermen and the New Jersey Marine Fisheries Council.

The proposed new rule also requires the possession of a free permit by all harvesters. To allow for monitoring of the fishery, all harvesters will have to provide monthly reports including information on the numbers of horseshoe crabs harvested, the areas of harvest and the gear utilized.

The new rule provides for the continued traditional harvesting of horseshoe crabs to be used as bait in some commercial fisheries and for medical research or any other purpose while, at the same time, providing for reduced disturbance of migratory shorebirds feeding on beaches and shorelines of marine waters during the horseshoe crab spawning season.

Social Impact

The proposed new rule will have a positive social impact upon birders and naturalists who come to the Delaware Bay Beaches to see horseshoe crabs and the migrating shorebirds that depend upon them. Harassment of the shorebirds, which would constitute a taking of endangered and nongame species of wildlife under the Endangered and Nongame Species Conservation Act, N.J.S.A. 23:2A-1 et seq., by the unrestricted harvest of horseshoe crabs during daylight hours along the Delaware Bay shoreline reduces normal bird activity in areas where people would otherwise be able to see shorebirds. The loss of these viewing opportunities would have a major negative impact on many New Jersey residents. The new rule should prevent these negative impacts from occurring, thus resulting in an overall positive social impact.

The adoption of this new rule would have little effect on local fishermen who use a limited number of horseshoe crabs for eel or conch bait. They could still take as many horseshoe crabs as necessary to supply their needs for bait. Horseshoe crab harvesters will be required to obtain a free permit, keep accurate records of their harvest and satisfy timely reporting requirements. Recordkeeping activities may exert a minor social impact on permitted harvesters. The rule should have no effect on those who take horseshoe crabs to extract blood for medical science or those taking horseshoe crabs under a scientific collecting permit.

Economic Impact

Restricting the harvesting of horseshoe crabs by hand to nighttime only on the beaches and shoreline of Delaware Bay from the Cape May

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Canal to Stow Creek may curtail the recent emergence of a large scale commercial harvest of horseshoe crabs from Delaware Bay beaches, but will allow traditional harvest by other means and in other areas. During the horseshoe crab spawning season in Delaware Bay, the horseshoe crabs are heavily concentrated and very abundant. Horseshoe crab harvesting will not be significantly curtailed by temporal and areal restrictions designed to preclude disruption of shorebird feeding. The Delaware Bay portion of this traditional fishery will remain active, but during the period from May 1 through June 7 will be required to concentrate its shoreline efforts to Mondays, Wednesdays and Fridays from one hour after sunset to one hour before sunrise the following day. Although harvesting of horseshoe crabs may be less convenient, there should be no significant adverse economic impact because the new rule does not limit the amount of horseshoe crabs that may be harvested.

Environmental Impact

In the last few years a growing number of horseshoe crabs were harvested from the bayshore beaches and marshes easily accessible by road. The harvest not only severely reduced the local availability of horseshoe crabs with possible adverse consequences to the horseshoe crab population but also kept shorebirds from feeding on the beaches and marsh mudflats. Many of these species depend on horseshoe crab eggs and other marsh invertebrates to build body condition to continue migration and/or to increase reproductive success. The decline or loss of horseshoe crabs or severe disturbance to the birds during this critical period could result in serious population declines of one or more of the migrant shorebird species. This proposed new rule will provide for recordkeeping and reporting of horseshoe crab harvest to monitor and protect the horseshoe crab resource, protect local horseshoe crab availability necessary for the migrant shorebird species and reduce shorebird disturbance during daylight hours, resulting in a positive environmental impact.

Regulatory Flexibility Analysis

This proposed new rule will affect a very limited number of horseshoe crab harvesters, some or all of which are "small businesses" as defined in the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Most of the horseshoe crab harvesters are fishermen who utilize the horseshoe crabs for bait in other fisheries such as for eels. While the rule requires no initial capital costs for each small business affected, they will be required to record and submit such management data as described in the summary to the Department. The Department does not anticipate that the additional recordkeeping requirement will require additional professional services or capital costs for compliance. The requirements for compliance imposed by the rule will make the harvest of horseshoe crabs less convenient but should not have any economic impact on small businesses.

In developing this rule, the Department has balanced the need to protect the environment against the economic impact of the proposed regulation and has determined that to minimize the impact of the rule would endanger the environment, public health and public safety and, therefore, no exemption from coverage is provided.

Full text of the proposed new rule follows:

7:25-18.16 Horseshoe crab (Limulus polyphemus)

(a) An individual shall not catch, take, or attempt to catch or take horseshoe crabs except by hand collection or while using other gear allowed under this chapter and/or N.J.S.A. Titles 23 and 50 from any beach or shoreline or from the marine waters of this State unless such individual has in his or her possession a valid permit to take horseshoe crabs issued by the Commissioner of Environmental Protection and Energy. Any individual who wishes to harvest horseshoe crabs may obtain a permit by completing an application available from the: Division of Fish, Game and Wildlife, Bureau of Marine Fisheries, CN 400, Trenton, NJ 08625. The following persons, in the following circumstances, are not subject to this prohibition:

1. Property owners, tenants or agents of property owners may, at any time, remove dead horseshoe crabs from their property for purposes of disposal. No sale, trade, or barter of horseshoe crabs is permitted under this paragraph.

2. Persons collecting horseshoe crabs for strictly scientific purposes only and operating under the terms and conditions specified by a required scientific collecting permit issued pursuant to N.J.S.A. 23:4-52 by the Administrator of the Marine Fisheries Administration within the Division of Fish, Game and Wildlife.

(b) The season for taking horseshoe crabs shall be January 1 through December 31, except:

1. A person shall not harvest horseshoe crabs from the beaches and shoreline of that portion of Delaware Bay and its tributaries and the adjacent waters and uplands within 1,000 feet of the mean high water line extending from the Cape May Canal in Cape May County to Stow Creek in Cumberland County from May 1 through June 7, except Monday, Wednesday and Friday commencing from one hour after sunset until one hour before sunrise the following day, prevailing time.

2. Possession of horseshoe crabs within the prohibited area, at a prohibited time, during the prohibited season shall be prima facie evidence of violation of this section.

(c) Any person harvesting horseshoe crabs by any method permitted by the Commissioner shall provide monthly reports within five working days following the end of the reported month to the Department on forms supplied to the permit holder. The monthly report shall include the number of horseshoe crabs harvested, the area of collection, the gear utilized and any other information as the Department may deem necessary for management of the horseshoe crab resource.

(d) Any person violating the provisions of this section shall be subject to the penalties prescribed in N.J.S.A. 23:2B-14 except that violations of (c) above, failure to provide monthly reports, shall subject the violator to a penalty of $20.00 for each offense.

(a)

POLICY AND PLANNING

Emission Statements; Confidentiality

Proposed New Rules: N.J.A.C. 7:27-1.6 through 1.30 and 7:27-21

Proposed Amendments: N.J.A.C. 7:27-1.4, 8.4, 8.24, 16.9 and 7:27A-3.10

Proposed Repeals: N.J.A.C. 7:27-8.14 through 8.23

Authorized By: Scott A. Weiner, Commissioner, Department of Environmental Protection and Energy.

Authority: N.J.S.A. 13:1B-3, 13:1D-9, and 26:2C-1 et seq., in particular N.J.S.A. 26:2C-9(c) and 19.

DEPE Docket Number: 35-92-08.

Proposal Number: PRN 1992-391.

A **public hearing** concerning this proposal will be held on:
Friday, October 9, 1992 at 10 a.m., at:
New Jersey Department of Environmental Protection and Energy
Hearing Room, 1st floor
401 East State Street
Trenton, New Jersey 08625

Submit written comments by October 23, 1992, to:
Richard McManus, Director
Office of Legal Affairs
New Jersey Department of Environmental Protection and Energy
CN 402
Trenton, New Jersey 08625-0402

Copies of the proposed new rule will be available for inspection during normal office hours until October 23, 1992, at:
Atlantic County Health Department
201 South Shore Road
Northfield, New Jersey 08225

Middlesex County Air Pollution Control Program
County Annex Building
841 Georges Road
North Brunswick, New Jersey 08902

Warren County Health Department
319 West Washington Avenue
Washington, New Jersey 07882

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New Jersey Department of Environmental Protection and Energy
Office of Energy
401 East State Street, Seventh Floor
Trenton, New Jersey 08625

New Jersey Department of Environmental Protection and Energy
Bureau of Enforcement Operations
Northern Regional Office
1259 Route 46, Bldg. #2
Parsippany, New Jersey 07054

New Jersey Department of Environmental Protection and Energy
Bureau of Enforcement Operations
Southern Regional Office
20 East Clementon Road, 3rd Floor North
Gibbsboro, New Jersey 08026

New Jersey Department of Environmental Protection and Energy
Bureau of Enforcement Operations
Metropolitan Regional Office
2 Babcock Place
West Orange, New Jersey 07052

New Jersey Department of Environmental Protection and Energy
Bureau of Enforcement Operations
Central Regional Office
Horizon Center, Building 300
Route 130
Robbinsville, New Jersey 08691

The new rule and amendments will become operative 60 days after adoption by the Commissioner (see N.J.S.A. 26:2C-8).

The agency proposal follows:

Summary

The New Jersey Department of Environmental Protection and Energy (the Department) is proposing new rules, N.J.A.C. 7:27-21, Emission Statements (Subchapter 21). The Department is proposing related amendments to N.J.A.C. 7:27A-3, Civil Administrative Penalties and Requests for Adjudicatory Hearings, at N.J.A.C. 7:27A-3.10.

Subchapter 21 establishes requirements for the annual reporting of the air contaminant emissions from stationary sources. The air contaminants required to be reported in the emission statements are carbon monoxide (CO), sulfur dioxide (SO_2), total suspended particulate matter (TSP), respirable particulate matter (PM_{10}), lead (Pb), and the precursors to the formation of ground level ozone (that is, volatile organic compounds (VOC) and oxides of nitrogen (NO_x)). For the first year that emission statements are due, only VOC, NO_x and CO will be reported, because facilities may not be keeping adequate records for the other pollutants. For the following years, all air contaminants specified above will be reported.

The proposed new Subchapter 21 would enable the State of New Jersey to comply with the mandates of the Federal Clean Air Act (CAA), as amended November 15, 1990. The CAA mandates that the Department do the following:

(1) Obtain emission statements from facilities which are sources of ozone precursors;

(2) Submit to EPA periodic emission inventories for ozone precursors and carbon monoxide;

(3) Track progress toward attainment of the National Ambient Air Quality Standard (NAAQS) for ozone;

(4) Track progress toward the attainment of the NAAQS for carbon monoxide (CO); and

(5) Submit to EPA annual point source reports for all criteria pollutants (VOC, NO_x, CO, SO_2, PM_{10}, and Pb).

The 1990 Clean Air Act amendments also require New Jersey to attain the National Ambient Air Quality Standard (NAAQS) for ozone by 1993 in Warren County, by 1996 in Atlantic and Cape May counties, by 2005 in the Philadelphia—Wilmington—Trenton Consolidated Metropolitan Statistical Area (CMSA), and by 2007 in the New York—Northern New Jersey—Long Island CMSA. The NAAQS for CO must be attained in all areas of New Jersey by 1995.

These proposed new rules and amendments represent one component of a broader program the Department is developing to progress toward attainment of the NAAQS for ozone and CO. The Department would use the data collected under Subchapter 21 primarily to guide efforts to attain the NAAQS for ozone and CO, as required by the 1990 CAA amendments. The Department would use the data collected to prepare annual emission statement reports to EPA, pursuant to Section 182(a)(3)(B) of the CAA, and to prepare periodic emission inventory submittals to EPA, required pursuant to Section 182(a)(3)(A) of the CAA. The Department would also use the data collected in order to track the progress toward attainment of NAAQS for ozone and CO, and to develop new emission control strategies as needed to attain the standard.

New Jersey's complete program to attain the ozone standard will be set forth in its State Implementation Plan (SIP). A SIP is a comprehensive plan for a state to attain the NAAQS for criteria pollutants. Components of the SIP are due to EPA on November 15, 1992, and on November 15, 1993, and the full plan is due to the United States Environmental Protection Agency (EPA) on November 15, 1994. The Department will provide the opportunity for public comment before submitting any component of the SIP to EPA.

EPA established the NAAQS for ozone pursuant to the 1970 amendments of the CAA. Volatile organic compounds (VOC) and oxides of nitrogen (NO_x)in the ambient air, in the presence of sunlight, participate in formation of ground level ozone. The EPA has established a maximum one-hour average of 0.12 parts per million, not to be exceeded more than once per year, as the primary NAAQS for ozone. This standard was established at a level that would protect public health. New Jersey has exceeded the maximum hourly concentration for ozone more than once each year since the standard was established, resulting in New Jersey's nonattainment status for ozone. Between May and September of 1988, 1989, 1990 and 1991, the NAAQS standard for ozone was exceeded in New Jersey 45, 18, 23 and 26 times, respectively.

EPA has established a maximum eight-hour average of nine parts per million and a maximum one-hour average of 35 parts per million, not to be exceeded more than once per year, as the NAAQS for CO. In 1990, New Jersey had the fewest recorded exceedances of the NAAQS for CO in recent years, with only one exceedance which was recorded in Elizabeth. However, data from 1991 indicate that, during 1991, two exceedances occurred in Elizabeth, one in East Orange, and one in North Bergen. The 1990 Clean Air Act amendments require New Jersey to attain the carbon monoxide standard by 1995.

EPA established NAAQS for sulfur dioxide (SO_2), nitrogen dioxide (NO_2), total suspended particulates (TSP), and lead (Pb) in 1970. The NAAQS for PM_{10} was established by EPA in 1987 and replaced the national standard for TSP; however, New Jersey has retained the standard as a state requirement. The following table specifies the Ambient Air Quality Standards applicable in New Jersey.

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Ambient Air Quality Standards[1]

Pollutant	Standard	Averaging Period	New Jersey (a)	National (b)
Sulfur Dioxide	Primary	12-month arith. mean	80 ug/m³ (.03 ppm)	80 ug/m³ (.03 ppm)
	Primary	24-hour average (c)	365 ug/m³ (.14 ppm)	365 ug/m³ (.14 ppm)
	Secondary	12-month arith. mean	60 ug/m³ (.02 ppm)	—
	Secondary	24-hour average	260 ug/m³ (.10 ppm)	—
	Secondary	3-hour average (c)	1300 ug/m³ (0.5 ppm)	1300 ug/m³ (0.5 ppm)
Total Suspended Particulates	Primary	12-month geom. mean	75 ug/m³	—
	Primary	24-hour average	260 ug/m³	—
	Secondary	12-month geom. mean (d)	60 ug/m³	—
	Secondary	24-hour average	150 ug/m³	—
Inhalable Particulates (PM_{10})	Prim. & Sec.	Annual arith. mean	—	50 ug/m³
	Prim. & Sec.	24-hour average	—	150 ug/m³
Carbon Monoxide	Prim. & Sec.	8-hour average	10 mg/m³ (9 ppm)	9 ppm (10 mg/m³) (e)
	Prim. & Sec.	1-hour average	40 mg/m³ (35 ppm)	35 ppm (40 mg/m³) (e)
Ozone	Primary	Max. Daily 1-Hr. Avg.	.12 ppm (235 ug/m³)	.12 ppm (235 ug/m³) (f)
	Secondary	1-hour average	.08 ppm (160 ug/m³)	.12 ppm (235 ug/m³) (f)
Nitrogen Dioxide	Prim. & Sec.	12-month arith. mean	100 ug/m³ (.05 ppm)	.053 ppm (100 ug/m³)
Lead	Prim. & Sec.	3-month average	1.5 ug/m³	—
		Quarterly Mean	—	1.5 ug/m³

(a) New Jersey short-term standards are not to be exceeded more than once in any 12-month period.
(b) National short-term standards are not to be exceeded more than once in a calendar year.
(c) National standards are block averages rather than moving averages.
(d) Intended as a guideline for achieving short-term standard.
(e) National secondary standards for carbon monoxide have been dropped.
(f) Maximum daily 1-hour average: averaged over a three year period the expected number of days above the standard must be less than or equal to one.

New Jersey is currently in attainment for $N0_2$, Pb and PM_{10}. Parts of Warren County are designated nonattaiment for SO_2. The following areas are designated nonattainment for TSP: Camden, Carteret, Perth Amboy, Woodbridge, Elizabeth, Linden, Newark, Jersey City and all of Hudson County.[2]

To involve the public in the development of the proposed new rules, the Department held a public workshop on October 24, 1991, to informally obtain comments from the public pertaining to this rulemaking. From this workshop, a work group was formed consisting of seven representatives from various industries, two representatives of consulting firms and one representative from an environmental group. This work group met on October 31, November 8, November 15, and November 25, 1991, and made further recommendations to the Department.[3] These recommendations concerned approaches for calculating actual emissions, eliminating duplicative reporting to the Department, and ensuring consistency with Federal requirements. The Department has reviewed these recommendations and considered them in developing the proposed new rules.

Much of the proposed new rules is based upon draft EPA guidance for emission statements. This EPA guidance only addresses section 183(a)(3)(B) of the CAA which requires information on sources of VOC and NO_x. Since these proposed rules are designed to accomplish a broader range of objectives than the EPA guidance, significant additions and clarifications above and beyond EPA's guidance have been made in these rules and amendments to accommodate these objectives. For example, information regarding CO is required in order to fulfill the emission inventory requirements, and information regarding other criteria air pollutants is required in order to fulfill the annual point source reports as required at 40 CFR 51.321-323. The Department will develop its annual emission statement reporting forms based upon final EPA guidance and the 1990 emission inventory survey forms.[4]

A description of the provisions of the proposed amendments and new rules follows:

N.J.A.C. 7:27-21.1 defines terms used in the subchapter. The following proposed definitions are drawn from N.J.A.C. 7:27-8, Permits and Certificates: "air contaminant," "AP-42," "certificate," "CFR," "control apparatus," "distillates of air," "EPA," "equipment," "facility," "liquid particles," "manufacturing process," "NESHAP," "NSPS," "operating certificate," "permit," "person," "raw material," "solid particles," "source operation," "stack equivalent," "stack or chimney," and "temporary operating certificate." The following proposed definitions are drawn from N.J.A.C. 7:27-13, Ambient Air Quality Standards: "carbon monoxide or CO," "lead or Pb," "sulfur dioxide or SO_2," and "total suspended particulate matter or TSP." The following proposed definitions are drawn from N.J.A.C. 7:27-16, Control and Prohibition of Air Pollution by Volatile Organic Compounds: "Department," "delivery vessel," "gasoline dispensing facility," "organic substance," and "Reid vapor pressure." The proposed definition of "fugitive emissions" is drawn from N.J.A.C. 7:27-18, Control and Prohibition of Air Pollution from New or Altered Sources Affecting Ambient Air Quality (Emission Offset Rule). The proposed definition of the term "gasoline" is drawn from proposed amendments to N.J.A.C. 7:27-25, Control and Prohibition of Air Pollution by Vehicular Fuels, as published in the July 6, 1992, edition of the New Jersey Register at 24 N.J.R. 2386(a). The proposed definitions of the following terms are drawn from EPA's Guidance on Emission Statements: "Actual emissions," "control efficiency," "emission units code," "oxides of nitrogen or NO_x," "potential to emit," "seasonal throughput," "SCC code," and "SIC code." The proposed definitions of the following terms are drawn from Federal regulations: "emissions information," "federally enforceable," "peak carbon monoxide season," "peak ozone season," "PM_{10}," and "volatile organic compound or VOC."

Some of the key terms defined in the proposed new rules include: "emissions information," "volatile organic compound (VOC)," "AP-42," "process level," "potential to emit," and "peak ozone season." The following paragraphs provide explanation of these terms.

The proposed definition of "emissions information" is consistent with the EPA definition under 40 CFR 2.301(a)(2)(i), and includes facility identification information and emissions parameters; however, the definition proposed herein includes certain control apparatus information as "emissions information," whereas the EPA definition does not explicitly include control apparatus information. This definition is important in determining whether information contained in the emission statement can be considered "confidential information." EPA has established that the types of data included in the definition of "emissions information" are not confidential; accordingly, the Department may disclose such data, notwithstanding the restriction on disclosure in N.J.A.C. 7:27-8.14 et seq.

The proposed definition of "VOC" is equivalent to the Federal definition of this term set forth at 40 CFR 51.100(s). EPA has stated that its definition of VOC is to be used for developing State Implementation Plans (SIP) to attain the NAAQS for ozone. Subchapter 21 implements the emission statement requirements at Section 182(a)(3)(B) of the CAA amendments of 1990; these requirements are a required component of the SIP of any state, including New Jersey, which is not fully in attainment of the NAAQS for ozone. In addition, the Department will transmit

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the VOC emission information it collects under Subchapter 21 into EPA's Aerometric Information Retrieval System (AIRS), the national database for emissions information. This emissions information needs to be determined and reported in a manner consistent with EPA's definition of VOC so as to be integrated onto the Federal database. For these reasons, the definition of VOC proposed herein is equivalent to the Federal definition of that term.

The proposed definition of VOC would apply only to the use of the term in Subchapter 21. The definition of VOC currently promulgated by the Department at N.J.A.C. 7:27-16 and in other subchapters of N.J.A.C. 7:27 differs from the Federal definition. Most importantly, the list of organic compounds which are excluded from VOC is broader under the Federal regulation than under N.J.A.C. 7:27-16.

The Department is considering revising the definitions of VOC in these other subchapters to be more consistent with EPA's definition. This consideration is in part in response to a petition for rulemaking submitted by the Alliance for Responsible CFC Policy (the Alliance) on August 17, 1990 (see 22 N.J.R. 3165(c)). In its petition for rulemaking, the Alliance requested that the Department consider revising its definition of VOC so as to exclude from the term the same list of organic compounds that EPA excludes from the term. EPA excludes compounds upon a finding that they are negligibly photochemically reactive and therefore do not significantly participate in the formation of ground level ozone; EPA has judged that it is therefore appropriate that such compounds be excluded from state regulations promulgated for the purpose of making progress toward the attainment of the ozone standard. If the revised definition of VOC to be proposed for the other subchapters differs from the definition proposed herein, the Department may also propose revision of this definition, in order to define the term VOC consistently throughout N.J.A.C. 7:27. The Department will reach a decision on this issue and will propose amendments to the definition of VOC throughout N.J.A.C. 7:27 by October 1992.

The proposed definition of "AP-42" explains that it is the EPA document, entitled "Compilation of Air Pollutant Emission Factors," which is useful for estimating actual emissions. The proposed definition of "AP-42" includes two sources where the document may be obtained.

Some of the required information in the rule is specific to the "process level." The term "process level" is proposed to be defined as the operation of a source operation, specific to the kind or type of fuel, input material, or mode of operation. For example, if a boiler is permitted to burn oil or natural gas, the required "process level" information for the boiler would include information when burning oil and information when burning natural gas.

A facility's "potential to emit" is used to determine whether Subchapter 21 applies to the facility. "Potential to emit" is proposed to mean the capability of all source operations within a facility to emit an air contaminant at maximum design capacity, except as constrained by any federally enforceable condition. For example, to determine a facility's potential to emit, one would sum the allowable emissions from all permitted sources within the facility, and the emissions at maximum design capacity of all sources which have no permit, and all fugitive emissions.

Some of the required information in the rule is specific to the "peak ozone season" and the "peak carbon monoxide season." The term "peak ozone season" is proposed to be defined as June 1 through August 31, inclusive. The term "peak carbon monoxide season" is proposed to be defined as December 1 through the last day of February, inclusive.

N.J.A.C. 7:27-21.2(a) provides that Subchapter 21 is applicable to any facility with the potential to emit 10 tons per year or more of VOC, or 25 tons per year or more of NO_x, or five tons per year or more of Pb, or 100 tons per year or more of CO, SO_2, TSP, or PM_{10}. The 10 tons per year threshold for VOC is consistent with the emission inventory threshold for point sources as required by section 182(a)(3)(A) of the CAA. The 25 tons per year threshold for NO_x is required by Section 182(a)(3)(B) of the CAA. The 100 tons per year threshold for CO is consistent with the emission inventory threshold as required by Section 187(a)(5) of the Clean Air Act. The reporting thresholds for SO_2, TSP, PM_{10} and Pb are consistent with 40 CFR 51.321-323. Based upon these reporting thresholds, the Department expects that about 1,000 facilities would be required to report their emissions pursuant to this rule. This is about 60 more facilities than were surveyed for the 1990 emission inventory. The facilities required to report their emissions pursuant to this rule will include petroleum refineries, manufacturing facilities, chemical plants, plants with incinerators or boilers and other institutions with incinerators or boilers.

N.J.A.C. 7:27-21.2(b) indicates that emission statements pertaining to the emission of SO_2, TSP, PM_{10}, and Pb are not required to be submitted until 1994 for the emissions of 1993. This phased-in approach is designed to allow companies one full year to prepare before beginning to report on these air contaminants which were not included in earlier inventory surveys.

N.J.A.C. 7:27-21.2(c) indicates that gasoline dispensing facilities are exempt from the requirements of this subchapter. Section 182(a)(3)(B)(ii) of the CAA amendments of 1990 allows States to exempt "any class or category of stationary sources which emit less than 25 tons per year of volatile organic compounds or oxides of nitrogen if the State, in its submissions under subparagraphs (1) or (3)(A), provides an inventory of emissions from such class or category of sources, based on the use of emission factors established by the Administrator or other methods acceptable to the Administrator." The Department has determined that there are currently no gasoline dispensing facilities that emit 25 tons of VOC or NO_x. New Jersey already includes gasoline dispensing facilities in periodic area source calculations for emission inventory submissions to EPA and will continue to do so in future emission inventory submissions to EPA.

Under N.J.A.C. 7:27-21.3, the owner or operator of a facility subject to Subchapter 21 must submit annual emission statements for each air contaminant (that is, VOC, NO_x, CO, SO_2, TSP, PM_{10} and/or Pb) for which the facility's potential to emit exceeds the threshold listed in the applicability section, N.J.A.C. 7:27-21.2. In the past, the Department has obtained emission information from these facilities through periodic emission inventory surveys. Emission statement submissions required by this rule will replace the emission inventory surveys. This section also clarifies that all owners and operators are jointly and severally liable for penalties assessed for failure to comply with Subchapter 21.

N.J.A.C. 7:27-21.4 establishes the procedure for submitting an emission statement. The owner or operator of a subject facility must submit an emission statement by April 15 of each year following a calendar year in which the facility was subject to Subchapter 21.

N.J.A.C. 7:27-21.4(d) states that emissions statements shall be transmitted to the Department on paper, and in lieu of a paper submission, an emission statement may be submitted on computer diskette or electronically, in a form approved by the Department. In its planning for the implementation of the emission statement program, the Department is developing procedures to accept emission statements on diskette or electronically in the near future. The Department intends to implement the submission of emission statements electronically and on diskette and will seek input from the regulated community in the development of alternative means to submit emission statements. This effort is intended to reduce the administrative burden on both industry and the Department and to conform with the Federal Paperwork Reduction Act (44 U.S.C. 3501 et seq.).

The Department recognizes that emission statements may contain information which an owner or operator considers confidential. The emissions information itself, however, is not confidential. As discussed above, the proposed new rules specify what information is considered "emissions information" and is therefore not confidential. These provisions are consistent with the corresponding EPA regulations (see the Federal Register notice of February 21, 1991 at 56 FR 7042). The proposed amendments also replace the existing confidentiality rules at N.J.A.C. 7:27-8.14 through 8.23 with new rules which are substantially consistent with the existing rules. The new rules clarify the procedures for obtaining confidential treatment of information and meaningful remedies when the Department and the person submitting the information disagree over proposed disclosures. The new confidentiality rules are relocated at N.J.A.C. 7:27-1.6 through 1.30. These new rules are consistent with the confidentiality rules for discharges of petroleum and other hazardous substances at N.J.A.C. 7:1E-7 through 10, but contain provisions tailored to the air pollution control program. The new confidentiality rules apply to all confidentiality claims under the Air Pollution Control Act and rules, orders, and other documents issued under the Act, including Subchapter 21.

N.J.A.C. 7:27-21.5 sets forth the required contents of an emission statement. Emission statements must include information identifying the facility and its owner or operator, operating data, emissions information, control equipment information, and process rate data. This information is required to be submitted in order for the Department to track emission changes in order to demonstrate reasonable further progress towards attaining ambient air quality standards and insuring maintenance of ambient air quality; to prepare emission inventories and annual point

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source reports for planning air pollution control strategies and for submittal to EPA.

N.J.A.C. 7:27-21.5(a) sets forth the certification requirements. The person who submits an emission statement is required to certify to the accuracy of the information, as required by N.J.A.C. 7:27-8.24, which is amended to include Subchapter 21 within its scope.

N.J.A.C. 7:27-21.5(b) establishes the required facility identification information.

N.J.A.C. 7:27-21.5(c), (e), and (g) set forth the operational data needed for each source operation.

N.J.A.C. 7:27-21.5(d), (f), and (h) establish the required emissions, control apparatus and process rate data at the "process level" for each source operation. The actual emissions must be determined by a method listed in Table 2. In some cases, the Department will be able to calculate the actual emissions based on the operating data provided and standard emission factors.

N.J.A.C. 7:27-21.5 requires that, for VOC, NO_x or CO, the actual emissions are required to be reported in pounds per day of operation during the ozone season. The following is provided as clarification of a "day of operation." A day is a period of 24 consecutive hours, beginning and ending at midnight. The emissions that were released during the peak ozone season are to be divided by the number of days in which the source was operated. For example, even if a facility operates a source operation for eight hours in one day, that counts as one day of operation, not one-third of a day.

N.J.A.C. 7:27-21.5(i) allows the emissions of small source operations (that is, source operations which have the potential to emit less than 0.1 ton per year for Pb and one ton per year for any other air contaminant) to be reported with a lower level of detail. The Department is proposing two options for such source operations to be reported. The first option is to allow any such small source operation to have its actual emissions reported as one ton per year (0.1 ton per year for Pb). The second option is to allow such source operation to have its actual emissions reported, as determined by the facility, along with the method used to quantify the actual emissions and any emission factor used. This provision is designed to allow flexibility in reporting the emissions of small source operations and thus reduce the burden on industry and the Department.

N.J.A.C. 7:27-21.5(j) requires that all fugitive emissions be reported.

N.J.A.C. 7:27-21.5(l) states that, when choosing an emission method to calculate actual emissions, the person submitting the emission statement shall choose the method which is readily available and best estimates the actual emissions. Also, the Department is proposing that the method for determining actual emissions may also be set in the conditions incorporated in any future operating permit. Operating permits are required by Title V of the CAA for major facilities and have not yet been issued. The Department is required to adopt a new subchapter setting forth the rules and procedures for the issuance of operating permits. This rule is required to be in effect by November 15, 1993; the Department expects to accomplish this well before the deadline.

N.J.A.C. 7:27-21.6 requires the owner or operator of a subject facility to retain a copy of each emission statement submitted to the Department, and any copies of any calculations, estimations and other data used to obtain the information submitted in the emission statement. The rule requires the owner or operator to maintain these records for five years after the due date of each emission statement and to make these records available to the Department for inspection at the facility during normal business hours.

N.J.A.C. 7:27-21.7 is a severability provision, which states that if any provision of Subchapter 21 is held to be invalid, the remainder of the subchapter will remain in full force and effect.

N.J.A.C. 7:27A-3.10(e)21 establishes the civil administrative penalties for violation of Subchapter 21. The general criteria used to determine the penalties have been previously established when N.J.A.C. 7:27A-3 was originally proposed at 21 N.J.R. 729(a). These criteria include the following:

1. Potential or actual health and environmental impact; including consideration of the characteristics of pollutants involved, the quantity of pollutants involved, the magnitude of the area affected, and remedial actions taken by the source;

2. The deterrent value of the penalty, including making penalties a disincentive to discourage future violations, ensuring that penalties exceed any savings achieved by noncompliance; and

3. Consistency with other environmental program penalties. Comparisons were made with other DEPE penalty regulations, as with the United States Environmental Protection Agency's guidance documents.

The specific penalty amounts proposed herein are identical to penalties in the existing rules for analogous violations. They are as follows:

Citation For Which A Penalty Is Proposed In These Amendments	Citation Of A Provision For Which A Similar Penalty Has Been Previously Promulgated
N.J.A.C. 7:27-21.4(a)	N.J.A.C. 7:27A-3.6(c)2—False information by act or omission
N.J.A.C. 7:27-21.5(a)	N.J.A.C. 7:27-25.4(a)—Certify/Document
N.J.A.C. 7:27-21.5(b)-(k)	N.J.A.C. 7:27-16.4(m)—Submittal
N.J.A.C. 7:27-21.6(a)	N.J.A.C. 7:27-25.4(b)—Records
N.J.A.C. 7:27-21.6(b)	N.J.A.C. 7:27-8.3(d)—Readily Available

Pursuant to N.J.A.C. 7:27A-3.12, the Department retains the ability to assess penalty amounts, in addition to the proposed penalties, to offset any economic benefit which the violator may have realized as a result of not complying with the rule.

Social Impact

The Department expects the proposed new rules to have a positive social impact. Subchapter 21 will enable the Department to obtain more complete and reliable information as to the quantity of volatile organic compounds (VOC), oxides of nitrogen (NO_x), carbon monoxide (CO), sulfur dioxide (SO_2), total suspended particulate matter (TSP), respirable particulate matter (PM_{10}), and lead (Pb) being emitted by facilities in New Jersey. This information is crucial to the effective regulation of these criteria pollutants to protect public health and the environment.

The emission statements required under Subchapter 21 are an important resource for use in the development of the Department's strategy to prevent and control the emissions of VOC, NO_x, CO, SO_2, TSP, PM_{10}, and Pb. The Department expects that it will obtain data enabling it to design and develop more precisely targeted, and therefore more effective, control strategies to attain and maintain the NAAQS. This data will also help the Department develop better informed strategies for monitoring compliance with promulgated standards and permit requirements, and thereby help ensure that anticipated emission reductions are in fact realized. The reporting requirements may also make owners and operators of subject facilities more aware of the extent of the emissions being released from their facilities. Such awareness may encourage facilities to make voluntary reductions in their emissions.

For the reasons discussed below, the proposed new rules will have a long-term positive social impact, by contributing to the more effective control of emissions of VOC, NO_x, CO, SO_2, TSP, PM_{10}, and Pb.

VOC and NO_x are precursors to the formation of ground level ozone. As part of its program to attain the NAAQS for ozone, New Jersey is required by the CAA to demonstrate significant progress toward reducing emissions of these precursors.

The frequent and widespread violations of the health-based National Ambient Air Quality Standard (NAAQS) for ozone in New Jersey constitute a serious public health problem in the State. In 1978, EPA established the NAAQS for ozone at 0.12 parts per million. However, adverse health effects have been observed at lower levels of ozone. The American Lung Association and several states have filed a lawsuit against EPA seeking reevaluation of the ozone standard in light of recent scientific findings, in order to ensure that the ozone standard is protective of public health.[5]

Short-term effects of elevated ozone concentrations on healthy exercising adults and children include coughing, painful breathing and loss of certain lung functions. The connection between respiratory disease and high levels of ozone have been reported by the University of Medicine and Dentistry of New Jersey (UMDNJ). After studying data from nine central New Jersey hospitals, UMDNJ researchers found that the incidence of asthma attacks rose from seven to 10 percent when elevated levels of ozone were reported by the Department[6]. These effects are exacerbated in sensitive populations, particularly the elderly, those with pre-existing respiratory diseases and children who play outdoors. Long-term effects are also of concern, because much of New Jersey's population has been exposed to unhealthful levels of ozone throughout their

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lifetime. Although chronic effects have not been conclusively demonstrated, repeated exposure to ozone over a lifetime causes biochemical and structural changes in the lung and may be a causal factor in the development of chronic respiratory diseases.

Increased ozone levels also cause damage to foliage. One of the earliest and most obvious manifestations of ozone's impact on the environment is its impact on sensitive plants. Subsequent effects include reduced plant growth and decreased crop yield. A reduction in ambient ozone concentrations would mitigate damage to foliage, fruits, vegetables, and grains.

The oxidizing properties of ozone lead to accelerated degradation of various human-made materials such as rubber, plastics, dyes and paints. Attainment of the NAAQS for ozone would reduce the rate of degradation of both natural and synthetic materials, thus preventing excess expenditure on maintenance and replacement of property.

Carbon monoxide may cause adverse health effects when local concentrations become elevated. CO interferes with the oxygen carrying capacity of the blood, causing reduced awareness, dizziness, headache, fatigue, and loss of consciousness. Exposure to high levels of CO has also been linked to increased incidence of arteriosclerotic heart disease. The health threat from CO is most serious for those who suffer from cardiovascular disease, particularly those with angina or peripheral vascular disease. Healthy individuals also are affected but only at higher levels[7]. EPA has established a maximum eight-hour average of nine parts per million and a maximum one-hour average of 35 parts per million, not to be exceeded once per year, as the NAAQS for CO.

The major health effects associated with high exposures to sulfur dioxide include effects on breathing, respiratory illness and symptoms, alterations in the lung's defenses, and mortality. Persons most sensitive to sulfur dioxide include asthmatics and individuals with chronic lung disease (such as bronchitis or emphysema) or cardiovascular disease. Children and the elderly may also be sensitive. Sulfur dioxide produces foliar damage to trees and agricultural crops. It and nitrogen oxides are major precursors to acidic deposition (acid rain), which is associated with a number of effects including acidification of lakes and streams, accelerated corrosion of buildings and monuments and visibility impairment.[7]

Nitrogen dioxide can irritate the lungs and lower resistance to respiratory infection (such as influenza). The effects of short-term exposure are still unclear but continued or frequent exposure to concentrations higher than those normally found in the ambient air may cause increased incidence of acute respiratory diseases in children. Nitrogen oxides are an important precursor both to ozone and acid deposition and may affect both terrestrial and aquatic ecosystems. Atmospheric deposition of NO_x is a potentially significant contributor to ecosystem effects including algal blooms in certain estuaries such as the Chesapeake Bay.[7]

Exposure to lead can occur through multiple pathways, including inhalation of air and ingestion of lead in food, water, soil, or dust. Lead accumulates in the body in blood, bone and soft tissue. Because it is not readily excreted, lead also affects the kidneys, liver, nervous system and blood-forming organs. Excessive exposure to lead may cause neurological impairments such as seizures, mental retardation and/or behavioral disorders. Even at low doses, lead exposure is associated with changes in fundamental enzymatic, energy transfer and homeostatic mechanisms in the body. Fetuses, infants and children are especially susceptible to low doses of lead, often suffering central nervous system damage. Recent studies have also shown that lead may be a factor in high blood pressure and subsequent heart disease in middle-aged white males.[7]

Based on studies of human populations exposed to high concentrations of suspended particulates (often in the presence of sulfur dioxide), and laboratory studies of animals and humans, the major effects of concern for human health include effects on breathing and respiratory symptoms, aggravation of existing respiratory and cardiovascular disease, alterations in the body's defense systems against foreign materials, damage to lung tissue, carcinogenesis and premature mortality. The major subgroups of the population that appear likely to be most sensitive to the effects of particulate matter include individuals with influenza, asthmatics, the elderly and children. Particulate matter soils and causes damage to materials, and is a major cause of substantial visibility impairment in many parts of the U.S.[7]

Economic Impact

Subchapter 21 will require approximately 1,000 facilities in New Jersey to maintain records and submit annual emission statements to the Department. The proposed new rules would increase the economic burden on these facilities. For all but approximately 60 facilities, the increased cost of reporting VOC, NO_x and CO emissions will be due to submitting an emission statement annually instead of submitting an emission inventory survey every three years. For the 1994 emission statements and thereafter, all facilities (which meet or exceed the reporting thresholds) will also bear the additional cost entailed in reporting SO_2, TSP, PM_{10} and Pb.

The Department estimates that, for most facilities, the cost of determining and reporting the actual emissions would range from $2,000 to $20,000 per year. These figures are based on informal verbal estimates from workgroup members. These costs include maintaining appropriate records of operation, staff resources to fill out and submit the emission statements, and possibly computer equipment and software to manage the data needed to submit the emission statement. Generally, the cost to comply with the proposed new rules increases as the number of sources at a facility increases. Factors which would decrease the cost of compliance include the level at which the facility already maintains operating and emission records containing information required to be reported under the proposed new rules, and whether the facility already has qualified staff available to collect and record the required information.

The Department has attempted to minimize the economic burden of these proposed new rules as much as possible by not requiring more than is mandated by EPA. In addition, these rules allow some flexibility in reporting the emissions from small source operations. Also, the Department plans to alleviate the burden on some companies by calculating the actual emissions for some types of source operations for the companies based on operating information provided in the emission statement as indicated in N.J.A.C. 7:27-21.5 Table 2. For example, the Department expects to be able to use standard emission factors to calculate actual emissions based on operating data for some storage tanks and some fuel burning operations.

Owners or operators of facilities may choose to modify equipment, add additional control measures or use alternative raw materials or processes to reduce a facility's potential emissions below the reporting thresholds listed at N.J.A.C. 7:27-21.2. In this way, they can avoid being subject to these reporting requirements for the emissions of the subsequent calendar year, and of following years as long as the facility's potential to emit remains below the reporting thresholds. The costs to such facilities would be the costs they incur in making these modifications.

The Department would also incur costs in implementing these rules. Additional staff will be needed for database management, outreach and assistance to the regulated community, mailing costs, enforcement, and quality assurance and quality control. In addition to current staff, the Department expects that it will need approximately two new staff members to perform the tasks of data entry, mailing, quality assurance and control, and reporting information to EPA. The Department is also considering the development of a system to aid in electronic data submittal from facilities, which is expected to cost approximately $250,000 over a three year period. Initially, the costs to operate the program will be funded by the federal air grant. In the future, the costs will be at least partly funded through the emission fees collected from the operating permit program pursuant to Section 502(b)(3) of the CAA.

The proposed new rules will have a long-term positive economic impact, by contributing to the more effective control of emissions of the reportable pollutants. Making progress toward the attainment of the NAAQS for ozone and CO will avoid a significant negative economic impact on the general public. The American Lung Association has recently estimated the cost of health programs attributed to air pollution, including the loss of worker productivity, to be in the range of $4.43 billion to $93.49 billion per year, nationally. There are also economic impacts resulting from other effects of high concentrations of ozone, such as reduced crop yield and the degradation of natural and synthetic materials.

Environmental Impact

Although Subchapter 21 would have no direct impact on air contaminant emissions, the Department expects the implementation of Subchapter 21 to have an indirect positive effect on the environment. The proposed new rules would provide information to enable the Department to track progress toward attainment of the NAAQS for ozone, and to develop regulatory strategies with the most environmental impact for the least economic cost. Up to date and accurate inventory and database management will allow better tracking of VOC, NO_x, SO_2, TSP,

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PM_{10}, Pb and CO emissions from the regulated facilities. This will result in a more effective regulatory program in New Jersey.

Regulatory Flexibility Analysis

In accordance with the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., the Department has determined that the proposed new rules would impose additional reporting and recordkeeping requirements on small businesses. These small businesses, defined by the Regulatory Flexibility Act as "any business which is a resident in this State, independently owned and operated and not dominant in its field, and which employs fewer than 100 full time employees," would include some small businesses which have the potential to emit 10 tons per year of VOC, 25 tons per year of NO_x, 100 tons per year of CO, SO_2, TSP or PM_{10}, or five tons per year of Pb. The Department estimates that approximately 300 small businesses will be subject to the new rules. The proposed new rules would require these small businesses to submit annual emission statements to the Department and make available to the Department the data from which the actual emissions are determined. As discussed in the Economic Impact statement above, the Department estimates that small businesses will incur annual costs of $2,000 to $20,000 to collect the required information, submit the emission statements, and maintain the required records.

Many of the small businesses subject to these rules have relatively large potentials to emit VOC, NO_x, CO, SO_2, TSP, PM_{10}, or Pb. And the Department cannot exempt small businesses from the requirements of Subchapter 21, or limit their obligations under Subchapter 21, while complying with the mandate of the CAA. Section 182(a)(3)(B) of the CAA does not provide the Department with the latitude to establish different requirements for small businesses. However, the Department has provided some flexibility in the reporting requirements that are available to small businesses. For example, small source operations may be reported at a lower level of detail. Also, for some source operations, the Department may calculate the actual emissions based on the operating data provided and standard emission factors.

References

[1]N.J.D.E.P.E. 1990 Air Quality Report, July 1991.

[2]N.J.D.E.P.E. Technical Manual: Guidance on Preparing an Air Quality Modeling Protocol, Appendix C—New Jersey Air Quality Non-Attainment Areas, April 1992.

[3]N.J.D.E.P.E. Memorandum, Emissions Reporting Rule Work Group Final Report, December 9, 1991.

[4]N.J.D.E.P.E. 1990 Inventory of Air Emissions Forms A through F.

[5]*American Lung Association et al. vs. EPA,* Case No. 91 Cov. No. 4114, Second Circuit Federal U.S. District Court, October 22, 1991.

[6]Cody, R. P., Weisel, C. P., Birnbaum, G., and Lioy, P. J., "The Effect of Ozone Associated with Summertime Photochemical Smog on the Frequency of Asthma Visits to Hospital Emergency Departments," Environmental Research, 1992.

[7]United States Environmental Protection Agency, "National Air Quality Trends Report, 1990," November 1991.

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

7:27-1.4 Definitions

The following words and terms, when used in this [Chapter] **chapter**, shall have the following meanings, unless the context clearly indicates otherwise.

. . .

"Emissions information" means, with reference to any source operation, equipment, or control apparatus:

1. Information necessary to determine the identity, amount, frequency, concentration, or other characteristics (to the extent related to air quality) of any air contaminant which has been emitted by the source operation, equipment or control apparatus;

2. Information necessary to determine the identity, amount, frequency, concentration, or other characteristics (to the extent related to air quality) of any air contaminant which, under an applicable standard or limitation, the source operation, was authorized to emit (including, to the extent necessary for such purposes, a description of the manner or rate of operation of the source operation), or any combination of the foregoing; and

3. A general description of the location and/or nature of the source operation to the extent necessary to identify the source operation and to distinguish it from other source operations (including, to the extent necessary for such purposes, a description of the device, installation, or operation constituting the source operation).

The following list includes specific data fields which the Department considers to constitute emissions information. This list is not exhaustive and, therefore, other data might be found, in a proper case, to constitute emissions information:

Facility Identification

Plant name and related point identifiers

- **Address**
- **City**
- **County**
- **AQCR (Air Quality Control Region)**
- **MSA, PMSA, CMSA (Metropolitan Statistical Areas)**
- **State**
- **Zip Code**

Ownership and point of contact information

Locational Identifiers:

- **Latitude & Longitude or UTM Coordinates**

SIC Code (Standard Industrial Classification)

Emission point, device or operation description, information

SCC Code (Source Classification Codes)

Emissions Parameters

Emission type (for example, nature of emissions such as CO, particulate or a specific toxic compound, and origin of emissions such as process vents, storage tanks or equipment leaks)

Emission rate (for example, the amount released to the atmosphere over time such as pounds per hour or tons per year)

Release height (for example, height above ground level where the air contaminant is emitted to the atmosphere)

Description of terrain and surrounding structures (for example, the size of the area, with adjacent structures and terrain descriptions such as mountainous, urban, or rural)

Stack or vent diameter at point of emissions (for example, the inside diameter of vent at the point of emission to the atmosphere)

Release velocity

Release temperature

Frequency of release (for example, how often a release occurs in events per year)

Duration of release (for example, the time associated with a release to the atmosphere)

Concentration (for example, the amount of an emission stream constituent relative to other stream constituents, expressed as parts per million (ppm), volume percent, or weight percent)

Density of the emissions stream or average molecular weight (for example, density expressed as fraction or multiple of the density of air; molecular weight)

Boiler or process design capacity (for example, the hourly gross heating value of fuel input to a boiler at its maximum design rate or maximum pounds per hour product rate)

Emission estimation method (for example, the method by which an emission estimate has been calculated such as material balance, stack test, use of AP-42 emission factors, etc.)

Percent space heat (for example, the percent of fuel used for space heating)

Hourly maximum design rate (for example, the greatest operating rate that would be expected for a source in a one hour period)

Control apparatus information (for example, type of primary and secondary control apparatus, capture efficiency, and control efficiency) . . .

7:27-1.6 [(Reserved)] **Procedure for making a confidentiality claim**

(a) Any person required to submit information to the Department under this chapter, or allow the Department to obtain such information, which such person believes in good faith to constitute confidential information, may assert a confidentiality claim by following the procedures set forth in this subchapter.

(b) A claimant shall submit to the Department (at the address provided in N.J.A.C. 7:27-1.8) a confidential copy and, upon the Department's request, a preliminary public copy of any record containing assertedly confidential information. The preliminary public copy shall carry a notation stating that confidential informa-

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tion has been deleted. The Department may disclose the preliminary public copy to any person, without restriction or limitation.

(c) The claimant shall label the first page of the confidential copy "CONFIDENTIAL COPY." At the top of each page of the confidential copy, which page contains information that the claimant asserts is confidential information, the claimant shall place a boldface heading reading "CONFIDENTIAL." The claimant shall clearly underscore or highlight all information in the confidential copy which the claimant asserts to be confidential, in a manner which shall be clearly visible on photocopies of the confidential copy.

(d) The claimant shall seal the confidential copy in an envelope displaying the word "CONFIDENTIAL" in bold type or stamp on both sides. This envelope shall be enclosed in another envelope for transmittal to the Department. The outer envelope shall bear no markings indicating the confidential nature of the contents.

(e) The claimant shall send the package containing the confidential copy to the Department by certified mail, return receipt requested, or by other means providing a receipt for delivery.

(f) The claimant shall include in the package a written designation of a person to receive notices pursuant to N.J.A.C. 7:27-1.7.

7:27-1.7 [(Reserved)] Designation by claimant of an addressee for notices and inquiries

A claimant shall designate a person as the proper addressee of communications from the Department under N.J.A.C. 7:27-1.6 through 1.30. To designate such a person, the claimant shall submit the following information to the Department in writing: the name and address of the claimant; the name, address, and telephone number of the designated person; and a request that all Department inquiries and communications (oral and written), including without limitation the inquiries and notices listed in N.J.A.C. 7:27-1.8(a), be directed to the designee.

7:27-1.8 [(Reserved)] Correspondence, inquiries and notices

(a) The Department shall direct all correspondence, inquiries and notices to the person designated by the claimant pursuant to N.J.A.C. 7:27-1.7, including without limitation the following:

1. Notices requesting substantiation of claims, under N.J.A.C. 7:27-1.10(a)1ii;

2. Notices of denial of confidentiality claims and proposed disclosure of information, under N.J.A.C. 7:27-1.13(a)1;

3. Notices concerning shortened comment and/or waiting periods under N.J.A.C. 7:27-1.21(a);

4. Notices of disclosure under N.J.A.C. 7:27-1.22; and

5. Notices of proposed use of confidential information in administrative proceedings, under N.J.A.C. 7:27-1.25.

(b) A claimant shall direct all correspondence, inquiries, notices and submissions concerning confidentiality claims under this chapter to the Department at the following addresses:

1. With respect to permits and certificates:
Bureau of New Source Review
Environmental Regulation Program
Department of Environmental Protection
and Energy
401 East State Street, Second Floor
CN 027
Trenton, New Jersey 08625-0027

2. With respect to emission statement submittals:
Bureau of Air Quality Planning
Department of Environmental Protection
and Energy
401 East State Street, Seventh Floor
CN 418
Trenton, New Jersey 08625-0418

3. With respect to compliance reports or enforcement actions:
Assistant Director, Air & Environmental Enforcement
Division of Facility Wide Enforcement
Department of Environmental Protection
and Energy
CN 422
Trenton, New Jersey 08625-0422

7:27-1.9 [(Reserved)] Time for making confidentiality determinations

(a) The Department shall make a confidentiality determination:

1. If the Department receives a request, by a person to whom the Department is restricted from disclosing confidential information pursuant to N.J.A.C. 7:27-1.26 through 1.30, to inspect or copy records containing assertedly confidential information which is the subject of a confidentiality claim; or

2. Before taking any action which is inconsistent with the requirements for treatment of confidential information set forth in N.J.A.C. 7:27-1.26 through 1.30.

(b) The Department may, in its discretion, make a confidentiality determination at any time.

7:27-1.10 Notice of initial confidentiality determination, and of requirement to submit substantiation of claim

(a) If the Department initially determines that any of the assertedly confidential information may be confidential information, the Department shall:

1. Notify each claimant who is known to have asserted a claim applicable to such information, and who has not previously been furnished with notice with regard to the information in question, of the following:

i. That the Department is in the process of making a confidentiality determination with respect to the claimant's claim:

ii. That the claimant is required to substantiate the claim as required by N.J.A.C. 7:27-1.11;

iii. The address of the office to which the claimant's substantiation must be addressed;

iv. The time allowed for submission of substantiation, pursuant to N.J.A.C. 7:27-1.12;

v. The method for requesting a time extension under N.J.A.C. 7:27-1.12(b); and

vi. That a claimant's failure to furnish substantiation within the time allocated in N.J.A.C. 7:27-1.12 shall operate as a waiver of the claimant's claim.

2. Furnish, to any requester whose request for inspection or copying of the information is pending, notice that:

i. The information which is the subject of the request may be confidential information;

ii. The Department must undertake further inquiry before granting or denying the requester's request; and

iii. After the Department has made a confidentiality determination concerning the information which is the subject of the request, the Department will grant or deny the request.

(b) The Department shall send the notice required by (a)1 and 2 above by certified mail, return receipt requested, or by other means providing a receipt for delivery.

(c) If the Department is able to determine whether all of the assertedly confidential information is or is not confidential information, without the need for submission of substantiation under N.J.A.C. 7:27-1.11, such determination shall have the effect of a final confidentiality determination pursuant to N.J.A.C. 7:27-1.13. The Department shall provide such notices of the determination as are required by N.J.A.C. 7:27-1.13.

7:27-1.11 Substantiation of confidentiality claims

(a) If the Department has determined that any assertedly confidential information may be confidential information, and notified the claimant pursuant to N.J.A.C. 7:27-1.10(a) and (b), the claimant shall substantiate the confidentiality claim by submitting information to the Department in the following areas within the time allotted in N.J.A.C. 7:27-1.12:

1. Measures taken by the claimant to prevent disclosure of the information to others;

2. The extent to which the information has been disclosed to others, and the precautions taken to prevent further disclosure;

3. If the Department, EPA or any other agency has previously made a confidentiality determination relevant to the pending confidentiality claim, copies of all such confidentiality determinations;

4. A description of any substantial harmful effects which disclosure would have upon the claimant's competitive position, an

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explanation of why such harmful effects are substantial, and an explanation of the causal relationship between disclosure and such harmful effects;

5. The period of time for which the claimant desires that the Department treat the assertedly confidential information as confidential information; and

6. Any other substantiation which is relevant in establishing that the assertedly confidential information is confidential information.

(b) The claimant may assert a confidentiality claim for any information submitted to the Department by the claimant as part of his or her substantiation pursuant to this section. If the claimant fails to assert a confidentiality claim for such information at the time of submission, the claimant shall be deemed to have waived all such claims with respect to the information.

7:27-1.12 Time for submission of substantiation

(a) The claimant shall submit substantiation within 30 days after the date of the claimant's receipt of the written notice provided under N.J.A.C. 7:27-1.10(a)1.

(b) The Department may, in its discretion, extend the time allotted for submission of substantiation pursuant to (a) above if, before the expiration of the allotted time the claimant submits a written request for the extension of such allotted time; provided, however, that except in extraordinary circumstances, the Department shall not approve such an extension of time in connection with a request to inspect or copy assertedly confidential information pursuant to N.J.S.A. 47:1A-1 et seq. without the consent of any person whose request to inspect or copy the allegedly confidential information under N.J.S.A. 47:1A-1 et seq. is pending.

(c) If a claimant fails to submit substantiation within the time allotted pursuant to this section, the claimant shall be deemed to have waived all confidentiality claims with respect to the information for which the substantiation was required.

7:27-1.13 Final confidentiality determination

(a) If, after review of all the information submitted pursuant to N.J.A.C. 7:27-1.10 and 1.11, the Department determines that the assertedly confidential information is not confidential information, the Department shall take the following actions:

1. The Department shall so notify the claimant by certified mail, return receipt requested. The notice shall state the basis for the determination, that it constitutes final agency action concerning the confidentiality claim, and that the Department shall make the information available to the public on the 14th day following receipt by the claimant of the written notice. The notice shall include a copy of the final public copy to be made available to the public.

2. On or after the 14th day following receipt by the claimant of the written notice required by (a)1 above, the Department shall send written notice of the determination to any requester with a pending request to inspect or copy the information which was the subject of the confidentiality claim. The Department shall send the notice by certified mail, return receipt requested.

(b) If, after review of the substantiation submitted pursuant to N.J.A.C. 7:27-1.11, the Department determines that the assertedly confidential information is confidential information, the Department shall treat such information as confidential information in accordance with N.J.A.C. 7:27-1.26 through 1.30. The Department shall send written notice of the determination to the claimant and to any requester with a pending request to inspect or copy the information which was the subject of the confidentiality claim. The notice shall state the basis for the determination and that it constitutes final agency action. The Department shall send the notice by certified mail, return receipt requested.

7:27-1.14 Treatment of information pending confidentiality determination

The Department shall treat assertedly confidential information as confidential information, until the Department has made a final determination that the assertedly confidential information is not confidential information.

7:27-1.15 Availability of information to the public after determination that information is not confidential

If the Department determines that assertedly confidential information is not confidential information pursuant to N.J.A.C. 7:27-1.13(a), the Department may disclose such information to any person on the date which is 14 days after the claimant's receipt of the written notice of the confidentiality determination.

7:27-1.16 Preparation of final public copy

After the Department makes a final confidentiality determination that a record contains confidential information, the Department shall prepare a final public copy of the record based upon the final confidentiality determination. The Department may disclose the final public copy to any person, without restriction or limitation.

7:27-1.17 Class confidentiality determinations

(a) The Department may make a class confidentiality determination if the Department finds that the items of information within the class share one or more characteristics, which characteristics, would cause the Department to determine consistently that such information is or is not confidential information.

(b) A class confidentiality determination shall clearly identify the class of information to which it applies. Such identification shall include a list of the common characteristics shared by all information within the class.

(c) A class confidentiality determination shall state that all of the information in the class is or is not confidential information.

7:27-1.18 Classes of information which are not confidential information

Without limiting the ability of the Department to determine that information not listed in this section is not confidential information, emissions information, as defined at N.J.A.C. 7:27-1.4, is not confidential information.

7:27-1.19 Disclosure of confidential information to other public agencies

(a) The Department may disclose confidential information to any other State agency or to a Federal agency if:

1. The Department receives a written request for disclosure of the information from a duly authorized officer or employee of the requesting agency;

2. The Department notifies the other agency of any pending confidentiality claim concerning the requested information, or of any confidentiality determination regarding the requested information;

3. The other agency has furnished to the Department a written opinion from the agency's chief legal officer or counsel stating that under applicable law the agency has the authority to compel the person who submitted the information to the Department (or allowed the Department to obtain such information) to disclose such information to the requesting agency;

4. The other agency has adopted regulations or operates under statutory authority that will allow it to preserve confidential information from unauthorized disclosure, and agrees in writing to refrain from disclosure and to safeguard the information in accordance with the requirements of N.J.A.C. 7:27-1.27 and 1.28, unless:

i. The requesting agency has statutory authority both to compel production of the information and to disclose it; or

ii. The claimant has consented to disclosure of the information by the requesting agency; and

5. The requesting agency agrees not to disclose the information further unless:

i. The requesting agency has statutory authority both to compel production of the information and to make the proposed disclosure; or

ii. The claimant has consented to disclosure of the information by the requesting agency.

7:27-1.20 Disclosure of confidential information to contractors

(a) The Department may disclose confidential information to a contractor, if it complies with the procedure established under (b) below, and if:

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1. The Department determines that such disclosure is necessary in order for the contractor to perform the work required by the contract;

2. The contract provides that the contractor and the contractor's employees shall use the confidential information only for the purpose of performing the duties required by the contract, shall refrain from disclosing the confidential information to anyone other than the Department, shall store all records containing the confidential information in locked cabinets in secure rooms, and shall return to the Department all originals and all copies of the information (and any abstracts or extracts therefrom, or any records containing any of the confidential information) when the confidential information is no longer necessary to enable the contractor to perform obligations under the contract, or at any time upon the request of the Department; and

3. If the claimant so requests, the contractor contracts with the claimant to refrain from further disclosure of the confidential information.

(b) Before disclosing confidential information to a contractor under (a) above, the Department shall notify the claimant of the proposed disclosure in writing, delivered by certified mail, return receipt requested, at least 14 days before making the disclosure. The notice shall state the information to be provided, the identity of the contractor, and the scheduled date of disclosure. If, at least three working days before the scheduled date of disclosure, the claimant delivers to the Department information sufficient to establish that the proposed disclosure would be likely to cause substantial damage either to the claimant's competitive position or to national security, the Department shall refrain from making the disclosure.

7:27-1.21 Disclosure to alleviate an imminent and substantial danger

(a) If the Department finds that disclosure of confidential information would serve to alleviate an imminent and substantial danger to public health, safety or the environment, the Department may, in its discretion, take one or more of the following actions:

1. Reduce the time allotted for providing substantiation pursuant to N.J.A.C. 7:27-1.12, and notify the claimant of such reduction;

2. Advance the date on which the Department may disclose information which the Department has determined is not confidential information, pursuant to N.J.A.C. 7:27-1.13(a), and notify the claimant of such advance; or

3. Immediately disclose the confidential information to any person whose role in alleviating the danger to public health and the environment makes such disclosure necessary. Any disclosure pursuant to this paragraph shall be limited to information necessary to enable the person to whom it is disclosed to carry out the activities in alleviating the danger. Any disclosure made pursuant to this paragraph shall not be deemed a waiver of a confidentiality claim and shall not be grounds for any determination that information is no longer confidential information.

7:27-1.22 Notice to claimants of disclosure of confidential information

(a) Promptly after the Department discloses confidential information pursuant to N.J.A.C. 7:27-1.19, 1.20 or 1.21, the Department shall notify any claimant from whom the Department has obtained confidential information of the disclosure. Such notice shall be in writing, and shall contain the following information:

1. The date on which disclosure was made;

2. The name of the agency or other person to which the Department disclosed the confidential information; and

3. A description of the confidential information disclosed.

7:27-1.23 Disclosure by consent

(a) The Department may disclose confidential information in accordance with the written consent of the claimant.

(b) A claimant's consent to a particular disclosure shall not operate as a waiver of a confidentiality claim with regard to further disclosures, unless the authorized disclosure is of such nature that the disclosed information is no longer confidential information.

7:27-1.24 Incorporation of confidential information into cumulations of data

Nothing in this chapter shall be construed as prohibiting the incorporation of confidential information into cumulations of data subject to disclosure as public records, provided that after consultation with the claimant, the Department has determined that such disclosure is not in a form that would foreseeably allow persons, not otherwise having knowledge of such confidential information, to deduce from it the confidential information or the identity of the person who supplied it to the Department.

7:27-1.25 Disclosure of confidential information in rulemaking, permitting, and enforcement proceedings

(a) Notwithstanding any other provision of this subchapter, the Department may disclose confidential information in rulemaking, permitting and enforcement proceedings.

(b) The following procedures shall apply to the disclosure of confidential information by the Department in rulemaking, permitting and enforcement proceedings:

1. The Department may disclose confidential information in an adjudicatory hearing, subject to the protection from making the information available to the public which the administrative law judge may impose under the Uniform Administrative Procedure Rules, N.J.A.C. 1:1 including without limitation N.J.A.C. 1:1-14.1.

2. The Department may disclose confidential information in any enforcement, permitting, or rulemaking proceeding which does not involve an adjudicatory hearing, pursuant to the following procedure:

i. The Department shall inform the claimant that the Department is considering using the information in connection with the proceeding and shall afford the claimant a reasonable period for comment;

ii. The claimant shall submit comments to the Department within the time allotted pursuant to (b)2i above, concerning the proposed uses of confidential information, including comments which may support a determination that the confidential information is not relevant to the proceeding, or that the disclosure of the confidential information in the proceeding is not necessary to serve the public interest;

iii. The Department may disclose the confidential information in the proceeding if, upon consideration of comments submitted pursuant to (b)2ii above, the Department determines that the information is relevant to the subject of the proceeding, that the use of the information in the proceeding will serve the public interest, and that it materially impairs such service of the public interest to limit the use of the information to a manner which preserves its confidentiality; and

iv. The Department shall give the affected person at least five days notice prior to using the information in the proceeding in a manner which may result in the information being made available to the public.

7:27-1.26 Hearing before disclosure of information for which a confidentiality claim has been made

(a) A claimant may request an adjudicatory hearing to contest disclosure of any information for which a confidentiality claim has been made, at any time before disclosure. The request shall be in accordance with requirements of N.J.A.C. 7:27A-3.4(a), and shall be delivered to the Department at the following address:

Department of Environmental Protection
and Energy
Office of Legal Afairs
ATTENTION: Adjudicatory Hearing Requests
401 East State Street
CN 402
Trenton, New Jersey 08625-0402

(b) The Department may deny a request for an adjudicatory hearing under (a) above if:

1. The claimant fails to provide all information required under N.J.A.C. 7:27A-3.4(a);

2. The Department receives the request after disclosure of the assertedly confidential information occurs;

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3. The Department has been ordered to disclose the information by a court of competent jurisdiction, or by any other person or entity with the power and authority to compel disclosure; or

4. The Department determines that disclosure is necessary to alleviate an imminent danger to the environment or to public health or safety, as provided in N.J.A.C. 7:27-1.21.

(c) All adjudicatory hearings shall be conducted in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

(d) At the adjudicatory hearing, the respondent shall have the burden of showing that the proposed disclosure is not in accordance with this N.J.A.C. 7:27.

(e) Pending the completion of the adjudicatory hearing, the Department will refrain from disclosing the assertedly confidential information, unless:

1. The Department has been ordered to disclose the information by a court of competent jurisdiction, or by any other person or entity with the power and authority to compel disclosure; or

2. The Department determines that disclosure is necessary to alleviate an imminent danger to the environment or to public health or safety.

7:27-1.27 Nondisclosure of confidential information

Unless specifically required by any Federal or State law, regulation or order, court order, or applicable court rule, the Department shall not disclose confidential information to any person other than as provided in N.J.A.C. 7:27-1.20 through 1.26.

7:27-1.28 Safeguarding of confidential information

(a) Submissions to the Department required under this chapter will be opened only by persons authorized by the Department to be engaged in administering this chapter.

(b) Only those Department employees whose activities necessitate access to information for which a confidentiality claim has been made may open any envelope which is marked "CONFIDENTIAL."

(c) The Department shall store any records containing confidential information only in locked cabinets in secure rooms; provided, however, that if such records are in a form which is not amenable to such storage, the Department shall store such records in a manner which similarly restricts access by persons to whom disclosure of the confidential information in question is restricted.

(d) Any records made, possessed, or controlled by the Department or its contractors, and containing confidential information, shall contain indicators identifying the confidential information.

(e) Every Department employee, representative, and contractor who has custody or possession of confidential information shall take appropriate measures to safeguard such information and to protect against its improper disclosure.

7:27-1.29 Confidentiality agreements

The provisions of this chapter shall supersede the provisions of any agreement imposing any duties of confidentiality or nondisclosure upon the Department or any employee, contractor or agent thereof. Such provisions imposing confidentiality or nondisclosure duties upon the Department or any employee, contractor or agent thereof shall be of no force or effect.

7:27-1.30 Wrongful access or disclosure; penalties

(a) No person shall disclose, obtain or have possession of any confidential information, except as authorized by this chapter.

(b) Except in accordance with this chapter, no Department employee, representative, or contractor shall disclose any confidential information which came into his or her possession, or to which he or she gained access, by virtue of his or her official position of employment or contractual relationship with the Department. No such person shall use any such information for his or her private gain or advantage, except as permitted by a contract between such person and the Department. If a contractor discloses confidential information in violation of this chapter or of contractual provisions restricting disclosure, such disclosure shall constitute grounds for debarment or suspension as provided in N.J.A.C. 7:1-5, Debarment, Suspension and Disqualification from Department Contracting.

(c) If the Department finds that any person has violated the provisions of this subchapter, it may:

1. Commence civil action in Superior Court for a restraining order and an injunction barring that person from further disclosing confidential information; and/or

2. Pursue any other remedy available at law or equity.

(d) In addition to any other penalty that may be sought by the Department, violation of this subchapter by a Department employee shall constitute grounds for dismissal, suspension, fine or other adverse personnel action.

(e) Use of any of the remedies specified under this section shall not preclude the use of any other remedy.

7:27-8.4 Applications for permits and certificates

(a) Applications for a permit or a certificate, or for a renewal thereof, shall be made to the Department on forms obtained from the Department. Application forms and information pertinent to applications, may be requested from:

Bureau of New Source Review
[Division of Environmental Quality]
Environmental Regulation Program
Department of Environmental Protection
and Energy
401 East State Street, Second Floor
CN 027
Trenton, New Jersey 08625-0027

(b) The Department may require the applicant to submit such details regarding the equipment or control apparatus as it considers necessary to determine that the equipment or control apparatus is designed to operate without causing a violation of any provisions of relevant State or Federal laws or regulations and that the equipment or control apparatus incorporates advances in the art of air pollution control developed for the kind and amount of air contaminant emitted by the applicant's equipment. Such information may include description of processes, raw materials used, operating procedures, physical and chemical nature of any air contaminant, volume of gas discharged, and such other information as the Department considers necessary. All information submitted to the Department shall be public information except that which is designated confidential in accordance with N.J.S.A. 26:2C-9.2 and in compliance with N.J.A.C. [7:27-8.14 through 8.23] **7:27-1.6 through 1.30**.

(c)-(i) (No change.)

7:27-8.14 **through 8.23 (Reserved)** [Confidentiality claims

(a) Any person required to submit any information, pursuant to the provisions of the Air Pollution Control Act (N.J.S.A. 26:2C-1 et seq.), this subchapter, or N.J.A.C. 7:27-16.2(n), 16.3(w), 16.5(l), 16.5(m), 16.6(m), or 16.8(g), which in the person's opinion constitutes trade secrets, proprietary information, or information related to national security, may assert a confidentiality claim by following the procedures set forth in this subchapter. Emissions information may not be claimed as confidential.

(b) Any person submitting any information to the Department and asserting a confidentiality claim covering any information contained therein shall submit two documents to the Department. One shall contain all the information required by the Department including any information which the person alleges to be entitled to confidential treatment. The second shall be identical to the first except that it shall contain no information which the person alleges to be entitled to confidential treatment. The second can be a photocopy of the first, with the allegedly confidential material blacked out. The second document may be released by the Department to the public as submitted.

(c) The top of each page of the first submission containing the information which the person alleges to be entitled to confidential treatment shall display the heading "CONFIDENTIAL" in bold type or stamp.

(d) All parts of the text of the first submission which the person alleges to be entitled to confidential treatment shall be underscored or highlighted in a clearly identifiable manner. The manner of marking confidential information shall be such that both the alleged-

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ly confidential information and the underscoring or highlighting is reproducible on photocopying machines.

(e) The first submission, containing the information which the person alleges to be entitled to confidential treatment, shall be sealed in an envelope which shall display the word "CONFIDENTIAL" in bold type or stamp on both sides. This envelope, together with the second, non-confidential submission (which may or may not be enclosed in a separate envelope, at the option of the person), shall be enclosed in another envelope for transmittal to the Department. The outer envelope shall bear no marking indicating the confidential nature of the contents.

(f) To ensure proper delivery, the complete package should be sent by certified mail, return receipt requested, or by other means which will allow verification of receipt. Ordinary mail may be used, but the Department will assume no responsibility for packages until they are actually received.

7:27-8.15 Access to information; non-disclosure

(a) Until such time as a final confidentiality determination has been made, access to any information for which a confidentiality claim has been made will be limited to Department employees, representatives and contractors whose activities necessitate such access and as provided at N.J.A.C. 7:27-8.18 and 8.21.

(b) No disclosure of information for which a confidentiality claim has been asserted shall be made to any other persons except as provided in this subchapter.

(c) Nothing in this section shall be construed as prohibiting the incorporation of confidential information into cumulations of data subject to disclosure as public records, provided that such disclosure is not in a form that would foreseeably allow persons not otherwise having knowledge of such confidential information to deduce from it the confidential information or the identity of the owner or operator who supplied it to the Department.]

7:27-8.16 Confidentiality determinations

(a) Information for which a confidentiality claim has been asserted will be treated by the Department as entitled to confidential treatment, unless the Department determines that the information is not entitled to confidential treatment as provided in this section and N.J.A.C. 7:27-8.17.

(b) The Department shall act upon a confidentiality claim and determine whether information is or is not entitled to confidential treatment whenever the Department:

1. Receives a request under N.J.S.A. 47:1A-1 et seq. to inspect or copy such information;

2. Desires to determine whether information in its possession is entitled to confidential treatment; or

3. Desires for any reason in the public interest to disclose the information to persons not authorized by this subchapter to have access to confidential information.

(c) The Department shall make the initial determination whether information is or is not entitled to confidential treatment.

1. If the Department determines that information is not entitled to confidential treatment, it shall so notify the applicant who submitted the information.

2. The notice required under this section shall be sent by certified mail, return receipt requested, and shall state the reasons for the Department's initial determination.

3. Any applicant who wishes to contest a determination by the Department shall, within 30 days of receipt of the notification of the determination, submit evidence to support the applicant's contention that the Department's initial determination was incorrect. The evidence may include, but need not be limited to, a statement indicating:

i. The period of time for which confidential treatment is desired by the applicant (for example, until a certain date, until the occurrence of a specified event, or permanently);

ii. The measures taken by the applicant to guard against undesired disclosure of the information to others;

iii. The extent to which the information has been disclosed to others, and the precautions taken in connection therewith; and

iv. The extent to which disclosure of the information would result in substantial damage to the applicant, including a description of the damage, an explanation of why the damage would be substantial, and an explanation of the causal relationship between disclosure and the damage.

4. Failure of an applicant to contest the Department's initial determination and submit supporting evidence within 30 days waives the applicant's confidentiality claim.

5. The applicant may assert a confidentiality claim to any information submitted to the Department by an applicant as part of its evidence pursuant to (c)3 above.

6. The Department may extend the time limit for submitting evidence pursuant to (c)4 above for good cause shown by the applicant and upon receipt of a request in writing.

(d) After receiving the evidence, the Department shall review its initial determination and make a final determination.

1. If, after review, the Department determines that the information is not entitled to confidential treatment, the Department shall so notify the applicant by certified mail, return receipt requested. The notice shall state the basis for the determination, that it constitutes final agency action concerning the confidentiality claim, and that the Department may make the information available to the public on the 14th day following receipt of the written notice by the applicant.

2. If, after review, the determination is made that information is entitled to confidential treatment, the information shall not be disclosed, except as otherwise provided by this subchapter. The applicant shall be notified of the Department's determination by certified mail, return receipt requested. The notice shall state the basis for the determination and that it constitutes final agency action.

7:27-8.17 Substantive criteria for use in confidentiality determinations

(a) When the applicant satisfies each of the following substantive criteria, the Department shall determine that the information for which a confidentiality claim has been asserted is confidential:

1. The applicant has asserted a confidentiality claim which has not expired by its terms or been waived or withdrawn;

2. The applicant has shown that sufficient responsible measures have been taken to protect the confidentiality of the information and that the applicant intends to continue to take such measures;

3. The information is not, and has not been, available or otherwise disclosed to other persons without the applicant's consent (other than by subpoena or by discovery based on a showing of special need in a judicial or quasi-judicial proceeding, as long as the information has not become available to persons not involved in the proceeding);

4. No statute specifically requires disclosure of the information;

5. Except for information related to national security, the applicant has shown that the disclosure of the information would be likely to cause substantial damage to its competitive position; and

6. The information relates to secret processes or methods of manufacture or production.

7:27-8.18 Disclosure of confidential information

(a) The Department may disclose confidential information to persons other than Department employees, representatives and contractors only as provided in this section or N.J.A.C. 7:27-8.20 or 8.21.

(b) The Department may disclose confidential information to any other State agency or to a Federal agency if:

1. The Department receives a written request for disclosure of the information from a duly authorized officer or employee of the other agency;

2. The request sets forth the official purpose for which the information is needed;

3. The Department notifies the other agency of the Department's determination that the information is entitled to confidential treatment, or of any unresolved confidentiality claim covering the information;

4. The other State or Federal agency has first furnished to the Department a written formal legal opinion from the agency's chief legal officer or counsel stating that under applicable law the agency

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has the authority to compel the person who submitted the information to the Department to disclose such information to the other agency;

5. The other agency agrees not to disclose the information further unless:

i. The other agency has statutory authority both to compel production of the information and to make the proposed disclosure; or

ii. The other agency has obtained the consent of the affected owner or operator to the proposed disclosure; and

6. The other agency has adopted rules or regulations or operates under statutory authority that will allow it to preserve confidential information from unauthorized disclosure.

(c) Except as otherwise provided at N.J.A.C. 7:27-8.20, the Department shall notify in writing the applicant who supplied the confidential information of:

1. Its disclosure to another agency;
2. The date on which disclosure was made;
3. The name of the agency to which it was disclosed; and
4. A description of the information disclosed.

7:27-8.19 Disclosure of confidential information to contractors

(a) The Department may disclose confidential information to a contractor of the Department when the contractor's activities necessitate such access.

(b) No information shall be disclosed to a contractor unless the contract in question provides that the contractor and the contractor's employees, agents, and representatives shall use the information only for the purpose of carrying out the work required by the contract, shall disclose the information only to a person authorized in writing by the Department to have access to the information, shall store the information in locked cabinets in secure rooms, and shall return to the Department the information, all copies of the information, and any abstracts or extracts therefrom, upon request by the Department or whenever the information is no longer required by the contractor for the performance of the work required by the contract.

(c) Disclosure in violation of this subchapter or the contractual provisions described in (b) above shall constitute grounds for debarment or suspension as provided in "Debarment, Suspension and Disqualification from Department Contracting", in addition to whatever other remedies may be available to the Department at equity or law.

7:27-8.20 Disclosure by consent

(a) The Department may disclose any confidential or allegedly confidential information to any person if it has obtained the written consent of the person claiming confidentiality to such disclosure.

(b) The giving of consent of person claiming confidentiality to disclose shall not be deemed to waive a confidentiality claim with regard to further disclosures unless the authorized disclosure is of such a nature as to make the disclosed information accessible to the general public.

7:27-8.21 Disclosure based on imminent and substantial danger

(a) Upon a finding that disclosure of confidential information would serve to alleviate an imminent and substantial danger to human health and welfare and the environment, the Department may:

1. Prescribe and make known to the applicant such shorter comment period (see N.J.A.C. 7:27-8.16(c)3), post-determination waiting period (see N.J.A.C. 7:27-8.16(d)1), or both, as it finds necessary under the circumstances; or

2. Disclose confidential information to any person whose role in alleviating the danger to human health and welfare and the environment necessitates that disclosure. Any such disclosure shall be limited to information necessary to enable the person to whom it is disclosed to carry out the activities in alleviating the danger.

(b) Any disclosure made pursuant to this section shall not be deemed a waiver of a confidentiality claim, nor shall it of itself be grounds for any determination that information is no longer entitled to confidential treatment.

(c) The Department will notify the applicant of any disclosure made pursuant to this section as soon as it is feasible.

7:27-8.22 Security procedures

(a) Submissions to the Department pursuant to the Act and this chapter will be opened only by persons authorized by the Department to engage in administering the Act and this chapter.

(b) Only those Department employees whose activities necessitate access to information for which a confidentiality claim has been made shall open any envelope which is marked "CONFIDENTIAL."

(c) All submissions entitled to confidential treatment as determined in accordance with N.J.A.C. 7:27-8.16 shall be stored by the Department or its contractors in locked cabinets only.

(d) Any record made or maintained by Department employees, representatives or contractors which contains confidential information shall contain appropriate indicators identifying the confidential information.

7:27-8.23 Wrongful access or disclosure; penalties

(a) A person shall not disclose, seek access to, seek to obtain or seek to have possession of any confidential information obtained pursuant to this chapter, except as authorized by this subchapter.

(b) Every Department employee, representative, and contractor who has custody or possession of confidential information shall take appropriate measures to safeguard such information and to protect against its improper disclosure.

(c) A Department employee, representative, or contractor shall not disclose, or use for his or her private gain or advantage, any information which came into his or her possession, or to which he or she gained access, by virtue of his or her official position of employment or contractual relationship with the Department.

(d) If the Department finds that any person has violated the confidentiality rules N.J.A.C. 7:27-8.14 through 8.23, it may:

1. Commence a civil action in Superior Court for a restraining order and an injunction barring that person from further disclosing confidential information; or

2. Pursue any other remedy available by law.

(e) In addition to any other penalty that may be sought by the Department, violation of the confidentiality rules, N.J.A.C. 7:27-8.14 through 8.23, by an employee of the Department shall constitute grounds for dismissal, suspension, fine or other adverse personnel action.

(f) Use of any of the remedies specified under this section shall not preclude the use of any other remedy.]

7:27-8.24 Certification of information

(a) Any person who submits an application, registration, **emission statement,** or report to the Department shall include, as an integral part of the application, **registration, emission statement,** or report, the following certification, signed by the highest ranking individual with direct knowledge and overall responsibility for the information contained in the certified documents:

"I certify under penalty of law that the information provided in this document is true, accurate and complete. I am aware that there are significant civil and criminal penalties, including fines or imprisonment or both, for submitting false, inaccurate or incomplete information."

(b) The following documents shall be additionally certified as set forth in (c) and (d) below:

1. (No change.)

2. Any **emission statement or** report which indicates that a violation has or may have occurred of any provision or condition of a permit or certificate or any applicable law, regulation, or rule.

(c) Any person who submits an application, **emission statement** or report to the Department, for which additional certification is required pursuant to (b) above, shall include, as an integral part of the application or report, the following additional certification:

"I certify under penalty of law that I have personally examined and am familiar with the information submitted in this application and all attached documents and, based on my inquiry of those individuals immediately responsible for obtaining the information, I believe that the submitted information is true, accurate and complete. I am aware that there are significant civil and criminal

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penalties, including the possibility of fine or imprisonment or both, for submitting false, inaccurate or incomplete information."

(d)-(e) (No change.)

7:27-16.9 Emission information, record keeping and testing

(a)-(h) (No change.)

(i) Any person who reports information to the Department pursuant to the requirements set forth at N.J.A.C. 7:27-16.2(n), 16.3(w), 16.5(l), 16.5(m), 16.6(m), or 16.8(g) may assert a confidentiality claim for that information in accordance with the procedures set forth at N.J.A.C. 7:27-[8.14]**1.6 through 1.30**.

SUBCHAPTER 21. EMISSION STATEMENTS

7:27-21.1 Definitions

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise.

"Actual emissions" means the rate at which an air contaminant is actually emitted, either directly or indirectly, to the outdoor atmosphere, in units of mass per calendar year, seasonal period, or other time period specified in this subchapter.

"Aerodynamic diameter" means the theoretical diameter of a nonspherical particle having the same terminal setting velocity as an equally dense, spherical particle of such diameter.

"Air contaminant" means any substance, other than water or distillates of air, present in atmosphere as solid particles, liquid particles, vapors or gases.

"AP-42" means the most recently published edition and any subsequent edition of the manual entitled "Compilation of Air Pollutant Emission Factors" published by the EPA. This document may be obtained from the National Technical Information Service (NTIS), 5285 Port Royal Road, Springfield, Virginia 22161, (703) 487-4650 or the Superintendent of Documents, Government Printing Office, Washington, D.C. 20402, (202) 783-3228.

"Capture efficiency" means the amount of an air contaminant collected by a control apparatus serving the source operation, expressed as a percentage of the total amount of the air contaminant emitted by the source operation.

"Carbon monoxide" or "CO" means an air contaminant which is a colorless, odorless gas at standard conditions, having a molecular composition of one carbon atom and one oxygen atom.

"Certificate" means either an operating certificate or a temporary operating certificate.

"CFR" means the United States Code of Federal Regulations. This document may be obtained from the Superintendent of Documents, Government Printing Office, Washington, D.C. 20402, (202) 783-3228.

"Control apparatus" means any device which prevents or controls the emission of any air contaminant directly or indirectly into the outdoor atmosphere.

"Control efficiency" means the amount of an air contaminant prevented from being discharged into the outdoor atmosphere by a control apparatus, expressed as a percentage of the total amount of the air contaminant collected by the control apparatus.

"Department" means the New Jersey Department of Environmental Protection and Energy.

"Delivery vessel" means any mobile storage tank including, but not limited to, a marine vessel, tank truck or railroad tank car.

"Distillates of air" means the following chemical species: helium (He), nitrogen (N_2), oxygen (O_2), neon (Ne), argon (Ar), krypton (Kr), xenon (Xe), and carbon dioxide (CO_2).

"Emissions information" means, with reference to any source operation, equipment, or control apparatus:

1. Information necessary to determine the identity, amount, frequency, concentration, or other characteristics (to the extent related to air quality) of any air contaminant which has been emitted by the source operation, equipment or control apparatus;

2. Information necessary to determine the identity, amount, frequency, concentration, or other characteristics (to the extent related to air quality) of any air contaminant which, under an applicable standard or limitation, the source operation was authorized to emit (including, to the extent necessary for such purposes, a description of the manner or rate of operation of the source operation), or any combination of the foregoing; and

3. A general description of the location and/or nature of the source operation to the extent necessary to identify the source operation and to distinguish it from other source operations (including, to the extent necessary for such purposes, a description of the device, installation, or operation constituting the source operation).

The following list includes specific data fields which the Department considers to constitute emissions information. This list is not exhaustive and, therefore, other data might be found, in a proper case, to constitute emissions information:

Facility Identification

Plant name and related point identifiers
Address
City
County
AQCR (Air Quality Control Region)
MSA, PMSA, CMSA (Metropolitan Statistical Areas)
State
Zip Code
Ownership and point of contact information
Locational Identifiers:
Latitude & Longitude or UTM Coordinates
SIC Code (Standard Industrial Classification)
Emission point, device or operation description, information
SCC Code (Source Classification Codes)

Emissions Parameters

Emission type (for example, nature of emissions such as CO, paticulate or a specific toxic compound, and origin of emissions such as process vents, storage tanks or equipment leaks)

Emission rate (for example, the amount released to the atmosphere over time such as pounds per hour or tons per year)

Release height (for example, height above ground level where the air contaminant is emitted to the atmosphere)

Description of terrain and surrounding structures (for example, the size of the area, with adjacent structures and terrain descriptions such as mountainous, urban, or rural)

Stack or vent diameter at point of emissions (for example the inside diameter of vent at the point of emission to the atmosphere)

Release velocity

Release temperature

Frequency of release (for example, how often a release occurs in events per year)

Duration of release (for example, the time associated with a release to the atmosphere)

Concentration (for example, the amount of an emission stream constituent relative to other stream constituents, expressed as parts per million (ppm), volume percent, or weight percent)

Density of the emissions stream or average molecular weight (for example, density expressed as fraction or multiple of the density of air; molecular weight)

Boiler or process design capacity (for example, the hourly gross heating value of fuel input to a boiler at its maximum design rate or maximum pounds per hour product rate)

Emission estimation method (for example, the method by which an emission estimate has been calculated such as material balance, stack test, use of AP-42 emission factors, etc.)

Percent space heat (for example, the percent of fuel used for space heating)

Hourly maximum design rate (for example, the greatest operating rate that would be expected for a source in a one hour period)

Control apparatus information (for example, type of primary and secondary control apparatus, capture efficiency, and control efficiency)

"EPA" means the United States Environmental Protection Agency.

"Equipment" means any device capable of causing the emission of an air contaminant either directly or indirectly to the outdoor atmosphere, and any stack or chimney, conduit, flue, duct, vent, or similar device connected or attached to, or serving the equipment.

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This term includes, but is not limited to, a device in which the preponderance of the air contaminants emitted is caused by a manufacturing process.

"Facility" means the combination of all structures, buildings, equipment, storage tanks, source operations, and other operations located on one or more contiguous or adjacent properties owned or operated by the same person. This term does not include delivery vessels.

"Federally enforceable" means all limitations and conditions on operation, production, or emissions which can be enforced by EPA pursuant to authorities which include, but are not limited to, those established in:

1. Any NSPS promulgated at 40 CFR 60;
2. Any NESHAP promulgated at 40 CFR 61;
3. Any provision of an applicable State Implementation Plan; or
4. Any permit issued pursuant to the requirements established at 40 CFR 52.21; 40 CFR 51, Subpart I; 40 CFR 70; 40 CFR 71; or N.J.A.C. 7:27.

"Fugitive emissions" means any emissions of an air contaminant released directly or indirectly into the atmosphere which do not pass through a stack or chimney.

"Gasoline" means any petroleum distillate or petroleum distillate/oxygenate blend having a Reid vapor pressure of four pounds per square inch (207 millimeters of mercury) absolute or greater, sold for use or used in a motor vehicle or motor vehicle engine, and commonly or commercially known or sold as gasoline.

"Gasoline dispensing facility" means a facility consisting of one or more stationary gasoline storage tanks together with dispensing devices used to fill vehicle fuel tanks.

"Lead" or "Pb" means elemental lead or any compound containing lead measured as elemental lead.

"Liquid particles" means particles which have volume but are not of rigid shape.

"Manufacturing process" means any action, operation or treatment embracing chemical, industrial, manufacturing or processing factors, methods or forms including, but not limited to, furnaces, kettles, ovens, converters, compressors, cupolas, kilns, crucibles, stills, dryers, roasters, reactors, crushers, grinders, mixers, regenerators, separators, filters, reboilers, columns, classifiers, screens, quenchers, cookers, digesters, towers, washers, scrubbers, mills, condensers or absorbers.

"NESHAP" means a National Emission Standard for a Hazardous Air Pollutant as promulgated under 40 CFR 61.

"NSPS" means Standard of Performance for New Stationary Sources as promulgated under 40 CFR 60, commonly referred to as New Source Performance Standards.

"Operating certificate" means a "Certificate to Operate Control Apparatus or Equipment" issued by the Department pursuant to the Air Pollution Control Act, and in particular N.J.S.A. 26:2C-9.2, which is valid for a period of five years from the date of issuance, unless sooner revoked by the Department.

"Organic substance" means any chemical compound of carbon, excluding carbon monixide, carbon dioxide, carbonic acid, metallic carbonates, metallic carbides, and ammonium carbonate.

"Oxides of nitrogen" or "NO_x" means all oxides of nitrogen, except nitrous oxide, as measured by test methods approved by the Department and EPA, such as the test methods set forth at 40 CFR 60 Appendix A Methods 7 through 7E.

"Pb" see "lead."

"Peak carbon monoxide season" means December 1 through the last day of February, inclusive.

"Peak ozone season" means June 1 through August 31, inclusive.

"Permit" means a "Permit to Construct, Install or Alter Control Apparatus or Equipment" issued by the Department pursuant to the Air Pollution Control Act, and in particular N.J.S.A. 26:2C-9.2.

"Person" means any individual or entity and shall include, without limitation, corporations, companies, associations, societies, firms, partnerships and joint stock companies as well as individuals, and shall also include all political subdivisions of this State or any agencies or instrumentalities thereof.

"PM_{10}" means a class of air contaminants which includes all particulate matter having an aerodynamic diameter less than or equal to a nominal 10 micrometers.

"Potential to emit" means the capability of a source operation or of a facility to emit an air contaminant at maximum design capacity, except as constrained by any federally enforceable condition. Such Federally enforceable conditions may include, but are not limited to, the effect of installed control apparatus, restrictions on the hours of operation, and restrictions on the type or amount of material combusted, stored, or processed.

"Process intermediate" means any material used in a process which is neither a raw material nor a product.

"Process level" means the operation of a source, specific to the kind or type of fuel, input material, or mode of operation.

"Process rate" means the quantity per unit of time of any raw material or process intermediate consumed, or product generated, through the use of any equipment, source operation, or control apparatus. For a stationary internal combustion unit or any other fuel burning equipment, this term may be expressed as the quantity of fuel burned per unit of time.

"Product" means the output from a source operation, equipment, or control apparatus. Such outputs may include mixtures, composites, compounds and elemental substances.

"Raw material" means any input to equipment, control apparatus, or a source operation, including fuels, but excluding heat and other forms of energy. Such inputs may include mixtures, composites, compounds and elemental substances.

"Reid vapor pressure" means the absolute vapor pressure of a petroleum product in pounds per square inch (kilopascals) at 100 degrees Fahrenheit (°F) (37.8 degrees Celsius (°C)) as measured by "Method 1—Dry RVP Measurement" or "Method 2—Herzog Semi-Automatic Method" promulgated at 40 CFR 80, Appendix E; or any other test method approved in advance in writing by the Department and the EPA.

"SCC code" means the eight-position Source Classification Code that provides a detailed analysis of a process. See EPA document "AIRS Facility Subsystem Source Classification Codes and Emission Factor Listing for Criteria Air Pollutants" EPA 450/4-90-003, which may be obtained from the National Technical Information Service (NTIS), 5285 Port Royal Road, Springfield, Virginia, 22161, (703) 487-4650 or the Superintendent of Documents, Government Printing Office, Washington, D.C., 20402, (202) 783-3228.

"Seasonal throughput" means the percent of the total yearly operating activity which occurs during each of the following periods:

1. December through February (for example, December 1992 through February 1993);
2. March through May;
3. June through August; and
4. September through November.

"SIC code" means the Standard Industrial Classification code devised by the United States Office of Management and Budget to classify establishments according to the type of economic activity in which they are engaged.

"Solid particles" means particles of rigid shape and definite volume.

"Source operation" means any process or any identifiable part thereof emitting or having the potential to emit any air contaminant either directly or indirectly into the outdoor atmosphere, including any fugitive emissions.

"Stack equivalent" means an aggregation of more than one stack or chimney approved by the Department for use in calculating or measuring air contaminant emissions from a single source operation or a group of source operations with a common exhaust ventilation system.

"Stack or chimney" means a flue, conduit or opening designed, constructed or used for the purpose of emitting any air contaminant into the outdoor atmosphere.

"Sulfur dioxide," or "SO_2," means an air contaminant which is a colorless gas at standard conditions having a molecular composition of one sulfur atom and two oxygen atoms.

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"Temporary operating certificate" means a "Certificate to Operate Control Apparatus or Equipment" issued by the Department pursuant to the Air Pollution Control Act, and in particular N.J.S.A. 26:2C-9.2, which is valid for a period not to exceed 90 days.

"Ton" means a unit of weight equal to 2,000 pounds (0.907 metric tons or 907.20 kilograms).

"Total suspended particulate matter," or "TSP," means any air contaminant dispersed in the outdoor atmosphere which exists as solid particles or liquid particles at standard conditions and is measured in accordance with N.J.A.C. 7:27B-1; 40 CFR 60, Appendix A, Methods 5 through 5H; or another method approved by the Department and EPA.

"UTM coordinates" means Universal Transverse Mercator geographic coordinates, specified by the UTM zone, horizontal coordinate and vertical coordinate.

"Volatile organic compound," or "VOC," means any organic substance which participates in atmospheric photochemical reactions. For purposes of determining compliance with emissions limits and emissions reported pursuant to this subchapter, VOC shall be measured by test methods approved by the Department and EPA (for example, N.J.A.C. 7:27B-3). The compounds listed at 40 CFR 51.100(s)(1) are excluded from this definition. The compounds listed at 40 CFR 51.100(s)(1) are:

methane
ethane
methylene chloride (dichloromethane)
1,1,1-trichloroethane (methyl chloroform)
trichlorofluoromethane (CFC-11)
dichlorodifluoromethane (CFC-12)
chlorodifluoromethane (CFC-22)
trifluoromethane (FC-23)
1,1,1-trichloro-2,2,2-trifluoroethane (CFC-113)
1,2-dichloro-1,1,2,2-tetrafluoroethane (CFC-114)
chloropentafluoroethane (CFC-115)
2,2,-dichloro-1,1,1-trifluoroethane (HCFC-123)
2-chloro-1,1,2-tetrafluoroethane (HCFC-124)
pentafluoroethane (HFC-125)
1,1,2,2-tetrafluoroethane (HFC-134)
1,1,1,2-tetrafluoroethane (HFC-134a)
1,1-dichloro-1-fluoroethane (HCFC-141b)
1-chloro-1,1-difluoroethane (HCFC-142b)
1,1,1-trifluoroethane (HFC-143a)
1,1-difluoroethane (HFC-152a)

and the following four classes of perfluorocarbons:

(1) Cyclic, branched, or linear, completely fluorinated alkanes;

(2) Cyclic, branched, or linear, completely fluorinated ethers with no unsaturations;

(3) Cyclic, branched, or linear, completely fluorinated tertiary amines with no unsaturations; and

(4) Sulfur containing perfluorocarbons with no unsaturations and with sulfur bonds only to carbon and fluorine.

7:27-21.2 Applicability

(a) Any owner or operator of a facility is subject to the requirements of this subchapter for any calendar year in which the facility has the potential to emit, directly or indirectly to the outdoor atmosphere, any air contaminant listed at Table 1 at a rate greater than or equal to the applicable threshold. For example, if a facility has the potential to emit an air contaminant listed at Table 1 at a rate greater than or equal to the threshold during 1993 and 1995, but not 1994 or any other year, the facility shall submit emission statements only in 1994 for the emissions of 1993 and in 1996 for the emissions of 1995.

TABLE 1
AIR CONTAMINANT REPORTING THRESHOLDS

Air Contaminant	Threshold in Tons per Year
VOC	10
NO_x	25
CO	100
SO_2	100
TSP	100
PM_{10}	100
Pb	5

(b) Notwithstanding (a) above, no facility is required, pursuant to this subchapter, to submit an emission statement for SO_2, TSP, PM_{10}, or Pb with respect to emissions occurring in or before 1992.

(c) Any facility which is solely a retail gasoline dispensing facility is exempt from the requirements of this subchapter.

7:27-21.3 General provisions

(a) Except as provided in N.J.A.C. 7:27-21.2(b), each owner or operator of a facility shall submit to the Department an emission statement pertaining to the emissions released directly or indirectly into the outdoor atmosphere during any calendar year in which the facility is subject to this subchapter pursuant to N.J.A.C. 7:27-21.2. Such emission statement shall include information only for the air contaminant(s) for which the facility's potential to emit equals or exceeds the applicable threshold set forth at N.J.A.C. 7:27-21.2, Table 1; however, if the facility's potential to emit equals or exceeds the reporting threshold for VOC or NO_x, the facility must report information for both VOC and NO_x. If, for example, in a given year, a facility has the potential to emit VOC at a rate greater than the applicable threshold and has the potential to emit the other air contaminants at a rate less than the applicable thresholds, the facility need only report information pertaining to its emissions of VOC and NO_x.

(b) The owner and operator of any facility subject to this subchapter shall be responsible for ensuring compliance with all requirements of this subchapter. Failure to comply with any provision of this subchapter shall subject the owner and operator to civil penalties in accordance with N.J.A.C. 7:27A-3 and applicable criminal penalties including, but not limited to, those set forth at N.J.S.A. 26:2C-19(f)1 and 2. All owners and operators are jointly and severally liable for such civil and criminal penalties.

(c) Compliance with the emission statement requirements of this subchapter does not relieve any owner or operator of a facility from the responsibility to comply with any other applicable reporting requirements set forth in any Federal or state law, rule, or regulation, or in the conditions of approval of any permit or certificate in effect.

(d) Submittal of an emission statement to the Department, or the Department's acceptance thereof, does not constitute approval by the Department of unauthorized releases of air contaminants into the outdoor atmosphere or of any exceedance of any applicable emission limit established in any Federal or state law, rule, or regulation, or in the conditions of approval of any permit or certificate in effect.

7:27-21.4 Procedure for submitting an emission statement

(a) Emission statements shall be submitted to the Department on or before April 15 of each calendar year following any calendar year in which the facility is subject to this subchapter.

(b) Emission statements shall be submitted to the following address:

Chief, Bureau of Air Quality Planning
Department of Environmental Protection
and Energy
CN 418
Trenton, NJ 08625-0418
ATTN: Emission Statements

(c) Emission statements shall be submitted on a form obtainable from the Department at the address listed in (b) above.

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(d) Any person submitting an emission statement shall transmit the report to the Department on paper. With the written prior approval of the Department, an emission statement may be submitted on computer diskette or electronically, in a form approved by the Department, in lieu of a submission of an emission statement on paper. Notwithstanding this subsection, certification in accordance with the provisions of N.J.A.C. 7:27-8.24 as required in this subchapter shall accompany any transmission of an emission statement to the Department.

(e) Any person who submits information to the Department may assert a confidentiality claim for that information in accordance with N.J.A.C. 7:27-1.6. Emissions information, as defined at N.J.A.C. 7:27-21.1, is not confidential. The Department will process and evaluate confidentiality claims in accordance with N.J.A.C. 7:27-1.6 through 1.30 inclusive.

7:27-21.5 Required contents of an emission statement

(a) Any person who submits an emission statement to the Department shall include, as an integral part of the report:

1. Certification, in accordance with the requirements of N.J.A.C. 7:27-8.24; and

2. The date of the signature of certification, and the telephone number of the certifying individual.

(b) Emission statements shall include the following facility identification information:

1. The full name of the facility;

2. The parent company name, if applicable;

3. The physical location of the facility (that is, the street address);

4. The mailing address of the facility;

5. The SIC code(s) of the facility;

6. The UTM coordinates or latitude and longitude of the facility; and

7. The calendar year of the emissions.

(c) Emission statements shall include the following operating data for each source operation which has the potential to emit VOC and NO_x:

1. Seasonal throughput;

2. Average days of operation per week;

3. Average hours of operation per day; and

4. Total hours of operation for the year.

(d) Emission statements shall include the following information at the process level for NO_x (expressed as molecular weight of NO_2) and VOC:

1. Emissions information:

i. The actual emissions of VOC and NO_x in tons per year;

ii. The average actual emissions of VOC and NO_x in pounds per day of operation during the peak ozone season;

iii. The code for the method used to quantify the actual emissions (see (1) and Table 2 below); and

iv. Any emission factor used to determine actual emissions;

2. Control apparatus information:

i. Current primary and secondary control apparatus identification codes (see Table 3 below);

ii. Actual capture efficiencies achieved by the control apparatus. If the actual capture efficiency is unavailable, the control apparatus design efficiency shall be used; and

iii. Actual control efficiencies achieved by the control apparatus. If the actual control efficiency is unavailable, the control apparatus design efficiency shall be used; and

3. Process rate data:

i. The annual process rate; and

ii. The average process rate per day of operation during the peak ozone season.

(e) Emission statements shall include the following operating data for each source operation which has the potential to emit CO:

1. Seasonal throughput;

2. Average days of operation per week;

3. Average hours of operation per day; and

4. Total hours of operation for the year.

(f) Emission statements shall include the following information at the process level for CO:

1. Emissions information:

i. The actual emissions of CO in tons per year;

ii. The average actual emissions of CO in pounds per day of operation during the peak ozone season;

iii. The average actual emissions of CO in pounds per day of operation during the peak carbon monoxide season;

iv. The code for the method used to quantify the actual emissions (see (1) and Table 2 below); and

v. Any emission factor used to determine actual emissions;

2. Control apparatus information:

i. Current primary and secondary control apparatus identification codes (see Table 3);

ii. Actual capture efficiencies achieved by the control apparatus. If the actual capture efficiency is unavailable, the control apparatus design efficiency shall be used; and

iii. Actual control efficiencies achieved by the control apparatus. If the actual control efficiency is unavailable, the control apparatus design efficiency shall be used; and

3. Process rate data:

i. The annual process rate;

ii. The average process rate per day of operation during the peak ozone season; and

iii. The average process rate per day of operation during the peak carbon monoxide season.

(g) Emission statements shall include the following operating data for each source operation which has the potential to emit SO_2, TSP, PM_{10} and/or Pb:

1. Seasonal throughput;

2. Average days of operation per week;

3. Average hours of operation per day; and

4. Total hours of operation for the year.

(h) Emission statements shall include the following information at the process level for SO_2, TSP, PM_{10} and/or Pb:

1. Emissions information:

i. The actual emissions in tons per year;

ii. The code for the method used to quantify the acutal emissions (see (1) and Table 2 below); and

iii. Any emission factor used to determine actual emissions;

2. Control apparatus information:

i. Current primary and secondary control apparatus identification codes (see Table 3);

ii. Actual capture efficiencies achieved by the control apparatus. If the actual capture efficiency is unavailable, the control apparatus design efficiency shall be used; and

iii. Actual control efficiencies achieved by the control apparatus. If the actual control efficiency is unavailable, the control apparatus design efficiency shall be used; and

3. Process rate data:

i. The annual process rate; and

ii. The average process rate per day of operation during the peak ozone season.

(i) The following information may replace the more detailed information required at (c) through (h) above only for any source operation which has the potential to emit less than 0.1 ton per year of Pb or less than one ton per year of any other air contaminant required to be reported pursuant to this subchapter:

1. The following information shall be supplied:

i. A description of each source operation; and

ii. Actual emissions of each air contaminant emitted from each source operation shall be estimated at 0.1 ton per year for Pb and one ton per year for any other air contaminant; and

iii. Code 10 from Table 2 below; or

2. The following information shall be supplied:

i. A description of each source operation;

ii. Estimated actual emission in tons per year;

iii. The code for the method used to quantify the actual emissions (see (1) and Table 2 below); and

iv. Any emission factor used to determine actual emissions.

(j) Emission statements shall include cumulative total fugitive emissions for the facility for all fugitive emissions that cannot be reported in the information pursuant to (c) through (i) above. Such fugitive emissions shall be expressed:

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1. In tons per year;

2. For CO, VOC and NO_x emissions, in average pounds per day of operation during the peak ozone season; and

3. For CO emissions, in average pounds per day of operation during the peak carbon monoxide season.

(k) Emission statements shall also include any other information required by any Federal regulation or emission statement guidance published by EPA. Any additional information required by this provision will be published in a New Jersey Register notice and will be clearly indicated on the emission statement forms for the applicable year.

(l) The method used for quantifying actual emissions for a source operation for use in preparing emission information required in (d)1, (f)1, (h)1 or (i)2 above shall be the method from Table 2 which is reasonably available and which best estimates the actual emissions from the source operation, unless an operating permit pursuant to Title V of the Federal Clean Air Act has been issued by the Department for the facility. In such case, the method used shall be the method specified in the operating permit.

TABLE 2
CODES FOR METHODS OF QUANTIFYING ACTUAL EMISSIONS

Method	Code
Emissions based on source test or other measurements	1
Emissions based on material balance using engineering knowledge of the process	2
Emissions based on AP-42	3
Emissions based on best engineering judgment	4
Emissions based on a state or local agency's emission factor	5
New construction not yet operational; emissions are zero	6
Source closed, operation ceased	7
Emissions to be computer calculated by the Department or EPA based on standard emission factor (SCC emission factor file)	8†
Emissions to be computer calculated by the Department or EPA based on other approved emission factor	9†
Emissions estimated at one ton per year (0.1 ton per year for Pb)	10‡

†Codes 8 and 9 may only be used for selected source operations with prior notice or approval from the Department

‡Code 10 may only be used for source operations which meet the criteria to report pursuant to (i)1 above

TABLE 3
CONTROL APPARATUS IDENTIFICATION CODES

Control Apparatus	Code
No control apparatus	000
Wet scrubber high efficiency	001
Wet scrubber medium efficiency	002
Wet scrubber low efficiency	003
Gravity collector high efficiency	004
Gravity collector medium efficiency	005
Gravity collector low efficiency	006
Centrifugal collector high efficiency	007
Centrifugal collector medium efficiency	008
Centrifugal collector low efficiency	009
Electrostatic precipitator high efficiency	010
Electrostatic precipitator medium efficiency	011
Electrostatic precipitator low efficiency	012
Gas scrubber—general	013
Mist eliminator high velocity	014
Mist eliminator low velocity	015
Fabric filter high temperature	016
Fabric filter medium temperature	017
Fabric filter low temperature	018
Catalytic afterburner	019
Catalytic afterburner-heat exchange	020
Direct flame afterburner	021
Direct flame afterburner-heat exchange	022
Flaring	023
Modified furnace or burner	024
Staged combustion	025
Flue gas recirculation	026
Reduced combustion-air preheat	027
Steam or water injection	028
Low excess-air firing	029
Fuel-low nitrogen content	030
Air injection	031
Ammonia injection	032
Control of % 0_2 in combustion air	033
Wellman-Lord/sodium sulfate scrubber	034
Magnesium oxide scrubbing	035
Dual alkali scrubbing	036
Citrate process scrubbing	037
Ammonia scrubbing	038
Catalytic oxidation—flue gas desulfuring	039
Alkalized alumina	040
Dry limestone injection	041
Wet limestone injection	042
Sulfuric acid plant—contact process	043
Sulfuric acid plant—double contact process	044
Sulfur plant	045
Process change	046
Vapor recovery system	047
Activated carbon adsorption	048
Liquid filtration system	049
Packed-gas absorption	050
Tray-type gas absorption column	051
Spray Tower	052
Venturi scrubber	053
Process enclosed	054
Impingement plate scrubber	055
Dynamic separator (dry)	056
Dynamic separator (wet)	057
Mat or panel filter	058
Metal fabric filter screen	059
Process gas recovery	060
Dust suppressor—water spray	061
Dust suppressor—chemical stabilization/wet agents	062
Gravel bed filter	063
Annular ring filter	064
Catalytic reduction	065
Molecular sieve	066
Wet lime slurry scrubbing	067
Alkaline fly ash scrubbing	068
Sodium carbonate scrubbing	069
Sodium-alkaline scrubbing	070
Fluid bed dry scrubber	071
Tube and shell condenser	072
Refrigerated condenser	073
Barometric condenser	074
Single cyclone	075
Multiple cyclone without fly ash reinjection	076
Multiple cyclone with fly ash reinjection	077
Baffle	078
Chemical oxidation	080
Chemical reduction	081
Ozonation	082
Chemical neutralization	083
Activated clay adsorption	084
Wet cyclonic separator	085
Water curtain	086
Nitrogen blanket	087
Conservation vent	088
Bottom filling	089
Conversion to variable vapor space tank	090

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Conversion to floating roof tank	**091**
Conversion to pressurized tank	**092**
Submerged filling	**093**
Underground tank	**094**
White paint	**095**
Vapor lock balance recovery system	**096**
Miscellaneous control devices	**099**

7:27-21.6 Recordkeeping requirements

(a) Each owner or operator of a facility subject to this subchapter shall maintain the following records for a period of five years from the due date of each emission statement:

1. A copy of the emission statement submitted to the Department; and

2. Records indicating how the information submitted in the emission statement was determined, including any calculations, data, measurements, and estimates used.

(b) Upon the request of the Department, the owner or operator of the facility shall make these records available at the facility for inspection by any representative of the Department during normal business hours.

7:27-21.7 Severability

If any section, subsection, provision, clause or portion of this subchapter or the application thereof to any person or circumstance is adjudged invalid or unconstitutional by a court of competent jurisdiction, the remainder of this subchapter and the application thereof to other persons or circumstances shall not be affected thereby, and shall remain in full force and effect.

7:27A-3.10 Civil administrative penalties for violations of rules adopted pursuant to the Act

(a)-(d) (No change.)

(e) The Department shall determine the amount of the civil administrative penalty for offenses described in this section on the basis of the provision violated and the frequency of the violation. Footnotes 3, 4, and 8 set forth in this subsection and (f) below are intended solely to put violators on notice that in addition to any civil administrative penalty assessed, the Department may also revoke the violator's operating certificate or variance. These footnotes are not intended to limit the Department's discretion in determining whether or not to revoke an operating certificate or variance, but merely indicate the situations in which the Department is most likely to seek revocation. The number of the following subsections corresponds to the number of the corresponding subchapter in N.J.A.C. 7:27.

1.-20. (No change.)

21. The violations of N.J.A.C. 7:27-21, Emission Statements, and the civil administrative penalty amounts for each violation are as set forth in the following table:

Citation	Class	First Offense	Second Offense	Third Offense	Fourth and Each Subsequent Offense
N.J.A.C. 7:27-21.4(a)	Failure to Submit	$2,000	$4,000	$10,000	$30,000
N.J.A.C. 7:27-21.5(a)	Failure to Certify	$1,000	$2,000	$5,000	$15,000
N.J.A.C. 7:27-21.5(b)-(k)	Omission of Required Information	$500	$1,000	$2,500	$7,500
N.J.A.C. 7:27-21.6(a)	Failure to Keep Records	$500	$1,000	$2,500	$7,500
N.J.A.C. 7:27-21.6(b)	Readily Available	$100	$200	$500	$ 1,500

22.-25. (No change.)

HEALTH

(a)

DRUG UTILIZATION REVIEW COUNCIL

List of Interchangeable Drug Products

Proposed Amendments: N.J.A.C. 8:71

Authorized By: Drug Utilization Review Council, Robert Kowalski, Chairman.

Authority: N.J.S.A. 24:6E-6(b).

Proposal Number: PRN 1992-392.

A **public hearing** concerning these proposed amendments will be held on Monday, October 5, 1992, at 2:00 P.M. at the following address:

Room 804, Eighth Floor
Department of Health
Health-Agriculture Bldg.
Trenton, New Jersey 08625-0360

Submit written comments by October 8, 1992 to:

Mark A. Strollo, R.Ph., M.S.
Drug Utilization Review Council
New Jersey Department of Health
Room 501, CN 360
Trenton, N.J. 08625-0360
609-292-4029

The agency proposal follows:

Summary

The List of Interchangeable Drug Products is a generic formulary, or list of acceptable generic drugs which pharmacists must use in place of brand-name prescription medicines, passing on the resultant savings to consumers.

For example, the proposed naproxen sodium 275 mg and 550 mg tablets could be used as a less expensive substitute for Anaprox, a branded prescription medicine. Similarly, the proposed diflunisal tablets could be substituted for the more costly branded product, Dolobid.

The Drug Utilization Review Council is mandated by law to ascertain whether these proposed medications can be expected to perform as well as the branded products for which they are to be substituted. Without such assurance of "therapeutic equivalency," any savings would accrue at a risk to the consumer's health. After receiving full information on these proposed generic products, including negative comments from the manufacturers of the branded products, the advice of the Council's own technical experts, and data from the generics' manufacturers, the Council will decide whether any of these proposed generics will work just as well as their branded counterparts.

Every proposed manufacturer must attest that they meet all Federal and State standards, as well as having been inspected and found to be in compliance with the U.S. Food and Drug Administration's regulations.

Social Impact

The social impact of the proposed amendments would primarily affect pharmacists, who would need to either place in stock, or be prepared to order, those products ultimately found acceptable.

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Many of the proposed items are simply additional manufacturers for products already listed in the List of Interchangeable Drug Products. These proposed additions would expand the pharmacist's supply options.

Physicians and patients are not adversely affected by this proposal because the statute (N.J.S.A. 24:6E-6 et seq.) allows either the prescriber or the patient to disallow substitution, thus refusing the generic substitute and paying full price for the branded product.

Economic Impact

The proposed amendments will expand the opportunity for consumers to save money on prescriptions by accepting generic substitutes in place of branded prescriptions. The full extent of the saving to consumers cannot be estimated because pharmacies vary in their prices for both brands and generics.

Some of the economies occasioned by these amendments accrue to the State through the Medicaid, Pharmaceutical Assistance to the Aged and Disabled Program, and the prescription plan for employees. A 1988 estimate of average savings per substituted Medicaid prescription was $7.31. However, the number of prescriptions that will be newly substituted due to these proposed amendments cannot be accurately assessed in order to arrive at a total savings.

Regulatory Flexibility Analysis

The proposed amendments impact many small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., specifically, over 1,500 pharmacies and several small generic drug manufacturers which employ fewer than 100 employees.

However, there are no reporting or recordkeeping requirements for pharmacies, and small generic drug manufacturers have minimal initial reports, and no additional ongoing reporting or recordkeeping requirements. Further, these minimal requirements are offset by the increased economic benefits accruing to these same small generic businesses due to these proposed amendments.

Full text of the proposed amendments follows:

Albuterol sulfate inh. soln. 0.083%	Copley
Amiloride/HCTZ 5/50 tabs	Danbury
Atenolol tabs 50 mg, 100 mg	W-C
Betamethasone dipropionate cream 0.05%	ICN
Betamethasone dipropionate cream 0.05%	Taro
Carbamazepine chewable tabs 100 mg	TEVA
Carbidopa/levodopa tabs 10/100, 25/100, 25/250	TEVA
Cephalexin caps 250 mg, 500 mg	Yoshitomi
Clofibrate caps 500 mg	Pharmacaps
Deconamine SR caps substitute	Nutripharm
Deconamine tabs substitute	Taro
Desonide cream 0.05%	Nutripharm
Diflunisal tabs 250 mg, 500 mg	TEVA
Diltiazem tabs 30mg, 60mg, 90mg, 120mg	Copley
Doxycycline hyclate caps 100 mg	Sidmak
Fluocinonide cream 0.05%	ICN
Granulex spray substitute	Topi-cana
Griseofulvin tabs 165 mg, 330 mg	Sidmak
Hydrocortisone cream 2.5%	ICN
Ibuprofen tabs 400mg, 600 mg, 800 mg	TEVA
Methotrexate tabs 2.5mg	Mylan
Midrin caps substitute	Nutripharm
Naphcon A ophthalmic sol. substitute	Optopics
Naproxen sodium tabs 275mg, 550mg	Danbury
Naproxen tabs 250mg, 375mg, 500mg	Danbury
Nitrofurantoin caps 50mg, 100mg	Zenith
Phenylephrine 2.5% ophthalmic sol.	Optopics
Pilocarpine 6% ophthalmic sol.	Optopics
Piroxicam caps 10 mg, 20 mg	Copley
Piroxicam caps 10 mg, 20 mg	Mylan
Potassium chloride powder 20mEq	ICN
Rondec tablet substitute	Nutripharm
Rondec TR tablet substitute	Nutripharm
Singlet caplet substitute	Nutripharm
Singlet LA caplet substitute	Nutripharm
Tolmetin caps 400 mg	TEVA
Triamterene/HCTZ 37.5/25 tabs	Danbury
Valproic Acid syrup 250mg/5ml	Copley

INSURANCE

(a)

DIVISION OF ADMINISTRATION

Medical Fee Schedules: Automobile Insurance Personal Injury Protection Coverage Physical Therapy Services

Proposed Amendment: N.J.A.C. 11:3-29.6

Authorized By: Samuel F. Fortunato, Commissioner, Department of Insurance.

Authority: N.J.S.A. 39:6A-4.6.

Proposal Number: PRN 1992-394.

Submit comments by October 8, 1992 to:
Verice M. Mason
Assistant Commissioner
Legislative and Regulatory Affairs
New Jersey Department of Insurance
CN 325
Trenton, New Jersey 08625-0325

The agency proposal follows:

Summary

The purpose of this proposed amendment is to establish an alternative fee schedule for reimbursement of medically necessary physical therapy services under automobile insurance personal injury protection (PIP) coverage which would achieve one specific objective: To provide an adequate reimbursement system for physical therapists reflecting a fair and reasonable charge for services consistent with the statutory mandate at N.J.S.A. 39:6A-4.6 which requires that the fee schedules "incorporate the reasonable and prevailing fees of 75 percent of the practitioners within the region."

In order to accomplish this objective, the Department solicited and received input from representatives of New Jersey's physical therapy providers, other State agencies and outside consultants to determine reasonable fee limits for these services. The response to the Department's inquiries did not reveal significant differences among the various regions of the State; therefore, the fee limits for each service are the same for each region.

CPT codes are designed to reflect the billing practice of physicians. The use of CPT codes as the basis for billing physical therapy services, therefore, results in a system which does not appropriately reflect patient care as generally practiced by physical therapists. However, as stated at proposed N.J.A.C. 11:3-29.6(f)5, CPT codes will continue to be used by physical therapists for reimbursement purposes to adequately describe the services rendered.

The present reimbursement approach which includes physical therapy in the physicians' medical fee schedule is based on the application of physical modalities. The evaluation skills, hands-on manual procedures, skilled therapeutic testing and exercise techniques, and patient education which are the core of most therapist based practices are therefore inadequately represented.

This proposed amendment establishes a per visit reimbursement system with charges that reflect the primary type of service rendered and the length of time the patient requires. The dollar amounts on the proposed fee schedule, as in all of the other fee schedules, define the upper limit of the auto insurer's liability for reimbursement for the services rendered. Reimbursement of medically necessary services will continue to be based on the provider's usual, customary and reasonable fee as set forth at N.J.A.C. 11:3-29.4(a). In many instances, the usual, customary and reasonable fee will be well below the upper limit appearing on the schedule.

If this proposed fee schedule is adopted by the Department, it will be effective as to services rendered by physical therapists on and after the date upon which the adoption notice is published in the New Jersey Register.

Proposed revisions to the fee schedules set forth at N.J.A.C. 11:3-29.6(a) through (e) will be published shortly in the New Jersey Register.

Social Impact

This proposed amendment, if adopted, will affect automobile insurers and physical therapists providing services to New Jersey residents who

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have sustained injuries as a result of auto accidents. Pursuant to this alternative approach, such services will be reimbursed on a per visit or time basis traditionally used by physical therapists rather than on a modality basis.

The Department believes that this approach will be supported by providers and automobile insurers alike since it will simplify the billing process, reduce the incidence of billing abuse and fraud, decrease significantly the time required to pay claims and result in more effective cost containment.

Economic Impact

Physical therapists and automobile insurers doing business in New Jersey may be affected economically if this alternative approach to reimbursement for physical therapy services provided to auto accident injured victims is adopted. However, it is impossible to quantify the net savings that would be realized by providers or insurers.

The Department anticipates that a traditional time based system of reimbursement, in contrast to the present modality based system, will result in significantly reducing the number of complaints brought by providers and consumers against automobile insurers thereby reducing the Department's administrative cost.

Regulatory Flexibility Statement

This proposed new fee schedule for reimbursement of physical therapy services will apply to "small businesses" as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. These "small businesses" include insurers authorized to write private passenger automobile insurance. Less than 10 of the more than 200 automobile insurers in New Jersey qualify as "small businesses."

A regulatory flexibility analysis is not required because the proposed amendment does not impose reporting, recordkeeping or other compliance requirements on small businesses beyond the statutory requirements.

The intent of this amendment is to provide a per visit reimbursement fee schedule for physical therapy services as the alternative to the modality based approach for such services currently reflected in the physicians' schedule.

The medical fee schedules contained in the rule set forth the limits of liability for the medical expense benefit portion of the personal injury protection coverage contained in automobile insurance policies. While the rules do not impose reporting, recordkeeping and other compliance requirements, it is fully expected that all automobile insurers, including those qualifying as small businesses, will implement the fee schedules in their claims adjudication processes so as to reduce loss expenses for personal injury protection medical expense claims.

Full text of the proposal follows (additions indicated in boldface **thus**):

11:3-29.6 Medical Fee Schedules

(a)-(e) (No change.)

(f) The following is the Medical Fee Schedule for reimbursement of services provided by physical therapists:

STATE OF NEW JERSEY
PERSONAL AUTO INJURY FEE SCHEDULE
SERVICES PROVIDED BY PHYSICAL THERAPISTS

1. Initial Evaluation

Includes comprehensive assessment of patient status, including documentation of patient history, relevant past and active medical histories and all normal testing procedures as indicated. These assessments may include, but are not limited to, ROM, MMT, sensory testing, functional activities, gait evaluation, prosthetic and orthotic checkouts, cardiopulmonary status and special neuromusculoskeletal testing procedures as indicated. Initial evaluation may include the opening of a patient record with all associated administrative costs and may include some treatment procedures.

i. Routine Visit	**$100.00**
ii. Extended Visit (more than one hour)	**$150.00**

2. Treatment Only

Includes application of treatment procedures such as manual techniques, therapeutic exercise, kinetic activities, functional training, gait training, prosthetic and orthotic training and the application of physical modalities; also any individual patient education sessions.

i. Routine Visit	**$ 65.00**
ii. Extended Visit (more than one hour)	**$110.00**

Under certain circumstances, treatment procedures for protracted periods of time in a single visit may be medically necessary and appropriate reimbursement on a usual, customary and reasonable basis may be in order. In such cases, prior consultation with the insurer from which reimbursement will be sought is recommended.

3. Special Assessments

Includes non-routine special testing procedures which require advanced skills and/or special equipment.

i. Computerized Joint Evaluation	
(1) 1 Plane	**$ 80.00**
(2) 2 Planes	**$120.00**
(3) 3 Planes (maximum per test)	**$160.00**
ii. Symptom Magnification	**$200.00**
iii. Functional Capacity Evaluation	
(1) Routine Visit	**$300.00**
(2) Extended Visit (half day)	**$600.00**
(3) Comprehensive Visit (full day)	**$900.00**

4. Patient Education

Applies to group educational sessions such as back school training.

i. Routine Visit	**$ 70.00**
ii. Extended Visit	**$140.00**

5. Billing Requirements

All bills submitted to insurers for reimbursement shall include the actual provider's name and professional license number and an adequate description of the services rendered which may include reference to CPT codes.

DOLLAR AMOUNTS ON THE FEE SCHEDULE DEFINE THE AUTOMOBILE INSURER'S UPPER LIMIT OF LIABILITY FOR THE SERVICE PROVIDED. REIMBURSEMENT WILL BE BASED ON WHAT IS USUAL, CUSTOMARY AND REASONABLE WITHIN THE UPPER LIMIT.

(a)

DIVISION OF FINANCIAL EXAMINATIONS

Financial Examinations Monitoring System Data Submission Requirements for All Domestic Insurers

Proposed New Rules: N.J.A.C. 11:19-2

Authorized By: Samuel F. Fortunato, Commissioner, Department of Insurance.

Authority: N.J.S.A. 17:1-8.1, 17:1C-6(e), 17:17-1 et seq., 17B:18-1 et seq., 17:23-1 et seq., 17B:21-1 et seq., 17:46A-1 et seq., 17:46B-1 et seq.

Proposal Number: PRN 1992-395.

Submit comments by October 8, 1992 to:
Verice M. Mason, Assistant Commissioner
Department of Insurance
Division of Legislative and Regulatory Affairs
20 West State Street
CN 325
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The Department of Insurance (Department) is responsible for monitoring the financial solvency of approximately 1,600 insurance and other risk assuming entities. In order to streamline the current manual, labor intensive regulatory process involved in carrying out this responsibility, the Department, with the help of the New Jersey Office of Telecommunications and Information Systems (OTIS), has designed and is in the process of implementing a multi-faceted automated Financial Examinations Monitoring System ("FEMS"). The Department is proposing a series of rules intended to set forth the data elements, format and filing requirements by which insurers and related entities will submit data to the Department for use in FEMS. On May 11, 1992 the Depart-

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ment issued Bulletin No. 92-14 which provided insurers and other related entities affected by FEMS with a brief overview of the project.

FEMS was designed with several objectives in mind: to improve the Department's ability to identify and react to financially troubled insurers in a timely manner; to improve the overall quality and effectiveness of Department's regulatory procedures; to provide up-to-date financial data for company analysis as soon as it is available; to reduce or eliminate rote number crunching and cross-checking activities so that examiners may spend more time on solvency analysis and less on compliance testing; to design a system that can accommodate yearly changes in data and analytical tests without significant reprogramming; and to be consistent with National Association of Insurance Commissioners ("NAIC") automation plans.

FEMS is comprised of a total of 11 subsystems. Six are mainframe application subsystems: (1) Financial Analysis Subsystem ("FAS"); (2) Descriptive Data Subsystem ("DDS"); (3) Investment Valuation Subsystem ("IVS"); (4) Surplus Lines Processing Subsystem ("SLPS"); (5) Information Retrieval Subsystem ("IRS"); and (6) Taxes and Assessments Subsystem ("TASS"). FEMS also includes two mainframe/microcomputer subsystems: the General Application Spreadsheet Software Subsystem ("GASSS") and the General Ledger Analytical Review Subsystem ("GLARS"); two minicomputer/microcoputer subsystems: the Actuarial Data and Analysis Subsystem ("ADAS") and the Billing and Scheduling Subsystem ("BASS"); and a stand alone microcomputer subsystem, the Examination Statistical Sampling Subsystem ("EXSSS").

Together, these 11 subsystems support the process of regulating and monitoring insurance entities.

Only certain subsystems will require supplemental data from those insurers, risk assuming entities or agents qualified to transact business in New Jersey. The following chart identifies those subsystems which will require supplemental/reformatted information.

FAS	All regulated insurers and entities
IVS	All domestic companies
IRS	All domestic companies
GLARS	All domestic companies
ADAS	All life/health domestic companies
SLPS	All surplus lines agents and eligible surplus lines insurers qualified to transact business in New Jersey

These proposed rules are the first of a series of proposals that will set forth the data elements, format and filing requirements by which insurers will submit data to the Department for use in the FEMS. These rules specifically implement the IVS mainframe subsystem.

The IVS analyzes investment information to determine that it is reasonably stated and verifies the accuracy of securities held by domestic insurers and reported in Schedule D of their Annual Statement. The IVS will assist the Department's examiners in verifying the securities reported on Schedule D to the securities held by custodians as reported on their certificate of verification or statement of assets held.

The IVS will load Schedule D detail information from the NAIC's financial database and custodian certificates of verification or statement of assets held into the FEMS database. It will reconcile the certificates of verification or statement of assets held received to the Schedule D detail and note exceptions. The IVS will maintain the custodian master information and company/custodian relationships needed to perform this reconciliation. Additionally, the IVS, integrated with the NAIC's Examination Jumpstart application, will verify key fields reported on Schedule D to the NAIC's Securities Valuation Office's ("VOS") manual. Among the fields checked are: the American Banking Association's (ABA) Committee on Uniform Security Identification Procedures ("CUSIP"), NAIC designation, market value, amortization and interest (accrued and paid). Currently, these tasks are performed manually. The automation will save the examiners time in that it will allow them to concentrate on exceptions without having to perform time consuming, rote tasks.

A summary of the various provisions of the proposed new rules follows:

N.J.A.C. 11:19-2.1 provides the purpose and scope of these rules.

N.J.A.C. 11:19-2.2 provides definitions for terms used in this subchapter.

N.J.A.C. 11:19-2.3 provides general data filing requirements.

N.J.A.C. 11:19-2.4 provides the IVS data filing information requirements that insurers must file with the Department.

N.J.A.C. 11:19-2.5 through 11:19-2.9 are being reserved for the other FEMS subsystems dealing with domestic insurers (IRS, GLARS, ADAS).

N.J.A.C. 11:19-2.10 provides a penalty for insurers which fail to comply with the provisions of this subchapter.

Social Impact

The proposed new rules have a beneficial social impact. The Department is charged with the responsibility of monitoring all insurance companies and other risk assuming entities authorized to do business in New Jersey in order to protect policyholders by determining the solvency of these insurers. The task to monitor the solvency of insurers is performed mainly by the Department's Financial Examinations Division and the Division of Actuarial Services. Due to the lack of automated systems, these Divisions presently have to carry out their functions primarily in a manual fashion. The Department believes that in order to regulate the very large and highly automated insurance industry, it is necessary for its Divisions to be supported by state-of-the-art, transaction-oriented systems.

By using state-of-the-art, transaction-oriented systems, the Department can more effectively monitor the financial condition of the insurance companies under its jurisdiction and act to avert impairments or insolvencies by recommending remedial action.

Economic Impact

These proposed new rules will impact the Department and domestic insurers and related entities required to submit data for use in the FEMS.

In order to carry out its fiscal responsibility to monitor the financial solvency of approximately 1,600 insurance companies and other risk assuming entities, most of which are highly automated, the Department implemented the FEMS System. The Department believes that it is important to provide its Financial Examinations Division and the Division of Actuarial Services with a computer system which will increase the Department's ability to perform its duty of monitoring the financial solvency of insurance companies. The Department has already expended funds in order to develop the FEMS System.

As a result of these proposed new rules, insurers will be required to submit information to the Department in the format specified by these rules. Insurers may incur costs in connection with assimilating, preparing and supplying the required information. Insurers will incur costs to develop the system. These costs will vary greatly from insurer to insurer depending on the nature of their existing information systems and the extent of programming changes that are necessitated to comply with these proposed new rules. For this reason, the Department cannot quantify with any degree of certainty the cost that will be incurred by an individual insurance company.

Insurers presently pay for regular examinations and incur costs in submitting that data. The Department believes that insurer's incurred costs as a result of the rules will be offset or reduced by more efficient, automated systems. Some insurers may find costs of examinations reduced.

These rules will improve the Department's ability to better monitor the financial solvency of a company which is beneficial to the public. The ability of the Department to detect insurance company insolvencies earlier can reduce or eliminate costs generally assumed by Guaranty Associations and funds.

Regulatory Flexibility Analysis

These proposed new rules impose compliance requirements on domestic insurance companies formed under the laws of this State, some of which may be small businesses as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The Department is unable practically or reliably to estimate the costs that will be incurred or the need for professional services that may be required by small businesses to comply with these rules. The costs and need for services will vary substantially depending upon each insurer's internal resources. These rules do not change the data reporting requirements for effected companies, but only the manner in which the data is reported. In order to effectuate the goals of these rules, no differentiation in requirements based upon business size can be provided.

Full text of the proposal follows:

CHAPTER 19
FINANCIAL EXAMINATIONS MONITORING SYSTEM

SUBCHAPTER 1. (RESERVED)

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SUBCHAPTER 2. DATA SUBMISSION REQUIREMENTS FOR ALL DOMESTIC INSURERS

11:19-2.1 Purpose and Scope

(a) The purpose of this subchapter is to set forth the filing requirements and procedures for the submission of financial data under various Financial Examinations Monitoring System (FEMS) subsystems, for all domestic insurers to the Department.

(b) These rules apply to all domestic insurers regulated under the laws of New Jersey unless specifically stated otherwise.

11:19-2.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"ADAS" means the Actuarial Data and Analysis Subsystem, which provides tools to help the Department's actuaries to value the reserves of domestic life insurance companies.

"BASS" means the Billing and Scheduling Subsystem, which facilitates the examination activities of the Department. This system provides for automated time and expense entry, produces examination schedules and generates company bills.

"Certificate of Verification or statement of assets held" means a certified listing from the custodian of the securities held as of a specified date (for example, year end) for a specified insurance company.

"CINS" means CUSIP International Numbering Standard.

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"CUSIP" means the American Banking Association's (ABA) Committee on Uniform Security Identification Procedures, a uniform security identification system for securities which are obtained, selected, arranged and published by Standard and Poors.

"Custodian" means an entity that is in custody of securities on behalf of an insurer or the insurer itself.

"DDS" means the Descriptive Data Subsystem, which provides online access to demographic information and a financial snapshot of all insurance and other risk assuming entities regulated by the Department. A tracking system for admissions and extensions of authority is also provided.

"Department" means the Department of Insurance.

"Domestic insurer" means an insurer formed under the laws of this State pursuant to N.J.S.A. 17:17-1 et seq., 17:46A-1 et seq., 17:46B-1 et seq., and 17B:18-1 et seq.

"DTC" means Depository Trust Corporation.

"Due date" means a date prior to or on which a submission must be received by the Department.

"EBCDIC" means the Extended Binary Coded Decimal Interchange Code which is a computer code for representing data. This is used in all IBM mainframe systems.

"EXSSS" means the Examination Statistical Sampling Subsystem, which is a statistical sampling package that runs on a personal computer to provide the field examiners with random number and statistical sample support tools.

"FAS" means the Financial Analysis Subsystem, which performs analysis on the annual/quarterly statement data filed with the NAIC under mandate of the Department. A series of solvency related tests are performed and companies are stratified based upon test results.

"FED" means Federal Reserve Book Entry.

"GASSS" means the General Application Spreadsheet Software Subsystem, which provides insurance analysts with a series of spreadsheet and query tools to analyze a specific company's data.

"GLARS" means the General Ledger Analytical Review Subsystem, which is a general ledger package that assists the Department's field examiners in their company examination activity by reconciling the company chart of accounts to the annual statement filing.

"Insurer" or "insurance company" means an entity authorized or eligible to transact the business of insurance in New Jersey.

"IRS" means the Information Retrieval Subsystem, which is an information retrieval tool that will aid the field examiner in reviewing insurance company files.

"IVS" means the Investment Valuation Subsystem, which analyzes the investment data submitted with the Annual Statement (Schedule D) and reconciles custodian information to the statement data.

"NAIC" means the National Association of Insurance Commissioners.

"PPN" means Privately Placed Securities.

"Risk assuming entity" means any entity regulated by the Department pursuant to New Jersey statutes.

"SLPS" means the Surplus Lines Processing Subsystem, which assists the Department in monitoring the activities of persons which sell surplus lines insurance to New Jersey residents and matches quarterly agent tax data to quarterly company policy data.

"SVO" means the Securities Valuation Office. This entity was created by the NAIC to provide insurers with a source for uniform prices and quality ratings for their securities holdings.

"TASS" means the Taxes and Assessments Subsystem, which calculates and verifies premium tax information filed by companies, and calculates various assessments which are levied by the DOI.

"VOS Manual" means the Valuation of Securities manual; this document is published annually by the NAIC SVO and contains market prices and NAIC Designations for all bonds and stocks owned by United States domiciled insurers when such securities have been filed with the SVO for this purpose.

11:19-2.3 General data filing requirements for all domestic insurers

(a) All domestic insurers shall file with the Department the information required by this subchapter on an annual basis beginning January 31, 1993, in accordance with Appendix A to this subchapter, incorporated herein by reference.

(b) Upon request by the Commissioner, any domestic insurer shall provide the information required by this subchapter to the Department in accordance with formats set forth in this subchapter.

11:19-2.4 IVS subsystem filing requirements

(a) All domestic insurers shall provide the Department with a report on their securities by either cartridge (3480 model) or computer tape (6250 BPI, IBM compatible) in accordance with (c) below.

(b) Domestic insurers owning securities which are held by custodians shall utilize custodians which shall:

1. Submit to the Department a certification of securities held; and

2. Provide the Department with an independent report of the insurer's securities by either cartridge (3480 model) or computer tape (6250 BPI, IBM compatible) in accordance with (c) below.

(c) All reports of securities held by domestic insurers filed with the Department shall include the information and be submitted in the format set forth in the record layouts in Appendix A to this subchapter. The report shall include the following information:

1. An internal IBM standard tape label containing:

i. Data set name ("INF.XXXXX.ZZZZZ"). The five Xs shall be replaced with the custodian code assigned by the Department and the give Zs shall be replaced with the company's NAIC number;

ii. The data must be EBCDIC character set and alphas in upper case;

iii. Volume serial number (six characters, shall be unique for each tape in a multi-volume data set);

iv. Tape density;

v. Record format;

vi. Record length;

vii. Block size; and

viii. Create date.

2. Tapes and cartridges may be delivered or mailed but shall be received by the Department by the due date to:

New Jersey Department of Insurance
FEMS-IVS Project
20 W. State Street
CN-325
Trenton, NJ 08625

i. If mailed, they shall be mailed in standard secure containers with a pre-addressed, prepaid return address label enclosed or attached.

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3. Tapes and cartridges shall be clearly labeled with the custodian's name, company's name and the date. The box and the label shall be printed or typed in capital letters.

4. Domestic insurers and/or the custodian shall submit either IBM compatible 3480 cartridges, or 6250 BPI tapes (3480 cartridges are preferred, with 6250 BPI tapes as a secondary preference.)

5. An external label shall be affixed to the tapes or cartridges and include the following information:

i. The custodian's name and custodian's code;

ii. The company's name and NAIC number;

iii. The volume sequence number if file is multi-volume (for example 1 of 5);

iv. The date when the tape or cartridge was mailed;

v. The letters "SL" on the external label indicating that the internal IBM standard tape information is included as provided in (c)1 above;

6. A cover letter indicating the same information on the internal and external labels; and

7. A signed affidavit of the custodian which shall accompany all transmissions attesting to the accuracy of the cartridges/tapes.

8. Domestic insurers and/or custodians that are not technically capable of providing the Department with an IBM standard internal label pursuant to (c)1 above, shall indicate that no internal label is included by writing the letters "NL" on the external label and on the cover letter.

(d) Domestic insurers and/or the custodian shall adhere to the attached record layouts in the appendices. In addition to transaction records, header and trailer records shall be included in all electronic media (that is, tapes and cartridges), in the format set forth in Appendix A to this subchapter.

11:19-2.5 through 11:19-2.8 (Reserved)

11:19-2.9 Penalties

Failure to comply with the provisions of this subchapter shall subject the insurer to penalties as provided in N.J.S.A. 17:23-2 and 17B:21-2.

APPENDIX A
Exhibit 1

Header Record Layout

Field No.	Field Name	Start Pos	Field Type & Length	Comments
1	Record Type	1	X(1)	Must fill w/"1"
2	Custodian Code	2	X(5)	DOI assigned custodian code
3	Insurance Company Code	7	X(5)	NAIC Code
4	Year Ended	12	X(4)	Format CCYY; CC = the century, YY = the year
5	Filler	16	X(135)	Space fill
			150	

Note:

X denotes alphanumeric

Alphanumeric fields containing numeric values should be right adjusted and zero filled to the left with the sign in the left most character (specific instructions for each field are documented in the comment section).

APPENDIX A
Exhibit 2

Header Record Layout
Description

Field No.	Field Name	Comments
1	Record Type	This field must contain the number "1" for this record type.
2	Custodian Code	This field must contain the custodian's code assigned by the DOI.
3	Insurance Company Code	This field must contain the Insurance company's NAIC company code.
4	Year Ended	This field must contain the year of the period for which the data applies.
5	Filler	Spaces

APPENDIX A
Exhibit 3

Detail Record Layout

Field No.	Field Name	Start Pos	Field Type & Length	Comments
1	Record Type	1	X(1)	Must fill w/"2"
2	Custodian Code	2	X(5)	DOI Custodian Code
3	Insurance Company Code	7	X(5)	NAIC Code
4	CUSIP/PPN/CINS Number	12	X(9)	If no assigned number, fill w/nine zeroes. This number must be unique. There may not be two records with the same CUSIP. The first 8 digits must be unique (e.g. 123456789—1 through 8 must be unique).
5	Issuer	21	X(30)	
6	Description	51	X(30)	
7	Stock/Bond Indicator	81	X(1)	S or B
8	Quantity	82	X(15)	Total Par Value or Number of Shares—12 digits to left of implied decimal point, 3 digits to right—sign is NOT included since this value should always be positive.
9	Market Value	97	X(12)	Market Value Per Security 8 digits to left of implied decimal point, 3 digits to right, the sign (+, -) should be in the first character
10	Market Price Source	109	X(20)	Source of Price (e.g. Wall Street Journal)
11	Filler	139	X(22)	Space fill
			150	

Note:

X denotes alphanumeric

Alphanumeric fields containing numeric values should be right adjusted and zero filled to the left with the sign in the left most character (specific instructions for each field are documented in the comment section).

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APPENDIX A
Exhibit 4

Detail Record Layout
Description

Field No.	Field Name	Comments
1	Record Type	This field must contain the number "2" for this record type.
2	Custodian Code	This field must contain the custodian's code which was assigned by the DOI.
3	Insurance Company Code	This field must contain the Insurance company's NAIC company code.
4	CUSIP/PPN/CINS Number	Must contain approved CUSIP, PPN, or CINS Number or (foreign issues) Agency number as assigned by Standard & Poor's Corporation. This number must be unique. There may be no duplicate CUSIP. It is the first 8 digits of the CUSIP that must be unique. For example, 222222212 and 222222222 are unique CUSIPs. However, the following are duplicate CUSIPs: 222222222 and 222222221. Therefore, each record must be a unique CUSIP according to the first 8 digits. The "first 8" refers to the first eight digits, starting from the left.
5	Issuer	Must contain name of company issuing security.
6	Description	Must contain shortened CUSIP security description.
7	Stock/Bond Indicator	Must contain an S to indicate security quantity is reported as number of shares or a B to indicate security quantity is reported as par value.
8	Quantity	Must contain total number of shares or total par value of bonds.
9	Market Value	Must contain market value per security. For stocks this field should contain market value per share. For bonds this field should contain market value per unit.
10	Market Price Source	Must contain the source of pricing for example, Wall Street Journal, Dow Jones, etc.
11	Filler	Spaces

APPENDIX A
Exhibit 5

Trailer Record Layout

Field No.	Field Name	Start Pos	Field Type & Length	Comments
1	Record Type	1	X(1)	Must fill w/"3"
2	Custodian Code	2	X(5)	DOI Custodian Code
3	Insurance Company Code	7	X(5)	NAIC Code
4	Total Records	12	X(8)	Exclude header & trailer
5	Total Quantity	20	X(18)	15 digits to the left of the implied decimal point, 3 digits to the right, no sign should be included, this should be a total of the quantity field for every detail record.
6	Filler	38	X(113)	Space fill
			150	

Note:
X denotes alphanumeric
Alphanumeric fields containing numeric values should be right adjusted and zero filled to the left with the sign in the left most character (specific instructions for each field are documented in the comment section).

APPENDIX A
Exhibit 6

Trailer Record Layout
Description

Field No.	Field Name	Comments
1	Record Type	This field must contain the number "3" for this record type.
2	Custodian Code	This field must contain the custodian's code assigned by the DOI.
3	Insurance Company Code	This field must contain the Insurance company's NAIC company code.
4	Total Records	Total number of detail records submitted.
5	Total Quantity	Cash total of total shares/par value (total of quantity field for all detail records).
6	Filler	Spaces

(a)

DIVISION OF FINANCIAL EXAMINATIONS

Financial Examination Monitoring System Data Submission Requirements for All Licensed Producers with Surplus Lines Authority and All Eligible Surplus Lines Insurers

Proposed New Rules: N.J.A.C. 11:19-3

Authorized By: Samuel F. Fortunato, Commissioner, Department of Insurance.

Authority: N.J.S.A. 17:1-8.1, 17:1C-6(e), 17:22-6.40 et seq., 17:22-6.70 and 17:22A-17.

Proposal Number: PRN 1992-396.

Submit comments by October 8, 1992 to:
Verice M. Mason, Assistant Commissioner
New Jersey Department of Insurance
Legislative and Regulatory Affairs
20 West State Street
CN 325
Trenton, NJ 08625

The agency proposal follows:

Summary

The Department of Insurance ("Department") is responsible for monitoring the financial solvency of approximately 1,600 insurance and other risk assuming entities. In order to streamline the current manual, labor intensive regulatory process involved in carrying out this responsibility, the Department, with the help of the New Jersey Office of Telecommunications and Information Systems ("OTIS"), has designed and is in the process of implementing a multi-faceted automated Financial Examination Monitoring System ("FEMS"). The Department is proposing a series of rules intended to set forth the data elements, format and filing requirements by which insurers and related entities will submit data to the Department for use in FEMS. On May 11, 1992 the Department issued Bulletin No. 92-14 which provided insurers and other related entities affected by FEMS with a brief overview of the project.

FEMS was designed with several objectives in mind: to improve the Department's ability to identify and react to financially troubled insurers in a timely manner; to improve the overall quality and effectiveness of the Department's surveillance procedures; to provide up-to-date financial data for company analysis as soon as it is available; to reduce or eliminate rote number crunching and cross-checking activities so that examiners may spend more time on solvency analysis and less on compliance testing; to design a system that can accommodate yearly changes in data and analytical tests without significant reprogramming; and to be consistent with National Association of Insurance Commissioners ("NAIC") automation plans.

These proposed rules are the second in a series of proposals that will set forth the data elements, format and filing requirements by which insurers submit data to the Department for use in the FEMS. These rules specifically implement the Surplus Lines Processing Subsystem ("SLPS").

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SLPS is designed to assist the Surplus Lines Examining Office in monitoring surplus lines activity in the State of New Jersey. SLPS maintains and monitors tax and surcharge data for all licensed producers with surplus lines authority. It is mainly a quarterly reconciliation system. Each calendar quarter, SLPS collects tax information from surplus lines producers and net written premiums information from surplus lines insurers. Tax and surcharge filings are entered into the system and are reconciled against the surplus lines insurer's report listing New Jersey business.

SLPS objectives are as follows:

1. To increase the efficiency of the Surplus Lines Examining Office by reducing the need for manual verification that taxes and surcharges were correctly paid by the insured and remitted to the State;

2. To reduce the current volume of paper received and processed by the Surplus Lines Examining Office; and

3. To enable the Surplus Lines Examining Office to track and follow up on reporting exceptions in a timely and effective manner.

SLPS also interfaces with the Descriptive Data Subsystem (which is a FEMS mainframe subsystem) to retrieve surplus lines company information and with the Insurance Licensing System to retrieve surplus lines producer information.

A summary of the various provisions of the proposed new rules follows:

N.J.A.C. 11:19-3.1 provides the purpose and scope of these rules.

N.J.A.C. 11:19-3.2 provides definitions for terms used in this subchapter.

N.J.A.C. 11:19-3.3 provides general data filing requirements.

N.J.A.C. 11:19-3.4 provides the SLPS subsystem filing requirements for all eligible surplus lines insurers.

N.J.A.C. 11:19-3.5 provides SLPS subsystem filing requirements for all licensed producers with surplus lines authority.

N.J.A.C. 11:19-3.6 is being reserved.

N.J.A.C. 11:19-3.7 provides a penalty for surplus lines insurers and producers which fail to comply with the provisions of this subchapter.

Social Impact

The proposed new rules have a beneficial social impact. The Department is charged with the responsibility of monitoring surplus lines activity in the State of New Jersey. The task of monitoring the net written premiums of surplus lines insurers and collecting tax information and taxes from surplus lines producers is performed by the Department's Surplus Lines Examining Office. Due to the lack of automated systems, this unit presently has to carry out its functions primarily in a manual fashion. The Department believes that in order to regulate this high volume and highly automated segment of the insurance industry, it is necessary for its Division to be supported by state-of-the-art, transaction-oriented systems.

By using state-of-the-art, transaction-oriented systems, the Department can increase the efficiency of the Surplus Lines Examining Office by reducing the need for manual verification that taxes and surcharges were correctly calculated and remitted by the surplus lines producers. This system will also increase the Surplus Lines Examining Office's ability to track and follow up on reporting exceptions.

Economic Impact

These proposed new rules will impact the Department, surplus lines producers and surplus lines insurers.

In order to monitor the financial solvency of approximately 1,600 insurance companies and other risk assuming entities, most of which are highly automated, the Department implemented the FEMS system. The Department believes that it is important to provide the Surplus Lines Examining Office with a computer system which will increase the Department's ability to perform its duty of monitoring surplus lines activity in this State. The Department has already expended funds in order to develop FEMS.

As a result of these proposed new rules, surplus lines producers may incur slight costs of retraining personnel to comply with new system requirements of SLPS. Surplus lines producers are currently required to submit tax and surcharge information to the Department.

As a result of these proposed new rules, surplus lines insurers will be required to submit information to the Department in the format specified by this subchapter. Surplus lines insurers may incur costs in connection with assimilating, preparing and supplying the required information. Surplus lines insurers will incur costs to modify their existing systems. These costs will vary greatly from surplus lines insurer to surplus lines insurer depending on the nature of their existing information systems and the extent of programming changes that are necessitated to comply with these proposed new rules. For this reason, the Department cannot quantify with any degree of certainty the cost that will be incurred by an individual surplus lines insurer.

Regulatory Flexibility Analysis

These proposed new rules impose compliance requirements on all surplus lines producers and eligible surplus lines insurers qualified to transact business in New Jersey. Some surplus lines producers may be small businesses as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The Department is unable to estimate the costs that will be incurred or the need for professional services that may be required by small businesses to comply with these rules. The costs and need for services will vary substantially depending upon each producer's internal resources. These rules do not change the data reporting requirements for producers, but only the manner in which the data is reported. In order to effectuate the goals of these rules, no differentiation in requirements based upon business size can be provided.

Full text of the proposal follows:

SUBCHAPTER 3. DATA SUBMISSION REQUIREMENTS FOR ALL LICENSED PRODUCERS WITH SURPLUS LINES AUTHORITY AND ELIGIBLE SURPLUS LINES INSURERS

11:19-3.1 Purpose and scope

(a) The purpose of this subchapter is to set forth the filing and reporting requirements and procedures for the submission of:

1. All eligible surplus lines insurers' quarterly net written premiums for the State of New Jersey; and

2. Tax and surcharge filings for all licensed surplus lines producers.

(b) These rules apply to all licensed producers with surplus lines authority and all insurers eligible to transact surplus lines insurance business in New Jersey in accordance with N.J.S.A. 17:22-6.40 et seq. and 17:22-6.70 et seq.

11:19-3.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Alien insurer" means an insurer formed under the laws of any country other than the United States of America, its states, districts, territories, commonwealths or possessions.

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"Department" means the Department of Insurance.

"Due date" means a date prior to or on which a submission shall be received by the Department.

"EBCDIC" means the Extended Binary Coded Decimal Interchange Code which is a computer code for representing data. This code is used in all IBM mainframe systems.

"Foreign insurer" means an insurer formed under the laws of a jurisdiction of the United States of America, other than the State of New Jersey.

"Insurer" or "insurance company" means an entity authorized or eligible to transact the business of insurance in New Jersey.

"ISI Number" means the nine digit identifying number issued by the NAIC to uniquely identify an "alien insurer."

"NAIC" means the National Association of Insurance Commissioners.

"NAIC number" means the five digit number assigned by the NAIC to uniquely identify a foreign or admitted insurer.

"Net written premiums" means direct gross premiums on insurance policies written by a surplus lines insurer less return premiums thereon. If a policy issued by a surplus lines insurer covers risks or exposures only partially located in this State, the "net written premiums" do not include premiums on the risks or exposures outside of the State.

"Transaction number" means the 14-character number made up of the producer's surplus line agent number (assigned by the Department), the year of the placements, and a sequential number (maintained by the agent).

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"SLPS" means the Surplus Lines Processing Subsystem, which assists the Department in monitoring the activities of licensees which sell surplus lines insurance to New Jersey residents and matches quarterly agent tax data to quarterly company policy data.

"Surplus lines insurer" means an unauthorized insurer eligible to transact surplus lines insurance business in this State, in which an insurance coverage is placed or may be placed pursuant to N.J.S.A. 17:22-6.40 et seq.

11:19-3.3 General data filing requirements

(a) All eligible surplus lines insurers qualified to transact business in New Jersey shall report to the Department the information required by this subchapter on a quarterly basis beginning January 1, 1993, in accordance with (a)1 or 2 below, and with the Appendices to this subchapter, incorporated herein by reference.

1. Foreign insurers and alien insurers shall report their net written premiums for the State of New Jersey no later than 45 days after the end of the calendar quarter. The due dates for the net written premiums reports are as follows: May 15 for the first quarter; August 15 for the second quarter; November 15 for the third quarter; and February 15 for the fourth quarter.

2. Alien insurers which are not technically capable to report pursuant to (a)1 above shall report their net written premiums for the State of New Jersey no later than nine months after the end of the calendar quarter. The due dates for the net written premiums reports are as follows: December 1 for the first quarter; March 1 for the second quarter; June 1 for the third quarter; and September 1 for the fourth quarter.

(b) All licensed surplus lines producers shall, on or before the end of the month following each calendar quarter, remit premium taxes and surcharges in accordance with the Appendices to this subchapter. The due dates for these filings are as follows: April 30; July 31; October 31; and January 31.

11:19-3.4 SLPS subsystem filing requirements for all eligible surplus lines insurers

(a) All eligible surplus lines insurers shall provide the Department with a report listing net written premiums for all insurance covering a subject of insurance resident, located, or to be performed in New Jersey by either cartridge (3480 model) or computer tape (6250 BPI, IBM compatible) in accordance with (b) and (c) below. Surplus lines insurers which write no business during a calendar quarter shall not file the report required by (c) below, but shall submit a signed affidavit to the Department attesting that no business was written for the quarter.

(b) An insurer's quarterly report to the Department shall list each policy and transaction number only once. Insurers shall combine all activity on the policy during the quarter and report only the policy's net written premiums for that quarter in conjunction with the transaction number assigned by the New Jersey surplus lines agent. If the placement is a multi-state policy, the net written premiums shall include only the New Jersey portion of the premium.

(c) Each eligible surplus lines insurer's report of their net written premiums for the State of New Jersey shall be set forth in the record layouts in the Appendices to this subchapter.

1. The report shall include an internal IBM standard tape label containing:

i. Data set name (INF.SLPS);

ii. The data shall be EBCDIC character set and alphas in upper case;

iii. Volume serial number (will be assigned by the company);

iv. Tape density;

v. Record format (must be fixed block);

vi. Record length (must be 253);

vii. Block size (must be 23,276); and

viii. Create date.

2. Tapes and cartridges may be delivered or mailed but shall be received by the Department by the due date to:

New Jersey Department of Insurance
FEMS—SLPS Project
20 W. State Street
CN-325
Trenton, NJ 08625

i. If mailed, they shall be mailed in standard secure containers with a pre-addressed, prepaid return address label enclosed or attached.

3. Tapes and cartridges shall be clearly labeled with the company's name and the date. The box and the label shall be printed or typed in capital letters.

4. Surplus lines insurers shall submit either IBM compatible 3480 cartridges, or 6250 BPI tapes. (3480 cartridges are preferred, with 6250 BPI tapes as a secondary preference.)

5. An external label shall be affixed to the tapes or cartridges and shall include the following information:

i. The company's name and NAIC (or ISI) number;

ii. The volume sequence number if the file is multi-volume (for example, 1 of 5);

iii. The date when the tape or cartridge was mailed; and

iv. The letters "SL" on the external label indicating that the internal IBM standard tape information is included as provided in (c)1 above.

6. The submission shall also include a cover letter indicating the same information on the internal and external labels, and a signed affidavit of the surplus lines insurer attesting to the accuracy of the cartridges or tapes.

7. Surplus lines insurers that are not technically capable of providing the Department with an IBM standard label pursuant to (c)1 above, shall indicate that no internal label is included by writing the letters "NL" on the external label and on the cover letter.

11:19-3.5 SLPS subsystem filing requirements for all licensed producers with surplus lines authority

(a) All licensed producers with surplus lines authority shall assign a transaction number to each policy he or she places. All subsequent endorsements shall be identified by the same transaction number. All surplus lines producers shall provide surplus lines insurers with the appropriate transaction number for each new, additional or return premium policy or endorsement.

(b) All licensed surplus lines producers shall file with the Department or other authority as required a quarterly tax return in the form set forth in Appendix B to this subchapter.

(c) A complete New Jersey surplus lines producer quarterly tax return shall consist of the following forms:

1. SLPS-1-TAX (Tax Return and Certified Account by Surplus Lines Producer);

2. SLPS-2-FRA, if applicable (Schedule showing Fire Premiums and Taxes Payable to New Jersey Firemen's Relief Association);

3. SLPS-3-TRS (Schedule to Support Tax Returns); and

4. SLPS-4-GFS (Quarterly Surcharge Statement).

11:19-3.6 (Reserved)

11:19-3.7 Penalties

(a) Failure to comply with the provisions of this subchapter shall subject an eligible surplus lines insurer to penalties as provided in N.J.S.A. 17:22-6.61.

(b) Failure to comply with the provisions of this subchapter shall subject a licensed producer with surplus lines authority to penalties as provided in N.J.S.A. 17:22-6.61 and 17:22A-17.

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APPENDIX A
Exhibit 1 (SLPS)

Header Record Layout

Field No.	Field Name	Start Pos	Field Type & Length	Comments
1	Record Type	1	X(1)	Format as "1"
2	Company Number	2	X(9)	NAIC or ISI number
3	Company Name	11	X(30)	
4	Quarter	41	X(1)	Format as 1,2,3, or 4
5	Year	42	X(4)	Format as CCYY
6	Filler	46	X(255)	Spaces
			300	

Note:

X denotes alphanumeric
Alphanumeric fields containing numeric values should be right adjusted and zero filled to the left with the sign in the left most character (specific instructions for each field are documented in the comment section).

APPENDIX A
Exhibit 2 (SLPS)

Header Record Layout
Description

Field No.	Field Name	Comments
1	Record Type	This field should contain the number "1" for this record type.
2	Company Number	This field should contain the company's NAIC or ISI number (If NAIC number, leave last four characters as spaces).
3	Company Name	This field should contain the first 30 bytes of the company's full business name.
4	Quarter	This field should contain the quarter of the year for which the data applies. Can only be a "1", "2", "3", or "4".
5	Year	This field should contain the year for which the data applies.
6	Filler	This field should contain spaces.

APPENDIX A
Exhibit 3 (SLPS)

Detail Record Layout

Field No.	Field Name	Start Pos	Field Type & Length	Comments
1	Record Type	1	X(1)	Format as "2"
2	Company Number	2	X(9)	NAIC or ISI number
3	Transaction Number	11	X(14)	Number assigned to the policy by the surplus lines agent
4	Name of Insured	25	X(30)	
5	Policy Number	55	X(20)	Number assigned to the policy by the company
6	Policy From Date	75	X(8)	Format as MMDDCCYY
7	Policy To Date	83	X(8)	Format as MMDDCCYY
8	Total Net Premium Amount	91	X(12)	Net premium amount (including cents). Should reflect the net amount of all business received on the policy for the quarter
9	Name of Producer	103	X(30)	Name of producing agent
10	Street1	133	X(30)	First 30 bytes of producer's street address
11	Street2	163	X(30)	Second 30 bytes of producer's street address
12	Street3	193	X(30)	Last 30 bytes of producer's street address
13	City	223	X(20)	Producer's city
14	State	243	X(2)	Two-letter abbreviation of producer's state
15	Zip5	245	X(5)	Producer's zip code
16	Zip4	250	X(4)	Last 4 bytes of producer's zip code
17	Filler	254	X(47)	Spaces
			300	

Note:

All fields must be filled. If producer is not known, fill all related fields with spaces.
X denotes alphanumeric

APPENDIX A
Exhibit 4 (SLPS)

Detail Record Layout
Description

Field No.	Field Name	Comments
1	Record Type	This field should contain the number "2" for this record type
2	Company Number	This field should contain the company's NAIC or ISI number (If NAIC number, leave last four characters as spaces).
3	Transaction Number	This field should contain the number assigned to the policy by the surplus lines agent. Format using the producer number (five characters), a dash ("—"), the year of the placement (two characters), a dash ("—"), and the sequential number (five characters). The format of this field is XXXXX—XX—XXXXX. The dashes must be included. If the policy is a direct placement, use the default number, 99999—99—99999.
4	Name of Insured	This field should contain the name of the insured. Left justify the name. Leave spaces in the unused portions of the field. Format placing last name first. Example: Doe, John.
5	Policy Number	This field should contain the number assigned to the policy by the company. Left justify the policy number. Leave spaces in the unused portion of the field.
6	Policy From Date	This field should contain the effective date of the policy.
7	Policy To Date	This field should contain the end date of the policy.
8	Total Net Premium Amount	This field should contain the total net premium information received for the policy during the quarter. The decimal point is implied. Should be right justified with leading zeros. The sign ("+" or "-") should be the first character.
9	Name of Producer	This field should contain the name of the producing agent (if known). Name must be provided if address is provided. Left justify the name. Leave spaces in the unused portion of the field. Format placing last name first. Example: Doe, John.
10	Street1	This field should contain the first 30 bytes of the producer's street address.
11	Street2	This field should contain the second 30 bytes of the producer's street address. This field may be spaces if street name fits in the Street1 field.
12	Street3	This field should contain the last 30 bytes of the producer's street address. This field may also be spaces if the street name does not require it.
13	City	This field should contain the producer's city.
14	State	This field should contain the two-position postal abbreviation of the producer's state.

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15	Zip5	This field contains the producer's zip code (first 5 digits).
16	Zip4	This field contains the last four bytes of the producer's zip code. If not applicable, it should contain spaces.
17	Filler	This field should contain spaces.

APPENDIX A
Exhibit 5 (SLPS)

Trailer Record Layout

Field No.	Field Name	Start Pos	Field Type & Length	Comments
1	Record Type	1	X(1)	Format as "3"
2	Total Records	2	X(7)	Exclude header & trailer
3	Total Net Premiums	9	X(12)	Total net premiums written amount for the quarter (including cents).
4	Filler	21	X(280)	Spaces
			300	

Note:
All fields must be filled
X denotes alphanumeric

APPENDIX A
Exhibit 6 (SLPS)

Trailer Record Layout
Description

Field No.	Field Name	Comments
1	Record Type	This field should contain the number "3" for this record type.
2	Total Records	This field should contain the total number of records submitted on the tape. This excludes the header and trailer records.
3	Total Net Premiums	This field should contain the sum of the net premium amounts reported for each policy. The decimal point is implied. Should be right justified with leading zeroes. The sign ("+" or "-") should be the first character.
4	Filler	This field should contain spaces.

APPENDIX B

Instructions for Completing
Licensed New Jersey Surplus Lines Producer
Quarterly Tax Return

Introduction

Effective January 1, 1993, the Surplus Lines Unit automated its operations through the implementation of the Surplus Lines Processing Subsystem (SLPS) of the Department of Insurance's Financial Examinations Monitoring System (FEMS). The system was designed to simplify activities for both the Surplus Lines Unit and you, the Surplus Lines Producer. However, the success of this sytem is dependent on full compliance and cooperation from you and your agency. Failure to cooperate will render the system ineffective and result in additional work for both parties. Before any forms can be completed, you must fully understand the five basic rules involved in filing a surplus lines producer quarterly tax return. They are listed as follows:

Rule #1—YOU MUST READ AND FOLLOW THE INSTRUCTIONS EXACTLY AS THEY ARE EXPLAINED!

Rule #2—YOU MUST COMPLETE EVERY LINE ON THE TAX RETURN AS INSTRUCTED!

Rule #3—YOU MUST COMPLETE AND INCLUDE EVERY FORM AS INSTRUCTED WITH EACH QUARTERLY FILING!

Rule #4—YOU MUST PUT THE TAX RETURN FORMS IN THE REQUIRED ORDER!

Rule #5—YOU MUST INCLUDE INDIVIDUAL PRODUCER ZERO TAX RETURNS WITH EACH QUARTERLY FILING!

Failure to comply with any of these rules will result in non-filer status for you and your agency. Your tax return will be sent back to you and the Surplus Lines Unit will have no record of receiving it. If it has to be returned, your resubmission will be subject to the penalties of a late filing. IF YOU HAVE ANY QUESTIONS PLEASE CALL ONE OF THE EXAMINERS AT THE SURPLUS LINES EXAMINING OFFICE! We are here to help you so feel free to call us at (609) 777-0498.

Completing the Tax Return

A complete New Jersey Surplus Lines Producer Quarterly Tax Return consists of the following forms:

1. SLPS-1-TAX (Tax Return and Certified Account By Surplus Lines Producer)
2. SLPS-2-FRA (Schedule Showing Fire premiums and Taxes Payable to New Jersey Firemen's Relief Association)
3. SLPS-3-TRS (Schedule to Support Tax Returns)
4. SLPS-4-GFS (Quarterly Surcharge Statement)

THESE FORMS MUST BE STAPLED TOGETHER OR OTHERWISE ATTACHED AND FILED IN THE ORDER LISTED ABOVE! For example, the form SLPS-1-TAX will **always** be the top form in the tax return filing, SLPS-2-FRA will **always** be the second, and so on.

Forms must be completed as necessary to support the Tax Return and Certified Account by the Surplus Lines Producer. For example, if a surplus lines producer does not place any Fire business, then that producer does not need to complete SLPS-2-FRA. It is important to note that no item line should be left blank. If there is an item that is not applicable, you must enter either "0" for a numeric entry, or "N/A" for an alpha entry. Always make sure that you check each form for any line items not completed. Additionally, return (negative) premiums should always be shown using parentheses, if not already provided. Also, all monetary figures must be reported to the cent, no rounding is permitted.

It is suggested that you use these instructions as a checklist until completely familiar with form requirements.

I. **SLPS-1-TAX (Tax Return and Certified Account By Surplus Lines Producer)**
—THIS FORM IS REQUIRED EVEN IF NO BUSINESS IS PRODUCED!

☐ Indicate the quarter and year of the tax return by circling the appropriate number to designate the calendar quarter and inserting the last 2 digits of the year as shown at the top of the form.

☐ Provide the name under which you do business on Line 1 of the form. This should be the **agency name** for an organization's tax return; **your name** (as it appears on your license) for an individual tax return.

☐ Print your assigned SLA number in the five boxes provided in the upper right corner of the form. Lead zeros **must** be printed in the boxes not used, i.e. SLA #003 would now be shown as 00003, SLA #125A would now be shown as 0125A. EVERY BOX MUST CONTAIN A CHARACTER!

☐ Provide the location of your principal place of business on Line 2 of the form. This address must be a New Jersey location and the Surplus Lines Examining Office should be able to contact you by phone and by mail at this address.

☐ Provide the phone number for the organization or a number where you may be contacted during the day on Line 3 of the form. For organizations, this phone number should be the number listed for the address given on Line 2.

☐ Provide the total **taxable** Fire premiums written for the quarter on Line 5 of the form. This should include 999 Fire, if any. On property policies, only the portion of the premium allocable to Fire should be included on this line. If no Fire premiums are written, then enter a "0" on this line.

☐ Multiply the total taxable Fire premiums entered on Line 5 by three percent (3%), and enter this amount on Line 6 of the form. Again, if no Fire premiums are written, enter a "0" on Line 6.

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- ☐ Provide the total **taxable** "All Other" premiums written for the quarter on Line 7 of the form. Simply stated, "All Other" premiums include any premiums that are not Fire premiums (e.g. Allied Lines and Casualty premiums are "All Other"). If no other "All Other" premiums are produced, then enter a "0" on Line 7.
- ☐ Multiply the total taxable "All Other" premiums entered on Line 7 by three percent (3%), and enter this amount on Line 8 of the form. Again, if no "All Other" premiums are written, enter a "0" on Line 8.
- ☐ Provide the total **non-taxable** Fire premiums written on Line 9 of the form. Total non-taxable Fire premiums DOES NOT INCLUDE 999 FIRE! Non-coded Fire premiums are included in taxable Fire premiums. If no non-taxable Fire premiums are written, then enter a "0" on Line 9.
- ☐ Provide the total **non-taxable** "All Other" premiums written on Line 10 of the form. If no non-taxable "All Other" premiums are written, then enter a "0" on Line 10.
- ☐ Add the total non-taxable Fire premiums entered on Line 9 to the total non-taxable "All Other" premiums entered on Line 10 and insert this amount on Line 11 of the form.
- ☐ Type or print your name and title, and sign and date the form on the lines provided at the bottom.
- ☐ Draw a check, made payable to the **"New Jersey Firemen's Relief Association** for the amount shown on Line 6 of the form. This check should be forwarded to the **New Jersey Firemen's Relief Association** (see section II—SLPS-2-FRA). Attach a **copy** of this check to your completed tax return that will be sent to the Surplus lines Examining Office as detailed under the "Introduction" section.
- ☐ Draw a second check, made payable to the **"Treasurer—State of New Jersey"**, for the amount shown on Line 8 of the form. This check will be attached to your completed tax return and sent to the Surplus Lines Examining Office as detailed in the "Introduction" section.

II. **SLPS-2-FRA (Schedule Showing Fire premiums and Taxes Payable to New Jersey Firemen's Relief Association)**

—THIS FORM IS NOT REQUIRED IF NO FIRE PREMIUMS ARE WRITTEN AND/OR NO BUSINESS IS PRODUCED!

- ☐ Print your assigned SLA number in the five boxes provided in the upper left corner of the form. Remember, lead zeros must be used, and all boxes must contain a digit or character.
- ☐ Indicate the quarter and year of the tax return by circling the appropriate number to designate the calendar year and inserting the last 2 digits of the year as shown under the SLA number.
- ☐ Provide the name under which you do business on the line provided. This should be the same as the name listed on Line 1 of SLA-1-TAX.
- ☐ Enter the page number and the total number of pages in the appropriate lines at the upper right corner of the form.
- ☐ Provide the three digit ISO code number for the municipality that corresponds with the location of the risk and enter it in the column marked "ISO Code". The ISO code can be found by using the list included with these instructions.
- ☐ Enter the municipality or appropriate fire district in the column marked "Location of Risk".
- ☐ Enter the zip code of the location in the column marked "Zip Code".
- ☐ Provide the Fire premium amount for the policy and enter it in the column marked "Premium". For property policies, include in this column only the portion of the premium allocable to Fire. YOU MUST USE PARENTHESES AROUND A NUMBER TO INDICATE A RETURN PREMIUM! **Do NOT use a minus (–) sign!** (e.g. use ($123.00) instead of –$123.00)
- ☐ Multiply the amount in the Premium column by three percent (3%) and enter this amount in the column marked "FRA Tax".
- ☐ Repeat the above steps each individual placement where Fire premiums are written. If you need additional space, use extra SLPS-2-FRA sheets and number them consecutively as necessary. Keep a cumulative total in the total boxes at the bottom right corner of the form.
- ☐ After verifying all entries, mail the completed form(s), along with a check made payable to the **"New Jersey Firemen's Relief Association"** for the amount of three percent (3%) of the total Fire premiums (as shown on Line 6 of SLPS-1-TAX), to the **New Jersey Firemen's Relief Association, 50 Evergreen Place, East Orange, NJ 07018.** Attach a **copy** of the form(s), together with a **photocopy** of your check, to the tax return that will be sent to the Surplus Lines Examining Office as detailed under the "Introduction" section.

III. **SLPS-3-TRS (Schedule to Support Tax Returns)**

—THIS FORM IS NOT REQUIRED IF NO BUSINESS IS PRODUCED!

- ☐ Print your assigned SLA number in the five boxes provided in the upper left corner of the form. Remember, lead zeros must be used, and all boxes must contain a digit or character.
- ☐ Indicate the quarter and year of the tax return by circling the appropriate number to designate the calendar quarter and inserting the last 2 digits of the year as shown under the SLA number.
- ☐ Provide the name under which you do business on the line provided. This should be the same as the name listed on Line 1 of SLA-1-TAX.
- ☐ Enter the page number and the total number of pages in the appropriate lines at the upper right corner of the form.
- ☐ Enter the transaction number assigned to the individual placement in the seven (7) boxes provided in Column 1 of the form. The first **two digits** of the transaction number indicate **the year** in which the placement occurred, i.e. if the placement occurred in the year 1993, then the first two digits of the transaction number would be "93". The remaining five digits of the transaction number represent a sequential number, assigned by you, indicating the order in which the placement occurred during the calendar year. For example, the first placement of the year would be numbered 00001, the second placement would be numbered 00002, and so on up to 99,999. EVERY BOX MUST CONTAIN A DIGIT! Remember to always use lead zeros when the sequential number is less than 5 digits. **The system will NOT accept alpha suffixes to transaction numbers.**
- ☐ Indicate the premium type code in Column 2 of the form. The premium type codes are "N" for new premiums; "A" for additional premiums; and "R" for return premiums. The new, additional, or return premiums must be listed on separate page(s). Do NOT put new, additional, or return premiums on the same page. YOU MUST USE A SEPARATE PAGE(S) FOR NEW, A SEPARATE PAGE(S) FOR ADDITIONAL, AND A SEPARATE PAGE(S) FOR RETURNS.
- ☐ Provide the name of the insured as shown on the policy in Column 3 of the form.
- ☐ Enter the policy number of the placement in the twenty (20) boxes provided in Column 4 of the form. Start with the first box on the left and use as many boxes as necessary. The policy number may be alpha-numeric. It is important to enter the policy number exactly as it appears on the policy, including spaces. YOU MUST LEAVE A BLANK BOX ON THE FORM TO INDICATE A SPACE BETWEEN CHARACTERS! Always be sure to check for any errors.
- ☐ Enter the effective dates of the placement in Column 5 of the form, using slashes between month, day, and year, which are 2 digits each.
- ☐ Indicate the insurance company issuing the policy by entering the corresponding NAIC or ISI number in the nine (9) boxes provided in Column 6 of the form. The NAIC number is five digits in length, and is used only by foreign insurance companies (those licensed in a U.S. jurisdiction). The ISI number (which is distinguished by its prefix, "AA") is nine characters in length, and is used only by alien (overseas) insurance companies. A list of each surplus lines insurer currently eligible in New Jersey and their respective NAIC/ISI number is included with these instructions. NOTE: When entering the five digit NAIC number, use only the required amount of boxes. That is, enter the five digits in the first five boxes and leave the remaining boxes blank.
- ☐ Provide the Fire premium amount, if any, and enter it in the column marked "Fire" under Column 7 of the form.
- ☐ Enter the "All Other" premium amount, if any, in the column marked "All Other" under Column 7 of the form.

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- ☐ If the premium is non-taxable, then enter a "Y" in the column marked "N/T". Otherwise, leave this column blank. As with new, additional, and return premiums, YOU MUST GROUP ALL NON-TAXABLE PREMIUMS ON A SEPARATE PAGE(S)!
- ☐ Repeat the above steps for each individual placement. If you need additional space, use extra SLPS-3-TRS sheets and number as necessary. Keep a cumulative total in the total boxes at the bottom right corner of the form.

IV. **SLPS-4-GFS (Quarterly Surcharge Statement)**

—THIS FORM IS REQUIRED EVEN IF NO BUSINESS IS PRODUCED!

- ☐ Indicate the quarter and year of the tax return by circling the appropriate number to designate the calendar quarter and inserting the last 2 digits of the year as shown at the top of the form.
- ☐ Print your assigned SLA number in the five boxes provided in the upper right corner of the form. Remember, lead zeros must be used, and all boxes must contain a digit or character.
- ☐ Provide the name under which you do business on the line provided. This should be the same as the name listed on Line 1 of SLA-1-TAX.
- ☐ Provide the location of your principal place of business on Lines 2 and 3 of the form. This address must be a New Jersey location and the Surplus Lines Examining Office should be able to contact you by phone or by mail at this address. Do not forget the zip code.
- ☐ Provide the phone number for the organization or a number where you may be contacted during the day on Line 4 of the form. For organizations, this phone number should be the number listed for the address given on Line 2.
- ☐ Provide the amount of new premiums written during the quarter on Line 5 of the form.
- ☐ Provide the amount of additional premiums written during the quarter on Line 6 of the form.
- ☐ Provide the amount of return premiums during the quarter on Line 7 of the form.
- ☐ Take the total of Line 5 plus Line 6 minus Line 7 and enter the result on Line 8 of the form.
- ☐ Compute the amount of surcharge due by multiplying the amount on Line 8 by four percent (4%) and enter this amount on Line 9 of the form.
- ☐ Provide the amount of interest received from your premium trust account deposits and enter it on Line 10 of this form.
- ☐ Total the dollar amount of the surcharges shown on Line 9 and the interest earned thereon from Line 10 and enter the total on Line 11 of the form.
- ☐ Provide the trust account number and the name and address of the financial institution in which it is established.
- ☐ Type or print your name, and sign and date the form on the lines provided at the bottom.
- ☐ Mail the completed form, along with a check made payable to the **"New Jersey Surplus Lines Insurance Guaranty Fund"** for the amount shown on Line 11, to the **New Jersey Surplus Lines Insurance Guaranty Fund, P.O. Box 463, Chatham, NJ 07928.** Attach a **copy** of the form, together with a **photocopy** of your check, to the tax return that will be sent to the Surplus Lines Examining Office as detailed under the "Introduction" section.

Procedures for Filing the Tax Return

The four (4) forms with required copies, completed and attached together in the correct order, comprise a complete tax return filing. The tax return filing is to be filed with the Surplus Lines Examining Office within thirty (30) days of the close of the calendar quarter. Therefore, they must be mailed **on** or **before** April 30, July 31, October 31, and January 31 for the first, second, third, or fourth calendar quarters, respectively.

Individual producer zero tax returns (i.e. no placements by that licensee) must accompany all quarterly surplus lines tax return filings and they must be filed for each surplus lines licensee of the organization. The zero tax return is made up of two (2) forms: SLPS-1-TAX, and SLPS-4-GFS. **These forms must be filled out completely, and all lines requiring a monetary entry must contain a zero ("0").** DO NOT FORGET TO FILE YOUR INDIVIDUAL PRODUCER ZERO TAX RETURNS ALONG WITH YOUR ORGANIZATIONAL PRODUCER SURPLUS LINES TAX RETURN! However, while the individual producer zero tax returns may accompany the organizational producer tax return in the same envelope, they SHOULD NOT be stapled or otherwise attached to the organizational producer tax return. Additionally, if your organization does not produce any business in a calendar quarter, you must also file an organizational producer zero tax return.

If you have any questions on the instructions, or any questions pertaining to surplus lines, then you are encouraged to call the Surplus Lines Examining Office and/or any of the examiners at (609) 777-0498.

Thank you for taking the time to read these instructions and completing the forms accurately.

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MAIL TO:

NEW JERSEY DEPARTMENT OF INSURANCE SURPLUS LINES EXAMINING OFFICE
CN 325, Trenton, NJ 08625

TAX RETURN AND CERTIFIED ACCOUNT BY SURPLUS LINES PRODUCER

For the 1 2 3 4 Quarter, 19_____
(circle one)

To the Commissioner of Insurance of New Jersey: SLA # [ ][ ][ ][ ][ ]

1. Name of Surplus Lines Producer _____

2. I have a bona fide office in this State in which is kept a record of contracts of insurance countersigned or issued by me located at:

_____
(Street Address) (City or Town) (State) (Zip Code)

3. Telephone # (____) _____ - _____
(area code)

4. Pursuant to *N.J.S.A.* 17:22-6.58, there is submitted on the accompanying pages a verified report, in duplicate, of the surplus lines insurance transacted during the quarter circled above, a summary of which follows:

TAXABLE NET PREMIUMS:

5. Total Taxable Fire Premiums $ _____.____

6. Amount Payable to "New Jersey Firemen's Relief Association" (3% of Line 5) $ _____.____

7. Total Taxable All Other Premiums $ _____.____

8. Amount Payable to the "State of New Jersey" (3% of Line 7) $ _____.____

NON-TAXABLE NET PREMIUMS
(Insurance of risks of state, county, or municipal government or agency thereof)

9. Total Non-Taxable Fire Premiums $ _____.____

10. Total Non-Taxable All Other Premiums $ _____.____

11. Total Non-Taxable Net Premiums (Add Line 9 and Line 10) $ _____.____

I declare under penalties of perjury that I have examined this statement including the schedules and statements attached thereto, if any and to the best of my knowledge and belief the matters and information set forth therein are true, correct, and complete. I further certify that I am authorized to sign for the producer identified on Line 1 above.

_____
Signature of Surplus Lines Producer

_____ _____
Date Name and Title
(Print or Type)

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SCHEDULE SHOWING FIRE PREMIUMS AND TAXES PAYABLE

MAIL TO:
NEW JERSEY FIREMEN'S RELIEF ASSOCIATION
50 Evergreen Place, East Orange, NJ 07018

SLA # | | | | | |

1 2 3 4 Quarter, 19 _____
(circle one)

Producer Name _____ Page ____ of ____

ISO Code	Location of Risk (Municipality or Fire District)	Zip Code	Premium	FRA Tax
			$	$
		Totals	$	$

SLPS-2-FRA 1/93

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SLA # ☐☐☐☐☐

SCHEDULE TO SUPPORT TAX RETURNS

Page ____ of ____

1 2 3 4 Quarter, 19 _____
(circle one)

Producer Name _____

(1) Transaction Number	(2) Code	(3) Name of Insured	(4) Policy Number	(5) Term From	(5) Term To	(6) NAIC/ISI #	(7) Premiums Fire	(7) Premiums All Other	(8) N/T
-							$	$	
-									
-									
-									
-									
-									
-									
-									
-									
-									
-									
-									
						Cumulative Totals	$	$	

SLPS-3-TRS 1/93

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MAIL TO:

NEW JERSEY SURPLUS LINES INSURANCE GUARANTY ASSOCIATION
P.O. Box 463, Chatham, New Jersey 07928

QUARTERLY SURCHARGE STATEMENT

For the 1 2 3 4 Quarter, 19____
(circle one)

SLA # | | | | | |

1. Name of Surplus Lines Producer: _____
2. Street Address: _____
3. City, State: _____ Zip Code _____
4. Telephone #: (____) _____ - _____
   (area code)
5. New Jersey new premiums written during quarter $ _____.
6. New Jersey additional premiums written during quarter (+) $ _____.
7. New Jersey return premiums written during quarter (–) $(_____.)
8. Total New Jersey Net Premiums (Line 5) + (Line 6) – (Line 7) $ _____.
9. Surcharge amount due (4% of Line 8) $ _____.
10. Interest received on deposits* $ _____.
11. Total surcharges and interest due (Line 9) + (Line 10) $ _____.

— Remit amount on Line 11 payable to "NJ Surplus lines Insurance Guaranty Fund".

— Send check with copy of this statement to the Association at P.O. Box 463, Chatham, New Jersey 07928.

— An additional copy of this statement, together with a photocopy of your check, should be attached to your Quarterly Premium Tax Return that is mailed to the Surplus Lines Examining Office.

*Trust Account # _____ is established at the following financial institution:

Name: _____

Address: _____

CERTIFICATION

I declare under penalties of perjury that I have examined this statement including the schedules and statements attached thereto, if any, and to the best of my knowledge and belief the matters and information set forth therein are true, correct, and complete. I further certify that I am authorized to sign for the producer identified on Line 1 above.

_____
Signature of Surplus Lines Producer

_____ _____
Date Name and Title
(Print or Type)

SLPF-4-GFS 1/93

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LABOR

(a)

DIVISION OF PROGRAMS

1993 Maximum Weekly Benefit Rates
1993 Taxable Wage Base Under the Unemployment Compensation Law
1993 Contribution Rate of Governmental Entities and Instrumentalities
1993 Base Week
1993 Alternative Earnings Test
Proposed Amendments: N.J.A.C. 12:15-1.3, 1.4, 1.5, 1.6 and 1.7

Authorized By: Raymond L. Bramucci, Commissioner, Department of Labor.

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.

Proposal Number: PRN 1992-397.

Submit written comments by October 8, 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

The proposed amendment to N.J.A.C. 12:15-1.3 establishes the 1993 maximum weekly benefit rate for benefits under the Unemployment Compensation Law and for State Plan benefits under the Temporary Disability Benefits Law.

The proposed amendment to N.J.A.C. 12:15-1.4 establishes the 1993 taxable wage base for the purpose of contributions under the Unemployment Compensation Law in accordance with N.J.S.A. 43:21-7(b)(3).

The proposed amendment to N.J.A.C. 12:15-1.5 establishes the 1993 contribution rate for governmental entities that elect to pay contributions under the Unemployment Compensation Law.

The proposed amendment to N.J.A.C. 12:15-1.6 raises the amount of earnings required in 1993 to establish a base week for an individual's claim for unemployment compensation and State Plan temporary disability benefits.

Finally, the proposed amendment to N.J.A.C. 12:15-1.7 raises the amount of base year earnings required to establish an individual's eligibility for unemployment compensation and State Plan temporary disability benefits in those instances in which the individual has not established 20 base weeks.

Social Impact

The proposed amendment to N.J.A.C. 12:15-1.3 will ensure that payments to unemployment and disability insurance recipients entitled to maximum benefits will increase in line with the upward trend of wages in the State's economy, thus preserving the real purchasing power of their benefits.

The proposed amendment to N.J.A.C. 12:15-1.4 will generate increased revenues for the Unemployment Insurance and Disability Insurance Trust Funds needed to offset the increased level of benefits for these programs, which are statutorily indexed to the upward trend of wages in the State's economy.

The proposed amendment to N.J.A.C. 12:15-1.5 will maintain the contribution rate for governmental entities that elect to pay contributions under the Unemployment Compensation Law and will have no social impact on the public.

The proposed amendments to N.J.A.C. 12:15-1.6 and 12:15-1.7 provide for the base week amount and the amount of earnings to establish eligibility, respectively, to be indexed to wage increases as benefit payments have been indexed since 1969. Some claimants who work temporarily or intermittently may not qualify for benefits under these eligibility standards.

Economic Impact

The proposed amendment to N.J.A.C. 12:15-1.3 will increase the weekly benefit rates received by individuals eligible for the maximum weekly benefit rate under the Unemployment Compensation Law and under the Temporary Disability Benefits Law beginning January 1, 1993, in compliance with statutory provisions which automatically adjust these benefit rates each year in accordance with changes in the Statewide average weekly wage. The maximum weekly benefit for Unemployment Compensation is computed as 56 2/3 percent of the Statewide average weekly wage in the second preceding calendar year. As of January 1, 1993, the maximum weekly benefit will increase from $308.00 to $325.00.

The maximum weekly benefit for State Plan Temporary Disability is computed as 53 percent of the Statewide average weekly wage in the second preceding calendar year. As of January 1, 1993, the maximum weekly benefit will increase from $288.00 to $304.00.

The proposed amendment to N.J.A.C. 12:15-1.4 will increase from $15,300 to $16,100 the wages of an individual employee of an employer that are subject to employer and worker contributions under the Unemployment Compensation Law, beginning January 1, 1993. The taxable wage base is computed as 28 times the Statewide average weekly wage in the second preceding calendar year.

The proposed amendment to N.J.A.C. 12:15-1.5, which will maintain the contribution rate for governmental entities at 0.4 percent of taxable wages for 1993, will result in no increase in costs to State and local government units that choose this financing option, provided that all other factors that might influence the level of contributions remain the same.

The proposed amendment to N.J.A.C. 12:15-1.6 will increase the amount an individual must earn to establish a base week under the Unemployment Compensation and Temporary Disability Benefits Laws. The amount is computed as 20 percent of the Statewide average weekly wage in the second preceding calendar year and will increase from $110.00 to $115.00 for benefit years and periods of disability commencing January 1, 1993.

The proposed amendment to N.J.A.C. 12:15-1.7 increases the alternative earnings eligibility standard under the law in those situations where the individual has not established 20 base weeks in the base year period. The amount will increase from $6,600 to $6,900 in 1993. The alternative earnings test is indexed each year at 12 times the Statewide average weekly wage in the second preceding calendar year.

The Department does not expect to experience any economic impact as a result of the proposed amendments.

Regulatory Flexibility Statement

The proposed amendments do not impose any reporting, recordkeeping or compliance requirements on small businesses as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed amendments affect benefit and contribution levels under the Unemployment Compensation and Temporary Disability Benefits Laws. Thus, a regulatory flexibility analysis is not required.

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

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 [$308.00] **$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 [$288.00] **$304.00** per week.

(c) These maximum benefits shall be effective for the calendar year [1992] **1993** on benefit years and periods of disability commencing on or after January 1, [1992] **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 [$15,300] **$16,100** during the calendar year [1992] **1993**.

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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 [1992] **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 [$110.00] **$115.00** per week for benefit years and periods of disability commencing on or after January 1, [1992] **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 [$6,600] **$6,900** for benefit years and periods of disability commencing on or after January 1, [1992] **1993**.

(a)

DIVISION OF WORKERS' COMPENSATION

1993 Maximum Workers' Compensation Benefit Rates

Proposed Amendment: N.J.A.C. 12:235-1.6

Authorized By: Raymond L. Bramucci, Commissioner, Department of Labor.

Authority: N.J.S.A. 34:1-5, 34:1-20, 34:1A-3(e) and 34:15-12a.

Proposal Number: PRN 1992-398.

Submit written comments by October 8, 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

The proposed amendment establishes the 1993 maximum workers' compensation benefit rates for temporary disability, permanent total disability, permanent partial disability, and dependency.

Social Impact

The proposed amendment will ensure that payments to workers' compensation recipients entitled to maximum benefits will increase in line with the upward trend of wages in the State's economy, thus preserving the real purchasing power of their benefits.

Economic Impact

The proposed amendment will increase from $409.00 to $431.00 the weekly benefit rate received by individuals eligible for the maximum weekly benefit rate for temporary disability, permanent total disability, permanent partial disability, and dependency under the Workers' Compensation Law.

The effect of this change will be to raise the employer's workers' compensation insurance costs, provided that all other factors that might influence workers' compensation insurance costs remain the same.

The Department does not expect to experience any economic impact as a result of the proposed amendment.

Regulatory Flexibility Statement

The proposed amendment does not impose any reporting, recordkeeping or compliance requirements on small businesses as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The amendment increases benefit rates to individuals. Thus, a regulatory flexibility analysis is not required.

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

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 [$409.00] **$431.00** per week.

(b) This maximum compensation shall be effective as to injuries occurring in the calendar year [1992] **1993**.

(b)

DIVISION OF WORKPLACE STANDARDS

Notice of Extension of Comment Period

Prevailing Wages for Public Works

Proposed Amendments: N.J.A.C. 12:60-3.2 and 4.2

Take notice that the Commissioner of the New Jersey Department of Labor is extending until October 2, 1992 the period for public comment on the proposed amendments to N.J.A.C. 12:60-3.2 and 4.2 which were published in the August 3, 1992 New Jersey Register at 24 N.J.R. 2689(a).

The Department received a request for an extension of time in which to submit written comments regarding the proposed amendments to the rules on prevailing wages for public works. To insure that interested persons are able to submit comments, the Department is hereby notifying the public that the comment period will be extended for 30 days.

Please submit written comments by October 2, 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

LAW AND PUBLIC SAFETY

(c)

MOTOR VEHICLE FRANCHISE COMMITTEE

Procedural Rules

Hearing Costs; Deposit; Sanctions

Proposed New Rule: N.J.A.C. 13:21-19.9

Authorized By: Motor Vehicle Franchise Committee, Stratton C. Lee, Jr., Chairman.

Authority: N.J.S.A. 56:10-25.

Proposal Number: PRN 1992-380.

Submit written comments by October 8, 1992 to:

Stratton C. Lee, Jr., Chairman
Motor Vehicle Franchise Committee
Attention: Legal Services Office
25 So. Montgomery Street
CN 162
Trenton, New Jersey 08666

Summary

The proposed new rule supplements the Motor Vehicle Franchise Committee's procedural rules. The proposed new rule requires that each party deposit $1,500 with the Chairman in advance to cover the costs associated with the administrative hearings conducted at the Office of Administrative Law in motor vehicle franchise cases. The new rule is intended to carry out the statutory provision regarding administrative hearing costs.

N.J.S.A. 56:10-24 provides in pertinent part as follows:

"The committee shall assess and equally apportion among the parties to the hearing, and shall transfer to the Office of Administrative Law, the administrative hearing costs resulting from a protest filed pursuant to this act ..."

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The current practice of the Motor Vehicle Franchise Committee is to bill parties after the administrative hearing has been concluded at the Office of Administrative Law. The bills are predicated upon the Office of Administrative Law's statements of billing which are filed with the Committee on a periodic basis. This method of collection has proved ineffectual. Billing records indicate that the Committee has collected only $5,946.62 of the $15,228 billed for administrative hearings conducted in 1990. Parties, for the most part, are not paying their portion of the hearing costs as required in N.J.S.A. 56:10-24. The proposed new rule requires that each party (that is, franchisor, franchisee(s) and proposed franchisee) deposit $1,500 with the Chairman at the time of filing of a protest letter, a responsive pleading or a motion for leave to intervene. The rule also provides for the return to the parties of that portion of the deposit that exceeds the apportioned hearing costs determined by the Office of Administrative Law. The rule further provides for the proportional payment by the parties of the balance of hearing costs when said costs determined by the Office of Administrative Law exceed the amounts on deposit with the Chairman. The rule provides for the imposition of sanctions, including the dismissal or affirmation of a protest, against parties who fail to comply with the deposit requirements of the new rule.

Social Impact

The proposed new rule implements the public policy of this State as set forth in N.J.S.A. 56:10-24 that parties to motor vehicle franchise hearings, rather than the general public, be responsible for the costs of such hearings.

Economic Impact

The proposed new rule has a beneficial economic impact on the State in that parties to the hearing, rather than the general public, will bear the hearing costs associated with administrative hearings conducted under the Motor Vehicle Franchise Act. It is anticipated that the rule will result in the recovery of a greater portion of the hearing costs that are attributed by statute to the parties.

Regulatory Flexibility Analysis

The proposed new rule has been reviewed with regard to the Regulatory Flexibility Act, N.J.S.A. 52:14B-14 et seq. The rule imposes no reporting or recordkeeping requirements on entities which are small businesses as defined by the Act. The rule does, however, impose compliance requirements on motor vehicle franchisees and franchisors, some of which are small businesses as defined in the Act. The compliance requirement is that a motor vehicle franchisee and franchisor deposit monies with the Motor Vehicle Franchise Committee to satisfy in whole or in part the administrative hearing costs imposed on such entities by statute.

The rule does not require small businesses to engage additional professional services. Other than the monetary deposit which is to be filed with the Chairman, the rule does not necessitate any capital or annual expenditures for compliance by small businesses. The compliance requirements are intended to carry out the statutory provision regarding administrative hearing costs which, by statute, must be paid by parties to such hearings. It is for this reason that no differentiation in compliance, based on business size, is provided.

Full text of the proposed new rule follows:

13:21-19.9 Hearing costs; deposit; sanctions

(a) Administrative hearing costs shall be equally apportioned among all parties to the hearing, including intervenors. Each party shall deposit with the Committee $1,500 to cover the costs of the hearing. The party making the deposit shall give notice thereof to all other parties. The deposit shall be paid to the Chairman at the time of the filing with the Committee of a protest letter or a responsive pleading or, in the case of an intervenor, with the filing of a motion for leave to intervene pursuant to N.J.A.C. 1:1-16. The deposit shall be made by certified check or money order payable to the Motor Vehicle Franchise Committee.

(b) That portion of the money on deposit that exceeds the total hearing costs as determined by the Office of Administrative Law pursuant to N.J.S.A. 56:10-24 shall be returned to the parties. The parties shall pay to the Committee their portion of the balance of the total hearing costs as determined by the Office of Administrative Law pursuant to N.J.S.A. 56:10-24 when said hearing costs exceed the amount on deposit with the Chairman. If the Office of Administrative Law determines during the course of the hearing that the costs of the hearing will exceed the amount on deposit with the Committee, the parties shall be required, on notice, to deposit with the Committee additional monies to cover the costs of completing the hearing.

(c) If a party fails to deposit monies as required in (a) or (b) above, the Committee may decline to transmit the case and make such orders in regards to the failure as are just, including the following:

1. An order dismissing the party's protest; or
2. An order striking the party's responsive pleading and affirming the adverse party's protest.

(a)

STATE BOARD OF MORTUARY SCIENCE

Advertising; Referral Fees

Proposed Amendment: N.J.A.C. 13:36-5.12
Proposed New Rule: N.J.A.C. 13:36-5.20

Authorized By: State Board of Mortuary Science, Michael A. Petrolle, President.

Authority: N.J.S.A. 45:7-37 and 38.

Proposal Number: PRN 1992-349.

Submit written comments by October 8, 1992 to:
Maurice McQuade, Executive Director
State Board of Mortuary Science
P.O. Box 45009
Newark, New Jersey 07101

The agency proposal follows:

Summary

The Board of Mortuary Science is proposing to amend several provisions of its advertising rule in order to clarify and supplement existing regulatory standards. The amendment seeks to allow new forms of advertising and to provide licensees with appropriate standards to make information concerning their services available to the public while at the same time assuring the clear flow of information to the public and preventing deceptive and misleading practices.

The changes proposed involve permitting the use of testimonials provided that such testimonials are based upon personal knowledge or experience obtained from a provider relationship or direct personal knowledge of the subject matter. Both lay and expert testimonials are contemplated with the responsibility of an advertiser to be able to substantiate any objective, verifiable statements of fact. The failure to do so may be found by the Board to be occupational misconduct. The Board's current required disclosure in any advertising where the name of a person not licensed by the Board is disclosed is continued. N.J.A.C. 13:36-5.12(d)1 and 2.

Claims of professional superiority or superior quality of services or merchandise will be permitted where the licensee is able to substantiate any such claim. Such substantiation may be demanded by the Board in the event of any investigative inquiry made concerning such a claim.

Proposed new rule N.J.A.C. 13:36-5.20 also prohibits a licensee from paying or receiving any fee or other form of compensation for the referral of a purchaser of goods or services. It is also made clear that this prohibition does not prohibit the division of fees among licensees engaged in bona fide employment or other associational relationships.

Social Impact

The proposed amendment would permit the communication of information to consumers in a new format while at the same time protecting against deceptive and misleading statements. As such, additional information is provided to the consumer in order to allow for improved decisionmaking in the selection of the providers of funeral services. By prohibiting the payment of referral fees, the choice by consumers of a funeral director or mortuary establishment will be made on the basis of factors such as business reputation for quality services and merchandise, the courtesy exhibited by the licensee and other factors directly relating to the rendering of funeral 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 funeral services to the benefit

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of consumers by removing a financial element which is unrelated to the quality of services or merchandise supplied by the licensees. The Board's law enforcement authority is strengthened by substantiation requirements and by a clearer statement of the regulatory guidelines applicable to advertising and other related activity.

Economic Impact

The proposed amendment should have no adverse economic impact upon either the public, individual licensees or licensees as a class. The Board will not sustain any additional expenditures as a result of the new standards. 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 informal 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 amendment cannot be measured, the changes will clearly tend to enhance competition to the benefit of consumers and econmically efficient licensees.

Regulatory Flexibility Analysis

The proposed amendment and new rule will apply to all of the Board's approximately 2,030 licensees regardless of the size of their individual operation. The amendment and new rule establish standards for advertising practices and prohibits the payment of referral fees, respectively, thus assuring that referrals are made on the quality of services and merchandise provided rather than the amount of money being paid by an individual licensee. The amendment and new rule involve no capital cost or reporting requirements, and no professional services are contemplated as necessary for a licensee to comply with the requirements. Since the intent of the amendment and new rule is to provide both a more specific standard in certain areas of advertising and to allow for the 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. Similarly, since the economic impact of the amendment and new rule, if any, upon licensees is minimal, and the need for uniformity of the standard in its operation on the licensee class is apparent, 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]):

13:36-5.12 Advertising

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

(d) In addition, it shall be deceptive and misleading for any advertisement to contain the following:

[1. The name of a person not licensed by the Board in connection with the name of a mortuary in any manner whatsoever, unless the unlicensed person is clearly and obviously identified in the advertisement as such by the use of the phrase "unlicensed and not qualified to make funeral arrangements, embalm or conduct funerals". The surname of an unlicensed person may appear in the title of a mortuary as registered with the Board.]

Recodify existing 2.-5. as **1.-4.** (No change in text.)

[6.]**5.** A claim of professional superiority or superior quality of services or merchandise, unless such claim can be [documented] **substantiated** by the licensee upon demand by the Board.

[7.]**6.** Intimidation, undue pressure or undue influence.

[8. Testimonials.]

(e) 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 beyond the testimonial giver's competence to comment upon. 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 occupational misconduct.

1. The name of a person not licensed by the Board when appearing in any testimonial for a mortuary shall be accompanied by the following: "unlicensed and not qualified to make funeral arrangements, embalm or conduct a funeral". The surname of an unlicensed person may appear in the title of a mortuary as registered with the Board.

Recodify existing (e)-(h) as **(f)-(i)** (No change in text.)

13:36-5.20 Referral fees

It shall be occupational misconduct for a licensee to pay, offer to pay, or to receive from any person any fee or other form of compensation for the referral of a 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 occupational services.

(a)

STATE BOARD OF VETERINARY MEDICAL EXAMINERS

Advertising; Endorsements; Referral Fees

Proposed Amendment: N.J.A.C. 13:44-2.11

Proposed Repeal: N.J.A.C. 13:44-2.7

Proposed Repeal and New Rule: N.J.A.C. 13:44-2.5

Authorized By: State Board of Veterinary Medical Examiners, George Cameron, President.

Authority: N.J.S.A. 45:16-3.

Proposal Number: PRN 1992-350.

Submit written comments by October 8, 1992 to:
Maurice McQuade, Executive Director
State Board of Veterinary Medical Examiners
P.O. Box 45020
Newark, New Jersey 07101

The agency proposal follows:

Summary

The Board of Veterinary Medical Examiners is proposing to amend its advertising rules in order to clarify and supplement the existing regulatory standards. In the course of reviewing the current rules, it became apparent that certain changes were desirable in order to remove unnecessary limitations and to provide consumers with valuable new information in order to allow for proper decision making in the selection and purchase of veterinary medical services.

The proposed amendments to N.J.A.C. 13:44-2.11 will permit the use of lay or expert testimonials provided that such testimonials are based upon personal knowledge or experience obtained from a provider relationship with a licensee or that direct personal knowledge of the subject matter is possessed. Safeguards are included to assure that expert testimonials are rendered only by individuals possessing the requisite expertise and knowledge to render such statements, and any advertiser using this format may be required to substantiate any objective, verifiable statement of fact. The failure to do so may be deemed professional misconduct by the Board. N.J.A.C. 13:44-2.11(c). The amendments permit the advertising of all professional veterinary services rather than ones which are merely "routine" which is the standard embodied in the current rules. The amendments continue and clarify existing limitations on claims relating to specialization. As such, claims of specialization may not be made unless the licensee is a specialist in an area where Board certification exists and that certification is possessed by the licensee. Where certification in a particular area of claimed expertise does not exist, the use of the term "specialist" or its substantial equivalent may not be used. Licensees are, however, permitted to make statements, of a truthful, non-deceptive nature concerning their experience or training in a particular area of veterinary practice (N.J.A.C. 13:44-2.11(c)). The amendments further clarify existing substantiation requirements to make the same applicable to objective material claims or representations set forth in advertisements. N.J.A.C. 13:44-2.11(d).

The Board's current rule N.J.A.C. 13:44-2.7 prohibiting licensee endorsements of products directly or by implication in any medium of mass communication is repealed as being unduly limiting and unnecessary.

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Finally, the proposed new rule at N.J.A.C. 13:44-2.5 clarifies the standard currently embodied within the Board's regulation prohibiting the payment of referral fees. As such, the rule makes it professional misconduct for a licensee to pay or to receive from any person any fee or other compensation for the referral of a patient. At the same time, the rule clarifies the current Board policy that this prohibition does not in any way prohibit the division of fees among licensees engaged in bona fide employment or other practice relationships.

Social Impact

The proposed amendment will provide licensees with a clearer framework in which to formulate and place advertising of their services to the public. As such it will also benefit consumers by improving the quality and expanding the availability of information in advertising so as to better enable the consumer to make an informed choice from among those offering veterinary services. By prohibiting the payment of referral fees, the choice by consumers of a veterinarian will be made on the basis of factors such as professional reputation, quality services and merchandise, the courtesy exhibited by the licensee and other factors directly relating to the rendering of veterinary 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 veterinary services to the benefit of consumers by removing a financial element which is unrelated to the quality of services or merchandise supplied by the licensee. The repeal of the current prohibition against a licensee's endorsement of any product in mass communication will also allow additional truthful information implicating specialized veterinary knowledge to flow into the marketplace to the benefit of informed consumer decision making.

Economic Impact

The proposed amendments, repeal and new rule will have a very limited economic impact upon licensees since the primary cost of compliance (maintaining copies of advertisements) will be nominal. No adverse economic impact on the Board is contemplated. By permitting truthful, non-deceptive claims of specialization, experience and training, licensees, through more effective advertising and the communication of important information to consumers, may experience a positive economic impact in the form of practice expansion and increased fees attributable to an enhanced competitive position. Correspondingly, better informed decision making will tend to convey positive economic benefits to consumers. Similarly, by removing the current ban on licensee endorsements, licensees may tend to experience positive economic benefits in the form of increased fees for such endorsements with the purchasers of said endorsement experiencing a corresponding detrimental impact. Such fees may also tend to increase prices for the products or services endorsed albeit in a relatively insignificant and currently unmeasurable amount.

To the extent that referral fees may have been paid, the recipients thereof will suffer a negative economic impact as a result of the further clarification of the prohibition. 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 fee reductions for goods and services provided to the public.

Regulatory Flexibility Analysis

If, for the purposes of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., veterinary medical practitioners are deemed "small businesses" within the meaning of the statute, the following statement is applicable. The proposed new rule and amendment will apply to the approximately 2,079 licensed veterinarians in the State, regardless of the size of their individual practice. These practitioners, by and large, practice individually or in small practice settings. The new rule and amendment do not involve reporting requirements or regular submissions to the Board. A recordkeeping requirement to maintain advertisements for three years is imposed, but will impose minimal costs upon the licensee. The maintenance of verifying data to support claims made which are in need of verification or substantiation on Board demand operates uniformly on all licensees and any nominal cost is outweighed by the utility of having records available in the event the Board needs to scrutinize the advertisement for compliance with N.J.A.C. 13:44-2.11. To the extent that expert testimonials may be utilized, the rule will require substantiation in the event of Board inquiry concerning the expertise of the individual giving the testimonial. The impact of these requirements is deemed to be minimal, especially when the correlative need on the part of the Board to protect the public from misleading statements is considered. Compliance requirements on licensees are reduced by the elimination of the endorsement prohibition at N.J.A.C. 13:44-2.7. The new rule on referral fees, N.J.S.A. 13:44-2.5, imposes no new requirements, but serves to clarify those already in effect. In view of the fact that the economic impact of the new rule and amendment, if any, is minimal, 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]):

13:44-2.5 Referral fees

[A licensee shall not pay a fee to obtain a patient nor accept a fee for the referral of a patient.] **It shall be professional misconduct for a licensee to pay, offer to pay, or to receive from any person any fee or other form of compensation for the referral of a patient. The prohibition in this section shall not prohibit the division of fees among licensees engaged in bona fide employment, partnership or corporate relationship for the delivery of professional services.**

13:44-2.7 [Product endorsements] **(Reserved)**

[No veterinarian shall endorse directly or by implication any product in any medium of mass communication.]

13:44-2.11 Advertising

(a)-(b) (No change.)

(c) A licensee who engages in the use of advertising which contains the following, shall be deemed to be engaged in professional misconduct:

1.-2. (No change.)

3. [Any statement or implication that the licensee is a specialist or possesses special training in a specialty including such phrases as "special interest in" or the actual use of a title such as cardiologist, dermatologist, etc., where the licensee does not possess board certification or special training in the area of practice named.] **Any statement or claim or implication arising therefrom that licensee is a specialist where Board certification in the claimed area exists and the licensee does not possess such certification. Where Board certification in an area of claimed expertise does not exist, the use of the term "specialist" or its substantial equivalent shall not be utilized provided, however, that nothing herein shall prohibit truthful and non-deceptive statements concerning a licensee's experience or training in a particular area of veterinary practice.**

4. (No change.)

5. [The use of any personal testimonial attesting to the professional competence of a service or treatment offered by a licensee.] **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 beyond the testimonial giver's competence to comment upon. 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.**

6.-8. (No change.)

(d) The board may require a licensee to substantiate the truthfulness of any [assertion] **objective material claim** or misrepresentation set forth in an advertisement. Failure of a licensee to provide factual substantiation to support that representation or [assertion] **claim** shall be deemed professional misconduct.

(e)-(j) (No change.)

(k) Copies of all printed advertisements and video or audio tapes of every advertisement communicated by electronics media shall be retained by the licensee and made available for review by the Board or its designee upon request for a period of three years. All advertisements in the licensee's possession shall indicate the accurate date and place of publication.

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(a)

DIVISION OF CONSUMER AFFAIRS

Per Diem Compensation for Members of Professional and Occupational Licensing Boards

Proposed Readoption with Amendments: N.J.A.C. 13:44B

Authorized By: Frederick DeVesa, Acting Attorney General, and Samuel Crane, State Treasurer.

Authority: N.J.S.A. 45:1-2.5.

Proposal Number: PRN 1992-401.

Submit written comments by October 8, 1992 to:
Emma N. Byrne, Director
Division of Consumer Affairs
Post Office Box 45027
Newark, New Jersey 07101

The agency proposal follows:

Summary

The Attorney General is proposing to readopt, with amendments, N.J.A.C. 13:44B, which is scheduled to expire on November 2, 1992 pursuant to Executive Order No. 66(1978). This chapter implements the provisions of N.J.S.A. 45:1-2.5 by establishing regulations regarding per diem compensation for members and officers of a professional board or commission designated in N.J.S.A. 45:1-2.1.

N.J.S.A. 45:1-2.5 authorizes a per diem rate of $25.00 or an amount to be determined by the Attorney General with the approval of the State Treasurer. Except for members of the Real Estate Commission and the Board of Medical Examiners, all of the designated board members have been compensated at the rate of $50.00 per diem since the adoption of this chapter effective May 3, 1982. Statutory amendments in 1985 and 1989 established an annual, rather than per diem, compensation rate for members of the Real Estate Commission and set the per diem rate for Medical Board members at $150.00.

N.J.A.C. 13:44B contains one subchapter entitled "Per Diem Payments." N.J.A.C. 13:44B-1.1 establishes the per diem rate of compensation. Amendments have been made to this section to include the statutory changes noted above. N.J.A.C. 13:44B-1.2 outlines the services for which a board member will be compensated, and N.J.A.C. 13:44B-1.3 lists services for which board members will not be compensated. These sections are proposed for readoption without change.

As amended, the rules continue to be reasonable, necessary and effective for the purposes for which they were promulgated. The per diem rate established in N.J.A.C. 13:44B-1.1 will continue to provide modest compensation for individuals who serve on New Jersey's professional boards, and N.J.A.C. 13:44B-1.2 and 1.3 will provide guidance to board members concerning services for which they may be compensated.

Social Impact

In setting per diem compensation rates and outlining compensable services, the rules proposed for readoption will have an advantageous impact on members of the 33 professional boards and advisory committees within the Division of Consumer Affairs. These professional board members provide invaluable services to the public by setting practice standards, evaluating applicants for licensure, investigating complaints and initiating appropriate disciplinary and endorsement actions, all of which help ensure professional competence and maintain high professional standards for the protection of the public health, safety and welfare.

Economic Impact

Readoption of this chapter, as amended, will have a favorable economic impact on members of the professional and occupational licensing boards designated in N.J.S.A. 45:1-2.1. With the exception of Medical Board members, whose current per diem rate is set by statute, board members will continue to receive $50.00 per diem for professional board work. If this chapter were not readopted, these board members would be compensated at the lower statutory rate.

There will be no economic impact upon the public or upon any State agency. Pursuant to N.J.S.A. 45:1-3.2, professional boards are required to be self-funding; that is, operating costs must be met through licensing and other fees. Accordingly, board member compensation will be absorbed by licensees of the regulated professions and occupations.

Regulatory Flexibility Statement

In accordance with the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., the Attorney General has determined that the rules proposed for readoption will not impose reporting, recordkeeping or other compliance requirements upon small businesses. The rules affect only individual members of professional and occupational licensing boards designated in N.J.S.A. 45:1-2.1.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 13:44B.

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

13:44B-1.1 Per diem rates for members and officers of a board or commission designated in N.J.S.A. 45:1-2.1

(a) [With respect to] **Except as set forth in (c) below,** each member and officer of a Board or commission designated in section 1 of P.L. 1971, c.60 (N.J.S.A. 45:1-2.1) [, the following per diem payment shall be made.] **shall be paid as follows:**

1. For a full day of services: $50.00;
2. For less than a full day of services: $25.00.

(b) For the purpose of (a) above, a full day of services shall constitute not less than five working hours. [Payments shall be made for services rendered on and after April 1, 1981.]

(c) The per diem payment schedule set forth in (a) above shall not apply to members of the New Jersey Real Estate Commission, who shall be paid pursuant to N.J.S.A. 45:15-6, or to members of the State Board of Medical Examiners, who shall be paid $150.00 for a full day of services and $75.00 for less than a full day of services.

(b)

DIVISION OF CONSUMER AFFAIRS
OFFICE OF CONSUMER PROTECTION

Toy and Bicycle Safety

Proposed New Rule: N.J.A.C. 13:45A-24

Authorized By: Emma N. Byrne, Director, Division of Consumer Affairs.

Authority: N.J.S.A. 52:17B-124.1, 56:8-52(b) and 39:4-14.7(a).

Proposal Number: PRN 1992-399.

Submit written comments by October 8, 1992 to:
Emma N. Byrne, Director
Division of Consumer Affairs
P.O. Box 45027
Newark, New Jersey 07101

The agency proposal follows:

Summary

In 1991, three Acts concerning toy and bicycle safety became law. The first, P.L. 1991, c.250, requires physicians to report toy-related injuries or deaths to the Division of Consumer Affairs. The information is then to be transmitted to the U.S. Consumer Product Safety Commission as well as made available to the public. The second law, P.L. 1991, c.295, mandates the posting of toy recall notices by toy retailers, for a period of no less than 120 days after receipt. The third new law is P.L. 1991, c.323, which requires bicycle dealers to ensure that a statement promoting the use of bicycle helmets is affixed to each bicycle sold. The Division of Consumer Affairs is instructed to promulgate rules implementing these laws. The public should also be aware of a fourth and related law, P.L. 1991, c.465, by which persons under the age of 14 are forbidden to operate a bicycle or ride as a passenger upon one, unless wearing a helmet that meets certain standards. The Director of the Division of Motor Vehicles is required to issue rules to effectuate the purposes of that Act.

The proposed new subchapter on toy and bicycle safety includes, after a purpose and scope section, N.J.A.C. 13:45A-24.2, which establishes the procedure for reporting toy-related injuries to the Division of Consumer Affairs, and the manner in which the information (without identification of physician or patient) will be disseminated. Failure of a physician or medical director of a health facility to report a toy-related injury to the

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Division will be referred to the State Board of Medical Examiners, or the State Board of Chiropractic Examiners, as applicable.

The next section, N.J.A.C. 13:45A-24.3, sets forth requirements for the posting by toy retailers of toy recall notices, which manufacturers, distributors, or dealers must send to the Director at the same time they inform the retailers. From those notices, as well as the findings of the U.S. Consumer Product Safety Commission, the Director will publish four times a year a summary of toys and articles, intended for use by children, that have been found to be defective or hazardous. If the Director believes an immediate public alert is warranted by the dangers of a particular item, the announcement will be made without delay.

In addition to posting the toy recall notices on the premises where the item was sold, the toy retailer must, under the proposed rules, place a five-by-eight inch sign near each cash register, informing customers where in the store the toy recall notices may be examined. Because many toy stores in New Jersey are immense, the Division believes this cash point sign is vital. Customers may have previously bought a toy that is now being recalled and, without these signs, a consumer in a giant toy retailer's premises (or even in a small store) might not be aware that toy recall notices have been posted. For the safety of children, the Division believes, in addition to independently publicizing certain recalls, it is urgent to inform toy-buyers who are at hand where such notices are to be found. The text and size of the simple signs are mandated in order to ensure clarity, uniformity and visibility.

Failue to comply with the requirements of N.J.A.C. 13:45A-24.3 will constitute a violation of the Consumer Fraud Act, N.J.S.A. 56:8-2 et seq.

Finally, N.J.A.C. 13:45A-24.4 details requirements for the tags or notices promoting the use of bicycle helmets that must, under the new law, be attached to each vehicle sold or, if it is sold unassembled, affixed to the carton. Either the card presently being distributed by the New Jersey Coalition for the Prevention of Developmental Disabilities (its address is supplied in the rule) or a notice designed by the bicycle supplier or retailer may be affixed, provided any alternative tag conforms to certain standards. A statement contained within other material, such as the bicycle manual, is insufficient.

Social Impact

Avoidance of injury to children is the first and most deeply-rooted concern of our society. This aim is clearly furthered by the quartet of new laws described above.

In specifying the manner in which toy-related injuries are to be reported by physicians and medical directors to the Division of Consumer Affairs (and thence to the U.S. Consumer Product Safety Commission), the rules set forth an orderly process that should ensure a timely, accurate, and well-documented record. The posting by toy retailers of toy recall notices is equally vital to child safety. Thus, rules are detailed in order to eliminate any confusion as to placement and visibility. The rules also require a small additional sign directing consumers to the location of the notices, which will be of special benefit to parents whose children may possess a recalled toy but who may not have noticed the recall announcements and may be unaware of the availability of such information. The final section of this proposed subchapter, relating to mandatory bicycle tags promoting the use of helmets, sets forth rules that insure the visibility of the tags and, for the convenience of retailers, also provides the address of the New Jersey Coalition for the Prevention of Developmental Disabilities. That organization distributes approved tags costing 10 cents each. Since a 1991 study in the Journal of the American Medical Association estimated that one life a day could be saved if all bicyclists in this country wore helmets, the positive social impact of this law and ensuing rules can be appreciated.

Economic Impact

The proposed new rules add little economic impact beyond that already created by the three toy and bicycle safety laws. The duty of physicians to report toy-related injuries and deaths initially involves a single phone call, to be followed by a written form mailed to the Office of Consumer Protection. Filling out the form will of course result in the expenditure of time by the physician or a designee. This economic impact is minimal, however, and cannot be avoided if the law is to work as intended. Written information is the only way to assure accuracy and efficiency in documenting the Division's reports to the U.S. Consumer Product Safety Commission and the public at large. The cumulative reports will thus become part of the national record and the ongoing effort to take dangerous or defective toys off the market.

Similarly, toy retailers will feel some slight economic impact caused by the time required to post any toy recall notices received, to keep a journal noting date of receipt, and to provide the additional small signs directing the consumer to the posting location. The expense of the signs is slight; they may even be hand-lettered, provided the mandatory wording is large and clear. However, persons who fail to comply with N.J.A.C. 13:45A-24.3 may be fined up to $7,500 under the Consumer Fraud Act.

As for the tags promoting the use of bicycle helmets, the proposed rules add little or no economic impact; they merely set forth standards to be met in the design of alternative tags if the retailer chooses not to use the approved Coalition notices. At 10 cents each, the Coalition's tags would cost a total of $10.00 for an in-store inventory of 100 bicycles.

Regulatory Flexibility Analysis

If, for the purposes of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., physicians are deemed "small businesses," the following statement is applicable. The number of medical doctors, osteopaths, and podiatrists presently licensed by the State Board of Medical Examiners is approximately 29,000, and the number of licensees of the State Board of Chiropractic is approximately 3,000. All of them are subject to the rules embodied in N.J.A.C. 13:45A-24. No capital costs or outside professional services are needed for compliance; as for the amount of recordkeeping, that will depend on customary internal procedures of the medical practice or health-related facility.

However, because the retail marketing of toys is so diverse, it is impossible to arrive at even an estimate of the number of other small businesses that will be affected by the proposed rules. Statewide, toy retailers undoubtedly number in the thousands, since toys are sold not only in chain stores and independent stores, but also in countless sweet shops, newspaper agencies, card shops, pharmacies, children's clothing stores, sporting goods emporia, etc. If these small businesses should receive a toy recall notice from a manufacturer, distributor, or dealer, the law mandates its display on the premises where it was sold. The only requirement added by the rules is a small sign at cash points, directing the consumer to the location of the notices that have been posted. The Division has attempted to minimize any burden on small businesses by not mandating that the sign be professionally printed; a required text is set forth, but it may be hand-lettered, if necessary, on a standard-size five-by-eight inch index card.

With regard to recordkeeping requirements, toy dealers, whether large or small, will have to maintain in each store a dated record of receipt of the toy recall notices. Because the law mandates that the recall notice be displayed for 120 days, this record both protects the retailer in case of inspections by the Office of Consumer Protection and makes the 120-day provision enforceable from a practical standpoint. The notices could be taped or thumbtacked to a wall, provided it is accessible and they are easily visible to the public.

The requirements for bicycle tags that promote the use of helmets do not involve recordkeeping or recording, and are mandated by the law itself.

The Division believes that no part of the proposed subchapter will have significant adverse economic impact upon small businesses since the rules in general merely set up orderly processes and uniform standards to make possible effective enforcement and to provide the public with cautionary information, as mandated by the new toy safety statutes. Consistent with the need to heighten public awareness and maximize notice of defective or hazardous toys, the compliance requirements in this proposal must be applicable to all physicians, medical directors, and toy retailers without differentiation as to the size of their enterprise.

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

SUBCHAPTER 24. [(RESERVED)] **TOY AND BICYCLE SAFETY**

13:45A-24.1 Purpose and scope

(a) The purpose of this subchapter is:

1. To implement P.L. 1991, c.250, by setting forth regulations for the reporting of toy-related deaths or injuries;

2. To implement P.L. 1991, c.295, by setting forth regulations for disseminating notice of defective or hazardous toys or other articles intended for use by children; and

3. To implement P.L. 1991, c.323, by setting forth regulations for a notice promoting the use of helmets to be affixed to bicycles sold at retail in the State of New Jersey.

(b) The sections of this subchapter shall apply as follows:

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1. N.J.A.C. 13:45A-24.2 applies to all physicians, defined for purposes of this section as Doctors of Medicine, Doctors of Osteopathy, and Doctors of Podiatric Medicine who are licensed by the State Board of Medical Examiners, and Doctors of Chiropractic who are licensed by the State Board of Chiropractic Examiners; and to the medical examiners of all licensed health-related facilities located within the State of New Jersey, such as hospitals, public health centers, emergency and other medical treatment centers, or the premises of health maintenance organizations if patients are seen or treated therein.

2. N.J.A.C. 13:45A-24.3 applies to manufacturers, importers, and distributors of toys or other articles intended for use by children, and to all dealers who offer to sell or sell such items to consumers in the State of New Jersey.

3. N.J.A.C. 13:45A-24.4 applies to all persons in the business of selling bicycles at retail in the State of New Jersey.

13:45A-24.2 Reporting of toy-related injuries

(a) As used in this section, the following words shall have the following meanings:

"Toy" means a plaything or item primarily intended for amusement or recreation, as well as any article that is designed for use by children, such as a stroller, crib, child-sized furniture, pacifier, teething ring, etc.

"Toy-related injury" means an injury to a person of any age caused or worsened by a toy as defined above; the term does not include an injury which involved a toy but was not directly caused by the toy or worsened by an apparent characteristic of the toy.

(b) Whenever a physician has before him or her a person whose injury or death the physician determines to be or reasonably suspects may be toy-related, the physician or designee shall, as soon as practicable but no later than the next business day, make a report as follows:

1. If the injured person was seen in a private office or non-institutional setting, the physician shall report the toy-related injury to:

Executive Director
Office of Consumer Protection
P.O. Box 45025
124 Halsey Street
Newark, New Jersey 07101
Tel: (201) 504-6257

2. If the injured person was seen in a licensed health-care facility or other medical treatment center, or on the premises of a health maintenance organization, the physician or designee shall promptly report the injury or death to the medical director of that organization.

3. The medical director shall transmit the information supplied pursuant to (b)2 above as soon as practicable but no later than the next business day to the Office of Consumer Protection at the address set forth in (b)1 above.

(c) The initial report to the Office of Consumer Protection shall be made by telephone during business hours (8:30 A.M. to 4:30 P.M. Monday through Friday); the physician or medical director, as applicable, shall then complete a written form provided by the Office of Consumer Protection and shall return it within seven days of receipt to the address set forth in (b)1 above.

(d) The Division Director shall maintain a record of the toy-related injuries or deaths reported by physicians and medical directors and shall:

1. Prepare a report which does not identify either the physician or patient involved;

2. Transmit the information on a regular basis to the U.S. Consumer Product Safety Commission; and

3. Make the report available monthly to the public, upon request to the Office of Consumer Protection at the address set forth in (b)1 above. The request shall include a check or money order, payable to "Division of Consumer Affairs," for the processing fee of $5.00. Cash will not be accepted.

(e) If upon review of such reports of injury or death, the Director determines that a specific toy may pose an immediate danger to the residents of this State, the Director shall issue a statement warning the public that such reports have been received.

(f) The Director may release the information identifying the physician and/or patient involved solely to an appropriate governmental organization for good cause shown.

(g) Failure by a physician or medical director to report a toy-related injury or death as set forth herein shall be referred by the Director to the attention of the State Board of Medical Examiners, or the State Board of Chiropractic Examiners, as applicable.

13:54A-24.3 Toy recall notices

(a) As used in this section, the following words shall have the following meanings:

"Dealer" means a person who sells at retail a toy or other article intended for use by children. A dealer who sells at wholesale such toy or article shall, with respect to that sale, be considered the "distributor" of that item.

"Director" means the Director of the Division of Consumer Affairs in the Department of Law and Public Safety.

"Distributor" means a person who sells at wholesale a toy or other article intended for use by children.

"Manufacturer" means a person who, under any name, manufactures or imports a toy or other article distributed in New Jersey. When the toy or other article is distributed or sold under a name other than that of the actual manufacturer of the toy or other article, the term "manufacturer" includes any person under whose name the toy or other article is distributed or sold.

(b) Any manufacturer, distributor or dealer who, pursuant to any law or any regulation of the U.S. Consumer Product Safety Commission, is required to give public notice or who voluntarily gives such notice, with regard to a defect or hazard in any toy or other article intended for use by children, shall at the same time notify the Director, in writing, at the following address:

Executive Director
Office of Consumer Protection
P.O. Box 45025
124 Halsey Street
Newark, New Jersey 07101
Tel. (201) 504-6257

(c) A dealer shall maintain a record of receipt of toy recall notices, including the date of receipt, and shall make it available upon request to a representative of the Office of Consumer Protection.

(d) A dealer who is notified by a manufacturer, a distributor, or the U.S. Consumer Product Safety Commission of a defective or hazardous toy or other article intended for use by children shall, if the dealer has carried or normally carries such item, prominently display that notification for at least 120 days after its receipt on each premises where the toy or article was sold or would normally be sold, as follows:

1. Each notification shall be displayed in a location that is readily accessible to the public, and placed so that it can be easily read by adult persons of average height and normal vision. No structures, furniture, boxes, merchandise, packaging material, etc., shall impede access to the location.

2. A sign constructed of cardboard, poster paper, or similarly durable substance, shall be placed in proximity to each cash register and shall contain the following wording in boldface capital letters printed in color that contrasts with the background:

WE HAVE POSTED NOTIFICATIONS OF TOYS OR OTHER ITEMS INTENDED FOR USE BY CHILDREN, WHICH ITEMS HAVE BEEN FOUND TO BE DEFECTIVE OR HAZARDOUS. PLEASE CHECK THESE NOTIFICATIONS! THEY ARE LOCATED AT [location]. IF WE CARRIED THESE ITEMS, WE HAVE REMOVED THEM FROM OUR SHELVES, BUT YOU MAY ALREADY HAVE ONE AT HOME. (YOU MAY ALSO BE ENTITLED TO A REFUND.)

The sign shall be easily visible and shall measure no less than five inches by eight inches.

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(d) The Director shall publish and disseminate to the public, at least quarter-annually, a summary of toys and other items intended for use by children, which items have been found to be defective or hazardous. The summary shall be drawn from findings of the U.S. Consumer Product Safety Commission and voluntary notices from manufacturers or distributors. In addition, the Director shall alert the public about particular toys or items, as warranted from time to time.

(e) Failure to comply with any requirement of this section shall be deemed a violation of the Consumer Fraud Act, N.J.S.A. 56:8-2 et seq.

13:45A-24.4 Bicycle safety notices

(a) A bicycle safety statement promoting the use of helmets shall be prominently affixed to every new or used bicycle offered to be sold or sold at retail by a person in the business of selling bicycles.

1. The statement shall be attached to the seat or handlebars of the bicycle or, if unassembled, firmly attached to the outside top of the box or carton containing the unassembled bicycle.

2. The statement may be in the form of the warning card, "This Bike Is Missing One Part," designed by the New Jersey Coalition for Prevention of Developmental Disabilities, available from:

The New Jersey Coalition for the Prevention of Developmental Disabilities
985 Livingston Avenue
North Brunswick, New Jersey 08902
Tel. (908) 246-2525

3. Alternatively, the statement promoting the use of bicycle helmets may be in the form of a tag or notice designed by the bicycle supplier or retailer, provided the wording is clear and concise, appears in no less than 20-point type and is printed in boldface capital letters, in color contrasting with the background. The tag or notice shall be made of cardboard or durable paper and shall be no smaller than four inches by six inches; it may be covered by transparent plastic but shall not be obscured.

4. A statement promoting the use of bicycle helmets that is incorporated in other material, such as an owner's manual, shall not satisfy the requirement.

(a)

DIVISION OF STATE POLICE

Licensing and Registration of Dealers and Manufacturers; Sale, Purchase, Acquisition and Transfer of Firearms by Dealers to Eligible Persons; Investigation of Applications and Qualifications for Permits to Carry Handguns; Security Systems

Proposed Amendment: N.J.A.C. 13:54-1.15

Authorized By: Colonel Justin J. Dintino, Superintendent, Division of State Police.

Authority: N.J.S.A. 2C:39-1 et seq. and 2C:58-1 et seq.

Proposal Number: PRN 1992-381.

Submit comments by October 8, 1992 to:
Colonel Justin J. Dintino, Superintendent
c/o Firearms Investigation Unit
New Jersey State Police
P.O. Box 7068
West Trenton, New Jersey 08625

The agency proposal follows:

Summary

N.J.A.C. 13:54-1.15 is amended to make clear that applications for licenses, permits, firearms purchaser identification cards or registrations in the possession of the State Police and municipal police departments are not public records. The section is also amended to make clear that originals or copies of licenses, registrations, firearms identification cards and registrations in the possession of municipal police departments or the New Jersey State Police are not public records. These records may not be disclosed to any person not authorized by law or this chapter to have access to them. Exceptions are persons acting in their official capacities in connection with the administration of justice or the order of a court of competent jurisdiction. This amendment also reaffirms that background investigations conducted by chiefs of police, the State Police or county prosecutors for licenses, permits, firearms purchaser identification cards or registrations are not public records. The purpose of the amendment is to protect the privacy rights of holders of the aforementioned licenses and permits and to protect those same individuals, as well as the general public, from being victimized by criminal elements.

The need for this amendment was recently exemplified by an action in the Burlington County Superior Court to compel production of the names and addresses of all those in a municipality who had obtained permits to purchase handguns over a specified period of time. This request was made under the Right to Know Law (N.J.S.A. 47:1A-2). While the Court denied the request premised upon the absence of need for the documentation, the Court apparently concluded that permits to purchase handguns in the possession of a municipal police department are public records under the Right to Know Law. This amendment reaffirms the long standing policy of the State Police and municipal police departments that such documents are not public records. The State Police and municipal police departments may, as they have in the past, properly continue to withhold such documentation from public disclosure.

Social Impact

The proposed amendment will serve to protect the privacy of persons who obtain firearms by virtue of licenses, firearms identification cards, permits and registrations. Their names and addresses will not be subject to public disclosure absent legitimate need or legal requirement. More importantly, however, exempting permits, licenses, firearms identification cards and registrations from being classified as public records will deny the criminal elements of our society the opportunity of obtaining "shopping lists" of names and addresses of persons who own firearms. As a result, these persons will not be targets for burglaries or thefts. In 1991 and 1992, the total number of firearms *reported* stolen in this State was approximately 2,800. Should the names and addresses of persons who obtain permits, licenses, firearms identification cards and registrations now be made public, that number could dramatically increase. The dangers inherent in such publication are not only applicable to those who may be victimized by burglaries and/or thefts, but are equally shared by the members of the public at large, who could also be victimized by persons who illegally obtain firearms from their rightful owners.

Economic Impact

The proposed amendment will not have any adverse economic impact upon the State, retailers or owners of firearms, or the public at large.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required because this 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 proposed amendment only impacts upon the ability of the Division of State Police and municipal police departments to disseminate information, this amendment will not have any adverse impact upon small businesses or private industry in general.

Full text of the proposal follows (additions indicated in boldface **thus**):

13:54-1.15 Confidentiality of background investigations**, permits, licenses, firearms identification cards, registrations and applications**

Any background investigation conducted by the chief of police, the Superintendent or county prosecutor of any applicant for a license, permit, **firearms identification** card or registration in accordance with the requirements of this chapter, **are not public records and** shall not be disclosed to any person, not authorized by law or this chapter to have access to such investigations, including the applicant, except upon order of a court of competent jurisdiction. **Any applications for licenses, permits, firearms identification cards or registrations and any permits, licenses, registrations and firearms identification cards or any records reflecting the issuance or denial of such permits, licenses, firearms identification cards or registrations, maintained by any State or municipal governmental agency, are not public records and shall not be disclosed to any person not**

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authorized by law or this chapter to have access to such documentation, except upon the request of persons acting in their governmental capacities for purposes of the administration of justice or upon order of a court of competent jurisdiction.

PUBLIC UTILITIES

(a)

BOARD OF REGULATORY COMMISSIONERS

All Utilities

Notification to Municipalities of Discontinuance of Gas and Electric Service to Residential Customer

Proposed Amendment: N.J.A.C. 14:3-7.15

Authorized By: Board of Regulatory Commissioners, Dr. Edward H. Salmon, Chairman, and Jeremiah F. O'Connor and Carmen J. Armenti, Commissioners.

Authority: N.J.S.A. 48:2-13.

BRC Docket Number: AX92060662.

Proposal Number: PRN 1992-385.

Submit comments by October 8, 1992 to:
Kent R. Papsun, Chief
Bureau of Customer Assistance
Board of Regulatory Commissioners
44 South Clinton Avenue
CN 350
Trenton, New Jersey 08625

The agency proposal follows:

Summary

In its present form, N.J.A.C. 14:3-7.15 requires each electric and gas utility company, on an annual basis, to advise those municipalities located within its service territory that said municipality and/or the local agency enforcing the Uniform Fire Code could choose to receive a list of all residential customers whose electric or gas service had been involuntarily discontinued the previous day.

The amendments proposed by the Board would make the forwarding of such a list to the municipality mandatory and would require that it also be sent to the municipal and county welfare offices as well as to the District Director and the District Office Manager of the Division of Youth and Family Services. Accordingly, the affected utility companies would no longer be required to file a report indicating which municipalities requested receipt of the list and which did not.

The proposed amendments would also expand the rule to include water service and would eliminate the limitation of the rule solely to residential service. The amendments also reflect the recent amendment of N.J.A.C. 14:3-3.6(c) which currently prohibits the discontinuance of residential utility services for nonpayment on Fridays, Saturdays, Sundays and on the day before a holiday or on a holiday absent a safety related emergency.

Social Impact

The proposed amendments establish mandatory notification procedures to be utilized in those instances where electric, gas or water service has been discontinued. Since there is a potential for the loss of life, health and property when these services are discontinued, the Board is of the opinion that there is a need to notify those officials who may be able to render some assistance to those customers who find themselves without service. In addition, the notice will alert local officials to potential safety hazards within their municipalities and counties. It was for these reasons that the Board also determined to eliminate the restriction of the rule to residential customers since many people live in dwelling units, for example, high rise apartment buildings, which are not served under residential rate structures.

Economic Impact

The proposed amendments would have no direct economic impact on the Board or utility customers. While electric and gas utility companies would save the expense of annually notifying municipalities in their respective service areas that they may choose to receive notice of those local residential customers who have had their service involuntarily discontinued, the affected electric, gas and water utility companies would incur additional expenses in sending out said notices to an expanded service list.

The Board would note that as the costs associated with complying with the proposed amendments would be considered to be incurred in the normal course of business, all reasonable levels of expenses would be recognized by the Board in an appropriate rate proceeding and could be recovered by the utilities through rates to customers.

Regulatory Flexibility Analysis

There are no gas utility companies in New Jersey that may be classified as small businesses as that term is defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. There are, however, approximately 80 small water utility companies and one small electric utility company.

Although small businesses will incur expenses associated with the forwarding of lists of those customers whose service had been terminated the previous day, such expenses, which may be recoverable through rates to customers, are commensurate with the number of customers served. Therefore, the burden of the administrative expense falls equally on both small and large businesses and no differentiation in compliance requirements based on business size is provided.

The annual cost of the compliance reporting requirement imposed on water utility companies involves only minor administrative costs to prepare the report. Because of the minimal cost and the Board's need for the information to monitor compliance, no lesser requirement or exemption is provided.

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

14:3-7.15 Notification to municipalities **and others** of **the** discontinuance of gas [and], electric **and water** service to [residential customer] **customers**

(a) [All] **Each** electric [and], gas **and water** public [utilities] **utility** shall [annually notify all municipalities located within their service area that, upon request, they, and/or any enforcing agency enforcing the Uniform Fire Code (N.J.A.C. 5:18) within the municipality, will be sent] **forward to the clerks of all municipalities located within its service area and to the enforcing agency enforcing the Uniform Fire Code (N.J.A.C. 5:18) within those municipalities,** a daily list of the [residential customer] **customers** of record and premises located within the municipality at which [gas or] electric**, gas or water** service was discontinued involuntarily on the preceding day. **In addition, each utility company shall also forward the daily list to the following:**

1. The welfare officer of the municipality in which the service is provided;

2. The Director of County Welfare in the county in which the service is provided;

3. The appropriate Regional Administrator of the Division of Youth and Family Services; and

4. The appropriate District Office Manager of the Division of Youth and Family Services.

(b) The list referred to in [subsection] (a) [of this section] **above** shall contain the following information[.]:

1. The name and address of every [residential] customer of record whose service was discontinued on the previous day for reasons other than at the customer's request and whose service remains discontinued as of 8:00 A.M. on the day the list is sent. The list shall also set forth the address of the premises where service was discontinued. Included on the list shall be those customers whose service has been discontinued for reasons such as [non-payment] **nonpayment** of bills, the absence of a customer of record, the existence of an unsafe condition, and theft of service. These examples shall not be construed as being exclusive.

2.-3. (No change.)

4. Those customers whose service has been discontinued on a Friday, Saturday or Sunday and whose service remains discontinued as of 8:00 A.M. on the following Monday shall be included on the list sent on that Monday. If a Monday falls on a holiday on which the utility company's commercial offices are closed, the list shall be sent on the next regular workday. Pursuant to N.J.A.C. 14:3-3.6(c), public utilities may not discontinue residential service **for nonpay-**

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ment on **Friday,** Saturday, Sunday or [a holiday on which the utility company's commerical offices are closed or after 1:00 P.M. of the business day prior to a weekend or such holiday for nonpayment] **on the day before a holiday or on a holiday absent a safety related emergency.**

5. When none of the customers within the municipality has service discontinued as of 8:00 A.M. on the day the list is to be sent, the utility shall not be required to send a list or otherwise notify **the clerk of** the municipality, **the enforcing agency enforcing the Uniform Fire Code (N.J.A.C. 5:18) within the municipality or others set out in (a) above** that there were no discontinuances. The next list subsequently sent shall state the date on which the last list was sent.

6. (No change.)

7. Specification of whether [gas and/or] electric, **gas or water** service was discontinued for each customer on the list.

(c) The list referred to in [subsection] (a) [of this section] **above** may be sent by ordinary mail.

(d) [Beginning on February 15, 1980, and on every February 15 thereafter,] **Annually, on February 15,** all electric [and], gas **and water** utilities shall file with the Board a report containing the following information:

1. A breakdown of the expenses incurred in complying with this [regulation] **rule** in the preceding calendar year;

2. Any additional information which the Board in its discretion may require in writing or the public utility may wish to submit.

[(e) Beginning on February 15, 1980, and on every August 15 and February 15 thereafter, all electric and gas utilities shall file with the Board a report containing the following information:

1. Those municipalities which requested the list referred to in subsection (a) of this section and those which have not requested the list as of the date of the report;

2. Those enforcing agencies referred to in (a) above enforcing the Uniform Fire Code which requested the list referred to in (a) above.

3. Any additional information which the Board in its discretion may require in writing or the public utility may wish to submit.]

TRANSPORTATION

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID

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

Proposed Amendments: N.J.A.C. 16:28A-1.4, 1.5, 1.6, 1.13 and 1.30

Authorized By: Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 39:4-138.1 and 39:4-198.

Proposal Number: PRN 1992-370.

Submit comments by October 8, 1992 to:
Charles L. Meyers
Administrative Practice Officer
Department of Transportation
Bureau of Policy and Legislative Analysis
1035 Parkway Avenue
CN 600
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The proposed amendments will establish revised "restricted parking and stopping" zones along Routes N.J. 4 in the Boroughs of Elmwood Park, Paramus, River Edge and Fort Lee, the Cities of Hackensack and Englewood and the Township of Teaneck in Bergen County; N.J. 5 in the Boroughs of Fort Lee, Ridgefield, Palisades Park, and Edgewater in Bergen County; N.J. 7 in the Town of Kearny and City of Jersey City in Hudson County, and in the Towns of Nutley and Belleville in Essex County; U.S. 22 in the Township of Readington in Hunterdon County; and N.J. 44 in the Township of Greenwich, Gloucester County, for the efficient flow of traffic, enhancement of safety, and the well-being of the populace.

Based upon requests from the local governments, in the interest of safety, and as part of a review of current conditions, the Department's Bureau of Traffic Engineering and Safety Programs conducted traffic investigations. The investigations proved that the establishment of the revised "restricted parking and stopping" zones along 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 was warranted.

The proposed amendments at N.J.A.C. 16:28A-1.4, 1.5, 1.6, 1.13 and 1.30 expand the restriction to both sides of the highway; add an exception for other approved parking restrictions; require signs notifying the motorists of the restrictions; and recodify the rules in compliance with the Department's format for clarity by placing the restrictions by municipality within respective counties. Additionally, N.J.A.C. 16:28A-1.13 adds a stopping or standing prohibition for Route 22 in the Township of Readington.

The Department therefore proposes to amend N.J.A.C. 16:28A-1.4, 1.5, 1.6, 1.13 and 1.30, based upon the requests from the local governments and the traffic investigations.

Social Impact

The proposed amendments will establish revised "restricted parking and stopping" along 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 for the efficient flow of traffic, the enhancement of safety, and the well-being of the populace. Appropriate signs will be erected to advise the motoring public.

Economic Impact

The Department and local governments will incur direct and indirect costs for mileage, personnel and equipment requirements. The Department will bear the costs for the installation of "restricted parking and stopping" zone signs. The costs involved in the installation and procurement of signs vary, depending upon the material used, size, and method of procurement. Motorists who violate the rules will be assessed the appropriate fine in accordance with the "Statewide Violations Bureau Schedule," issued under New Jersey Court Rule 7:7-3.

Regulatory Flexibility Statement

The proposed amendments do not place any reporting, recordkeeping or compliance requirements on small businesses, as the term is defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed amendments primarily affect the motoring public and the governmental entities responsible for the enforcement of the rules.

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

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 of Route 4 for the entire corporate limits of the Borough of River Edge, including all marginal roadways, ramps and connections under the jurisdiction of the Commissioner of Transportation.

2. No stopping or standing in East Paterson Borough, Bergen County:

i. Along the northerly (westbound side):

(1) Between a point 60 feet west on the westerly curb line of Sterling Street and a point 240 feet westerly thereof.]

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;

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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.)

[4. No stopping or standing in the Borough of Elmwood Park, Bergen County, along the southerly (eastbound) side from River Drive to East 53rd Street and from East 54th Street to East 55th Street.]

(b)-(c) (No change.)

16:28A-1.5 Route 5

(a) The certain parts of State highway Route 5 described in [(a) of this section,] **this subsection** shall be designated and established as "no [parking] **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 Edgewater Borough, Bergen County:

i. Along both sides between Edgewater-Cliffside Park Borough Line and Upper Undercliff Avenue:

ii. Along the East side:

(1) From a point 100 feet south of Lower Undercliff Avenue to a point 750 feet north of River Road;

(2) From River Road to a point 185 feet northerly therefrom;

(3) From Upper Undercliff Avenue to a point 200 feet north of Lower Undercliff Avenue;

iii. Along the West side:

(1) From Hudson Avenue to a point 150 feet north of River Road;

(2) From Upper Undercliff Avenue to a point 100 feet south of Valley Place extended.

2. No stopping or standing in Palisades Park Borough, Bergen County:

i. Along the northerly (westbound) side:

(1) Between the intersection of the Homestead Avenue cutoff to Route US 46 and the intersection of East Columbia Avenue.

3. No stopping or standing in Ridgefield Borough, Bergen County:

i. Along the eastbound side:

(1) From the center line of Ray Avenue, to the Ridgefield Borough-Palisades Park Borough corporate line.

ii. Along the westbound side:

(1) From the Palisades Park Borough-Ridgefield Borough corporate line, to the center line of Linden Avenue;

(2) From the center line of Elm Avenue to the center line of Route US 1 and 9.

4. No stopping or standing in Fort Lee Borough, Bergen County:

i. Along both sides (Palisades Avenue):

(1) For the entire corporate limits of Fort Lee Borough]

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 [(a) of this section] **this subsection** shall be [and hereby are] designated and established as "no [parking] **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 corporate limits of the Town of Kearny and North Arlington Borough, including all ramps and connections thereto which are under the jurisdiction of the Commissioner of Transportation.

2. No stopping or standing in Nutley:

i. Washington Avenue: East side from the northerly curb line of Hancox Avenue to a point 75 feet north of the northerly curb line of Hancox Avenue;

ii. Washington Avenue: East side from the southerly curb line of Pershing Avenue to the southerly curb line of Kingsland Street;

iii. Kingsland Street and Cathedral Avenue: North side and east side of the City of Clifton-Town of Nutley corporate line of Kingsland Street to the Town of Nutley-City of Clifton corporate line on Cathedral Avenue;

iv. Cathedral Avenue and Kingsland Street: West side and south side from the City of Clifton-Town of Nutley corporate line on Cathedral Avenue to a point 160 feet east of the easterly curb line of Franklin Avenue on Kingsland Street;

v. Kingsland Street: South side from the easterly curb line of Passaic Avenue to a point 125 feet east of the easterly curb line of Passaic Avenue;

vi. Washington Avenue: West side from the southerly curb line of Park Avenue to the northerly curb line of Walnut Street;

vii. Washington Avenue: West side from a point 90 feet north of the northerly curb line of Hancox Avenue to the northerly curb line of Hancox Avenue.

3. No stopping or standing along the southbound side of Route 7 (Washington Avenue) in Belleville beginning 115 feet south of the southerly curb line of Joralemon Street to a point 57 feet south therefrom.

4. No stopping or standing in the Town of Belleville, Essex County:

i. Along the northbound side from a point 175 feet north of the prolongation of the northerly curb line of Carmer Avenue to a point 700 feet south of the southerly curb line of Carmer Avenue.]

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.)

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16:28A-1.30 Route 44

(a) The certain parts of State highway Route 44 described [herein below] **in this subsection** shall be[, and hereby are] designated and established as "no [parking] **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 Township of West Deptford along both sides from Woodbury Terrace to a point 100 feet west of the westerly curb line of Delaware Avenue.

2. No stopping or standing in Greenwich Township, Gloucester County along the southbound side from Democrat Road to North Ulmer Avenue.]

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.)

(a)

DIVISION OF TRANSPORTATION ASSISTANCE
OFFICE OF AVIATION
Notice of Extension of Comment Period
Licensing of Aeronautical and Aerospace Facilities
Proposed Repeal and New Rules: N.J.A.C. 16:54

Take notice that the New Jersey Department of Transportation, in its rule proposal of July 20, 1992, established a comment date of August 19, 1992, as the final date of receipt of comments concerning N.J.A.C. 16:54, Licensing of Aeronautical and Aerospace Facilities. Said notice appeared at 24 N.J.R. 2542(a).

In view of the numerous requests for extensions received from the municipalities to afford time for preparation of comments, the Department of Transportation is **extending the comment period** to September 18, 1992.

Submit comments, in writing, by September 18, 1992 to:

Charles L. Meyers
Administrative Practice Officer
Department of Transportation
1035 Parkway Avenue
CN 600
Trenton, New Jersey 08625

OTHER AGENCIES

(b)

ELECTION LAW ENFORCEMENT COMMISSION
Pre-Candidate Activity; "Testing the Waters"
Reporting of Expenditures: Independent Expenditures
Public Financing of Primary Election for Governor
Proposed 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
Proposed Repeal: N.J.A.C. 19:25-16.16
Proposed New Rule: N.J.A.C. 19:25-16.48
Proposed Repeal and New Rule: N.J.A.C. 19:25-16.30

Authorized By: Election Law Enforcement Commission, Frederick M. Herrmann, Ph.D., Executive Director.

Authority: N.J.S.A. 19:44A-6 and 19:44A-38.

Proposal Number: PRN 1992-378.

A **public hearing** concerning this proposal will be conducted on Wednesday, September 16, 1992 at 10:00 A.M. at:

Election Law Enforcement Commission
28 West State Street, 12th Floor
Trenton, New Jersey

To reserve time to speak, telephone the Commission offices at (609) 292-8700 by Monday, September 14, 1992.

Submit written comments by October 8, 1992 to:

Nedda Gold Massar, Esq.
Election Law Enforcement Commission
CN 185
Trenton, New Jersey 08625-0185

The agency proposal follows:

Summary

The New Jersey Election Law Enforcement Commission (hereafter, the Commission) proposes to amend its rules concerning pre-candidacy activity (N.J.A.C. 19:25-3.1) and independent expenditures (N.J.A.C. 19:25-12.7), and proposes a new rule and amendments to its rules concerning the public financing of primary election candidates for Governor (N.J.A.C. 19:25-16). These amendments and new rule are derived from the Commission's experience in administering past gubernatorial public financing programs and have also been necessitated by recent court decisions concerning political party activity in the primary election and by enactment of statutory changes concerning gubernatorial debate sponsors (see N.J.S.A. 19:44A-46, as amended by P.L. 1991, c.317, effective November 19, 1991).

1. N.J.A.C. 19:25-3.1(a), Exemption for activities conducted solely for the purpose of determining whether an individual will become a candidate; "Testing the Waters", has been amended to conform to N.J.A.C. 19:25-16.5, which provides that a prospective candidate or a committee on behalf of that prospective candidate may undertake pre-candidacy activity, and to specify the precise period of time for which the written records of precandidacy financial activity must be kept. The four-year record retention period is the same as that established for all other financial records required to be maintained pursuant to the New Jersey Campaign Contributions and Expenditures Reporting Act.

2. N.J.A.C. 19:25-12.7(a), Independent expenditures, has been changed to include the term "continuing political committee" (CPC) to clarify that an independent expenditure by a CPC is subject to the disclosure and other requirements of the Act and Commission regulations. Without this specific reference in N.J.A.C. 19:25-12.7 to a CPC, it is unclear that reporting requirements attach to independent expenditures by a CPC.

3. N.J.A.C. 19:25-16.3, Definitions, has been amended to include the definition of "principal campaign committee." A gubernatorial candidate receiving public matching funds may maintain only one campaign committee, a "principal campaign committee," for the purpose of receiving all contributions and making all disbursements. The existence of a single campaign committee permits monitoring of the contribution and expenditure limits which apply to a publicly-financed gubernatorial campaign. A similar definition currently exists in the rules for public financing of the general election for governor.

4. N.J.A.C. 19:25-16.5(a), Pre-candidacy activity, has been amended and a new subsection (c) has been added to implement statutory changes concerning pre-candidacy or "testing the waters" activity enacted in January, 1989, which appear now in the New Jersey Campaign and Contributions and Expenditures Reporting Act as N.J.S.A. 19:44A-11.1.

The proposed amendments specify that written records be kept of all pre-candidacy activity and establish the required period of retention for such records. They clarify that once an individual becomes a candidate for governor, funds received and expenditures made during pre-candidacy or "testing the waters" activity are to be counted as subject to the gubernatorial contribution and expenditure limits. The amendments reiterate the statutory distinction that general public political advertising and activity to amass campaign funds to be spent on a candidacy are not within the "testing the waters" exceptions. They further state that pre-candidacy activity may not be limited on the basis of total amounts raised or spent for such activity.

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Also in N.J.A.C. 19:25-16.5, a new subsection (d) contains text deleted from subsection (c).

5. N.J.A.C. 19:25-16.16, Political party committee contributions prohibited, has been repealed to comport with recent United States Supreme Court and New Jersey court decisions.

The United States Supreme Court in *Eu v. San Francisco County Democratic Central Committee,* 489 *U.S.* 214 (1989), held that California statutes prohibiting political party endorsement of or opposition to candidates in a primary election were invalid as violative of the First Amendment protection of free political speech. Subsequently, on April 12, 1991, a consent order was entered in the matter of *New Jersey Republican State Committee v. Del Tufo, et al,* Dkt. No. L-91-1645, Superior Court, Mercer County, which found unconstitutional portions of N.J.S.A. 19:44A-11, contained within the Campaign Contributions and Expenditures Report Act, prohibiting the receipt and expenditure of funds by a State, county, or municipal political party committee in a primary election setting. N.J.A.C. 19:25-16.16, which implemented N.J.S.A. 19:44A-11 and specifically prohibited political party committee activity in the primary election has, therefore, been deleted.

6. N.J.A.C. 19:25-16.18(b), Matching of funds, has been changed to require that the bank account established by a publicly-financed gubernatorial campaign for the deposit of contributions eligible to be matched with public funds be specifically named the "Matching Fund Account of (name of candidate)." The use of this specific account title will avoid confusion and facilitate audit and review of campaign activity. The Commission further proposes changes to subsection (d) to require that lists of contributors submitted as documentation with applications for public matching funds be identified by the candidate by type of contributor to speed the processing of candidate submissions for public matching funds. This procedure will reduce the administrative burden upon Commission staff, permit more efficient processing of claims for public funds, and ultimately speed up the distribution to candidates of public funds. For the same reasons, the Commission is proposing changes to subsections (d), (f), and (g) to require that additional copies of all public funds submission documents be filed with each request for public funds. A new subsection, (k), has been added to require that each application for public matching funds be accompanied by an alphabetized cumulative list of all contributors from which Commission staff can monitor compliance with the contribution limit and which may be disclosed to the public. A publicly-financed candidate may elect to disclose to the public all contributors or only those contributors whose aggregate contributions exceed $100.00.

7. N.J.A.C. 19:25-16.24, Disclosure of information, has been changed to clarify that the list of contributors to a publicly-financed campaign, which is disclosed to the public by the Commission and which is derived from documents submitted as part of applications for public matching funds, will include contributions of all types, not just contributions submitted for match with public funds, by contributors whose aggregate contributions exceed $100.00. A candidate may also authorize disclosure of all contributors, including those whose aggregate contributions do not exceed $100.00.

8. A new subsection, (c), has been added to N.J.A.C. 19:25-16.25, Use of public funds, to require that publicly-financed campaigns obtain media affidavits from radio and television outlets at the time their advertisements are broadcast, certifying that the media time paid for with public funds was actually aired. The Commission believes that such documentation of media time purchased and used is necessary to determine whether refunds for unused media time are owed to the campaign and therefore potentially available for return to the State.

The Commission also proposes to add a new subsection, (d), requiring that the purpose of each disbursement from the candidate's public funds account be specifically identified on campaign reports and on submissions for public funds. Disclosure of this information permits Commission staff to monitor that public funds are being spent only for the uses permitted by the statute (N.J.S.A. 19:44A-35).

N.J.A.C. 19:25-16.25 has also been amended to include a new subsection, (e), to establish strict campaign and submission reporting requirements which apply when a publicly-financed campaign reimburses with public funds a non-public fund account for a disbursement which might have been made with public funds. These reporting procedures are necessary to permit verification that public matching funds are being used in accordance with the statutorily permitted uses of public funds pursuant to N.J.S.A. 19:44A-35.

Former subsection (c) has been recodified as subsection (f), with no change in the text.

9. N.J.A.C. 19:25-16.27, Expenses not subject to expenditure limits, has been amended to change an incorrect citation.

10. A new subsection, (c), has been added to N.J.A.C. 19:25-16.28, Travel expenses, to clarify that reporting requirements attach to the use by a gubernatorial campaign of any government or State-owned vehicle and to establish the appropriate method for valuation of such expenditures for transportation. The new subsection also requires that reimbursement to a governmental entity for the use of governmental vehicles must be made immediately.

11. N.J.A.C. 19:25-16.29(a), Independent expenditures, has been changed to include within its requirements independent expenditures made by continuing political committees. An incorrect citation has also been corrected.

12. The text of N.J.A.C. 19:25-16.30, Coordinated expenditures, adopted for the 1989 primary election, has been deleted and reformulated as a new rule to conform to the Coordinated Expenditures rule adopted by the Commission for the 1989 general election. The general election text was the result of suggestions received from representatives of gubernatorial campaigns and identifies which voter communication activity by others on behalf of gubernatorial candidates would or would not count toward a candidate's expenditure limit.

13. N.J.A.C. 19:25-16.39, Application to sponsor debates, has been amended at paragraph (a)2 to modify the policy on endorsement of gubernatorial candidates by a sponsor organization so that it conforms to the general election rules. Subsection (a) now requires that a debate sponsor organization agree not to endorse any candidate until the completion of the debate which it is selected to sponsor. Subsection (a) has also been changed to delete the requirement that a sponsor be a private organization. This change was contained in P.L. 1991, c.317, and appears at N.J.S.A. 19:44A-46c. New subsection (b) has been added to include a new category of debate sponsor organization which is exempt from the requirement to demonstrate prior experience in televised debates for Statewide office.

Former subsection (b) now appears as subsection (c), with no change in the text of the subsection.

14. The language of N.J.A.C. 19:25-16.43(b), Complaint alleging failure to participate in debate, requiring personal service of a complaint alleging a violation of the primary election debate requirement has been modified to conform to the text proposed in new N.J.A.C. 19:25-16.48.

15. New N.J.A.C. 19:25-16.48, Complaint alleging violation of primary election expenditure limit, has been added to establish procedural steps which must be taken by a party requesting Commission consideration of an alleged violation of the primary election expenditure limit.

Social Impact

The Commission's proposed amendments will affect primarily publicly-financed gubernatorial candidates and their campaign treasurers in the primary election and may also affect individuals contemplating a gubernatorial candidacy who are engaged in pre-candidacy activity and continuing political committees making independent expenditures. The proposed amendments establish recordkeeping requirements associated with "testing the waters" activity and clarify recordkeeping requirements for expenditures by gubernatorial candidates. They therefore enhance disclosure of disbursements by those candidates to the Commission and to the public. The amendments require improved documentation of campaign disbursements for radio and television, and imposes uniform reporting and disclosure requirements for reimbursements using public funds. The proposed changes advance the ability of the Commission to monitor campaigns' compliance with the contribution limit, statutory restrictions on the uses of public matching funds, and their compliance with the primary election expenditure limit. The public will benefit not only from the improved disclosure but also from the Commission's resulting ability to identify and recapture unspent campaign funds available for return to the State.

The proposed amendment concerning coordinated expenditures by gubernatorial and non-gubernatorial candidates will have the beneficial effect of permitting gubernatorial and non-gubernatorial candidates to undertake certain specifically identified activities together without violating the gubernatorial candidate's expenditure limit. This coordinated activity has been recognized as beneficial to New Jersey's political parties.

The amendment implementing N.J.S.A. 19:44A-46 which deletes the requirement that a debate sponsor be a private organization and which provides for an additional category of debate sponsors will have the positive impact of expanding the pool of potential gubernatorial debate sponsor organizations. The Commission also believes that its proposed new rule establishing specific procedural steps for a party alleging a

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violation of the primary election expenditure limit has the desirable effect of creating certainty and reducing frivolous complaints in the electoral process.

Economic Impact

The Commission believes that the proposed amendments will have only a minimal economic impact on prospective and actual primary election candidates for governor. Individuals or committees acting for individuals contemplating a gubernatorial candidacy (that is, "testing the waters") are already required by existing Commission rules to keep records of receipts and disbursements. Requiring that such records be kept for a fixed period of time imposes little, if any, additional financial burden. All gubernatorial candidates are required to make and maintain detailed records of all receipt and expenditure activity. Therefore, the additional costs associated with maintaining documentation of media purchases and travel expenditures and with detailed reporting of disbursements and reimbursements on campaign reports are marginal. The Commission believes that the benefit to the public of enhanced disclosure and the possibility that unspent campaign funds may be identified and returned to the State outweigh the economic burden upon prospective and actual gubernatorial campaigns. Requiring campaigns to identify contributors by type assures more complete and accurate disclosure because candidates and treasurers possess immediate knowledge of or access to those who contribute to them. Each gubernatorial candidate who qualifies for receipt of public matching funds has demonstrated to the Commission that he or she has raised and spent at least $150,000 on his or her campaign. The Commission believes that the cost to such a campaign of providing an alphabetized contributor list as part of a submission for matching funds and the cost of the additional copies of reports to be filed with the Commission are reasonable expenditures for campaigns of such complexity. Further, the costs associated with preparation of contributor lists and photocopies of reports are compliance costs which are not subject to the primary election expenditure limit. Requiring that publicly-financed campaigns provide this additional documentation will permit more cost-effective use of Commission staff and be offset for the campaigns by the increased speed with which submissions for matching funds may be processed.

The economic impact of the new rule establishing steps required to lodge a complaint for violation of the expenditure limit is imposed by the proposal upon the entity making the complaint. Scarce Commission economic resources may therefore be allocated for consideration of those matters where sufficient evidence has been provided by a complaining party.

Regulatory Flexibility Statement

The Commission's proposed amendments and new rules do not impose any 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. While it is conceivable that small businesses may be employed to provide goods or services to gubernatorial candidates or to prospective gubernatorial candidates, the reporting and recordkeeping requirements generated by the amendments contained in this proposal are solely on the gubernatorial, non-gubernatorial, and prospective candidates purchasing such goods or services.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [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. [The] **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 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, [or] 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] **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 separate depository established under (a) above may be designated by that individual as or incorporated with the matching fund account under N.J.A.C. 19:25-16.18(b), provided that the account and all of the contributions deposited in it meet all of the requirements of N.J.A.C. 19:25-16.18(b)] **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 [Political party committee contributions prohibited] **(Reserved)**

[No State, county or municipal committee of any political party in a primary election may make any contributions or expend any funds in furtherance and in aid of the candidacy of any candidate of such party; nor may any candidate receive or accept any contribution from any State, county or municipal committee of any political party.]

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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 [one photocopy] **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 [and], 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 include an original and [one photocopy] **two photocopies** of a list of repayment by the candidate of any contribution, including any loan described under N.J.A.C. 19:25-[16.29] **16.31** (Borrowing of funds; repayment).

(e) (No change.)

(f) The certification shall include [two] **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 [two] **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] **Commission** shall from time to time publish a listing which shall contain the information included in the statements and certifications for each contribution [approved for match], 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.

[(c)]**(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)]**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-[16.33(b)] **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 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, [or] political committee, **or continuing political committee** making in-

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dependent expenditures who is required to file [election] reports purusant to N.J.A.C. 19:25-[12.5] **12.7 or 12.8** shall include in the reports required under the act a sworn statement on a form provided by the [commission] **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 a candidate other than a gubernatorial candidate is a contribution by such candidate subject to the contribution limit 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 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 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, direct mail or similar type of general public communication or political advertising.

(c) 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,

(d) 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 feature 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.

(e) A gubernatorial candidate determining the reasonable value to his or her candidacy of a coordinated communication pursuant to (d) 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 total cost.]

(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, 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

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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 corporation, 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, [a private] **an** organization:

1. (No change.)

2. Must not have endorsed any candidate in the pending primary election for the office of Governor and must [represent to the Commission that no such endorsement will be forthcoming] **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.

[(b)]**(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 [in person] **by personal service** or by certified mail, return receipt requested, upon the respondent candidate, the Commisison, 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. 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.

(a)

ELECTION LAW ENFORCEMENT COMMISSION

Lobbyists and Legislative Agents

Reporting of Identity of State Officials Receiving Benefits

Proposed Amendments: N.J.A.C. 19:25-20.11 and 20.13

Authorized By: Election Law Enforcement Commission, Frederick M. Herrmann, Ph.D., Exeucutive Director.

Authority: N.J.S.A. 52:13C-23.2.

Proposal Number: PRN 1992-379.

A public hearing concerning this proposal will be conducted on Wednesday, September 16, 1992 at 10:00 A.M. at:

Election Law Enforcement Commission
28 West State Street, 12th Floor
Trenton, New Jersey

To reserve time to speak, telephone the Commission offices at (609) 292-8700 by Monday, September 14, 1992.

Submit written comments by October 8, 1992 to:

Gregory E. Nagy, Legal Director
Election Law Enforcement Commission
CN 185
Trenton, New Jersey 08625-0185

The agency proposal follows:

Summary

The Election Law Enforcement Commission (hereafter, the Commission) proposes three amendments affecting reporting of the identity of State officials receiving benefits from lobbyists and legislative agents. The anticipated operative date of these amendments is January 1, 1993, so that the changes will be effective in time for the Annual Report required of lobbyists and legislative agents for calendar year 1993. The 1993 calendar year Annual Report will be due for filing with the Commission on February 15, 1994.

The proposed amendments affect the rules under which a lobbyist or legislative agent must identify the name of a State official receiving a benefit from the lobbyist or legislative agent. Pursuant to the Legislative Activities Disclosure Act, N.J.S.A. 52:13C-18 et seq. (hereafter, the Lobbying Act), a lobbyist or legislative agent must provide on the Annual Report the name of a State official covered under the Lobbying Act who has received a benefit, or aggregate benefits, exceeding $25.00 per day, or exceeding $200.00 per calendar year from the lobbyist or legislative agent (see N.J.S.A. 52:13C-22.1). Therefore, a legislative agent who, for example, purchased a meal in a restaurant for a State official at a cost exceeding $25.00 would be required to disclose the name of the official, the date and type of expenditure, the amount of the expenditure and the name of the restaurant to which it was paid. State officials covered under the Lobbying Act include a member of the Legislature, legislative staff, the Governor, the Governor's staff, or an officer or staff member of the Executive Branch (see N.J.A.C. 19:25-20.2 defining specifically which officials are included in these categories).

The proposed amendments are as follows:

1. Subsection (b) of N.J.A.C. 19:25-20.13, Contents of Annual Report, is amended to require that the cost of benefits provided to State officials at a specific event (that is, a reception) conducted by a lobbyist or legislative agent be allocated among the State officials attending or participating in the event with the actual or constructive knowledge of the lobbyist or legislative agent.

Under the current rule, a lobbyist or legislative agent making an expenditure, or aggregate expenditures, to conduct a specific event, such as a reception, is not required to allocate its costs for benefits provided at the event to the attending State officials for the purpose of counting those costs towards either the $25.00 per day or $200.00 per calendar year thresholds that determine whether the name of the State official must be identified (see N.J.A.C. 19:25-20.13(b)). Therefore, the name of a State official attending a specific event will not normally appear on the lobbyist's or legislative agent's Annual Report. Under this proposed amendment, the lobbyist or legislative agent making such expenditures would be required to allocate the costs among the State officials attending or participating in the event if the attendance or participation was with the actual or constructive knowledge of the lob-

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byist or legislative agent, and would be required to report the name of the official if the allocated cost exceeded the thresholds. Only if a lobbyist or legislative agent did not actually know, or could not have been reasonably expected to know, of the attendance of a State official could the name of the official not be reported.

The proposed amendment is intended to implement lobbying reporting procedures in regard to expenditures for benefits distributed at specific events as described in Advisory Opinion No. 03-1992 (April 16, 1992). That opinion provides that the costs borne by a lobbyist or legislative agent for benefits such as gifts, entertainment, or food and beverages provided to a State official at a specific event must be reported, and that the identity of the official as well as the date and type of expenditure and name of the payee must be disclosed in the Annual Report, when such costs exceed $25.00 per day, or $200.00 in a calendar year. This reporting requirement arises whenever the lobbyist or legislative agent has actual or constructive knowledge of the official's attendance or participation at such an event. Therefore, even in the absence of a prior invitation to a State official to attend, if the lobbyist or legislative agent knows of the attendance of the official, or has reason to know of the attendance, the official must be identified in the Annual Report if the value of benefits allocated to that official exceed the $25.00 per day or $200.00 per calendar year thresholds.

2. Subsection (b) of N.J.A.C. 19:25-20.11, Expenditures, is amended to remove the requirement that the cost of entertainment or food and beverage for a legislative agent in the company of a State official be included in the calculation of the $25.00 per day or $200.00 per calendar year thresholds for benefit-passing activity.

Under the existing rules, the cost of the entertainment (for example, a theater ticket) or food and beverage for a legislative agent while in the company of a State official covered by the Lobbying Act must be included in the calculation of the thresholds for determining whether more than $25.00 per day or $200.00 per calendar year was provided in benefits to the State official. If the resulting total of expenses incurred for the State official and for the lobbyist or legislative agent in the company of the offical exceeds $25.00 per day, or $200.00 per year, the name of the official must be disclosed on the lobbyist's or legislative agent's Annual Report as having received benefits in excess of those thresholds. For example, if a legislative agent takes a legislator to lunch, and the cost of the lunch for the official is $5.00, and the cost for the lunch of the legislative agent is $21.00, the legislative agent must disclose on the Annual Report the name of the official, and the expenditure of $26.00 for providing benefits to that official.

The Commission is not persuaded that costs incurred on behalf of a lobbyist or legislative agent while in the company of a State official constitute a benefit to that official within the meaning of the Lobbying Act. The fact that a legislative agent has made an expenditure for his or her own entertainment while in the company of a State official, or his or her own food and beverage while in the company of a State official, does not confer any cognizable benefit on the official. Inclusion of the costs for the lobbyist or legislative agent inflates the value of the benefits provided to the official, and arguably results in arbitrary reporting treatment. For example, by including the costs of the hosting lobbyist, the determination of whether any single official has received a benefit in excess of $25.00 per day is determined by the number of officials who received benefits rather than by the value of the benefit received. If the host spends $15.00 each for a ticket for himself or herself and an official, the official's name must be disclosed because under the current regulation a total of $30.00 in benefits was provided to the State official. However, if the host spends $15.00 each for a ticket for himself or herself and for two State officials, there is no obligation to report the name of either official because no single official received a benefit in excess of $25.00. Each official received a $15.00 ticket, plus one-half of the value of the hosting agent's ticket ($7.50), for a total benefit of $22.50 each. Therefore, the Commission proposes to amend N.J.A.C. 19:25-20.11(b) to delete expenses incurred by a lobbyist or legislative agent on himself or herself while in the company of a State official from the calculation of the benefit-passing thresholds that govern the requirement to disclose the name of a benefit-receiving State official.

The Commission notes that although this amendment may in some instances relieve a lobbyist or legislative agent from disclosing the name of a State official who has received a benefit under the threshold amounts, the amounts of these expenditures, including expenditures for entertainment or food and beverage for a lobbyist or legislative agent, must still be included in the amounts reported as spent for lobbying purposes (see N.J.A.C. 19:25-20.11(b)).

3. Subsection (c) of N.J.A.C. 19:25-20.11, Expenditures, is amended to define the term "immediate family" as used in the context of benefit-passing reporting.

Under the existing rules, the $25.00 per day or $200.00 per calendar year thresholds for reporting benefit-passing to a State official must also be applied to "a member of the immediate family" of such an official. For example, if a lobbyist or legislative agent provides a benefit to the spouse of such an official, the lobbyist must disclose the name of the spouse and of the official if the benefit exceeds the benefit-passing thresholds.

The Commission believes that the term "immediate family" should mean the spouse of the official if that spouse is residing in the same domicile, and any dependent children of that official. The Commission believes that requiring disclosure of benefit-passing activity to a spouse or dependent children of a State official is consistent with the salutary disclosure purposes of the Lobbying Act as set forth in N.J.S.A. 52:13C-18 because a benefit passed to such an immediate family member of a State official has the potential to exercise as much influence as a benefit passed directly to that official.

Social Impact

The Commission anticipates that these proposed amendments will promote improved disclosure of benefit-passing activity by lobbyists and legislative agents. Of particular importance is the proposed requirement that the cost of any specific event conducted by a lobbyist or legislative agent be allocated among the State officials attending or participating in the event with the actual or constructive knowledge of the lobbyist or legislative agent.

On January 1, 1992, comprehensive amendments to the Lobbying Act became effective (see P.L. 1991, c.243 and c.244). Among other statutory changes, expenditures made by lobbyists or legislative agents to establish "good will" among legislators or regulators became subject to reporting, even in the absence of an accompanying communication concerning a legislative or regulatory objective (see Summary statement, paragraph 3, at 23 N.J.R. 3077(a) (October 21, 1991)). In order to further the public interest in disclosure of the identity of State officials receiving benefits from lobbyists or legislative agents in the context of "good will" activities such as receptions or other specific events, the Commission believes that it is no longer appropriate to exclude "specific event" expenditures from allocation rules. Therefore, the lobbyist or legislative agent making an expenditure for a reception at which a State official receives entertainment or food and beverage where the value exceeds $25.00, must report the name of the State official.

The Commission also believes that lobbyists or legislative agents should not include entertainment or food and beverage expenses incurred on behalf of a lobbyist or legislative agent in the calculation of the benefits passed to a recipient State official. The inclusion of the amount spent on behalf of the lobbyist or legislative agent in this calculation inflates the true amount of benefits being received by the State official.

Finally, the Commission believes that defining the term "immediate family" will provide both filing entities and the public with greater clarity and understanding of which family members of a State official come under the rule.

Economic Impact

The proposed changes are not expected to have any economic impact other than possible compliance costs that may be incurred in conforming to the reporting changes. However, these compliance costs are perceived as minimal because the changes do not create any new class of reporting entities.

Regulatory Flexibility Analysis

Some legislative agents may be considered small businesses, as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14-16 et seq. The proposed amendments impose changes in the reporting of expenditures made to provide benefits to State officials; however, compliance costs associated with these changes are anticipated to be minimal. Because of the minimal cost imposed, and the need for uniform reporting in order to effectuate the purposes of the Lobbying Act, as amended, no lesser requirements or exemptions for small businesses are provided.

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

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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[, as well as the cost of entertainment for a legislative agent when in the company of any member of the Legislature, legislative staff, the Governor, the Governor's staff, or an officer or staff member of the Executive Branch].

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. [This shall include food and beverages for the legislative agent when in the company of any member of the Legislature, legislative staff, the Governor, the Governor's staff, or an officer or staff member of the Executive Branch.] 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 [need not] **shall** be allocated among the members of the Legislature, legislative staff, the Governor, members of the Governor's staff, or officers or staff members of the Executive Branch present [at], **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).

(c)-(d) (No change.)

(a)

CASINO CONTROL COMMISSION

Gaming Equipment
Rules of the Games
Roulette Table; Physical Characteristics; Double Zero Roulette Wheel Used As a Single Zero Roulette Wheel;
Roulette; Inspection Procedures; Security Procedures
Roulette; Payout Odds
Proposed Amendments: N.J.A.C. 19:46-1.7 and 1.9, and 19:47-5.2

Authorized By: Casino Control Commission, Joseph A. Papp, Executive Secretary.

Authority: N.J.S.A. 5:12-69(a), 70(f) and 100(e).

Proposal Number: PRN 1992-383.

Submit comments by October 8, 1992 to:
Seth H. Briliant, Assistant Counsel
Casino Control Commission
Arcade Building
Tennessee Avenue and the Boardwalk
Atlantic City, NJ 08401

The agency proposal follows:

Summary

Present Commission rules permit casino licensees to offer two different variations of the authorized game of roulette: single zero roulette, which uses a 37-pocket single zero roulette wheel, and double zero roulette, which uses a 38-pocket roulette wheel. See N.J.A.C. 19:46-1.7(b). Although both wheels display the numbers 1 to 36, each wheel has the numbers arranged in a different sequence. Each game also has its own corresponding single zero or double zero table layout (see N.J.A.C. 19:46-1.7(c)) and the results of certain wagers are different in the two roulette games. See N.J.A.C. 19:47-5.2(b) and (c).

These proposed amendments would permit the game of single zero roulette to be played with a double zero roulette wheel and a double zero table layout. If the roulette ball drops in the double zero pocket of the wheel, the dealer would call "No Spin," declare that spin void, and respin the wheel. The "00" wager area on the table layout would be required to be obscured with a cover or other approved device that clearly indicates that the "00" wager is not available, even though it appears on the roulette wheel. Appropriate signage would also be required to be posted at any single zero roulette table using a double zero wheel and table layout, to inform players of the above.

The use of a double zero roulette wheel and layout in a single zero roulette game would not alter the wagers, the odds, the house advantage, or any other facet of the game of single zero roulette. It would, however, permit the game of single zero roulette to be played with a double zero number configuration on the roulette wheel, an arrangement in which some players have expressed interest.

Social Impact

The proposed amendments would offer casino licensees and their patrons another option in the game of single zero roulette, which may stimulate additional interest in that game.

Economic Impact

The proposed amendments may have a favorable impact upon casino licensees because they could use double zero roulette wheels and layouts in double zero or single zero roulette games, and would not be required to purchase, maintain and use separate single zero roulette wheels or layouts. However, any such cost savings may be offset by the somewhat slower pace of the game when played with a double zero roulette wheel, due to the respins of the wheel that will have to occur if the ball drops into the double zero (00) pocket. Moreover, the house advantage on a single zero roulette wheel is smaller than on a double zero roulette wheel, because the latter contains one additional pocket. Accordingly, the ultimate economic impact of this proposal upon casino licensees is unknown.

The amendments are not expected to have any economic impact upon the Commission, the Division of Gaming Enforcement, or casino patrons.

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Regulatory Flexibility Statement

A regulatory flexibility analysis is not required since the proposed amendments will only affect New Jersey 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.

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

Recodify existing (c) as **(d)** (No change in text.)

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; [and]

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).

BANKING

(a)

DIVISION OF REGULATORY AFFAIRS

Applications and Objections: Capital

Proposed Amendments: N.J.A.C. 3:1-2.9, 2.18 and 2.21

Proposed Repeals: N.J.A.C. 3:1-2.1 to 2.6 and 3:1-2.8

Proposed Recodification and Amendment: N.J.A.C. 3:1-2.7 to 2.8

Proposed New Rules: N.J.A.C. 3:1-2.1 through 2.7, and 2.20

Authorized By: Jeff Connor, Commissioner, Department of Banking

Authority: N.J.S.A. 17:1-8.1, 17:9A-10, 17:12B-17, 17:12B-24, 17:12B-226 and 17:16J-1 et seq.

Proposal Number: PRN 1992-376.

Submit comments by October 8, 1992 to:

Rule Comments
c/o William B. Waits
Regulatory Officer
Department of Banking
CN 040
Trenton, NJ 08625

The agency proposal follows:

Summary

The Department of Banking proposes to amend its rules regarding branch and charter application procedures for banks, savings banks and savings and loan associations to conform these rules with the relevant statutory law, as amended. In general, the same application procedures are set for banks, savings banks and savings and loan associations, consistent with the Department's policy of establishing similar rules for all depositories. In addition, the rules are amended to insure that all interested persons are given notice early enough in the application process to insure that they have an opportunity to participate.

Consistent with current procedures, the proposed rules require the following to be included with an application to establish a branch office: (1) a completed application form; (2) the application filing fee; (3) an original certification of a copy of the resolution authorizing the application; (4) a map of the trade area of the branch with all State and Federally chartered depositories marked thereon; (5) a copy of the depository's latest Consolidated Reports of Condition and Income as filed with the FDIC or Federal Reserve Board if a bank or a savings bank or its latest OTS Thrift Financial Report statement of condition if a savings and loan association; (6) if the proposed transaction involves the acquisition of deposits from another banking institution, pro forma balance sheet projections and projections of the ratio of Tier 1 capital to total assets before and after the transaction; (7) an executed indicia of title to the proposed site, an agreement to purchase or a lease; (8) if the branch site is to be acquired or leased from an affiliated person, an application as required by N.J.A.C. 3:1-10.2; (9) a copy of the depository's most recent Community Reinvestment Act Statement; (10) if a savings and loan association, proof of newspaper publication as required by N.J.S.A. 17:12B-24(B); and (11) all other documentation required of a specific applicant by the Commissioner or which the applicant wishes the Department to consider. An application to relocate a branch office has similar requirements, except it is not necessary for the depository to provide consolidated reports of condition or Community Reinvestment Act Statements.

Charter applicants must include the following: (1) an economic feasibility study, a business plan and yearly deposit estimates for five years; (2) a pro forma profit and loss statement; (3) the required application fee; (4) biographical and financial forms from each incorporator and prospective officer or director, and background check authorizations; (5) an indicia of title for the proposed site; (6) a filed copy of an application to the Federal Deposit Insurance Corporation ("FDIC") for deposit insurance; (7) the proposed directors' code of conduct governing their activities both in and outside the bank; (8) if the site is to be acquired or leased from an affiliated person, an application as required by N.J.A.C. 3:1-10.2; and (9) all other information required of a specific applicant by the Commissioner. The proposed rules require the Commissioner to accept or reject a charter application within one year after application.

The notice that must be given upon a branch or charter application is also defined. For charter applications, the proposed rules require notice for four weeks in a local newspaper, and notice to all nearby depositories. For branch applications, the proposed rules require notice to be published in a local newspaper. Notice of both charter and branch applications would also be published in the bulletins of the New Jersey Bankers Association, the New Jersey Council of Savings Institutions and the New Jersey Savings League.

The proposed rules also set guidelines for objections to charter applications, To be considered by the Commissioner, an objection to a charter application must be in writing and contain: (1) a summary of the reasons for protest; (2) the facts supporting the protest, including relevant economic or financial data; (3) any adverse effects on the objector which

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may result from the approval of the application; (4) an indication as to whether the objector will object at the charter hearing, together with a fee of $750.00 if the objector does intend to appear; and (5) proof that the objection and a request for a copy of the application were mailed to the applicant. The Commissioner is entitled to reject the objection of any person not complying with these rules.

Upon receipt of an objection, the applicant shall forward copies of the application and supportive data to the objector. The objector may then file additional comments regarding matters contained in the application. The Commissioner is specifically authorized to extend the time periods for objections set forth in the rules.

The proposed rules also set procedures for objections to branch applications. Such an objection must be filed with the Department within 10 days of the last day of publication of notice, unless an extension is granted. The objection must be in writing and contain: (1) a summary of the reasons for protest; (2) facts supporting the protest, including relevant economic or financial data; (3) any adverse effects on the objector which may result from approval of the application; (4) an indication as to whether the objective applies to have a branch hearing, accompanied with a fee of $750.00 if he does; and (5) proof that the objection and a request for a copy of the application were mailed to the applicant. The $750.00 fees for branch and charter hearings is intended to reimburse the Department for administrative costs.

Upon receiving notice that an objection has been filed, the applicant must forward to the objector copies of the application and all supportive data. The objector may then file additional comments regarding matters contained in the application. Within 10 days after receiving final comments from the objector, the Commissioner shall notify the objector and the applicant as to whether the objection is substantial and will therefore be considered. An objection is considered substantial if: (1) it is in writing and filed on time; (2) it contains a summary of the reasons for protest, a statement of the specific matters in the application to which the protestant objects and the reason for the objection, facts supporting the protest and a summary of any adverse effects on the objector which may result from the approval of the application; and (3) it pertains to at least one of the criteria for approval. The applicant may then respond to these protests. The proposed rules also set standards for the Department to follow when considering requests for oral presentations on branch applications. Ordinarily, there are no oral presentations on minibranch, communication terminal branch, auxiliary or limited facility branch office applications.

The proposed amendments also set forth a $6 million capital requirement before chartering a bank or association. A depository with $6 million in capital and average asset growth over its first five years can in most instances maintain a satisfactory capital rate. Trust companies which do not take depositos, otherwise known as limited purpose trust companies, are required to have capital of $4 million. In addition, an application for a charter incident to the purchase of a failed institution or a branch or branches or a failed institution, may provide for stated capital of $4,000,000 or more, or six percent of deposits acquired, whichever is greater, so long as the depository agrees to raise additional capital to reach $6,000,000 within one year following issuance of the Certificate of Authority while also satisfying the capital requirements set forth in N.J.A.C. 3:4.

The incorporators are required under the proposed rules to subscribe to at least 25 percent of the total capital. The balance shall be offered to the general public. The proposed amendments prohibit one individual from subscribing to more than 24.9 percent of the total capital stock. In addition, no company may subscribe for stock in excess of 24.9 percent of the total capital required, except a holding company that has registered in accordance with State and Federal law and regulations if required.

Finally, the new rules set forth the conditions for charter approval. These conditions are as follows: (1) if the depository is authorized to take deposits, the depository must become a member of the Federal Deposit Insurance Corporation (FDIC); (2) the depository may not merge, consolidate or sell, either directly or indirectly, with or to any other institution or holding company for five years after issuance of the certificate of authority unless the Commissioner, upon application and as a result of unusual circumstances, deems it advisable; (3) the depository will issue and sell shares of its authorized capital stock in sufficient amount to raise its capital base before commencement of operations to at least the minimum amount set forth in N.J.A.C. 3:1-2.21, and will obtain prior approval from the Department for any person purchasing more than five percent of the authorized capital stock; (4) the depository shall not make loans to directors of the depository, corporations in which a director has a controlling interest or in which a director together with one or more other director has a controlling interest, partnerships in which a director is a general or limited partner or persons owning over five percent of the depository or its holding company, for the first three years after issuance of the certificate of authority; (5) the depository for the first three years after issuance of the certificate of authority shall not offer deposits which yield more than 50 basis points above the highest rate offered by a depository in its trade area; (6) for the first three years after issuance of the certificate of authority, the depository shall obtain prior approval from the Commissioner before installing any person on the board of directors or employing any person with the depository in an executive officer position as defined in N.J.A.C. 3:6-3.1; and (7) such other conditions for a specific applicant as the Commissioner deems appropriate.

Social Impact

Upon being chartered, depositories are uniquely authorized to safeguard the deposits and other funds of persons in the State. To do this, it is necessary for the depository to have substantial amounts of capital to withstand lean years. Otherwise, an institution unable to meet its obligations could reduce public confidence in the industry and cost the taxpayers significant amounts in deposit insurance. The proposed amended rules require an applicant for a charter to have $6 million in capital, and for a trust company to have $4 million. These minimum capital amounts, it is thought, will provide those institutions with sufficient strength to survive their difficult, formative years and flourish.

The proposed new rules place conditions on charter approval. By conditioning approval on FDIC insurance, there will be a beneficial social impact of having all deposits up to $100,000 insured by the FDIC. This provides total security to most consumers. The conditions regarding loans to directors will have a beneficial social impact of deterring persons from chartering banks for personal benefit at the expense of the institution. By limiting the interest rates which depositories may pay in early years, the proposed rules will prevent unhealthy growth by an institution soon after being chartered.

The proposed rules and amendments will have the beneficial impact of insuring that notices of applications are available to the public and to financial institutions in the affected communities. The proposed rules also set guidelines for comments and objections to applications. By providing for these notices and objections, the Department will learn of pertinent information concerning an application before the Commissioner decides the matter.

Economic Impact

The proposed new rules and amended rules do not impose any new fees on depositories or others. The fees imposed for attending a charter hearing and for a branch hearing are codified in currently existing rules which will be repealed upon adoption. However, the fee for appearing at a charter hearing is increased from $500.00 to $750.00 to reflect increased administrative costs.

Regulatory Flexibility Analysis

Banks, savings banks and savings and loan associations are predominantely small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., and these proposed new rules and amendments impose requirements in the application process. In particular, depositories will be required to provide specified materials to the Department upon a branch or charter application, will have to provide notice of an application to the public and to institutions in their community. In addition, applicants will need to provide copies of applications by objectors upon request. Beyond the specific fees imposed, the cost of these requirements will vary with the circumstances of each specific bank or branch application. Compliance with the requirements of these rules may require the services of an accountant or attorney.

Most, if not all, of these requirements are imposed by current statutes, rules and policies of the Department. To the extent that new requirements are imposed, no differentiation based on business size is made because these procedures are necessary in all applications to ensure that objectors have input and the Department has sufficient information to make informed decisions.

Full text of the proposed repeals may be found in the New Jersey Administrative Code at N.J.A.C. 3:1-2.1 to 2.6 and 2.8.

Full text of the proposed amendments and new rules follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

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3:1-2.1 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise.

"Bank" shall mean a New Jersey chartered bank, as defined in section 1 of P.L. 1948, c.67 (N.J.S.A. 17:9A-1).

"Banking institution" shall mean a depository, or a similar institution chartered by the Federal government or another state.

"Branch application" shall mean an application by a depository to establish a full branch or a minibranch office, or to relocate a principal office, full branch office or minibranch office, or to interchange a principal office and full branch office.

"Commissioner" shall mean the Commissioner of the New Jersey Department of Banking.

"Company" means any corporation, partnership, business trust, association or any other person except an individual.

"Controlling interest" means ownership or control of a majority of the issued and outstanding capital stock or securities of a corporation, having voting rights.

"Department" shall mean the New Jersey Department of Banking.

"Depository" shall mean a bank, savings bank or savings and loan association.

"Individual" shall mean a natural person.

"Savings and loan association" shall mean a New Jersey chartered savings and loan association, and shall include a capital stock association and a mutual association.

"Savings bank" shall mean a New Jersey chartered savings bank, and shall include a capital stock savings bank and a mutual savings bank.

3:1-2.2 Charter applications

(a) Every applicant for a depository charter is required to file with the Department the following data in addition to the statutorily required certificate of incorporation and affidavits (see N.J.S.A. 17:9A-9, 17:12B-14 and 17:12B-246):

1. An economic feasibility study delineating the proposed trade area to be served by the applicant, as well as yearly deposit estimates for the first five years of operation;

2. A pro forma balance sheet and profit and loss statement which shall project the financial condition and net income or loss of the depository on an annual basis for a period of five years and shall indicate the anticipated break-even date, and a business plan for the depository;

3. Departmental forms completed by each incorporator and prospective officer and director containing biographical and financial information, and authorizations by such persons for background checks;

4. The required non-refundable application filing fee;

5. An indicia of title for the proposed site;

6. A filed copy of an application to the Federal Deposit Insurance Corporation for deposit insurance;

7. The proposed directors' code of conduct governing activities both inside and outside the bank;

8. If the site is to be acquired or leased from an affiliated person, an application as required by N.J.A.C. 3:1-10.2; and

9. All other information required of a specific applicant by the Commissioner.

(b) The Commissioner may return to the applicant any charter application which does not comply with (a) above.

(c) The Commissioner shall accept or reject a charter application within one year after the applicant submits the application. The failure of the applicant to provide all necessary information within one year shall constitute sufficient grounds to reject the application. The Commissioner may extend the one-year limitation when the applicant is not substantially at fault for the delay.

3:1-2.3 Bank applications

(a) An application by a depository to establish a branch office or a minibranch office shall contain the following before it will be accepted by the Department:

1. A completed current application form, including the name of the depository and the location of the applied for branch or minibranch office;

2. The required application filing fee;

3. An original certification of a copy of the resolution authorizing the application;

4. A map of the trade area of the branch with all State and Federally chartered depositories marked thereon;

5. A copy of the depository's latest Consolidated Reports of Condition and Income as filed with the FDIC or Federal Reserve Board if a bank or a savings bank, or its latest OTS Thrift Financial Report statement of condition if a savings and loan association;

6. If the proposed transaction involves the acquisition of deposits from another banking institution:

i. Pro forma balance sheet projections reflecting the acquiring depository before and after the acquisition; and

ii. Projections of the ratio of Tier 1 capital to total assets of the depository before and after the acquisition;

7. An executed indicia of title to the proposed site, an agreement to purchase or a lease;

8. If the branch site is to be acquired or leased from an affiliated person, an application as required by N.J.A.C. 3:1-10.2;

9. A copy of the depository's most recent Community Reinvestment Act Statement;

10. If a savings and loan association, proof of newspaper publication as required by N.J.S.A. 17:12B-24(B); and

11. All other documentation required of a specific applicant by the Commissioner or which the applicant wishes the Department to consider.

(b) An application by a depository to relocate a principal office, full branch office or minibranch office shall contain the following before it will be accepted by the Department:

1. A completed current application form, including the name of the depository and both locations involved in the applied for relocation;

2. The required application filing fee;

3. An original certification of a copy of the resolution authorizing the application; and

4. A map of the trade area where the principal office, branch office or minibranch office will be located with all State and Federally chartered depositories marked thereon;

5. An executed indicia of title to the proposed site, an agreement to purchase or a lease;

6. If the branch site is to be acquired or leased from an affiliated person, an application as required by N.J.A.C. 3:1-10.2;

7. If a savings and loan association, proof of newspaper publication as required by N.J.S.A. 17:12B-27.1; and

8. All other documentation required of a specific applicant by the Commissioner or which the applicant wishes the Department to consider.

(c) An application by a depository to interchange a branch office and a principal office shall contain the following before it will be accepted by the Department:

1. A completed current application form, including the name of the depository and the location of each office involved in the applied for interchange;

2. The required application filing fee;

3. An original certification of a copy of the resolution authorizing the application; and

4. All other documentation required of a specific applicant by the Commissioner or which the applicant wishes the Department to consider.

(d) The Commissioner may return to the applicant any branch application which does not comply with (a), (b) or (c) above.

(e) The Commissioner shall accept or reject a branch application within one year after the applicant submits the application. The failure of the applicant to provide all necessary information within one year shall constitute sufficient grounds to reject the application. The Commissioner may extend the one-year limitation when the applicant is not substantially at fault for the delay.

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3:1-2.4 Charter applications; notice and publication

(a) When a charter application is complete, the Department shall send written notice to the applicant setting forth a hearing date. In addition, the Department shall send written notice to the New Jersey Bankers Association, the New Jersey Council of Savings Institutions and the New Jersey Savings League for publication in their weekly bulletins.

(b) Within 10 calendar days after notification of the formal hearing date for any charter application, the applicant shall publish notice of the application once a week for four successive weeks in a newspaper designated by the Commissioner, which is published and circulated in the municipality in which said charter is proposed to be established, or if there be no such newspaper, then in a newspaper of general circulation in the municipality.

(c) The notice shall contain the following:

1. The names of the incorporators;

2. The name and mailing address of the applicant;

3. The proposed location of the principal office;

4. The amount of capital stock and surplus, or the amount of capital deposits, whichever is applicable; and

5. The hearing dates.

(d) The incorporators shall cause a copy of the notice in the form prescribed in (b) above to be forwarded to the chief executive officer of every banking institution having an office within five miles of the proposed location, and to such other offices as the Commissioner shall designate, not more than 10 calendar days after formal notification of the formal hearing date and at least three weeks before the scheduled hearing. Regarding applications of savings and loan associations, the incorporators shall also cause a copy of the notice in the form prescribed by (b) above to be forwarded to the chief executive officer of every banking association having an office within the county where the principal office of the State association is to be located, if not within five miles.

3:1-2.5 Branch applications; notice and publication

(a) When a branch application is accepted, the Department shall send written notice to the applicant and to the New Jersey Bankers Association, the New Jersey Council of Savings Institutions and the New Jersey Savings League for publication. Each notice shall contain the following:

1. The name and mailing address of the applicant;

2. A brief statement of the nature of the application;

3. The precise location of the site involved in the particular application; and

4. The date the Department accepted the application.

(b) Notice prescribed by (a) above shall be published in the weekly bulletins of the New Jersey Bankers Association, the New Jersey Council of Savings Institutions, and the New Jersey Savings League in the week following acceptance thereof. The publication of notice shall also include the following statement:

"You are hereby advised that an individual, bank, savings bank or savings and loan association may object to any full branch or relocation application, and may request that an oral presentation be conducted if so requested in writing and if filed within 10 calendar days of the date of this bulletin. Individuals or financial institutions interested in perfecting an objection or request for oral presentation should immediately consult the Department's procedural rules for guidance."

(c) Within 15 days after receiving notification from the Department that the application was accepted, the applying depository shall publish notice if the application in a newspaper published within the municipality in which it proposes to locate the branch office if there is one, and if there is no such newspaper, in a newspaper published in the county and having a substantial circulation in the municipality. The notice shall contain the name and address of the applying depository, the proposed location and the statement contained in (b) above.

3:1-2.6 Charter applications; objections and oral presentations

(a) An objection to a new charter application of a depository must be filed in the Department of Banking within five business days of the last day of publication or notice of application, or within 10 business days after receiving mailed notice from the applicant as provided in these rules, whichever is later.

(b) To be considered by the Commissioner, an objection shall be in writing and contain:

1. A summary of the reasons for protest;

2. Facts supporting the protest, including relevant economic or financial data;

3. Any adverse effects on the objector which may result from the approval of the application;

4. An indication as to whether the objector will object at the charter hearing. A fee of $750.00 shall accompany a notice of intent to appear at a charter hearing; and

5. Proof that the objection and a request for a copy of the application were mailed to the applicant.

(c) Upon receipt of notice that an objection has been filed, an applicant shall within five calendar days forward and deliver to the objector copies of the application and all supportive data submitted relative to the application. The applicant shall file with the Commissioner proof of delivery to and receipt by the objector of this data. Within seven days after receiving this data, the objector may then file additional comments with the Department regarding matters contained in the application, and shall send copies of all comments to the applicant.

(d) The Commissioner may dismiss the objection of any objector not complying with this section, and may consider noncompliance by an applicant when considering the charter application.

(e) The Commissioner may extend any time period set forth in this section to allow for an objection and/or for consideration of an objection by the applicant or the Department.

(f) A formal hearing, pursuant to the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq., shall be held on all charter applications. Only those objectors which comply with this section shall be permitted to appear at the hearing.

3:1-2.7 Branch applications; objections and oral presentations

(a) An objection to a branch application must be filed with the Department within 10 days of the last day of publication of notice, or 30 days after that day if an extension is requested in writing within the 10-day period. An objection to a minibranch application must be filed within 20 days after publication.

(b) An objection shall be in writing and contain:

1. A summary of the reasons for protest;

2. Facts supporting the protest, including relevant economic or financial data;

3. Any adverse effects on the objector which may result from approval of the application;

4. An indication as to whether the objector applies to have a branch hearing. A fee of $750.00 shall accompany an application for a branch hearing. If it is later determined that an oral presentation will not be held, the fee will be returned to each of the objectors requesting an oral presentation; and

5. Proof that the objection and a request for a copy of the application were mailed to the applicant.

(c) Upon receiving notice from the objector that an objection has been filed, an applicant shall within seven calendar days forward and deliver to the objector copies of the application and all supportive data submitted relative to the application. The applicant shall file with the Department proof of delivery to and receipt by the objector of this data. Within 14 calendar days after receiving data from the applicant, the objector may file additional comments with the Commissioner regarding matters contained in the application, and shall send copies of all comments to the applicant.

(d) Within 10 days after receiving final comments from an objector, the Commissioner shall notify the objector and the applicant as to whether the objection is substantial and will therefore be considered. An objection is substantial only if:

1. It is in writing and filed on time;

2. It contains a summary of the reasons for protest, a statement of the specific matters in the application to which the protestant objects and the reason for the objection, facts supporting the protest including relevant economic or financial data, and a summary of

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any adverse effects on the objector which may result from the approval of the application; and

3. It pertains to at least one of the criteria for approval.

(e) The applying depository may file an answer to any substantial objection until 15 days after receipt of written notice from the Commissioner that such protest is considered substantial by furnishing four copies of the answer to the Commissioner.

(f) The Department may grant a request for oral presentation on applications for branch application only if:

1. The objector requesting the oral presentation has filed and perfected an objection and oral presentation request; and

2. The objector requesting the oral presentation has presented sufficient reasons indicating that it is necessary and warranted and that the matter cannot be resolved on the papers.

(g) Notwithstanding (f) above, the Department may schedule a hearing or oral presentation on any application if deemed necessary or warranted under the circumstances.

(h) There shall ordinarly be no oral presentations on minibranch, communication terminal branch, auxiliary or limited facility branch office applications.

3:1-[2.7]**2.8** Insufficiency of data in support of application; hearing

(a) In any matter where the [Commissioner, deputy commissioner or regulatory officer] **Department** shall find that the applicant or objector has not filed sufficient data, information or material in support of or in opposition to [the] **a branch application or a charter** application, the applicant or objector may be required to file supplementary data, information or material, or be subject to dismissal of the application or objection.

(b) and (c) (No change.)

3:1-2.9 Oral presentations

(a) If there is to be oral presentation, the Department shall notify the applicant and objector, if any, of the date, time, place and nature of the proceeding.

(a) through (d) recodified as **(b) through (e).** (No change in text.)

3:1-2.18 Officially recognized data sources

(a) The [department] **Department** will take official notice of one or more of the following data sources when testing the accuracy of data submitted in conjunction with applications and objections, when resolving factual discrepancies and when weighing accuracy, reasonableness and applicability of documentary and oral evidence before it:

1. to 21. (No change.)

22. Various County Planning Board Reports, for example, population studies and projections, employment trends, industrial-commercial development studies, and so forth; **and**

23. New Jersey Department of Banking, [Division of Banking,] Annual Report[; and].

[24. New Jersey Department of Banking, Division of Savings and Loan Associations, Annual Report.]

(b) and (c) (No change.)

3:1-2.20 [Reserved] **Charter applications; conditions for approval**

(a) The Commissioner shall condition approval of a charter application by a depository on the following:

1. If the depository is authorized to take deposits, on the depository becoming a member of the Federal Deposit Insurance Corporation;

2. The depository will not merge, consolidate or sell, either directly or indirectly, with or to any other institution or holding company for five years after issuance of the certificate of authority unless the Commissioner, upon application and as a result of unusual circumstances, deems it advisable;

3. The depository will issue and sell shares of its authorized capital stock in sufficient amount to raise its capital base before commencement of operations to at least the minimum amount set forth in N.J.A.C. 3:1-2.21, and will obtain prior approval from the Department for any person purchasing more than five percent of the authorized capital stock;

4. The depository shall not make loans to directors of the depository, corporations in which a director has a controlling interest or in which a director together with one or more other directors has a controlling interest, partnerships in which a director is a general or limited partner, and persons owning over five percent of the depository or its holding company, for the first three years after issuance of the certificate of authority;

5. The depository for the first three years after issuance of the certificate of authority shall not offer deposits which yield more than 50 basis points above the highest rate offered by a depository in its trade area;

6. For the first three years after issuance of the certificate of authority, the depository shall obtain prior approval from the Commissioner before installing any person on the board of directors or employing any person with the depository in an executive officer position as defined in N.J.A.C. 3:6-3.1; and

7. Such other conditions for a specific applicant as the Commissioner deems appropriate.

3:1-2.21 Mininum **and maximum** stock subscriptions [for capital stock associations]

(a) Each charter application for a [capital stock association] **depository** shall provide for stated capital of **at least** [$7,000,000] **$6,000,000**, or such other amount as required by the Commissioner; **except that an application for a charter for a trust company, which does not have authority to take deposits, may provide for stated capital of $4,000,000 or more; and except that an application for a charter incident to the purchase of a failed institution or a branch or branches of a failed institution, may provide for stated capital of $4,000,000 or more, or six percent of deposits acquired, whichever is greater, so long as the depository agrees to raise additional capital to reach $6,000,000 within one year following issuance of the Certificate of Authority while also satisfying the capital requirements set forth in N.J.A.C. 3:4.**

(b) The incorporators of a [capital stock association] **depository** shall subscribe to [such number of shares as may be required by the Commissioner] **all stock listed as issued on the certificate of incorporation, which shall be at least 25 percent of the total capital required by (a) above.**

(c) The balance of the capital stock, if any, shall be offered to the general public in the area to be served by the [capital stock association] **depository** if and when the application is approved and under such terms and conditions as set forth in the Commissioner's Decision and Order.

(d) No individual shall subscribe for stock in excess of 24.9 percent of the total capital required by (a) above.

(e) No company may subscribe for stock in excess of 24.9 percent of the total capital required by (a) above, except a holding company that has registered in accordance with state and Federal law and regulations if required.

EDUCATION

(a)

STATE BOARD OF EDUCATION

Pupil Records

Conditions for Access to Pupil Records

Proposed Amendment: N.J.A.C. 6:3-2.6

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, 18A:4-15, 18A:36-19, 18A:36-192 and Public Law 94-142.

Proposal Number: PRN 1992-388.

Submit written comments by October 8, 1992 to:
Irene Nigro, Rules Analyst
N.J. Department of Education
225 West State Street, CN 500
Trenton, New Jersey 08625-0500

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The agency proposal follows:

Summary

The proposed amendments to N.J.A.C. 6:3-2.6 were developed in response to the United States Department of Education's Office of Special Education (OSEP) review of the State Department of Education Special Education "Program Plan For Fiscal Years 1992-1994 Under the Individuals with Disabilities Education Act." This program plan is a requirement of the Individuals with Disabillities Education Act, P.L. 101-476, as amended by P.L. 102-119. Federal funding for State special education programs is dependent upon compliance with the Federal requirements under this Act.

OSEP reviews the State's implementation of the pupil records requirements as provided for in the Federal Family Education Rights and Privacy Act (FERPA), otherwise known as the Buckley amendment, 20 U.S.C. §1232g. As a result of this review, N.J.A.C. 6:3-2.6 was found to be in conflict with 34 CFR 300.562 of the FERPA requirements. The OSEP is requiring that the Department amend N.J.A.C. 6:3-2.6 to conform with the FERPA before they will approve State special education program plan and release special education funds to New Jersey.

The proposed amendments would eliminate the provision in N.J.A.C. 6:3-2.6 which allows the chief school administrator to determine if disclosure of a pupil record would create substantial risk of harm to the pupil or to the person with whom the record is concerned. New language has been added which requires, before a record may be withheld from a parent of a pupil under 18 or from an adult pupil, that the district board of education obtain a court order or that the district board be provided with evidence that there is a court order revoking the right to access. N.J.A.C. 6:3-2.6 would further be amended to require that only that portion of the record designated by the court order may be withheld. These amendments would also require the board of education to notify, in writing, within five days, the parent or adult pupil that the request to access a pupil record has been denied. Such decision may be appealed to the court issuing the order. The proposed amendments will bring N.J.A.C. 6:3-2.6 into conformity with the Federal Family Education Rights and Privacy Act and assure continued funding for our State's special education programs.

Social Impact

It is expected that the proposed amendments to bring N.J.A.C. 6:3-2.6 into conformity with the Federal Family Education Rights and Privacy Act will have a positive social impact. By specifying the conditions under which a pupil record may be withheld from a parent of a pupil under 18 or from an adult pupil, the amendments will ensure the protection of parents and adult pupil's rights of access to information in pupil records.

Economic Impact

Adoption of the proposed amendments will have no significant economic impact for the State, district boards of education or the public since no additional staff or resources are required. However, if these amendments are not made the United States Department of Education Office of Special Education Programs (OSEP) will not approve the State's special education program plan for the fiscal years 1992-1994 and release special education funds to New Jersey. New Jersey stands to lose $69,814,471 in funds. These amendments bring N.J.A.C. 6:3-2.6 into compliance with the Federal Family Education Rights and Privacy Act.

Regulatory Flexibility Statement

A regulatory flexibility statement is not required because these rules do 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. The rules impact 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]):

6:3-2.6 Conditions for access to pupil records

(a) All authorized organizations, agencies and persons defined in this subchapter shall have access to the records of a pupil, subject to the following conditions:

1.-4. (No change.)

5. A record may be withheld from a parent of a pupil under 18 or from an adult pupil only when the [chief school administrator in consultation with the professional staff is convinced that the disclosure would create a subtantial risk of harm to the pupil or to a person with whom the record is concerned] **local education agency obtains a court order or is provided with evidence that there is a court order revoking the right to access. Only that portion of the record designated by the court may be withheld.** When the [chief school administrator is convinced that the risk is of such high degree, he or she shall notify] **local education agency has or obtains evidence of such court order** the parent or adult pupil **shall be notified** in writing within five days **of his or her request** that access to the record has been denied and that the person has the right to appeal this decision to the [Commissioner of Education] **court issuing the order.** [If an appeal is made, the Commissioner shall designate a professional of the same discipline as the originator of the record to review the record and to recommend whether access should be granted. The Commissioner shall make a determination within 30 days of the receipt of the request. Any decision made by the Commissioner may be appealed to the State Board of Education.]

(a)

STATE BOARD OF EDUCATION

Thorough and Efficient System of Free Public Schools

Proposed Repeal and New Rules: N.J.A.C. 6:8-1, 2, 3 and 4

Proposed Recodification: N.J.A.C. 6:8-5 as 6:8-5A.3 through 5A.7

Proposed Amendments: N.J.A.C. 6:8-8.1 and 8.4

Proposed New Rules: N.J.A.C. 6:8-5 and 6:8-5A.1 and 5A.2

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, 18A:4-15, as supplemented and amended by N.J.S.A. 18A:7A-1 et seq.

Proposal Number: PRN 1992-389.

Submit written comments by October 8, 1992 to:
Irene Nigro, Rules Analyst
N.J. Department of Education
225 West State Street, CN 500
Trenton, New Jersey 08625-0500

The agency proposal follows:

Summary

In accordance with the provisions of N.J.S.A. 18A:7A-1 et seq., the rules at N.J.A.C. 6:8 were originally adopted in January 1976 to ensure the existence of a thorough and efficient system of free public schools. The underlying premise of the law as implemented by these rules is the requirement for educational program planning by the local school district. The law and rules emphasize involvement of the public and teaching staff members in the setting of educational goals. The rules extend provisions for involvement of the public by mandating consultation with parents and guardians regarding pupil progress toward district and school educational goals and objectives; communication regarding pupil participation in State preventive and/or remedial programs; and establishment of a policy for reporting progress to parents and guardians. Community involvement is enhanced by the requirement for annual reporting prior to September 30, of the district's progress and plans in implementing local goals, objectives and standards. These rules require the Commissioner of Education to recommend to the State Board of Education for certification those districts that have met the prescribed standards.

P. L. 1991, c.3 amended the provisions in N.J.S.A. 18A:7A-1 et seq. and halted the evaluation of all school districts except those in Level II or Level III monitoring until July 1993. The legislation also required the appointment of a State Task Force on Educational Assessment and Monitoring to establish new standards for the evaluation of school districts. The task force reviewed the Statewide system for evaluating the performance of each school to determine the State performance standards that would most effectively achieve the legislative goal of a thorough and efficient system of free public schools. The task force

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recommended criteria for the certification of school districts and performance indicators for certified school districts. The task force submitted its report to the State Board of Education and the Joint Committee on the Public Schools. The report included recommendations for a uniform, Statewide system to evaluate the performance of each school pursuant to State performance standards.

Based upon this law, the State Board of Education must establish State goals and standards, and adopt rules concerning procedures for the establishment and assessment of educational goals, learning objectives and performance standards for local boards of education by December 1992. The procedure for evaluation of all public schools in the State shall become effective July 1, 1993.

Subchapters 1, 2, 3, and 4 are being repealed in their entirety. A review of each of the proposed subchapters of N.J.A.C. 6:8 follows:

Subchapter 1. Definitions

This proposed subchapter defines words and terms used in the chapter. Definitions were added for the following terms: behavior standard, benchmark, certification with conditions, challenge objective, curriculum, curriculum content standards, information processing skills, performance assessment, quality assurance annual report, school-level plan, school profile, and statement of assurance.

Subchapter 2. State Educational Goals and Standards

This proposed subchapter lists the State educational goals developed by the State Board of Education and describes State standards for the administration of a thorough and efficient system of free public schools. Pursuant to P. L. 1991, c.3, the subchapter also requires the State Board of Education to review the State educational goals and standards in consultation with the Commissioner and the Joint Committee on the Public Schools.

Subchapter 3. Reporting and Staffing of School Districts

This proposed subchapter requires district boards of education annually to submit data on each school on demographics, dropouts, pupil achievement in basic skills and required fiscal reports. This subchapter also requires district employment of certified teaching staff members and other support personnel to meet the specific instructional needs of pupils. The requirement for a July 1 report is now contained in N.J.A.C. 6:8-4.4, School-level Planning.

Subchapter 4. Procedures for the Evaluation of the Performance of Each Public School District

This proposed subchapter describes the standards and procedures for the evaluation and certification of school districts. N.J.A.C. 6:8-4 contains the eight elements and the prescribed indicators of standards of acceptable performance which are to be evaluated by the State monitoring teams. Quality assurance and school-level planning are two new elements. Under the quality assurance program, school-level plans will be developed and linked directly to student performance. Parents must be involved in the development of these plans. Statewide assessments will be administered in grade four as well as grades eight and 11. In addition to mathematics, reading and writing, Statewide assessments will be conducted in science, geography, history and civics.

Subchapter 5. Rules for Level II and Level III Districts

This proposed subchapter provides for the appointment of a team of persons by the county superintendent of schools to review the performance of a district which has failed to become certified. N.J.A.C. 6:8-5 also provides for intervention, by recommendation of the Commissioner of Education and administrative order of the State Board of Education, in cases where a non-certified district does not demonstrate reasonable progress toward compliance with school law or regulation and/or resolution of major problems. In accordance with the amendments to the monitoring law, the external review process now occurs at Level II, rather than Level III.

Subchapter 5A. Interim Rules for Districts in Level II and III Monitoring Prior to July 1, 1993

Subchapter 5 is being recodified as Subchapter 5A and provides rules for those districts that were placed in Level II and III before July 1, 1993. These rules are part of the interim monitoring code adopted in January 1992 and will be in effect for a period of two years (July 1, 1993 through June 30, 1995). At that time, these rules will be repealed and all districts will need to comply with Subchapter 5.

Subchapter 8. Approved Public Elementary and Secondary School Summer Sessions

This subchapter delineates the rules for the operation, staffing, admissions and grade placement of pupils in elementary and secondary school summer sessions. As a result of public comment and after careful study, the Department of Education has amended this subchapter to include the options for receiving credit for approved summer sessions which are consistent with options provided during the regular-year program.

Social Impact

Adoption of these new rules and amendments will ensure a thorough and efficient pupil school system pursuant to the provisions of N.J.S.A. 18A:7A et seq. and P. L. 1991, c.3 and will have a positive social impact upon the State of New Jersey. The proposed changes will limit both the monitoring and the paperwork aspects of the rules to that which is essential. Under supervision of the county superintendents, every district in the State will be rigorously monitored. Thereafter, the monitoring process will become considerably more focused. Districts that meet essential requirements and are found to be in compliance will be monitored only at seven-year intervals.

Limiting review of districts that are in compliance with the law and rules will not only free them from unproductive paperwork but also will allow the State to direct more of its efforts and limited resources towards assisting districts which are not in compliance. Such districts will be subject to more frequent, indepth and, if necessary, continuous review and assistance until their problems are satisfactorily resolved.

Those few districts which cannot or will not resolve their problems will be held accountable. When necessary, the Commissioner will use his or her authority under law to assure the delivery of appropriate educational programs and services by local districts.

It is expected that these new rules will also have a positive impact on the population of public school pupils at risk of school failure by creating a structure for district boards of education to plan for their educational needs on an annual basis. The rules provide a flexible framework for planning programs and services and create mechanisms for review and approval of district plans and fiscal support of the program structure.

Economic Impact

The assistance, monitoring and evaluation prescribed by these rules in effect provides oversight of proper expenditure of State and local funds pursuant to the State aid funding formula in N.J.S.A. 18A:7D-1 et seq.

As a result of the current level of appropriation to the Department of Education for fiscal year 1993, funds are insufficient to implement the proposed rules, specifically, to:

1. Provide sufficient staff to prepare and monitor school districts;
2. Develop fourth grade assessments in reading, mathematics, writing, science and social studies;
3. Develop eighth and eleventh grade assessments in science and social studies; and
4. Develop curriculum content standards.

In order to implement the proposed rules, an additional $9 million is needed: $4 million for adequate staff and $5 million for development of assessments and curriculum content standards.

In addition, funds will be needed to support the external review teams required under the Level II monitoring process. Review team members will be reimbursed for travel, meals and lodging expenses incurred during the on-site review of a district. It is estimated that approximately $60,000 will be needed (eight teams at $7,500 each).

Regulatory Flexibility Statement

A regulatory flexibility statement is not required because these new rules and amendments do 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 rules impact solely upon New Jersey school districts and on schools operated by the New Jersey State Department of Education.

Full text of the rules proposed for repeal may be found in the New Jersey Administrative Code at N.J.A.C. 6:8-1, 2, 3 and 4.

Full text of the proposed amendments and new rules follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

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SUBCHAPTER 1. DEFINITIONS

6:8-1.1 Words and terms defined

The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

"Articulation" means continuity, consistency and interdependence in the curricular offerings of the successive divisions of the school system and among constituent, regional and sending-receiving districts.

"Assessment" means a written analysis of the current status of an educational system in terms of achieving its goals and objectives.

"Average daily attendance" means the total number of days present divided by the total possible number of days of attendance.

"Behavior standard" means a school-level standard related to attendance, dropout rate, expulsions, out-of-school suspensions, acts of violence and substance abuse.

"Benchmark" means interim performance level which is set to measure a school's progress toward the achievement of minimum State standards.

"Certification" means an acceptable rating in all indicators in the eight elements of the monitoring process.

"Certification with conditions" means certification that is contingent upon the district correcting identified deficiencies without additional diagnostic monitoring or technical assistance, within a specific period of time.

"Challenge objective" means a school-level objective which is developed when student performance or behavior is at or above minimum State standards.

"Community" means the community at large, including, but not limited to, the parents of pupils.

"Curriculum" means planned learning opportunities in order for pupils to achieve the intended outcomes of instruction.

"Curriculum content standards" means standards adopted by the State Board of Education in K-12 curriculum areas which define the knowledge and skills that a school should impart to all pupils to demonstrate competency in challenging subject matter.

"Element" means one of the eight components of the educational process which is reviewed during monitoring for the purpose of certifying school districts.

"Evaluation" means procedures used to determine the success of programs, projects, techniques and materials in relation to the achievement of goals, objectives and standards; that is, the act of making judgments based upon the data gathered.

"Goals" means a written statement of educational aspirations for learner achievement and the educational process stated in general terms.

"Indicator" means one of the subsections of the eight elements that contain specific criteria reviewed during the monitoring process.

"Information processing skills" means library, study, computer and technology skills.

"Minimum level of proficiency" means passing scores on the State tests established pursuant to N.J.S.A. 18A:7A-6 and the State-approved minimum levels of proficiency in grades where State testing does not take place.

"Monitoring" means the process by which the Commissioner of Education or his or her designee evaluates the status of each school district every seven years for the purpose of determining certification status.

"Municipal alliance" means the coordinated efforts of a community and school district with regard to substance abuse prevention programs.

"Objective" means a written statement of the intended outcome of a specific educational process.

"Performance assessment" means a variety of techniques for assessing pupil's achievement in areas that are not well measured by typical multiple choice tests, including such things as open-ended or constructed response questions, essays, portfolios of pupil's work, performance of what pupils know and can do, projects, demonstrations, and laboratory problems.

"Pupil at risk" means a pupil who is in danger of failure or dropping out of school because of specific cognitive, affective, economic, social and/or health needs. Pupils at risk shall be defined as pupils affected by one or more of the following conditions:

1. Failure to acquire the essential skills needed to stay on grade level, or performance below minimum levels of proficiency;
2. History of adjustment or behavioral problems;
3. Having been placed on long-term suspension for violation of school policies;
4. Being pregnant or a parent;
5. Being in jeopardy of not graduating;
6. Living in conditions of poverty as defined by eligibility for free meals or free milk;
7. History of poor school attendance;
8. Being limited in English language proficiency;
9. Being disaffected as defined in this subchapter;
10. Being disruptive as defined in this subchapter; and
11. Other characteristics identified by the district board of education which may place pupils at risk.

"Quality assurance annual report" means a report provided by the chief school administrator to the public which includes: implementation of school-level plans, achievement of performance objectives, school profiles, professional development activities, condition of school facilities, status of mandated program reviews and community support data.

"School-level plan" means a two-year plan which is developed by each school, is based on school profile data and includes student performance objectives, progress review by teaching, and administrative staff and parent involvement.

"School profile" means a profile of each school which is compiled annually by the district and which contains statistical information specified by the State Department of Education.

"Statement of assurance" means a document submitted by the chief school administrator to the county superintendent which verifies the development and implementation of the school-level plan, conduct of school-level meetings, written curricula, curriculum articulation and the development and implementation of a substance abuse prevention program.

SUBCHAPTER 2. STATE EDUCATIONAL GOALS AND STANDARDS

6:8-2.1 State educational goals

(a) The following State goals are applicable to all public school districts. It is the Department's intention that:

1. All children in New Jersey start school ready to learn.

i. Quality preschool opportunities be provided for all children, through collaboration between public schools and community agencies.

ii. Parent education programs be designed and implemented by all districts to assist parents in providing readiness experiences for their preschool children.

2. The high school graduation rate be at least 90 percent Statewide.

i. Al districts provide least restrictive, alternative programs for pupils who cannot succeed in the regular high school environment, including those students with disabilities.

ii. All districts provide dropout prevention programs for pupils at risk.

3. New Jersey pupils leave grades four, eight, and 11 having demonstrated competency in challenging subject matter including reading, writing, mathematics, science, and social studies (civics, history, and geography), health, physical education, and fine, practical and performing arts.

i. All districts implement State-approved curriculum content standards and appropriate assessments to enable pupils to succeed and to evaluate their performance.

ii. All districts provide staff development opportunities to ensure that teachers are adequately equipped to teach challenging and up-to-date subject matter and to implement effective teaching techniques.

4. All pupils learn to use their minds well, so that they may be prepared for responsible citizenship, further learning, and productive employment in our modern economy.

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i. All districts provide students with experiences in higher level thinking, information processing, the responsibilities of citizenship, and employability skills.

ii. All pupils demonstrate competency in the subject areas of health, physical education, fine, practical and performing arts, and career education.

iii. All pupils demonstrate respect for racial, cultural, ethnic and religious diversity.

5. All pupils increase their achievement levels in science and mathematics to contribute to our country's ability to compete academically with all other countries of the world.

i. All districts revise their curriculum offerings in science and mathematics according to State standards as they are developed.

ii. All districts provide staff training in the teaching of mathematics and science at grades K-12 to increase teachers' understanding of and ability to teach these subjects.

6. Every adult be literate and possess the knowledge and skills necessary to compete in a global economy and exercise the rights and responsibilities of citizenship.

i. Adult education programs be increased, in conjunction with local districts, community colleges and other educational agencies, to provide greater opportunities for adults to continue learning for work skills, leisure pursuits, intellectual and cultural growth and to assist their children in learning.

ii. Business and industry be encouraged to collaborate with educational agencies to design and increase access to educational programs for adults, such as flex time, distance learning, and interactive technology.

7. Every school in New Jersey be free of drugs and violence and offer a safe, disciplined environment conducive to learning.

i. All school districts develop partnerships with parents to establish the responsibilities of each to create and maintain safe and healthy educational environments for all pupils.

ii. All districts provide programs and staffing to deal with pupils at risk.

iii. All schools and communities expand their cooperative efforts to create drug and violence-free environments.

iv. All students develop a positive view of self and learn to use effective interpersonal skills.

6:8-2.2 State educational standards

The State educational standards shall be those set forth in N.J.A.C. 6:8-4.3 through 4.10 which shall be used for the implementation of a thorough and efficient system of free public schools in accordance with N.J.S.A. 18A:7A-1 et seq. and the New Jersey Constitution.

6:8-2.3 Review of State educational goals and standards

(a) The State Board of Education, after consultation with the Commissioner and review by the Joint Committee on the Public Schools, shall, from time to time, but at least once every five years, review and update the State goals and standards.

(b) In reviewing and updating these goals and standards, the State Board shall consult with the Commissioner of Labor, the Chancellor of Higher Education, the Commissioner of Health, the Commissioner of Human Services and other State employees and officers as deemed necessary.

SUBCHAPTER 3. REPORTING AND STAFFING OF SCHOOL DISTRICTS

6:8-3.1 Reports

(a) Each district board of education shall, on forms approved by the Commissioner and at specified times, submit:

1. Demographic data relative to each school;

2. Number and reasons for school dropouts;

3. Results of district and school assessment programs of pupil achievement; and

4. All required annual fiscal reports pursuant to law and rule.

6:8-3.2 Staffing

(a) Teaching staff members shall be employed by the district board of education based upon the specific instructional needs of pupils of the district and each school within the district. Pursuant to N.J.A.C. 6:11, the district board of education shall provide certified personnel needed to implement a thorough and efficient system of free public schools.

(b) Each school shall be assigned the services of a full-time non-teaching principal to be responsible for administration and supervision of the school.

1. When a full-time non-teaching principal is not assigned to a school, the district board of education, upon advice of the chief school administrator, shall submit to the Commissioner for approval a plan that ensures adequate supervision of pupils and staff.

SUBCHAPTER 4. PROCEDURES FOR THE EVALUATION OF THE PERFORMANCE OF EACH PUBLIC SCHOOL DISTRICT

6:8-4.1 General requirements

(a) The Commissioner of Education shall evaluate each school district's implementation of the standards required by this chapter.

(b) Based upon the evaluation, the Commissioner shall recommend to the State Board of Education the certification of each district meeting the criteria established in this chapter.

(c) The State Board of Education shall determine the certification of each district.

(d) A district certified pursuant to this chapter shall not be required to be formally evaluated for seven years.

(e) The Commissioner reserves the right to recommend that the State Board of Education rescind the certification of any district which may fall into non-compliance with the standards set forth in this chapter.

6:8-4.2 Evaluation procedures

(a) Each school district within a county shall be monitored beginning July 1, 1993, and if certified, every seven years thereafter by the monitoring team under the supervision of the county superintendent of schools.

1. The county superintendent of schools shall establish a monitoring schedule with the approval of the Assistant Commissioner, Division of County and Regional Services.

2. Each district scheduled for monitoring shall be notified in advance by the county superintendent of schools. The dates for such monitoring visits to the district shall be established in consultation with the chief school administrator of the district and, for special needs district, the director of the regional urban assistance center.

3. A representative of the county superintendent of schools shall conduct a pre-monitoring conference with a representative of the district to establish the monitoring format.

4. Prior to the monitoring visit, the county office representative shall request that the district representative provide such documentation materials that are unavailable at the county office. The district representative shall be directed to either forward the documentation materials or make them available at the time of the monitoring visit.

(b) During the monitoring visit, the team shall evaluate the school district pursuant to the elements and standards set forth in N.J.A.C. 6:8-4.3 through 4.10.

6:8-4.3 Quality assurance

(a) The quality assurance element shall be rated acceptable upon demonstration of performance in the following two indicators:

1. A quality assurance annual report:

i. By September 30 of each year, the chief school administrator shall provide a report to the public at a regular board of education meeting, which includes:

(1) Implementation of school-level plans (N.J.A.C. 6:8-4.4);

(2) Achievement of performance objectives (N.J.A.C. 6:8-4.4);

(3) Each school profile, including pupil performance results and student behavior data (N.J.A.C. 6:8-4.4);

(4) Professional development activities (N.J.A.C. 6:8-4.8);

(5) Condition of school facilities (N.J.A.C. 6:8-4.9);

(6) Status of mandated program reviews (N.J.A.C. 6:8-4.10); and

(7) Community support data contained in (a)2 below.

ii. By October 30 of each year, the chief school administrator shall submit a copy of the annual report to the county superintendent.

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iii. The documentation/activities shall be:
(1) The quality assurance annual report; and
(2) Board minutes; and
2. Community support:
i. Over a seven-year period, the district shall document community support through the following components:
(1) A review of demographic data;
(2) A community survey;
(3) Identification of available resources and linkages to social service agencies;
(4) Strategies to overcome any community and environmental conditions that hinder learning;
(5) Methods to eliminate any barriers to community participation;
(6) Planned level of community involvement; and
(7) Strategies for parental involvement and parent-teacher interaction.
ii. The documentation/activities shall be the quality assurance annual report.

6:8-4.4 School-level planning
(a) The school-level planning element shall be rated acceptable upon demonstration of performance in the following three indicators:
1. School profile:
i. By September 30 of each year, the district shall compile a profile of each school, which shall contain statistical information specified by the State Department of Education. This profile shall be disseminated to all staff and parents, and made available to the media.
ii. The documentation/activities shall be the school profile included in the annual report;
2. School-level plan:
i. By September 30, each school in the district shall develop and implement a two-year plan based on school profile data. This plan shall include pupil performance objectives, a review of progress by teaching and administrative staff, and the involvement of parents.
ii. At least once per semester, each school shall conduct meetings by grade level, department, team or similarly appropriate group to review the school level plan. Such review shall include:
(1) School profile data;
(2) Progress toward achieving pupil performance objectives; and
(3) Progress toward achieving content standards and core course proficiences.
iii. The documentation/activities shall be a statement of assurance, signed by each principal and submitted on the form prescribed by the Commissioner; and
3. Pupil performance objectives:
i. Each school in the district shall develop two or more objectives based on pupil performance or behavior standards as defined in N.J.A.C. 6:8-4.6 and 4.7. The objectives shall cover a period of no more than two years and be linked to State goals.
ii. The objectives shall be developed according to the following criteria:
(1) If pupil performance is below minimum State standards as defined in N.J.A.C. 6:8-4.6 and 4.7, objectives to meet such standards shall be established. Benchmarks (interim performance levels) shall be set to measure the school's progress toward the achievement of minimum State standards.
(2) If pupil performance is at or above minimum State standards, challenge objectives shall be established.
iii. By June 30 of each year, the chief school administrator shall submit each school's objectives to the county superintendent for review and approval. The report on the achievement of objectives or progress toward benchmarks for the previous year shall be contained in the September 30 annual report.
iv. Each school shall achieve its pupil performance objectives by:
(1) Meeting established benchmarks for minimum State standards; and/or
(2) Achieving challenge objectives or demonstrating progress toward meeting such objectives.
v. Each school that does not meet established benchmarks for pupil performance objectives or demonstrate progress toward meeting challenge objectives for two successive years shall be assigned a technical assistance team by the county superintendent to facilitate accomplishment of these objectives.
vi. The documentation/activities shall be:
(1) The quality assurance annual report; and
(2) Performance objectives.

6:8-4.5 Curriculum and instruction
(a) The curriculum and instruction element shall be rated acceptable upon demonstration of performance in the following four indicators:
1. Written curriculum:
i. By September 30 of each year, the chief school administrator shall verify that there are board-approved, written curricula for all pupils including the following programs and services:
(1) High school graduation requirements (N.J.A.C. 6:8-7.1(c)i);
(2) Instruction in the United States Constitution (N.J.S.A. 18A:6-3);
(3) New Jersey civics, history and geography (N.J.S.A. 18A:35-3);
(4) Drug and alcohol education (N.J.S.A. 18A:40A-1 and N.J.A.C. 6:29-6);
(5) Health, safety and physical education (N.J.S.A. 18A:35-5, 7, 8);
(6) Accident and fire prevention (N.J.S.A. 18A:6-2; and
(7) Family life education (N.J.A.C. 6:29-7.1).
ii. The district board of education shall provide a curriculum evaluation schedule for all content areas at all grade levels.
iii. The documentation/activities shall be a statement of assurance submitted on the form prescribed by the Commissioner;
2. Implementation of curriculum and content standards:
i. The district shall implement all approved curricula and include, for each curriculum area in grades K through 12, curriculum content standards when they are adopted by the State Board of Education.
ii. The documentation/activities shall be:
(1) Written curriculum including content standards;
(2) Lesson plans;
(3) The master schedule;
(4) Classroom observations; and
(5) Staff interviews;
3. Curriculum articulation:
i. The district shall ensure that the curriculum is articulated among grades and schools in the district, and that teaching staff are involved in the process. Constituent, regional and sending-receiving districts shall also demonstrate curriculum articulation between/among districts.
ii. The documentation/activities shall be a statement of assurance submitted on the form prescribed by the Commissioner; and
4. Gifted and talented programs and services:
i. The district shall make provisions for identifying pupils with gifted and talented abilities and for providing them with an educational program and services.
ii. The documentation/activities shall be:
(1) The written identification process;
(2) Lesson plans;
(3) Classroom observations; and
(4) Staff interviews.

6:8-4.6 Pupil performance: skills and competencies
(a) The pupil performance: skills and competencies element shall be rated acceptable upon demonstration of performance in the following five indicators:
1. Fourth-grade assessment:
i. Beginning in July 1993, 75 percent of fourth-grade pupils in the district shall score at or above the minimum level of proficiency established by the State Board of Education for norm- or criterion-referenced tests in mathematics, reading, writing, science and social studies (geography and history).
ii. Beginning in July 1995, 75 percent of fourth-grade pupils in the district shall score at or above the proficiency level established

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by the State Board of Education on a State-developed assessment of pupil performance in mathematics, reading, writing, science and social studies (geography and history).

iii. The documentation/activities shall be:

(1) Fourth-grade assessment results; and

(2) Pupil performance objectives, if required.

2. Eighth-grade assessment:

i. Beginning in July 1993, 75 percent of eighth-grade pupils in the district shall score at or above the minimum level of proficiency established by the State Board of Education on the Eighth-Grade Early Warning Test (EWT) in mathematics, reading and writing. Matrix sampling of each school using the National Assessment of Educational Progress (NAEP) test exercises shall demonstrate that a percentage, as determined by the State Board of Education, of eighth-grade pupils tested shall achieve the minimum level of proficiency in science and social studies (civics, geography and history).

ii. Beginning in July 1996, eighth-grade district pupil performance in mathematics, reading, writing, science and social studies (civics, geography and history) shall be assessed using State-developed assessments that measure content standards adopted by the State Board of Education. Proficiency levels and performance standards shall be established by the State Board of Education.

iii. The documentation/activities shall be:

(1) Results of the EWT;

(2) Results of the NAEP matrix sampling; and

(3) Pupil performance objectives, if required.

3. Eleventh-grade assessment:

i. Beginning in July 1994, 85 percent of eleventh-grade pupils in the district shall score at or above the minimum level of proficiency established by the State Board of Education on the Grade 11 High School Proficiency Test (HSPT) in mathematics, reading and writing.

ii. Beginning in July 1996, eleventh-grade district pupil performance in mathematics, reading, writing, science and social studies (civics, geography and history) shall be assessed using State-developed assessments that measure content standards. Proficiency levels and performance standards shall be established by the State Board of Education.

iii. The documentation/activities shall be:

(1) Results of the HSPT; and

(2) Student performance objectives, if required.

4. Sixth-grade assessment:

i. The district shall develop performance assessments and establish minimum levels of proficiency. These assessments shall measure sixth-grade students' understanding of curriculum content standards according to the following schedule:

(1) Information processing (1994-95);

(2) Art and music (1995-96); and

(3) Health/physical education (1996-97).

ii. The documentation/activities shall be district-developed assessments.

5. High school core course proficiencies assessments:

i. The district shall develop performance assessments and establish minimum levels of proficiency. These assessments shall contain measures of core course proficiencies according to the following schedule:

(1) Science (1993-94);

(2) Social studies (1994-95);

(3) Fine, practical and performing arts (1995-96);

(4) Health/physical education (1996-97); and

(5) Career education (1996-97).

ii. The documentation/activities shall be district-developed assessments.

6:8-4.7 Pupil behavior

(a) The pupil behavior element shall be rated acceptable upon demonstration of performance in the following four indicators:

1. Pupil attendance:

i. The average daily attendance rate for each district shall average 90 percent or higher as calculated for the three years prior to the school year in which the district is monitored.

ii. Each school with a three-year average below 90 percent shall develop performance objectives to improve pupil attendance, pursuant to N.J.A.C. 6:8-4.4.

iii. The documentation/activities shall be:

(1) The "New Jersey School Register" provided by the Department;

(2) The "School Register Summary Report", prepared by the Department of Education; and

(3) Pupil performance objectives, if below State standard;

2. Dropouts:

i. The dropout rate for pupils in grades seven through 12 shall not exceed 10 percent, as calculated on a cohort basis for three years prior to the school year in which the district is monitored.

ii. Each school with a three-year average dropout rate exceeding 10 percent, as calculated for the three years prior to monitoring, shall develop performance objectives to reduce the dropout rate, pursuant to N.J.A.C. 6:8-4.4.

iii. The document/activities shall be:

(1) The fall report (consolidated enrollment: dropout information);

(2) The application for State school aid; and

(3) Pupil performance objectives, if required;

3. Guidance and counseling:

i. The district shall provide all pupils with a board-approved program of guidance and counseling services.

ii. The documentation/activities shall be:

(1) A written description of guidance and counseling services;

(2) Board minutes;

(3) Staff interviews; and

(4) School visits; and

4. Substance abuse prevention:

i. The district shall develop and implement a board-approved substance abuse prevention program for all grades which includes:

(1) Policies and procedures in accordance with N.J.A.C. 6:29-6, the substance abuse code;

(2) Provisions for evaluation, intervention and treatment/referral services by appropriately certified staff;

(3) Reporting, notification and examination procedures;

(4) Curriculum and instruction consistent with N.J.A.C. 6:29-6.6 and N.J.S.A. 18A:40A-16;

(5) Cooperation with local law enforcement in accordance with Enforcement of the Drug-Free School Zone Code, N.J.A.C. 6:3-6; and

(6) Cooperation with local municipal alliance committees and other appropriate organizations and agencies.

ii. The documentation/activities shall be:

(l) A statement of assurance submitted on the form prescribed by the Commissioner.

6:8-4.8 Teaching staff and professional development

(a) The teaching staff and professional development element shall be rated acceptable upon demonstration of performance in the following five indicators:

1. Certified teaching staff:

i. The district shall employ teaching staff members who hold appropriate certificates for each area of assignment pursuant to N.J.A.C. 6:11.

ii. The documentation/activities shall be:

(1) The fall certificated staff report;

(2) Classroom visits;

(3) Teacher schedules; and

(4) Staff lists;

2. Evaluation of teaching staff:

i. The district shall observe and evaluate tenured and nontenured teaching and administrative staff pursuant to N.J.A.C. 6:3-1.19, 1.21 and 1.22.

ii. The documentation/activities shall be:

(1) The observation/evaluation schedule; and

(2) Observation/evaluation reports;

3. Professional improvement plans:

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i. The district shall develop and cause to be implemented annual professional improvement plans for each teaching staff member pursuant to N.J.A.C. 6:3-1.19, 1.21 and 1.22.

ii. The documentation/activities shall be:

(1) A review of professional improvement plans and

(2) Interviews with teaching staff members;

4. Professional development plan:

i. The district shall develop and implement a multi-year plan for professional development containing the following components:

(1) Teaching staff needs;

(2) Link to pupil performance;

(3) Relationship to professional improvement plans;

(4) Integration with curriculum development; and

(5) Follow-up evaluation.

ii. The documentation/activities shall be:

(1) Interviews with teaching staff; and

(2) A review of the quality assurance annual report; and

5. Teaching staff appointments:

i. The chief school administrator shall recommend formal appointment of all teaching staff members to the district board of education.

ii. The documentation/activities shall be:

(1) The review of board minutes; and

(2) An interview with the chief school administrator.

6:8-4.9 School resources: finance and facilities

(a) The school resources: finance and facilities element shall be rated acceptable upon demonstration of performance in the following eight indicators:

1. State aid:

i. The district shall accurately report enrollment and other data necessary for State aid calculations by October 15.

ii. The most recent adjusted aid data shall demonstrate that aid is at least 95 percent accurate. Adjustments due to district errors shall be less than five percent of the total aid. The district shall meet this performance standard for at least five of seven years, including the year monitored.

iii. The documentation/activities shall be the application for State school aid;

2. Generally Accepted Accounting Principles (GAAP):

i. The district shall implement a uniform system of double entry bookkeeping and GAAP accounting in accordance with N.J.A.C. 6:20-2A.

ii. The documentation/activities pursuant to N.J.A.C. 6:20-2A shall be:

(1) The general ledger (double entry bookkeeping);

(2) Required subsidiary journals and ledgers; and

(3) Monthly and annual reports in compliance with the uniform system prescribed by the State Board of Education; and

(4) The annual audit;

3. Overexpenditure of funds:

i. The district board of education shall implement adequate controls to prevent the overexpenditure of any funds or yearly deficit in major accounts in accordance with N.J.A.C. 6:20-2A.10.

ii. The documentation/activities shall be:

(1) The annual audit;

(2) The board secretary's monthly financial reports to the district board of education and the district board of education's Comprehensive Annual Financial Report;

(3) Official notification of deficit from the district board of education; and

(4) Board minutes;

4. Annual audit and recommendations:

i. By November 5, the district shall file an annual audit of accounts and financial transactions with the Division of Finance in accordance with N.J.S.A. 18A:23-1 et seq.

ii. The district board of education shall implement a plan resulting in the correction of all audit recommendations. Recommendations shall not be repeated for the two years immediately preceding monitoring.

iii. The documentation/activities shall be:

(1) The district's annual audit and audit synopsis;

(2) The corrective action plan for audit recommendations; and

(3) Board minutes;

5. Transportation contracts:

i. The district shall administer school transportation contracts.

ii. All transportation contracts shall be submitted to the county superintendent for approval in accordance with N.J.S.A. 18A:39-2 and 3 and N.J.A.C. 6:21-16.1.

iii. The documentation/activities shall be pupil transportation contracts and addenda;

6. Health and safety:

i. The district shall comply annually with health and safety requirements pursuant to regulation, including, but not limited to, N.J.A.C. 6:22 and 6:53.

ii. The documentation/activities shall be:

(1) The New Jersey Department of Education checklist for the evaluation of school buildings and

(2) School visits;

7. Comprehensive maintenance plan:

i. The district board of education shall develop and implement a multi-year (three to five years) comprehensive maintenance plan. The comprehensive maintenance plan shall be both corrective and preventative, including the interior and exterior conditions of each school building and grounds. The plan shall address each of the major systems and areas of: heating/ventilating/air conditioning, mechanical, plumbing, electrical, structural and grounds.

ii. The documentation/activities shall be:

(1) The district's comprehensive maintenance plan;

(2) Implementation records;

(3) The current and prior years' budget;

(4) The annual audit;

(5) Board minutes;

(6) School visits; and

(7) Staff interviews; and

8. Facilities master plan—substandard classrooms:

i. The district board of education shall review and revise the long-range facilities master plan at least once every five years, pursuant to N.J.A.C. 6:22-7.1.

ii. The long-range facilities master plan shall be approved by the county superintendent pursuant to N.J.A.C. 6:22-7.1(b).

iii. The district board of education shall approve and implement a plan to upgrade or eliminate all substandard classrooms pursuant to N.J.A.C. 6:22-6.1.

iv. The temporary use of trailers shall be approved by the Bureau of Facility Planning Services.

v. A district with a school or schools on split sessions shall fail to meet the standards of this indicator.

vi. The documentation/activities shall be:

(1) The district's long-range facilities master plan;

(2) The application for initial approval/renewal of substandard instructional areas; and

(3) School visits.

6:8-4.10 State and Federally mandated programs and services

(a) The State and Federally mandated programs and services element shall be rated acceptable upon demonstration of performance in the following two indicators:

1. Review of mandated programs and services:

i. Regularly-scheduled reviews will be conducted in each district by the appropriate division of the State Department of Education to determine compliance according to State or Federal law or regulation. The mandated reviews shall cover the following areas:

(1) Affirmative action;

(2) Programs and services for pupils at risk;

(3) Bilingual education;

(4) English as a second language;

(5) Desegregation;

(6) Special education;

(7) Vocational education;

(8) Child nutrition; and

(9) Educational improvement plans for special needs districts.

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ii. If the district is rated compliant as a result of the review, it shall not be required to undergo additional monitoring as part of the seven-year monitoring cycle.

iii. If the district is rated noncompliant as a result of the review, it shall develop and implement a corrective action plan. The status of the corrective action plan shall be reviewed prior to monitoring.

iv. The documentation/activities shall be State Department of Education program and service review reports and corrective action plans, if required; and

2. Grants management:

i. Each district shall expend funds allocated through grants for State and Federally mandated programs and services in accordance with the contract.

ii. The documentation/activities shall be State Department of Education program and service review reports.

6:8-4.11 Findings

(a) The monitoring team shall record its findings on each element required by this chapter, using worksheets prescribed by the Commissioner of Education.

1. The monitoring team shall meet with the chief school administrator and board secretary at an exit conference to review its findings and outline future directions for the districts.

2. The county superintendent of schools shall send a formal notification of the findings to the chief school administrator and board secretary within 20 workdays of the completion of the monitoring visit.

3. The formal notification of findings shall include:

i. Completed worksheets;

ii. A recommendation to the Commissioner of the certification status of the district; and

iii. A statement of future actions to be taken by the district, if necessary.

4. The district shall, within 60 days of the receipt of the formal notification, discuss the findings of the monitoring team at a regular or special meeting of the district board of education.

6:8-4.12 Certifying a district with or without conditions

(a) The following pertains to certification without conditions:

1. For each district that receives an acceptable rating on all indicators in the eight elements required by this chapter, the county superintendent of schools shall submit a summary report of findings and a recommendation for certification to the Commissioner of Education. The Commissioner, with approval of the State Board of Education, shall notify the district of State certification for a period of seven years.

(b) The following pertain to certification with conditions:

1. When a district does not meet the required standards of the evaluation of school districts pursuant to N.J.A.C. 6:8-4, the county superintendent of schools shall meet with the chief school administrator and board secretary to review the identified deficiency(ies) and determine if the district:

i. Can correct the identified deficiency(ies) without additional diagnostic monitoring or technical assistance within a period of time not to exceed 12 months; or

ii. Should be directed by the Commissioner to enter Level II.

2. Following the meeting with the school district representatives, the county superintendent of schools, in consultation with the Assistant Commissioner, Division of County and Regional Services, shall recommend to the Commissioner that the district be granted certification with conditions or be directed to Level II pursuant to N.J.A.C. 6:8-5.1.

i. Any district rated as unacceptable may, with approval of the district board of education, petition the county superintendent of schools to rescind the rating by presenting written documentation of its performance on indicators rated as unacceptable. The Assistant Commissioner, Division of County and Regional Services, shall rule on petitions where there is a lack of agreement on acceptable performance.

3. Within 30 days of the county superintendent's recommendation, the district shall be formally notified by the Commissioner of Education that the district is certified with conditions and that the deficiency(ies) must be corrected within the specified period of time.

4. The district shall proceed with the correction of monitoring deficiencies according to established timelines.

5. At the conclusion of the established timeline for correction of deficiencies, the county superintendent of schools, in consultation with the Assistant Commissioner, Division of County and Regional Services shall determine the validation necessary to document the district's current status with regard to previously approved indicators.

6. The county superintendent of schools shall verify the district's correction of deficiencies and its current status with regard to previously approved indicators; and shall, in consultation with the Assistant Commissioner, Division of County and Regional Services, recommend to the Commissioner that the district be:

i. Recommended to the State Board of Education for certification;

ii. Granted an extended amount of time to correct deficiencies; or

iii. Directed by the Commissioner to enter Level II monitoring pursuant to law.

(1) The district board of education of a school district which is directed to enter Level II monitoring may appeal that decision to the State Board of Education pursuant to N.J.S.A. 18A:7A-14A(2).

SUBCHAPTER 5. RULES FOR LEVEL II AND III DISTRICTS

6:8-5.1 Level II Districts

(a) A district which is directed by the Commissioner to enter Level II monitoring shall be examined by an external review team appointed by the county superintendent of schools. The review team shall consist of members qualified by training and experience to examine specific conditions within the district. The entire cost of the activities associated with the external review team shall be paid by the Department of Education.

(b) The Commissioner shall direct the county superintendent to establish an open public meeting within the district that is duly advertised and posted whereby parents, school employees and community residents may meet with the county superintendent and external review team to discuss their concerns regarding the district.

(c) In conjunction with the Department of Education, and at the direction of the Commissioner, the external review team shall determine which aspects of the district's operation to examine. The examination may be limited to identified deficiencies within the district or may include all aspects of the district's operations such as education, management, governance and finance.

(d) The external review team shall, in addition, examine conditions in the community which may adversely affect the ability of pupils to learn.

(e) Within 30 calendar days after its review, the external team shall submit a report to the Commissioner of Education. The report shall include:

1. Findings, conclusions and directives to be used by the district in the development and implementation of a corrective action plan to achieve certification; and

2. Recommendations as to the technical assistance the district will require to effectively implement the corrective action plan.

(f) In addition, the external team may recommend measures to be taken to mitigate adverse community conditions which affect the ability of pupils to learn.

(g) The Commissioner shall transmit, within 15 calendar days from receipt, the findings of the external review team and shall direct the district to develop a corrective action plan to implement the recommendations.

(h) The district, within 30 days of formal notification, shall discuss the findings of the external team at a regular or special meeting of the district board of education.

(i) Within 60 calendar days of formal notifications, the chief school administrator shall submit a corrective action plan approved by the district board of education to the Commissioner for approval.

(j) In reviewing the district's corrective action plan, the Commissioner shall determine the cost of implementing the plan and shall identify those aspects of the plan which are already contained in the district's current expense budget.

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(k) The Commissioner, where appropriate, shall reallocate funds within the district's budget to support the corrective action plan. Any line item transfers of reallocated funds shall have prior approval of the Commissioner.

(l) The district shall implement the corrective action plan activities within one year of the Commissioner's formal notification that the plan has been approved. The Commissioner shall ensure that technical assistance is provided to the district to implement the corrective action plan.

1. Until the district is certified, the county superintendent of schools shall assess the progress of the district in implementing the corrective action plan and shall submit quarterly reports to the Assistant Commissioner, Division of County and Regional Services.

2. The county superintendent of schools, upon completion of the district's corrective action plan activities shall determine whether the standards for certification have been achieved and shall submit a formal report to the Assistant Commissioner, Division of County and Regional Services.

3. The Assistant Commissioner, Division of County and Regional Services, shall submit to the Commissioner of Education a formal report which recommends that the district be:

i. Recommended to the State Board of Education for certification;

ii. Granted an extended amount of time to correct deficiencies; or

iii. Directed by the Commissioner to enter Level III Monitoring pursuant to law.

(1) The board of education of a school district which is directed to enter Level III monitoring may appeal that decision to the State Board of Education pursuant to N.J.S.A. 18A:7A-14c(3).

6:8-5.2 Level III districts

(a) A district which fails to correct the deficiencies noted in the Level II evaluation process shall be directed by the Commissioner to enter Level III monitoring.

(b) When a district which has undergone an external review is directed to enter Level III monitoring, the Commissioner shall prepare an administrative order directing the corrective actions which shall be taken by the district.

1. The corrective actions shall be based on the findings and conclusions of the external review team and the monitoring of the Level II plan by the county superintendent.

2. The Commissioner shall ensure that technical assistance is provided to the district to implement the corrective actions.

3. If the Commissioner determines, based on the findings of the Level II or Level III review team, that conditions within the district may preclude the successful implementation of a corrective action plan, he shall direct that a comprehensive compliance investigation be conducted by the State Department of Education pursuant to N.J.A.C. 6:8-5.3. In the case of a Level III review the Commissioner may order any necessary action to insure the security of the books, papers, vouchers and records of the district in accordance with N.J.S.A. 18A:7A-14c.

4. In reviewing the district's corrective action plan, the Commissioner shall determine the cost of implementing the plan and shall identify those aspects of the plan which are already contained in the district's current expense budget.

5. The Commissioner, where appropriate, shall reallocate funds within the district, or take whatever other measures deemed necessary and appropriate to insure implementation of the corrective action. Any line item transfers of reallocated funds shall have prior approval by the Commissioner.

6. The district shall implement the corrective action plan within one year of the Commissioner's formal issuance of the administrative order.

i. Monthly, until the district is certified, the county superintendent shall monitor and assess the progress of the district in implementing the corrective action plan and shall submit quarterly reports to the Assistant Commissioner, Division of County and Regional Services.

ii. The county superintendent, upon completion of the district's corrective action plan, shall determine whether the standards for certification have been met and shall submit a formal report to the Assistant Commissioner, Division of County and Regional Services.

iii. The Assistant Commissioner, Division of County and Regional Services, shall submit to the Commissioner a formal report which recommends that the district be:

(1) Recommended to the State Board of Education for certification; or

(2) Directed by the Commissioner to undergo a comprehensive compliance investigation pursuant to N.J.A.C. 6:8-5.3.

(c) When a district which has not had a comprehensive examination of all aspects of the district's operations by an external review team is directed to enter Level III, the Commissioner shall designate the county superintendent to appoint an external review team, whose members shall be qualified by training and experience to examine the conditions in the district.

1. Within three months, in conjunction with the Department of Education, the team shall examine all aspects of the district's operation, including, but not limited to education, governance, management and finance.

2. Within 30 calendar days after its review, the external team shall report its findings and conclusions, including directives to be used in the preparation of a corrective action plan to achieve certification, to the Commissioner.

3. If the Commissioner finds, based on the findings of the Level II or Level III review team, that conditions within the district may preclude the successful implementation of a corrective action plan, he or she shall direct that a comprehensive compliance investigation be conducted by the State Department of Education pursuant to N.J.A.C. 6:8-5.3 and may order any necessary action to insure the security of the books, papers, vouchers and records of the district in accordance with N.J.S.A. 18A:7A-14c.

4. Within 30 calendar days of the receipt of the report, the Commissioner shall prepare an administrative order directing the corrective actions which shall be taken by the district based upon the findings and conclusions of the Level III external review team and the county superintendent's monitoring of the Level II plan.

5. The Commissioner shall insure that technical assistance is provided to the district in order to implement the corrective actions.

6. In reviewing the district's corrective action plan, the Commissioner shall determine the cost of implementing the plan and shall identify those aspects of the plan which are already contained in the district current expense budget.

7. The Commissioner, where appropriate, shall reallocate funds within the district's budget or take whatever other measures deemed necessary and appropriate to support the district's corrective action plan. Any line item transfers of reallocated funds shall have prior approval by the Commissioner.

8. The district shall implement the corrective action plan within one year of the Commissioner's formal issuance of the administrative order.

i. Monthly, until the district is certified, the county superintendent shall monitor and assess the progress of the district in implementing the corrective action plan and shall submit quarterly reports to the Assistant Commissioner, Division of County and Regional Services.

ii. The county superintendent, upon completion of the district's corrective action plan shall determine whether the standards for certification have been achieved and shall submit a formal report to the assistant commissioner, Division of County and Regional services.

iii. The Assistant Commissioner, Division of County and Regional Services, shall submit to the Commissioner a formal report which recommends that the district be:

(1) Recommended to the State Board of Education for certification; or

(2) Directed by the Commissioner to undergo a comprehensive compliance investigation pursuant to N.J.A.C. 6:8-5.3.

6:8-5.3 Comprehensive compliance investigation

(a) A comprehensive compliance investigation shall be conducted under the direction of the Assistant Commissioner, Division of

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County and Regional Services, under one of the following circumstances:

1. The review team's report indicates that conditions exist within the district that may preclude the successful implementation of a corrective action plan; or

2. After completion of the corrective action plan activities, a district fails to achieve certification and does not demonstrate reasonable progress toward meeting certification standards, pursuant to N.J.A.C. 6:8-4.3 through 4.10.

(b) The director of the Department of Education's compliance unit shall organize and supervise an investigatory team to assess conditions in the district.

1. A comprehensive audit of the district's governance, management and fiscal operations shall be conducted by a private auditing agency under contract to the Department of Education.

2. The compliance unit shall conduct a thorough investigation of the district's programmatic, fiscal and management activities.

(c) The director of the Department of Education's compliance unit shall submit a report of investigatory findings to the Assistant Commissioner, Division of County and Regional Services.

(d) Based on the report of investigatory findings, the Assistant Commissioner shall submit to the Commissioner a recommended administrative order outlining such corrective action as is deemed necessary.

(e) The Commissioner, after a plenary hearing before an administrative law judge pursuant to N.J.S.A. 52:14B-1 et seq., may order the implementation of an administrative order requiring the district to implement the corrective action.

6:8-5.4 Corrective action by Commissioner of Education

Any noncertified district which does not demonstrate reasonable progress toward compliance with the provisions of N.J.S.A. 18A:7A-1 et seq. (Public School Education Act of 1975) and New Jersey Administrative Code Title 6, Education, and toward the resolution of major problems shall be subject to further intervention by the Commissioner of Education, as provided by law.

SUBCHAPTER [5.]5A. INTERIM RULES FOR DISTRICTS PLACED IN LEVEL II AND III [DISTRICTS] MONITORING PRIOR TO JULY 1, 1993

6:8-5A.1 Applicable districts

(a) This subchapter applies to those districts placed in Level II or Level III prior to July 1, 1993. Those districts were unable to meet the evaluation standards of the evaluation of school districts pursuant to N.J.A.C. 6:8-5A.2.

(b) This subchapter is only in effect for two years, July 1, 1993 through June 30, 1995.

(c) Level II and III districts that are not certified by June 30, 1995 shall be required to meet the evaluation standards as cited in N.J.A.C. 6:8-4.3 through 4.10.

6:8-5A.2 Evaluation of elements and standards

(a) The following 10 essential elements and the prescribed indicators of standards of acceptable performance shall be evaluated by the monitoring team under the supervision of the county superintendent of schools as specified in this section.

1. The annual educational planning element of the district shall be rated acceptable upon demonstration of performance in three indicators as follows:

i. Written educational goals, based on district educational needs and consistent with the intent of State educational goals, shall be developed and shall serve as the basis for the educational program (curriculum) of the district. Goals shall be developed in consultation with teaching staff members, pupils, parents or guardians of pupils and other district residents, under the direction of the chief school administrator.

(1) The district board of education shall give public notice of the proposed goals or revisions thereof and shall provide opportunity for comment at a public meeting.

(2) District educational goals shall be reviewed, updated and adopted by the district board of education at least once every five years.

ii. Three or more written educational objectives, which shall include standards of pupil achievement and action plans based upon district needs, shall be developed annually in consultation with teaching staff members and the community under the direction of the chief school administrator in accordance with requirements established by the Commissioner.

(1) The district board of education shall review, discuss and adopt the annually developed objectives and action plans at a public meeting prior to September 30.

(2) The objectives and action plans of the district shall be submitted by September 30 to the county superintendent of schools who shall review and approve them no later than October 31.

(3) The district shall submit a report on the attainment of objectives to the county superintendent of schools by July 1. The county superintendent of schools shall by August 15 submit a written analysis on the district's attainment of objectives to the chief school administrator and board secretary.

iii. A long-range plan containing a five-year written schedule and procedure for evaluation and improvement of all curriculum and educational services shall be developed and implemented.

2. The school and community relations element of the district shall be rated acceptable upon documentation of performance in five indicators as follows:

i. The district board of education shall share information with the community.

ii. The district board of education shall provide parents or guardians as well as other district residents and teaching staff members opportunities for discussion regarding State rules and local district procedures for implementation of district goals, objectives and standards through one or more public meetings of the district board of education. The initial meeting shall be held prior to September 30 of each year. The district board shall publish a special notice 10 days in advance of each meeting describing the purpose, listing the items to be discussed and indicating the availability of material relative to such items. The discussion at such meeting(s) shall include, but not be limited to:

(1) The annual reports of the district submitted to the Commissioner of Education, pursuant to N.J.S.A. 18A:7A-11 and N.J.A.C. 6:8-3.1;

(2) The result of:

(A) The annual evaluation of the district's objectives and action plans;

(B) The Statewide and district testing programs including analysis and interpretation of schools and district performance; and

(C) The objectives and action plans to be implemented to remediate needs identified through district needs assessment; and

(3) The documents listed in (a)2ii(1) and (2) above shall be accessible to the public for inspection at such meetings and shall be available upon request at the earliest possible time in accordance with the provisions of the public records laws, N.J.S.A. 47:1A-1 et seq.;

iii. The district board of education shall provide opportunity for comment by the public at its regularly scheduled meetings.

iv. The district shall involve business, industry and other community resources in the schools.

v. The district shall involve the community as advisors in the decision-making process.

3. The comprehensive curriculum and instruction element of the district shall be rated acceptable upon documentation of performance in seven indicators as follows:

i. The district board of education shall approve annually a curriculum for all grades from pre-kindergarten through grade 12 for all subjects including all State-mandated programs and services.

(1) The district shall implement the curriculum which was adopted by the district board of education.

(2) The district shall provide for articulation of the curriculum.

(3) In accordance with N.J.A.C. 6:8-7.1(c)2iii and N.J.A.C. 6:39-1.3(b), district boards of education shall provide for:

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(A) Development of course proficiencies, which shall include, but not be limited to, those identified and established by the Department of Education as core course proficiencies;

(B) Establishment of a standard of student mastery; and

(C) Annual assessment of all students in those proficiencies necessary to meet all State and local high school graduation requirements;

ii. The district shall make provisions for identifying pupils with exceptional abilities and for providing them with an educational program and services;

iii. The instructional program shall provide all pupils with guidance and counseling;

iv. The instructional program of the district shall provide all pupils with a library skills program;

v. The district shall introduce instruction in effective study and work skills early in the curriculum and reinforce such instruction throughout the curriculum;

vi. The district shall make provisions for identifying disruptive pupils and for providing them with an appropriate educational program and services; and

vii. The district shall make provisions for identifying disaffected pupils and for providing them with an appropriate educational program and services.

4. The pupil attendance element of the district shall be rated acceptable upon documentation of performance in three indicators as follows:

i. The average daily attendance rate for each district shall be 90 percent or higher as calculated for the school year immediately prior to the school year in which the district is monitored.

(1) The district shall develop and implement an attendance improvement plan when the average daily attendance rate is between 85 and 89.9 percent.

(2) If the attendance rate for the district is less than 85 percent, performance for this element shall be rated unacceptable;

ii. The average daily attendance rate for each school within the district shall be 85 percent or higher.

(1) The district shall develop and implement an attendance improvement plan for each school within the district that has an average daily attendance rate between 80 and 84.9 percent.

(2) If the attendance rate for any school is less than 80 percent, performance for this element shall be rated unacceptable; and

iii. The district shall develop and implement an improvement plan to reduce the rate of pupils who drop out after completion of eighth grade.

5. The facilities element of the district shall be rated acceptable by documentation of performance in four indicators as follows:

i. The district board of education shall develop and implement a five-year comprehensive maintenance plan;

ii. The district shall perform an annual inspection of buildings to insure adherence to health and safety laws;

iii. The district board of education shall approve and implement a plan to upgrade or eliminate all substandard classrooms pursuant to law and rule; and

iv. The district board of education shall review and revise, as necessary, the long-range facilities plan of the district at least every five years.

6. The staff element of the district shall be rated acceptable by documentation of performance in seven indicators as follows:

i. All professional staff members shall be certified in their area(s) of assignment pursuant to law and rule;

ii. All substitute teachers and aides shall be employed pursuant to law and rule;

iii. The annual rate of occasional professional staff absenteeism, including teachers and administrators, shall not exceed five percent;

iv. The district shall develop and implement an attendance improvement plan approved by the board of education when the annual rate of occasional professional staff absenteeism exceeds 3.5 percent;

v. The district shall observe and evaluate tenured and nontenured teaching and administrative staff pursuant to law and rule;

vi. The district shall adopt and implement a staff development program based on the assessed needs of the district; and

vii. The chief school administrator shall recommend to the district board of education formal appointment of all teaching staff members.

7. The mandated programs element of the district shall be rated acceptable upon documentation of performance in three indicators as follows:

i. The district shall implement a basic skills improvement plan pursuant to N.J.A.C. 6:8-6.2.

(1) The basic skills improvement plan shall be approved by the county superintendent of schools.

(2) The district shall communicate a description of the basic skills improvement plan to the public;

ii. The district shall implement the bilingual and English-as-a-second language (ESL) education plan pursuant to N.J.A.C. 6:31.

(1) The bilingual and ESL education plan shall be approved by the county superintendent of schools.

(2) The district shall communicate a description of the bilingual and ESL plan to the public; and

iii. The district shall implement the special education plan pursuant to N.J.A.C. 6:28.

(1) The special education plan shall be approved by the county superintendent of schools.

(2) The district shall communicate a description of the special education plan to the public.

8. The mandated basic skills test element of the district shall be rated acceptable upon documentation of achievement in two indicators as follows:

i. Seventy-five percent of the pupils in grade nine of each school shall have passed the State-mandated High School Proficiency Test pursuant to N.J.A.C. 6:39-1.2(a) and (b); and

ii. Seventy-five percent of the pupils in grade three and 75 percent of the pupils in grade six in each school of the district shall score at or above the minimum level of proficiency established by the State Board of Education for commercially published tests or district criterion-referenced tests.

9. The equal educational opportunity and affirmative action element of the district shall be rated acceptable by documentation of performance in three indicators as follows:

i. Where applicable, the district shall implement a desegregation plan approved by the Commissioner of Education;

ii. Annually, the district shall review progress toward the objectives of the State-approved affirmative action plans for classroom and employment practices of the district; and

iii. Annually, the district shall implement the affirmative action plans, including inservice training.

10. The financial element of the district shall be rated acceptable upon documentation of performance in six indicators as follows:

i. The chief school administrator shall present to the district board of education accurate and timely fiscal and statistical reports of the district pursuant to law and rule;

ii. The fiscal and statistical reports of the district shall be accurate and timely in transmittal to county, State and Federal offices pursuant to law and rule;

iii. The annual budget for the district shall be developed, approved and presented to the public pursuant to law and rule.

(1) The district board of education shall submit a proposed budget to the county superintendent of schools on or before January 15 in an authorized budget format.

(2) The proposed budget shall be reviewed and approved by the county superintendent of schools prior to its advertisement;

iv. The district shall have an annual audit of accounts and financial transactions pursuant to law and rule and State audits as determined by the Commissioner of Education.

(1) Within 30 days of receipt, the district board of education shall accept and discuss the annual or State audit at a regularly scheduled board meeting.

(2) The district board of education shall implement the recommendations cited in the annual or State audit and shall report such implementation to the Commissioner of Education;

v. The district shall not incur a deficit pursuant to N.J.A.C. 6:20-2.13; and

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vi. All pupil transportation costs shall be reviewed and recommended for approval of State aid by the county superintendent of schools.

Recodify existing N.J.A.C. 6:8-5.1 and 5.2 as **5A.3 and 5A.4** (No change in text.)

6:8-[5.3]**5A.5** Compliance investigation

(a) A comprehensive compliance investigation will be conducted under the supervision of the assistant commissioner, Division of County and Regional Services, under one of the following circumstances:

1. (No change.)

2. After completion of the corrective action plan activities, a district fails to achieve certification and does not demonstrate reasonable progress toward meeting certification standards, pursuant to N.J.A.C. 6:8[5.2(b)9] **5A.4(b)9**.

(b)-(e) (No change.)

6:8-8.1 Operation

(a)-(b) (No change.)

(c) **For pupils domiciled within the district, the district board of education shall not charge tuition for any remedial or advanced course.** Reasonable tuition may be charged for enrichment courses which carry no credit and are determined by the county superintendent of schools to [be unrelated] **have no direct relationship** to the curriculum [of the regular school program].

(d) (No change.)

6:8-8.4 Credit and grade placement

(a)-(b) (No change.)

(c) Full-year subjects which are given for review, **remediation** or for other purposes not including advanced credit must be conducted for 3,600 minutes of instruction under standards equal to those during the regular term **or through an established number of curricular activities as determined by the district board of education and approved by the county superintendent of schools.**

(d)-(e) (No change.)

(a)

STATE BOARD OF EDUCATION

Governor's Teaching Scholars Program

Proposed Amendments: N.J.A.C. 6:12

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

Authority: N.J.S.A. 18A:4-15, 18A:71-86 and P.L. 1991, c.467.

Proposal Number: PRN 1992-390.

Submit written comments by October 8, 1992 to:

Irene Nigro, Rules Analyst
NJ Department of Education
225 West State Street
CN 500
Trenton, New Jersey 08625-0500

The agency proposal follows:

Summary

These proposed amendments to N.J.A.C. 6:12, Governor's Teaching Scholars Program (GTSP), reflect the language and intent of P.L. 1991, c.467. The proposed amendments are designed to expand the employment opportunities for loan redemption available to program participants.

The GTSP is designed to attract highly qualified students to the field of teaching by providing a financial incentive to high school seniors to pursue teaching careers. The program offers scholarship loans of up to $7,500 per year for four years of college study. High school seniors in New Jersey's public and nonpublic high schools who are interested in becoming teachers are eligible to apply for the loans provided they meet rigorous academic and personal criteria. When the program was designed, the entire amount borrowed, including accrued interest, was to be redeemed upon successful teaching service in New Jersey public schools.

The purpose of the proposed amendments is to enable program participants to redeem their loans through teaching in nonpublic schools and State and county colleges in addition to public schools. In addition, the amendments provide the Commissioner with the flexibility to permit other teaching service by a program participant as credit toward loan redemption provided that such services are performed within the State and require the performance of professional duties similar to those of a public school teacher. An amendment also permits the Commissioner in unusual circumstances to extend the term of deferral for loan redemption.

A detailed summary of the proposed amendments is presented below.

N.J.A.C. 6:12-1.2 Definitions: The definitions of "nonpublic school" and "public school" were added to reflect the language of P.L. 1991, c.467, and to add the proposed option for loan redemption.

N.J.A.C. 6:12-1.7(a)4: The word "public" has been deleted and the words "college and other approved teaching services" have been added to agree with the proposed amendment in N.J.A.C. 6:12-1.9.

N.J.A.C. 6:12-1.8(d): The words "per diem" were added to clarify that the only acceptable substitute service would be that which is continuous over a period of at least three months (see proposed N.J.A.C. 6:12-1.9(a)4). Per diem substitute teaching is not permitted as approved redemption service.

N.J.A.C. 6:12-1.9(a): New language has been added describing the additional ways the GTSP loan may be redeemed.

N.J.A.C. 6:12-1.9(d): The rates of loan cancellation have been added for county or State college teaching as well as for other approved teaching service.

N.J.A.C. 6:12-1.9(g): The words "district board of education" have been removed and the words "school college or other institution" have been added to conform to the proposed amendment permitting loan redemption through teaching in situations other than in public schools. New language details the GTSP graduate's responsibility when seeking one of the expanded employment opportunities described in N.J.A.C. 6:12-1.9(a)1 through 4.

N.J.A.C. 6:12-1.9(i)5: A new paragraph has been added which extends the options for deferment.

N.J.A.C. 6:12-1.10(a)2: New language concerning broadened employment possibilities has been added.

N.J.A.C. 6:12-1.14: An amendment was added to clarify the fact that an individual aggrieved by the determination of the Commissioner may appeal from his or her determination to the State Board of Education.

Social Impact

The Governor's Teaching Scholars Program was designed to assure a supply of qualified public school teachers for New Jersey. To date, three classes of scholars have graduated from college and are currently redeeming their loans through public school teaching, or if they chose other careers, are repaying their loans. Of the scholars who wish to teach, approximately 20 percent have not been able to find public school teaching positions. The proposed rules will enable these scholars and succeeding classes of scholars to redeem their loans through nonpublic school or college teaching as well as public school teaching in New Jersey. This will have a positive social impact on the students in these institutions. Without the expanded employment opportunities, scholars who borrowed money from the program with the understanding that they would be able to redeem their loans, will be forced to repay.

Economic Impact

The proposed rules are designed to expand employment opportunities for Governor's Teaching Scholars who are unable to find public school teaching positions. Of the 240 scholars who have graduated from college during the first two years of the program, approximately 20 percent of those wishing to redeem their loans through teaching have been unable to find public school teaching positions.

When the program was designed, interest rates for loan repayment were set to discourage repayment and to encourage loan redemption through teaching. Without the proposed rules, graduates of the program who had planned to teach, and who still wish to redeem their loans through teaching, are forced to repay their loans at a rate pegged to the Federal PLUS Program, a rate which is higher than that of many loan programs. The expanded employment opportunities will have a direct and very positive economic impact upon the participants in the GTSP.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required because these rules do not impose reporting, recordkeeping or other compliance requirements

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on small businesses as defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The rules impact solely upon individuals participating in the GTSP Program.

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

6:12-1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

. . .

"Loan redemption schedule" means the plan whereby redemption (forgiveness) of the loan is based upon number of years the borrower has taught **either** in a public **or nonpublic school** in New Jersey **or a New Jersey county or State college, or performed other approved teaching service in the State of New Jersey,** and the schedule shall take into account [the location of teaching assignment] **whether the teaching assignment is in an urban or non-urban location.**

. . .

"Nonpublic school" means an elementary or secondary school within the State, other than a public school, offering education for grades kindergarten through 12, or any combination of those grades, where any child may legally fulfill compulsory attendance requirements and which complies with the requirements of Title IV of the Civil Rights Act of 1964 (P.L. 88-352).

"Public school" means any elementary or secondary education program that is supported by public funds and is operated by or under contract with a board of education, or an educational services commission established pursuant to section 1 of P.L. 1968, c.143, (N.J.S.A. 18A:6-51) or a State facility as defined in Section 3 of P.L. 1975, c.213 (N.J.S.A. 18A:7A-3).

. . .

6:12-1.7 Program participant responsibilities

(a) Students selected for GTSP participation shall:

1.-3. (No change.)

4. Represent and declare an intention to enter the teaching profession in [a public] school, **college and other approved teaching services** in the State of New Jersey upon graduation from college;

5.-11. (No change.)

(b) (No change.)

6:12-1.8 Source of loan funds

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

(d) Loans shall accrue interest at the highest established rate by the U.S. Department of Education at the time of disbursement, and during the time a participant is enrolled as a full-time student in the program; however, the combination of principal and interest can be redeemed after graduation for full-time teaching service in the State of New Jersey. Interest will not accrue while the loan recipient is engaged in the approved redemption service. [Substitute] **Per diem substitute** teaching is not permitted as approved redemption service.

(e) (No change.)

6:12-1.9 Redemption

(a) Redemption (forgiveness) of the loan is contingent upon [teaching] **the following:**

1. Teaching service in the New Jersey public school system;

2. Teaching service in a New Jersey nonpublic school;

3. Teaching service in a New Jersey State college or county college; or

4. Other teaching service as approved by the Commissioner provided that the service is performed within the State and requires the performance of professional duties similar to those of a public school teacher. Teaching service may include, but need not be limited to, teaching for the State Departments of Correction or Human Services; teaching in pre-kindergarten or day care settings; or designing and developing educational activities relating to teaching in museums. Such service should include responsibility for classroom instruction, professional planning, implementation and evaluation activities of at least three consecutive months duration.

(b) Prior to commencing service in (a)2 through 4 above, a participant must have pursued employment as a teacher in the public schools and have sought the assistance of the Department of Education as provided pursuant to N.J.S.A. 18A:71-83.

[(b)]**(c)** Borrowers with earned baccalaureate degree will be eligible for the redemption phase of the GTSP.

[(c)]**(d)** Depending on the location of the teaching assignment, the principal balance of each loan will be cancelled with cumulative percentages as per the following schedule:

Urban Location (high priority)							
Years teaching in New Jersey public **and nonpublic** schools:	1	2	3	4			
Rate of loan cancellation:	10%	20%	30%	40%	= 100% total redemption		
Non-Urban Location							
Years teaching in New Jersey public **and nonpublic** schools:	1	2	3	4	5	6	
Rate of loan cancellation:	5%	10%	10%	20%	25%	30%	= 100% total redemption
Years teaching in New Jersey county or State college:	**1**	**2**	**3**	**4**	**5**	**6**	
Rate of loan cancellation:	**5%**	**10%**	**10%**	**20%**	**25%**	**30%**	**= 100% total redemption**

(e) The rate of loan cancellation for years teaching in approved other service will be determined by whether the teaching is performed in an urban or non-urban location as per the following schedule:

Urban Location							
Years teaching in approved other service in New Jersey:	**1**	**2**	**3**	**4**			
Rate of loan cancellation:	**10%**	**20%**	**30%**	**40%**	**= 100% total redemption**		
Non-Urban Location							
Years teaching in approved other service in New Jersey:	**1**	**2**	**3**	**4**	**5**	**6**	
Rate of loan cancellation:	**5%**	**10%**	**10%**	**20%**	**25%**	**30%**	**= 100% total redemption**

[(d)]**(f)** Total cancellation of loan indebtedness will not exceed the maximum of $30,000 plus accrued interest per student. Any [other] loans obtained by the borrower **from any other New Jersey State agency** will not be eligible for loan redemption.

[(e)]**(g)** The participant's loan indebtedness will be redeemed each year based on submission of a copy of:

1. The signed contract between the [district board of education] **school, college or other institution** and the borrower indicating a full-time teaching agreement is in force, submitted by a specified date; and

2. A letter from the chief school administrator **or equivalent officer in a school, college or other institution** submitted by a specified date indicating a year of service has been completed **or that at least three months of teaching in approved other service has been rendered.**

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[(f)](**h**) If a participant is unable to secure a position in New Jersey's [public] schools **or colleges** or perform **other approved teaching service** after demonstrably showing that he or she has applied for and been interviewed for positions, the participant may request a one year deferment from loan redemption. No interest shall accrue during the period of deferment. This request will be referred to a three member panel appointed by the Commissioner. The panel will make its recommendation for deferment to the Commissioner who shall issue a final determiation to the participant and inform the Department of Higher Education of the decision.

[(g)](**i**) Temporary deferments of loan repayment/redemption may be granted by the Commissioner of Education upon receipt of written requests from GTSP candidates for the following additional reasons. The candidate is:

1.-3. (No change.)

4. Unable to secure employment for a period not to exceed 12 months by reasons of the care required by a spouse who is disabled; [or]

5. Seeking and unable to secure full-time employment in a public elementary or secondary school, nonpublic school, county or State college, or through other approved teaching service not to exceed 12 months as per (h) above; or

6. (No change.)

6:12-1.10 Terms of repayment

(a) Repayment of loans under the GTSP shall be governed under the following conditions:

1. (No change.)

2. Interest will be waived from the month of graduation until employment begins the following September. Interest will begin to accrue again on or as close to September 16 as possible if a copy of the [teaching] **employment** contract has not been presented to the Commissioner. The interest period will be deferred while the borrower is employed as a full-time teacher [in the New Jersey public school system] **in a school or college, or performs other approved teaching service,** and is therefore participating in the redemption plan[. Substitute teaching is not permitted as approved redemption service];

3. (No change.)

6:12-1.14 Appeals

If, for any reason, a student believes that the application of the rules in this subchapter results in an unfair determination of eligibility or selection, an appeal may be filed with the Commissioner of Education within 60 days of notification. Appeals should be in the form of a letter addressed to the Commissioner of Education, Department of Education, 225 West State Street, CN 500, Trenton, New Jersey 08625, and should contain the student's full name, social security number, high school of attendance, and a description of the basis for the appeal. **Any party aggrieved by any determination of the Commissioner may appeal from his or her determination to the State Board pursuant to N.J.A.C. 6:2.**

HIGHER EDUCATION

(a)

BOARD OF HIGHER EDUCATION

State College Personnel System

Proposed Readoption: N.J.A.C. 9:6A

Authorized By: Board of Higher Education,
Edward D. Goldberg, Chancellor and Secretary.

Authority: N.J.S.A. 18A:3-14(h) and 18A:64-6(h).

Proposal Number: PRN 1992-384.

Submit comments by October 8, 1992 to:
Brett Lief
Acting Administrative Practice Officer
Department of Higher Education
20 West State Street
CN 542
Trenton, NJ 08625

The agency proposal follows:

Summary

P.L. 1986, c.42 (N.J.S.A. 18A:3-14 et seq.), the State College Autonomy Law, provided in part for the removal of professional members of the academic, administrative and teaching staffs of New Jersey State Colleges from the jurisdiction of the Department of Civil Service through Title 11 of the Revised Statutes (now the Department of Personnel and Title 11A of the Revised Statutes). The legislation directed the Board of Higher Education to establish salary range, policies and other guidelines with regard to such employees at the State Colleges. Career service employees covered by the provisions of Title 11A, Civil Service, New Jersey Statutes remained under the purview of the Department of Personnel. The State College Personnel Rules were first adopted in January 1988 (see 20 N.J.R. 89(c)), and one set to expire January 4, 1993 pursuant to Executive Order No. 66(1978). The rules include such areas as: classification, reclassification and reevaluation of titles, appeal procedures, compensation salary adjustments, sick leave, vacation leave, sick leave injury benefits and equal employment opportunity and affirmative action procedures. The rules have been in effect for over four years and the Board of Higher Education is proposing readoption of the rules without change.

Social Impact

The purpose of the rules proposed for readoption is to provide an effective and efficient personnel system for the New Jersey state colleges. The readoption, without change, allows for the continuation of the State College Personnel System and its components. The rules proposed for readoption, which comprise seven subchapters, include rules on: classification (including procedures for reclassification appeals and title reevaluation requests), leave issues (including sick, vacation and holiday leave, leave without pay and special leave situations, as well as sick leave injury (SLI) procedures for managerial employees), standards of conduct and protection of employee rights with respect to equal employment opportunity and affirmative action. It is anticipated that the rules will have a positive social impact on affected employees because they will continue to ensure that employees are treated in a fair and impartial manner.

Generally, authority in these areas continues to be maintained by the Board of Higher Education. The rules also continue to provide each individual State college with greater flexibility and efficiency for managing personnel matters within the higher education context. Proposal and publication of these rules informs the public, students, employees, individual colleges and collective bargaining unions of the applicable rules and ensures confidence in the independence and impartiality of the State college personnel system.

Economic Impact

The rules are proposed for readoption without change; therefore, continuation of the rules is not expected to result in either an increase or a decrease in financial costs. The costs involved are all incurred by the nine State colleges and are generally associated with the payment of unclassified employee salaries.

The chapter ensures the administration of a State college compensation plan, which sets forth procedures for salaries and pay adjustments for staff and managerial employees. The compensation plan is adopted on an annual basis for managerial employees and generally every three years for faculty, professional staff and librarians, in coordination with the cycle of contract negotiations as may be appropriate. As discussed above, the chapter also sets forth classification of titles and leave procedures for employees, which both have economic components.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required because the rules proposed for readoption do not impose reporting, recordkeeping or other compliance requirements on small businesses as defined by the Regulatory Flexibility Act, N.J.S.A. 52:13B-16 et seq. The proposed readoption only maintains a personnel system for State Colleges in New Jersey.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 9:6A.

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HUMAN SERVICES

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Pharmaceutical Services Manual

Proposed Repeal and New Rules: N.J.A.C. 10:51

Authorized By: Alan J. Gibbs, Commissioner, Department of Human Services

Authority: N.J.S.A. 30:4D-6a(5)b(6), 30:4D-7, 7a, b and c; 30:4D-12; 30:4D-20-22, 24; 1927 of the Social Security Act, 42 U.S.C. 1396s; 42 C.F.R. 440.120.

Agency Control Number: 92-P-6.

Proposal Number: PRN 1992-393.

Submit comments by October 8, 1992 to:
Henry W. Hardy, Esq.
Administrative Practice Officer
Division of Medical Assistance
and Health Services
CN-712
Trenton, NJ 08625-0712

The agency proposal follows:

Summary

The Division of Medical Assistance and Health Services (the Division) is proposing to repeal the current text of the Pharmaceutical Services Manual, N.J.A.C. 10:51, and replace it with proposed new rules. The Pharmaceutical Services Manual (the Manual) sets forth the Division's prescription policies for both the Title XIX (Medicaid) program and the Pharmaceutical Assistance for the Aged and Disabled (PAAD) program. The Manual also sets forth the policies for services to Medicaid recipients in a nursing facility (NF), formerly called long-term care facilities (LTCF's). There is also a subchapter explaining the provisions governing consultant pharmacist services.

The codification of this Manual is as follows: N.J.A.C. 10:51-1 (Subchapter 1) describes general policies governing phamaceutical services in the New Jersey Medicaid program; N.J.A.C. 10:51-2 (Subchapter 2) pertains to pharmaceutical services provided to Medicaid recipients in a NF; N.J.A.C. 10:51-3 (Subchapter 3) describes consultant pharmacist services; and N.J.A.C. 10:51-4 (Subchapter 4) describes PAAD pharmaceutical policies. This outline is similar in substantive content to the existing text, except that N.J.A.C. 10:51-2, Billing Procedures, is being deleted because these procedures are no longer applicable now that Paramax/Unisys is the Division's fiscal agent. The Fiscal Agent Billing Supplement, which is being added as an appendix to this Manual, describes the procedures pharmaceutical providers are required to follow when submitting Medicaid and/or PAAD claims to Paramax/Unisys. The fiscal Agent Billing Supplement is referenced, but not reproduced, in the New Jersey Administrative Code. A copy is available from the Division, its fiscal agent or from the Office of Administrative Law.

The substantive provisions of the respective subchapters will now be discussed, with emphasis on those changes that are being made with these proposed new rules.

N.J.A.C. 10:51-1.1 Introduction

The contents of this section follow the same general format as the current text published in the New Jersey Administrative Code. The introduction gives an overall view of the contents and structure of the Pharmaceutical Services Manual. There are similar sections at N.J.A.C. 10:51-2.1, 3.1 and 4.1.

N.J.A.C. 10:51-1.2 Participation of eligible providers

There are two general concepts regarding provider participation. The first concept indicates that the pharmacy must operate under a valid retail and/or institutional permit issued by the Board of Pharmacy of the State of New Jersey or the state in which the pharmacy is located. This provision is a re-statement of current policy (see current N.J.A.C. 10:51-1.4).

The rule describes the provider's responsibility when there is a sale or change of ownership. Because the existing agreement with New Jersey Medicaid is automatically terminated, the new owner(s) must apply to the Division of Medical Assistance and Health Services (DMAHS) to obtain a new provider agreement.

There is a new provision pertaining to a pharmacy provider who supplies parenteral nutrition and/or intravenous therapy. The Medicaid program is expanding the scope of services for pharmaceutical providers so long as they comply with the provisions of N.J.A.C. 13:39-10 or similar provisions in the state in which the pharmacy is located. The out-of-State pharmacy must submit a copy of their state's requirements when applying to the New Jersey Medicaid program for participation. The current policy, as expressed in N.J.A.C. 10:51-1.4, limited pharmacy providers to traditional pharmaceutical services. There are similar provisions in N.J.A.C. 10:51-2.2 and 4.2.

N.J.A.C. 10:51-1.3 Conditions for participation as a provider of pharmaceutical services

Providers are required to dispense prescriptions in compliance with all current existing Federal and state laws. All drugs must be prescribed by a practitioner licensed or authorized by the State of New Jersey, or the state in which the prescriber practices. The drugs must be dispensed in accordance with applicable state and Federal laws and the provider must maintain records which are available to the Division for review.

N.J.A.C. 10:51-1.4 Program restrictions affecting payment for prescribed drugs

Certain conditions or restrictions on payment for prescribed drugs which are listed in N.J.A.C. 10:51-1.4 are discussed in more detail in subsequent sections. A brief description of the pertinent provisions follows.

Covered pharmaceutical services are prescribed legend drugs pursuant to Section 1927(k)(6) of the Social Security Act, 42 U.S.C. 1396(k). The non-legend drugs for which Federal funding is available are contraceptive devices, family planning supplies, pharmaceutical inhalation devices, diabetic testing materials, insulin and insulin syringes and/or needles, and antacids. The regulations governing limitations on non-legend drugs and/or devices were adopted as R.1991 d.353 at 23 N.J.R. 2035(a). Covered services are listed in more detail at N.J.A.C. 10:51-1.11.

With respect to non-covered services, these are set forth in N.J.A.C. 10:51-1.12 below. The first requirement is that there must be a "medically accepted indication" for all prescribed drugs pursuant to the Federal law cited above.

The rule also indicates that drugs available through an Investigational New Drug (IND) shall be prior authorized.

There are also provisions which deny payment for drugs not covered by a rebate agreement as defined in Section 1927(a) of the Social Security Act, codified as 42 U.S.C. 1396s(a). In essence, the Federal statute requires that the manufacturer enter into a rebate agreement with the Health Care Financing Administration, U.S. Department of Health and Human Services. The terms of the agreement would have to comply with Federal law, Section 1927(a) through (c) of the Social Security Act, 42 U.S.C. 1396s(a)-(c).

There are similar provisions in N.J.A.C. 10:51-2.4 and 4.4.

N.J.A.C. 10:51-1.5 Basis of payment

There are three ways by which reimbursement for Medicaid prescriptions can be calculated. This section sets forth the elements for reimbursement for dispensing medications. The lower of the Federal Maximum Allowable Cost (MAC) as published by the Federal government and the Average Wholesale Price (AWP) constitutes the basis of payment for prescriptions. For those prescriptions based on the AWP, a regression (discount) rate is determined on the basis of the pharmacy's volume of Medicaid dispensing: this discount is deducted from the drug Average Wholesale Price (AWP). Added to either the MAC price or the discounted AWP price is the dispensing fee. Alternatively, the provider's "usual and customary" charge is used.

There are similar provisions in N.J.A.C. 10:51-2.5 and 4.5.

N.J.A.C. 10:51-1.6 Regression (discount) categories

The mechanism for calculating the discount on prices based on the AWP remains unchanged. Six categories are based on the pharmacy's total prescription volume in the preceding calendar year, ranging from less than 15,000 prescriptions in Category I to 50,000 prescriptions or more in Category VI. As the prescription volume increases, the discount which is applied to the AWP price of the prescriptions dispensed by the provider increases.

The same provisions appear at N.J.A.C. 10:51-2.6 and 4.6.

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N.J.A.C. 10:51-1.7 Legend drug dispensing fee

The components, or money value, of the dispensing fee are not being changed. To the basic dispensing fee are added increments for maintaining 24-hour emergency service, for patient consultation, and for impact area location.

A new provision in this section is the description of the reference drug file which is compiled by the fiscal agent and accepted by the Division as the primary source of pricing information for the New Jersey Medicaid Management Information System.

There are similar but not identical provisions at N.J.A.C. 10:51-2.7 and 4.7. Pharmacies with institutional permits have a reimbursement limitation that is 75 percent of the fee for pharmacies with retail permits. This is a long-standing Medicaid policy.

N.J.A.C. 10:51-1.8 Compounded prescriptions

Compounded prescriptions are defined in this section, as well as those conditions which exclude these preparations from reimbursement by New Jersey Medicaid.

Compounded prescriptions can be rendered non-reimbursable in two ways. Inclusion of any drug produced by a manufacturer who has not entered into the Federal drug rebate program will render the compounded prescription non-reimbursable by Medicaid because Federal statute requires manufacturers of pharmaceuticals to enter into the drug rebate program. Inclusion of any drug, whether non-legend or legend, which is not covered by New Jersey Medicaid will render the preparation non-reimbursable by the Program.

This section also defines the calculation of the prescription cost. A similar provision appears at N.J.A.C. 10:51-2.8 because compounded prescriptions for Medicaid recipients are filled the same way, whether the patient is in the community or resides in a NF. However, there is a limitation at N.J.A.C. 10:51-4.9 because the PAAD Program cannot pay for a compounded prescription that contains a non-legend drug.

N.J.A.C. 10:51-1.9 Non-proprietary or generic dispensing

When generic medications are dispensed, the provider must supply on the claim the labeler code and drug product code of the actual product dispensed. The same concept appears at N.J.A.C. 10:51-2.9 and 4.10.

N.J.A.C. 10:51-1.10 Provider's usual and customary charge or advertised charge

The "usual and customary" charge is defined in this section as the actual charge made to the majority of the total patient population served by the individual pharmacy. This charge is determined to be, in a pharmacy where the general public, including private third party plans, accounts for more than 50 percent of the provider's prescription volume, the price the provider would charge a cash customer, including private third party plans. Where prescriptions provided through Medicaid and/or PAAD (the Program(s)) constitute more than 50 percent of the provider's total volume, the provider's usual and customary charge may be considered the amount the Program(s) would reimburse for the same services. When private third party prescription plans account for 50 percent of the provider's total third party reimbursement, the provider may not charge the Program(s) a greater dispensing fee than the weighted average dispensing fee charged to the private third party plans.

There is no similar section in the Nursing Facility subchapter because it is not applicable to pharmaceutical services rendered in a NF. There is a similar section in PAAD at N.J.A.C. 10:51-4.11.

N.J.A.C. 10:51-1.11 Covered pharmaceutical services

With respect to covered pharmaceutical services, these are prescribed legend drugs pursuant to Section 1927(k)(6) of the Social Security Act. The Medicaid Program covers only the following non-legend drugs: contraceptive devices/supplies, family planning supplies, pharmaceutical inhalation devices, insulin, insulin syringes and/or needles, diabetic testing materials, and antacids. Certain non-legend drugs, which include insulin, insulin needles and syringes, and diabetic testing materials, are available for PAAD beneficiaries pursuant to N.J.S.A. 30:4D-22. Similar provisions can be found at N.J.A.C. 10:51-2.10 and 4.12.

N.J.A.C. 10:51-1.12 Non-covered pharmaceutical services

The new policy, as set forth in N.J.A.C. 10:51-1.12(a), limits non-coverage to prescriptions which are not medically necessary. The Division is continuing the policy of non-coverage of experimental drugs.

With respect to non-legend drugs, Medicaid reimbursement is limited to contraceptive devices/supplies, family planning supplies, pharmaceutical inhalation devices, insulin, insulin needles and/or syringes, diabetic testing materials, and antacids. Broader non-legend drug coverage is provided by the Garden State Health Plan which includes all FDA-approved non-legend drugs (see N.J.A.C. 10:51-1.12(a)7i).

Other restrictions being removed from the current text of N.J.A.C. 10:51-1.14 include: (1) the reference to preventive drugs, vaccines and biologicals when available free of charge, because although these services are still available free of charge, these services are provided in hospital clinics, and/or community health centers, which bill the program only for the administration of these medications; (2) the specification of non-legend drug products not listed in Appendix B or C, because the appendices are being deleted; (3) the reference to injectable drug products, because they are no longer being prior authorized; and (4) the reference to patient administered medications because patients who administer their own medications do not subsequently bill the program.

Parallel provisions are located at N.J.A.C. 10:51-2.11 and 4.13.

N.J.A.C. 10:51-1.13 Services requiring prior authorization

With the exception of methadone and protein replacement products, the pharmaceuticals previously listed as requiring prior authorization no longer appear in this section. Services now requiring prior authorization include enteral nutritional products and special infant formulas (when not available from the Supplemental Food Program for Women, Infants and Children (WIC)), methadone, protein replacement products, drugs available only for treatment through an Investigational New Drug (IND) Application, approved anorexics and antiobesics, and legend and non-legend drugs or devices requiring authorization at the discretion of the Commissioner, prescriptions for persons covered under a managed care program, which have not been ordered by the person's physician case manager.

The proposed section describing quantity of medication in N.J.A.C. 10:51-1.14 replaces the existing text of N.J.A.C. 10:51-1.7. There is no change in the Medicaid policy limiting the quantity of medication prescribed to a 60-day supply or 100 unit doses whichever is greater.

Because prior authorization no longer applies to pharmaceutical services in nursing facilities or in the PAAD Program, there is no equivalent section in either Subchapter 2 or 4.

Prior authorization is required for those legend and non-legend drugs or devices which are not prescribed by the Garden State Health Plan Physician Case Managers.

N.J.A.C. 10:51-1.14 Quantity of medication

The Division is deleting from this section the specific reference to vitamins and vitamin/mineral combinations, hypodermic syringes and/or handles, and legend drug quantities because these preparations are subject to the same rules regarding the quantities to be dispensed as other medications provided through the Medicaid and PAAD programs.

The limit on 60-day supply or 100 unit doses, whichever is greater, remains in effect, for both Medicaid and PAAD (N.J.A.C. 10:51-1.14 and 4.14, respectively).

With respect to N.J.A.C. 10:51-2.12, patients in a NF are limited to a 30-day supply.

N.J.A.C. 10:51-1.15 Dosage and directions

The proposed section regarding dosage and directions which appears at N.J.A.C. 10:51-1.15 replaces N.J.A.C. 10:51-1.8 in the current text. Dosage and directions for use shall be indicated on all prescriptions except for topical preparations, aerosol inhalers, and nitroglycerin. There is a change in that the pharmacist shall enter a value of "1," rather than "N/A" in the field for "Days Supply" when dispensing the medications listed in this section. This change is necessary in order to comply with the new billing procedures in connection with the new fiscal agent.

Similar provisions will be found for nursing facilities and the PAAD program at N.J.A.C. 10:51-2.13 and 4.15, respectively.

N.J.A.C. 10:51-1.16 Telephone-rendered original prescriptions

This section is unchanged except that the title is being revised from "telephone-ordered" to "telephone-rendered." Comparable provisions are located at N.J.A.C. 10:51-2.14 and 4.16. The rule for nursing facility telephone-rendered prescriptions at N.J.A.C. 10:51-2.14 provides that prescriptions may be ordered by telephone or a technologically transmitted device, such as a "FAX" machine, in accordance with all applicable Federal and state laws and regulations. If the prescriber chooses not to allow product interchange on a telephone rendered original prescription, there must be a written statement on the medication order.

N.J.A.C. 10:51-1.17 Changes or additions to the original prescription

This section is unchanged from the current N.J.A.C. 10:51-1.10.

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N.J.A.C. 10:51-1.18 Prescription refill

Telephone authorized refills for prescriptions with no refill remaining must now be assigned a new prescription number. A replacement prescription for lost or destroyed prescriptions, which requires dispensing a replacement prescription before the original prescription could have been consumed according to the prescriber's directions, must be a new prescription with a unique prescription number. The reference to vitamin and vitamin/mineral combinations is being deleted.

Similar provisions can be found at N.J.A.C. 10:51-2.16 and 4.18.

The next four sections (N.J.A.C. 10:51-1.19 to 1.22) are mentioned briefly because they are really a restatement of policy that is already described by Federal or State law or regulation.

N.J.A.C. 10:51-1.19 Prescription Drug Price and Quality Stabilization Act

This section is unchanged. The requirement regarding substitution, and whether this is permissible or not, is a recognition of State law, N.J.S.A. 24:6E-1. The law requires that every prescription blank contain the statements "Substitution Permissible" and "Do Not Substitute." The prescriber shall initial one of the statements in addition to signing the prescription blank.

Prices of certain covered drugs are Federally regulated. These drugs are listed on the Maximum Allowable Cost (MAC) list, and are designated as MAC drugs. To order a proprietary drug for which a generic is available, Federal regulations require a handwritten statement by the prescribing physician: "BRAND MEDICALLY NECESSARY." Check-off is not permitted. Drugs not appearing on the MAC list are subject to state statute as cited above. With respect to Medicaid, if the prescriber initials "substitution permissible" the pharmacist shall dispense and bill Medicaid for one of the less expensive products listed as interchangeable with the brand name prescribed. For prescriptions dispensed through the PAAD program, the prescriber's initials in connection with substitution, on a signed prescription is acceptable.

The comparable provisions are located at N.J.A.C. 10:51-2.17 and 4.19.

N.J.A.C. 10:51-1.20 Drug Efficacy Study Implementation (DESI)

Provisions denying reimbursement for non-effective drugs are not being changed. In essence, the Federal government has a long standing policy of non-payment for "less than effective drugs," which are commonly referred to as DESI drugs. The Division follows the Federal policy and does not pay for DESI drugs.

Similar provisions can be found at N.J.A.C. 10:51-2.18 and 4.20.

N.J.A.C. 10:51-1.21 Drug Manufacturers Rebate Agreement

Legend drugs must be covered under a rebate agreement as required by OBRA '90 in order to be reimbursed by Medicaid. The reference drug file, as noted above, is the primary source of pricing information for the New Jersey Medicaid Management Information System (NJMMIS).

With respect to the rebate agreement noted in this section, this is new text based upon Federal law, Section 1927(a)-(o) of the Social Security Act, 42 U.S.C. 1396s(a)-(c).

The Drug Manufacturers' Rebate does not pertain to the PAAD Program. In respect to nursing facilities, this provision is located at N.J.A.C. 10:51-2.19.

N.J.A.C. 10:51-1.22 Bundled drug service

The section on bundled drug services, proposed N.J.A.C. 10:51-1.22, was adopted as N.J.A.C. 10:51-1.14(a)17 at 24 N.J.R. 845(a). The provisions regulating bundled drugs are not being changed in this proposal.

Comparable provisions are found at N.J.A.C. 10:51-2.20 and 4.21.

With respect to the PAAD program, a bundled drug service shall not be eligible for reimbursement. The cost of the drug product, which is a component of a bundled drug service, shall be covered by the PAAD program, (see N.J.A.C. 10:51-4.21).

N.J.A.C. 10:51-1.23 Tape-to-Tape Incentive Program

This section remains generally unchanged. (Current text for this section is codified at N.J.A.C. 10:51-1.21.) Provision is being added to recover the incentive payment for a voided claim(s), and to update the name of the application form for eligibility to submit magnetic tape claims.

Comparable rules for nursing facilities and the PAAD program are located at N.J.A.C. 10:51-2.21 and 4.22, respectively.

Proposed N.J.A.C. 10:51-2, pertaining to pharmaceutical services to Medicaid recipients in a nursing facility, is basically a recodification and transfer of the existing text of N.J.A.C. 10:51-3.

Proposed N.J.A.C. 10:51-3, Consultant Pharmacist Services, is basically the same as the current text of N.J.A.C. 10:51-4. However, N.J.A.C. 10:51-3.4 is being revised to indicate that records of disposal, disposition or destruction of unused or discontinued drugs shall be maintained by or supervised by the consultant pharmacist. In addition, the consultant pharmacist shall serve as an active member of the pharmacy and therapeutic committee, and provide in-service training programs.

N.J.A.C. 10:51-4, regarding pharmacy services provided to beneficiaries under the PAAD program, is basically the same as N.J.A.C. 10:51-1. However, there are some exceptions in the PAAD program, since this is a wholly State funded program. Only legend drugs and certain non-legend drugs (as noted above, contraceptive devices/supplies, family planning supplies, pharmaceutical inhalation devices, insulin, insulin syringes and/or needles, diabetic testing materials, and antacids) are available pursuant to state law (see N.J.S.A. 30:4D-22).

The appendices in the current text are being deleted. Appendix A, which describes preventive vaccines, biologicals and therapeutic drugs issued free of charge by the New Jersey State Health Department is being deleted and replaced by the text in N.J.A.C. 10:51-1.12(a)16, below. Appendix B, a list of general non-legend drugs, Appendix C, insulin syringes and/or needles, Appendix D, legend/non-legend devices, and Appendix E, protein replacements and other special items, are all being deleted. The reason for the deletion is a change in the New Jersey Medicaid Management Information System (MMIS) which occurred when Paramax/Unisys became the Division's fiscal agent. The MMIS Drug File is updated weekly by Paramax/Unisys based upon data supplied by First Data Bank (FDB) of California. The update process provides drug file data which includes updates to the existing drug file relevant to changes in product description.

Pharmaceutical providers are made aware of the therapeutic indications for various classes of drugs by product literature distributed by drug manufacturers, or by trade publications, including one publication issued by FDB. Based upon market information, providers are able to determine a product's therapeutic classification. Once a pharmaceutical provider has recognized this classification, they can apply this knowledge to the Division rules at N.J.A.C. 10:51-1.11 to determine if the drug or drug product can be covered by the New Jersey Medicaid program, and/or PAAD program.

The Division is adding two new appendices with this rule. Appendix A is the list of DESI drugs. The acronym DESI refers to Drug Efficacy Study Implementation and appears at N.J.A.C. 10:51-1.20, 2.18 and 4.20 below. Appendix B is the list of MAC drugs. The acronym MAC refers to the Maximum Allowable Cost and is described at N.J.A.C. 10:51-1.5, 2.5 and 4.5 below. Both lists are supplied by the Federal government. The lists will be referenced but not reproduced in the New Jersey Administrative Code.

Social Impact

The proposed new rules impact upon both Medicaid recipients and PAAD beneficiaries. Medicaid recipients can obtain both legend and certain non-legend drugs that are prescribed by an authorized prescriber. However, non-legend drugs are limited by the 1992 State FY Appropriations Act, P.L. 1992, c.185, and the rules adopted at 23 N.J.R. 2035(a). The rules are codified at N.J.A.C. 10:51-1.2, 1.13, 1.14, 1.20 and Appendices B, C, D and E of the current text.

There is also another limit for Medicaid recipients, and that is the aged, blind or disabled persons under the Medically Needy category who can not receive prescription drug services pursuant to N.J.S.A. 30:4D-g. Many of these persons, however, will qualify for these services through the PAAD program.

The proposed new rules benefit patients who may require pharmaceutical intervention to stabilize or ameliorate their condition following an appropriate clinical diagnosis.

The proposed new rules also impact upon pharmaceutical providers that participate in the Medicaid and/or PAAD program. Pharmaceutical providers are required to comply with the recent changes in Federal law cited above, especially in regard to rebate agreements. Pharmaceutical providers are expected to be aware of the respective eligibility criteria, that is, only those Medicaid recipients who are categorically eligible qualify for pharmaceutical services. In addition, both New Jersey Medicaid and the PAAD program have restrictions specifying availability of non-legend drugs. Pharmaceutical providers must also be aware of

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the specific requirements governing patients in NF's. Pharmacists who function as consultant pharmacists must comply with the requirements of N.J.A.C. 19:51-3.

The proposed new rules impact on drug manufacturers who are required to sign a rebate agreement with the Federal Department of Health and Human Services in order to be reimbursed by Title XIX (Medicaid).

The proposed new rules also impact upon physicians and other prescribers because they are required to indicate whether or not substitution is permitted.

Economic Impact

The proposed new rules impose no economic impact on any of the Medicaid coverage groups, whether categorically needy, Medically Needy or optionally categorically needy, because they are not required to pay for pharmaceutical services. The rules are not changing eligibility criteria for pharmaceutical services through New Jersey Medicaid.

PAAD beneficiaries are required by law to pay a co-payment for each prescription. The co-payment is currently $5.00 as established by the 1993 State FY Appropriations Act, P. L. 1992, c.40.

There may be some minor economic impact upon pharmaceutical providers who might have to modify their billing system, whether automated or manual, to accommodate these requirements. However, modifications should be minor because the Division is still requiring submission of the same data on the same claim form within the same time periods.

Pharmaceutical providers must also recognize those drug manufacturers who participate in the Medicaid drug rebate program to ensure proper payment for drugs dispensed.

Drug manufacturers who participate in the Medicaid rebate program established by the Federal government will have their drugs or drug products covered by Title XIX. Those manufacturers who do not sign the rebate agreement will not have their drugs covered by Title XIX.

Regulatory Flexibility Analysis

The proposed new rules impose reporting, recordkeeping, paperwork and other compliance requirements upon pharmaceutical providers, some of which may be considered small businesses under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq.

There are reporting, recordkeeping and compliance requirements already specified in the New Jersey Medicaid Statute, N.J.S.A. 30:4D-12. These statutory requirements, which are an expression of existing policy in both Medicaid and PAAD, require the provider to keep sufficient records, whether automated or manual, to indicate the name of the recipient/beneficiary being treated, date of service, nature of service, and such other information as may be required by regulation. The type of additional information pharmacies must maintain is the National Drug Code (NDC) number and other information required by the Federal Food and Drug Administration.

Providers are required to submit an annual report listing prescription volume as indicated in N.J.A.C. 10:51-1.6 below. This is an existing program requirement and appears at N.J.A.C. 10:51-1.16 in the current text. The purpose of this requirement is to calculate the pharmacy regression, or discount, for a calendar year.

The Division recognizes that the control of drugs and pharmaceuticals is heavily regulated to insure the health, safety and welfare of the general public. The Division has tried to minimize any adverse economic impact by not imposing any requirements other than those already established by Federal and/or state law or regulation. Pharmacists dispensing medications under Medicaid and PAAD must meet appropriate licensure and professional criteria. Consulting pharmacists must meet the criteria specified in N.J.A.C. 10:51-3. Pharmaceutical providers are not required to hire additional professional staff, such as accountants, unless they choose to do so.

There should be no capital costs associated with this proposed new rule.

Full text of the proposed repeal may be found in the New Jersey Administrative Code at N.J.A.C. 10:51.

Full text of the proposed new rules follows.

CHAPTER 51
PHARMACEUTICAL SERVICES MANUAL

SUBCHAPTER 1. PHARMACEUTICAL SERVICES

10:51-1.1 Introduction

(a) This chapter provides information about the provision of pharmaceutical services under the New Jersey Medicaid program and the Pharmaceutical Assistance to the Aged and Disabled (PAAD) program. It is divided into four subchapters:

1. N.J.A.C. 10:51-1 provides a pharmacy operating under a retail permit with the policies and procedures relevant to the provision of services to New Jersey Medicaid recipients, excluding those residing in a nursing facility.

2. N.J.A.C. 10:51-2 pertains to a pharmacy providing pharmaceutical services to Medicaid recipients in a nursing facility.

3. N.J.A.C. 10:51-3 explains the responsibility of a pharmacist acting as a consultant in a nursing facility or other public medical institution.

4. N.J.A.C. 10:51-4 provides information about the provision of pharmaceutical services under the PAAD program.

(b) Incorporated by reference into this chapter as Appendix D is the Fiscal Agent Billing Supplement that provides information about claim processing and related activities.

10:51-1.2 Participation of eligible providers

(a) A pharmacy, with a retail or institutional permit, may participate in the Medicaid program as a provider of pharmaceutical services; as a Medical Supplier providing medical supplies and durable medical equipment; and/or as a provider of parenteral nutrition and/or intravenous therapy. The requirements for approval as a provider of these services are listed in (b) through (d) below.

(b) To be approved as a provider of pharmaceutical services, the pharmacy must:

1. Operate under a valid retail and/or institutional permit issued by the Board of Pharmacy of the State of New Jersey or by the board of pharmacy of the state in which the pharmacy is located. A pharmacy operating under an out-of-state institutional permit may not participate as an approved provider in the New Jersey Medicaid program; and

2. File an application and sign an agreement with the Division of Medical Assistance and Health Services.

i. Upon sale or other change of ownership of an approved pharmacy, the agreement is automatically terminated. To execute a new agreement to participate in the New Jersey Medicaid program, the new owner(s) shall apply to the Division of Medical Assistance and Health Services, Department of Human Services, by contacting the Medicaid Provider Enrollment Unit (see N.J.A.C. 10:49—Administration Chapter, Enrollment Process) or the fiscal agent Provider Enrollment Unit (see Appendix, Fiscal Agent Billing Supplement).

3. To enroll as a Medicaid provider of pharmaceutical services, a pharmacy shall contact the fiscal agent Provider Enrollment Unit (see Appendix, Fiscal Agent Billing Supplement).

(c) A pharmacy may also participate as a medical supplier. The Medical Supplier Manual, N.J.A.C. 10:59, available from the Medicaid fiscal agent, provides information concerning the provision of and reimbursement for covered medical supplies and durable medical equipment provided by a Medical supplier.

1. A pharmacy may apply to participate as a medical supplier by contacting the Medicaid Provider Enrollment Unit (see N.J.A.C. 10:49—Administrative Chapter, Enrollment Process) or the fiscal agent Provider Enrollment Unit (see Appendix, Fiscal Agent Billing Supplement).

(d) Requirements for approval as a provider of parenteral nutrition and/or intravenous therapy are as follows:

1. In addition to the requirements for approval as a pharmacy provider listed under (b) above, a pharmacy who supplies parenteral nutrition and/or intravenous therapy must:

i. Comply with the requirements of the N.J.A.C. 13:39-10, Sterile Admixture Services in Retail and Institutional Pharmacies; or

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ii. Comply with similar applicable requirements of the state in which the applicant is located and submit a copy of the requirements of that state when applying for participation. A copy of the N.J.A.C. 13:39-10, Sterile Admixture Services in Retail and Institutional Pharmacies, is available, subject to copying charges, from OAL Publications, Office of Administrative Law, CN 301, Trenton, New Jersey 08625.

2. Parenteral nutrition and/or intravenous therapy may be provided by either a pharmacy/medical supplier or a medical supplier approved to provide these services by the New Jersey Medicaid program; however, billing for the ancillary supplies associated with parenteral nutrition and/or intravenous therapy are subject to the requirements of the Medical Supplier Manual (N.J.A.C. 10:59).

i. "Ancillary supplies" means medical supplies and/or durable medical equipment which are medically necessary to facilitate administration of parenteral or intravenous therapy.

10:51-1.3 Conditions for participation as a provider of pharmaceutical services

(a) All participating pharmacies shall provide complete prescription services, including injectables and injectable anti-neoplastic agents, compounding, and prescription refill services, when allowable. Prescriptions must be dispensed in compliance with all current existing Federal and State laws.

(b) All drugs must be prescribed.

1. "Prescribed drugs" mean simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are:

i. Prescribed by a practitioner licensed or authorized by the State of New Jersey, or the state in which he or she practices, to prescribe drugs and medicine within the scope of his or her license and practice;

ii. Dispensed by licensed pharmacists in accordance with regulations promulgated by the New Jersey State Board of Pharmacy, N.J.A.C. 13:39; and

iii. Dispensed by licensed pharmacists on the basis of a written prescription that is maintained in the pharmacist's records.

(c) Participating pharmacies shall permit properly identified representatives of the Division of Medical Assistance and Health Services to:

1. Inspect written prescriptions on file;

2. Audit records pertaining to covered persons;

3. Inspect private sector records, where deemed necessary to comply with the Federal regulations to determine a pharmacy's usual and customary charge to the public;

i. Information pertaining to the patient's name, address, and prescriber will remain confidential within the limits of the law. Only the following items may be reviewed:

(1) Drug name;

(2) Quantity dispensed;

(3) Price;

(4) Prescription number (for reference purposes only); and

(5) Date dispensed;

ii. The pharmacy shall provide sufficient information with regard to its contractual agreement(s) and payment history with other private third party prescription plans to identify and verify number of claims, amount paid, and dispensing fee paid by group contracts within the plan. Records and contracts shall be available on-site at the time of audit; or available within 10 working days of an on-site audit. Records shall include, but not be limited to:

(1) Payment vouchers;

(2) Contracts; and

(3) Agreements; and

4. Inspect records of purchases of covered drugs for which claims have been made for reimbursement.

10:51-1.4 Program restrictions affecting payment for prescribed drugs

(a) The choice of prescribed drugs shall be at the discretion of the prescriber within the limits of applicable laws. However, the prescriber's discretion is limited for certain drugs. Reimbursement may be denied if the requirements of the following rules are not met:

1. Covered and non-covered pharmaceutical services as listed in N.J.A.C. 10:51-1.11 and 10:51-1.12, respectively;

2. Pharmaceutical service requiring prior authorization (see N.J.A.C. 10:51-1.13);

3. Quantity of medication (see N.J.A.C. 10:51-1.14);

4. Dosage and directions (see N.J.A.C. 10:51-1.15);

5. Telephone-rendered original prescriptions (see N.J.A.C. 10:51-1.16);

6. Changes or additions to the original prescription (see N.J.A.C. 10:51-1.17);

7. Prescription refill (see N.J.A.C. 10:51-1.18);

8. Prescription Drug Price and Quality Stabilization Act (N.J.S.A. 24:6E-1 et seq.) (see N.J.A.C. 10:51-1.19);

i. Products listed in the current New Jersey Drug Utilization Review Council (DURC) Formulary (hereafter referred to as "the Formulary"), and all subsequent revisions, distributed to all prescribers and pharmacists; and

ii. Non-proprietary or generic dispensing (see N.J.A.C. 10:51-1.9).

9. Federal regulations (42 CFR 447.301, 331-333) that set the aggregate upper limits on payment for certain multi-source drugs if Federal Financial Participation (FFP) is to be made available. The limit applies to all "maximum allowable cost" drugs (see N.J.A.C. 10:51-1.5, Basis of payment);

10. Drug Efficacy Study Implementation (DESI): "Less than effective drugs" subject to a Notice of Opportunity for Hearing (NOOH) by the Federal Food and Drug Administration (see N.J.A.C. 10:51-1.20 and listing of DESI drugs in Appendix A herein incorporated by reference); and

11. Drug Manufacturers' Rebate Agreement with the Health Care Financing Administration of the United States Department of Health and Human Services (see N.J.A.C. 10:51-1.21);

(b) A properly completed claim form must be submitted or a properly formatted electronic media claim (EMC) must be transmitted to the fiscal agent for claims processing.

1. The claim form may be completed manually or by computer, but only one prescription shall be billed on each claim form. See Appendix Fiscal Agent Billing Supplement for instructions concerning the completion and submission of the specified claim form;

2. All claim forms must contain the National Drug Code (NDC). The 11-digit NDC has three components. The first five digits are the manufacturer's labeler code, the next four digits are the product code, and the final two digits are the package size code. For claim submission, leading zeros must be included in all fields. For example, 00003-0234-01.

i. The Dispenser must always report the actual labeler code and drug product code of the drug dispensed. The package size code reported may differ from the actual stock package size used to fill the prescriptions.

10:51-1.5 Basis of payment

(a) This section provides a summary of the elements involved in the calculation of the payment of a legend or non-legend drug. The elements include the following:

1. Program restrictions affecting reimbursement for the dispensing of drugs as listed in N.J.A.C. 10:51-1.4;

2. Price information as supplied from a reference drug file contracted for this purpose by the fiscal agent and accepted by the Division as the primary source of pricing information for the New Jersey Medicaid Management Information System (NJMMIS). The drug price or ingredient cost shall not exceed the lower of the average wholesale price as supplied by the reference drug file contractor; the provider's usual and customary charge; or the drug's maximum allowable cost, if applicable (see (b) below);

3. Federal regulations (42 CFR 447.301, 331-333) that set the aggregate upper limits on payment for certain covered drugs in the pharmaceutical program. The New Jersey Medicaid program refers to these upper limits as the "maximum allowable cost" (see (b) below); and

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4. The provider's usual and customary charge for legend or non-legend drugs (see (c) below), contraceptive diaphragms and legend or non-legend devices.

(b) Payment for legend drugs is based upon the maximum allowable cost. This means the lower of the upper payment limit price list (MAC price) as published by the Federal government or the average wholesale price (AWP). Appendix B is the listing of MAC drugs, and is hereby incorporated by reference.

1. Maximum allowable cost is defined as:

i. The MAC price for listed multi-source drugs published periodically by the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services;

ii. The Estimated Acquisition Cost (EAC), which is defined as the average wholesale price (AWP) listed for the package size (billed to the New Jersey Medicaid program), in current national price compendia or other appropriate sources (such as the First Data Bank (FDB) reference drug file contractor), and their supplements.

(1) Maximum cost for each eligible prescription claim not covered by (b)1i above is based on the lower of the AWP minus regression (discount) category, if applicable, plus dispensing fee, or usual and customary charge. For information about the "regression (discount) categories," see N.J.A.C. 10:51-1.6, and for usual and customary charge, see N.J.A.C. 10:51-1.10.

2. If the published MAC price as defined in (b)1i above is higher than the average wholesale price which would be paid as defined in (b)1ii above, then (b)1ii above shall apply.

(c) The maximum charge to the New Jersey Medicaid program for a legend drug, including the charge for the cost of medication and the dispensing fee, shall not exceed the lowest of the following:

1. Maximum allowable cost (MAC) as determined in (b)1 above, plus dispensing fee (see N.J.A.C. 10:51-1.7); or

2. The provider's usual and customary and/or posted or advertised charge.

(d) The maximum allowance for the non-legend drugs, devices, or supplies under the New Jersey Medicaid program is:

1. The product AWP plus 50 percent; or

2. The usual over-the-counter OTC retail price charged to the other persons in the community, whichever is less.

10:51-1.6 Regression (discount) categories

(a) The maximum cost for each eligible prescription claim not covered by the **Maximum Allowable Cost price** (see N.J.A.C. 10:51-1.5—Basis of Payment) is subject to the following fiscal conditions based upon six categories. The category, as determined by the New Jersey Medicaid program, is based on the previous year's total prescription volume for each participating pharmacy. The categories shall be reviewed annually and adjusted as appropriate.

1. Those pharmacy providers who have been in business for less than one calendar year shall have their prescription volume projected for the entire year, to determine the appropriate category.

(b) The pharmacy provider shall submit, in writing, an annual report on form FD-70 (See Appendix C, Pharmacy Provider Certification Statement) certifying its prescription volume. The Division shall determine a provider's total prescription volume, which includes all prescriptions filled (both new and refills), including nursing facility prescriptions, for private patients, Medicaid, PAAD, and other third party recipients for the previous calendar year. Failure to submit this report annually shall result in the provider being placed in the maximum discount category (category VI) for the year of non-compliance, or until the required report is received.

1. Category I: Pharmacies whose total prescription volume in the preceding calendar year was not more than 14,999 prescriptions.

i. Pharmacy providers in this category shall receive reimbursement for Medicaid prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-1.5, as the maximum.

2. Category II: Pharmacies whose total prescription volume in the preceding calendar year was at least 15,000 but not greater than 19,999 prescriptions.

i. Pharmacy providers in this category shall receive reimbursement for Medicaid prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-1.5, less two percent, as the maximum.

3. Category III: Pharmacies whose total prescription volume in the preceding calendar year was at least 20,000 but not greater than 29,999 prescriptions.

i. Pharmacy providers in this category shall receive reimbursement for Medicaid prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-1.5, less three percent, as the maximum.

4. Category IV: Pharmacies whose total prescription volume in the preceding calendar year was at least 30,000 but not greater than 39,999 prescriptions.

i. Pharmacy providers in this category shall receive reimbursement for Medicaid prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-1.5, less four percent, as the maximum.

5. Category V: Pharmacies whose total prescription volume in the preceding calendar year was at least 40,000 but not greater than 49,999 prescriptions.

i. Pharmacy providers in this category shall receive reimbursement for Medicaid prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-1.5, less five percent, as the maximum.

6. Category VI: Pharmacies whose total prescription volume in the preceding calendar year was 50,000 prescriptions or more.

i. Pharmacy providers in this category shall receive reimbursement for Medicaid prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-1.5, less six percent, as the maximum.

7. The appropriate calculated discount shall be automatically deducted, by the fiscal agent, from the cost of each covered drug or device during claim processing by the New Jersey Medicaid Management Information System (NJMMIS).

8. For covered drugs or devices with an average wholesale price (AWP) of more than $24.99, there shall be no discount from the AWP.

10:51-1.7 Prescription drug dispensing fee

(a) The dispensing fee for legend drugs, dispensed by providers having retail permits to recipients other than those in nursing facilities, is $3.73. Additional dispensing fees (add-ons) per prescription shall be given to pharmacy providers who provide the following:

1. Twenty-Four Hour Emergency Service: $0.11. The provider shall have a 24-hour per day, 365 days per year prescription service available and shall have provided Medicaid recipients opportunities to utilize this service.

2. Patient Consultation: $0.08. In addition to routinely monitoring recipient profiles for drug interactions, contraindications, allergies, etc., the provider shall, where appropriate, discuss the course of drug therapy with the recipient. This discussion must include emphasis on compliance with the prescriber's orders; proper drug utilization; cautions about possible side affects; foods to avoid; proper drug storage conditions; and any other information that will prove beneficial to the recipient while on drug therapy.

3. Impact Area Location: $0.15. The provider shall have a combined Medicaid and PAAD prescription volume equal to or greater than 50 percent of the provider's total prescription volume.

i. The nursing facility prescription volume shall be included for the determination of total prescription volume in determining entitlement to the impact allowance.

(b) Price information is supplied from a reference drug file subcontracted for this purpose by the fiscal agent and accepted by the Division as the primary source of pricing information for the New Jersey Medicaid Management Information System (NJMMIS). The calculated price shall not exceed the lower of the average wholesale price (AWP) or the Federal Fund Participation Upper Limit (FFPUL) as supplied by the reference drug file contractor.

(c) In order to receive any or all of the above increments, the provider shall certify annually to the Division on Form FD-70, that the service(s) as defined in (a) above, are being provided and/or that the provider is entitled to the impact increment as defined in (a) above.

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1. Each claimed increment is subject to audit and retroactive recovery with appropriate penalties, if warranted, if the New Jersey Medicaid program determines that the provider was not entitled to reimbursement for them.

10:51-1.8 Compounded prescriptions

(a) Compounded prescriptions extemporaneously prepared and dispensed by approved pharmacy providers are reimbursable by the Medicaid program as follows:

1. Total ingredient cost is defined in N.J.A.C. 10:51-1.5. The provider may charge up to $0.25 for any ingredient whose "cost" is less than $0.25; plus

2. The dispensing fee is allowed in N.J.A.C. 10:51-1.7; plus

3. The maximum charge for a compounded prescription must not exceed the limits set forth in N.J.A.C. 10:51-1.14.

(b) Restriction in payments for compounded prescriptions are as follows:

1. All legend and non-legend (OTC) ingredients which are contained in compounded prescriptions must be covered by a manufacturer rebate agreement (see N.J.A.C. 10:51-1.21). If the labeler code of any single ingredient is not manufactured by an approved manufacturer, the compounded prescription is not covered. Chemical ingredients without NDC codes are excluded.

2. All non-legend ingredients which are contained in compounded prescriptions must be covered by the Medicaid program. If a non-legend drug is not listed as covered in N.J.A.C. 10:51-1.11, the compounded prescription is not covered.

3. All legend ingredients which are contained in compounded prescriptions must be covered by the Medicaid program. If a legend drug is a DESI (Drug Efficacy Study Implementation, see N.J.A.C. 10:51-1.20) drug, the compounded prescription is not covered.

4. Compounded prescriptions containing drugs not eligible for reimbursement under N.J.A.C. 10:51-1.12 are not covered.

10:51-1.9 Non-proprietary or generic dispensing

When medication is prescribed by its non-proprietary or generic name, the pharmacist shall dispense the least expensive, therapeutically effective equivalent product available, preferably one listed in the DURC Formulary. The labeler code and drug product code of the actual product dispensed must be reported on the claim form. The package size code reported may differ from the stock package size used to fill the prescription.

10:51-1.10 Provider's usual and customary charge or advertised charge

(a) The provider's usual and customary charge or advertised charge is an element considered in the calculation of the basis of payment for legend drugs (see N.J.A.C. 10:51-1.5, Basis of payment).

(b) The usual and customary charge to the Medicaid program is defined as the amount a provider charges the general public for a prescription for the same drug product (same NDC number) in the same quantity as the prescription being dispensed to a Medicaid recipient. "Usual and customary charge" means the actual charge made to the majority (51 percent) of the total patient population served by the individual pharmacy.

1. The provider shall not charge the Program more than would be charged to a cash customer when the general public, including private third party plans, accounts for more than 50 percent of a provider's total prescription volume.

i. In the event Medicaid and/or PAAD represent more than 50 percent of a provider's total prescription volume, then, for reimbursement purposes, the provider's usual and customary charge may be considered the amount the Program would reimburse for the same services.

10:51-1.11 Covered pharmaceutical services

(a) All covered pharmaceutical services shall be provided within the scope of the N.J.A.C. 10:49, Administration, and this chapter, and billed to the fiscal agent on the claim form or other approved billing method (see Appendix, Fiscal Agent Billing Supplement).

(b) Covered pharmaceutical services include:

1. Prescribed legend drugs (for their medically accepted indication) as defined in Section 1927(k)(6) of the Social Security Act. "Legend drugs" mean those drugs whose labels include the legend statement "Caution: Federal Law Prohibits Dispensing Without a Prescription."

2. Non-legend drugs, as follows, for which Federal Financial Participation (FFP) is available:

i. Contraceptive devices and contraceptive supplies (such as diaphragms, jellies, foams and condoms);

ii. Over-the-counter, family planning supplies (such as pregnancy test kits);

iii. Pharmaceutical inhalation devices;

iv. Diabetic testing materials;

v. Insulin needles and/or syringes;

vi. Insulin; and

vii. Antacids.

(c) For recipients in the Medically Needy component of the New Jersey Care ... Special Medicaid programs, pharmaceutical services are only available to pregnant women and dependent children. For information on how to identify a Medicaid recipient, see N.J.A.C. 10:49, Administration.

10:51-1.12 Non-covered pharmaceutical services

(a) The following classes of prescription drugs or conditions are not covered under the New Jersey Medicaid program. For recipients in the Medically Needy component of the New Jersey Care ... Special Medicaid programs, pharmaceutical services are not available to the aged, blind nor the disabled. For information on how to identify a covered person, see N.J.A.C. 10:49, Administration.

1. Prescriptions which are not for medically accepted indications (as defined in Section 1927(k)(6) of the Social Security Act);

2. Antiobesics and anorexiants when used in treatment of obesity (see N.J.A.C. 10:51-1.13, Prior authorization);

3. Drug products for which adequate and accurate information is not readily available, such as, but not limited to, product literature, package inserts and price catalogues;

4. Experimental drugs;

i. Exception: Drugs available only for treatment through an Investigational New Drug (IND) application shall be prior authorized;

5. Medication furnished by a prescriber or an employee of a prescriber;

6. Medication prescribed for hospital inpatients;

7. Non-legend drugs other than antacids; contraceptive devices and contraceptive supplies; diabetic testing materials; over-the-counter (OTC) family planning supplies; inhalation devices (pharmaceutical); insulin; and insulin needles and/or syringes;

i. Exception: Antihistamines, antacids, OTC analgesics, laxatives, anti-diarrheal medications, OTC dermatological preparations, cold and cough medications, insulin, diabetic testing materials, family planning supplies and protein replacement supplements are services covered by the Garden State Health Plan;

8. Prescriptions written and/or dispensed with nonspecific directions;

9. Food supplements, milk modifiers, infant formulas, therapeutic diets, special liquid or powdered diets used in the treatment of obesity;

i. Exception: Enteral nutritional products and electrolyte replacement supplements;

10. Methadone in any form (tablets, capsules, liquid, injectables, or powder) when used for drug detoxification or addiction maintenance (see N.J.A.C. 10:51-1.13, Prior authorization);

11. Drug products for which final orders have been published by the Food and Drug Administration, withdrawing the approval of their new drug application (NDA);

12. Drugs or drug products not approved by the Food and Drug Administration, when such approval is required by Federal law and/or regulation;

13. Radiopaque contrast materials (for example, Telepaque);

14. Drugs for which Federal Financial Participation (FFP) is not available, including:

i. Drug Efficacy Study Implementation (DESI) drugs and identical, similar and related drugs (see N.J.A.C. 10:51-1.20); and

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ii. Drugs not covered by rebate agreements as defined in Section 4401 of OBRA '90 and Section 1927(a) of the Social Security Act (see N.J.A.C. 10:51-1.21);

15. Any bundled drug service (see N.J.A.C. 10:51-1.22); and

16. If the provider has a delivery service, he or she may waive or discount delivery charges to the recipient but is prohibited from charging more than his or her usual customary charge to the general public for delivery.

(b) Otherwise reimbursable products shall be excluded from payment, under the following condition(s):

1. Products whose costs are found to be in excess of defined costs outlined in N.J.A.C. 10:51-1.5, Basis of payment;

2. Drug products in dosage forms whose labeling, prescription or promotional material indicate the primary use is cosmetic in nature; for example, hair restoration;

3. Covered non-legend drug products, devices and diabetic testing materials which do not offer significant price and/or therapeutic advantage. In the case of diabetic testing materials, the criteria shall be cost and improvement in accuracy over existing reimbursable products. Therapeutic advantage (in the case of diabetic testing materials, improvement in accuracy) shall be determined by evaluation of literature and/or cost effectiveness data submitted in support of a request for admission of a non-legend product for inclusion in the list of reimbursable products;

i. Manufacturers and distributors may request the review of a denial of reimbursement for products under this subsection by providing supportive information not previously submitted, within 30 days of the date of the denial. Agency decision after review of support material is final; and

4. Drug products available in unit-dose packaging and dispensed to residents in a boarding home or residential care setting.

i. Exception: Drug products available only in a unit-dose package are covered.

(c) Reimbursement shall not be made for any claim submitted by a provider which involves a recipient restricted to another pharmacy, except for an emergency situation (see N.J.A.C. 10:49, Administration).

10:51-1.13 Services requiring prior authorization

(a) The provider shall obtain prior authorization, when required, by phone or in writing, from the Medicaid District Office (MDO) professional staff. The appropriate form that must be used to request prior authorization is indicated in the Fiscal Agent Billing Supplement. Information on the form is transmitted, on-line, from the MDO to the fiscal agent who, in turn, confirms the status of the authorization request by mail and provides the specific prior authorization number.

1. In an administrative emergency (see N.J.A.C. 10:49, Administration) when the MDO is unavailable, the provider may dispense a 72 hour supply of the prescribed drug. If the drug is to be continued beyond 72 hours, the provider shall hold the claim and obtain prior authorization for the balance of the prescription when the MDO is available during normal business hours.

(b) The following drugs and specific therapeutic classes require prior authorization:

1. Enteral nutritional products and special infant formulas may only be authorized when medically necessary and when not available from the Women, Infant and Children (WIC) Nutritional program;

i. Medically necessary enteral nutritional products for treatment of recipients, which may be administered orally, via nasogastric tube, gastrostomy tube or needle catheter jejunostomy must be prior authorized. Special liquid or powdered diets for treatment of obesity or regular infant formulas are not considered enteral nutritional products;

2. Methadone (not eligible for reimbursement when used for drug detoxification or for addiction maintenance);

3. Drugs available only for treatment through an Investigational New Drug (IND) application shall be prior authorized;

4. Anorexiants and antiobesics when used for treatment of conditions approved by New Jersey State Board of Medical Examiners at N.J.A.C. 13:35-6.7; and

5. Those legend and non-legend drugs or devices which are not prescribed by the Garden State Health Plan Physician Case Managers (PCMs).

10:51-1.14 Quantity of medication

(a) The quantity of medication prescribed shall provide a sufficient amount of medication necessary for the anticipated duration of the illness or an amount sufficient to cover the interval between visits to the prescriber, but may not exceed a 60-day supply or 100 unit doses, whichever is greater. Any medication used continuously (that is, daily, three times daily, every other day, and so forth) for 14 days or more is considered a sustaining drug or maintenance medication and shall be prescribed in sufficient quantities to treat the recipient for at least 60 days or in 100 unit doses, whichever is greater. The pharmacist shall dispense the full quantity prescribed, within Program limits. Prescriptions shall not be split or reduced in quantity, unless the quantity prescribed exceeds Program limits, in which case the quantity shall be reduced to meet these limitations.

1. Exceptions:

i. Oral contraceptives may be prescribed and dispensed up to a supply of three ovulatory cycles; and

ii. When the full quantity prescribed (within Program limits) is not available at the time of dispensing, the pharmacist may dispense the quantity available and inform the Medicaid recipient accordingly. The pharmacist shall retain the claim form until the balance of the medication is dispensed.

10:51-1.15 Dosage and directions

(a) Dosage and directions for use shall be indicated on all prescriptions. Prescriptions written and dispensed with no specific directions, such as "prn," "as directed" or "ad lib," etc. are not eligible for reimbursement. Specific directions such as "1 tablet 4 times a day PRN" are required.

1. Exceptions:

i. Topical preparations including ophthalmic and otic drops and ointments;

ii. Aerosol inhalers; and

iii. Nitroglycerin.

2. For all oral medication and injectables, the number of days the medication should last, based on the prescriber's directions for use, shall be entered in the "Days Supply" filed on the pharmacy claim form.

(b) Dosage for the medications, under (a)1 above, cannot be related to the number of days supply. The pharmacist shall enter a value of "1" in the "Days Supply" filed on the pharmacy claim form.

10:51-1.16 Telephone-rendered original prescriptions

(a) Telephone orders from prescribers for original prescriptions shall be permitted in accordance with all applicable Federal and State laws and regulations.

(b) For purposes of reimbursement, telephone authorization to refill an original prescription with no refill remaining is considered a new order and requires a new written prescription with a new prescription number. Stamping or writing a new number on the original prescription order does not constitute a new prescription under the Medicaid program.

(c) When a prescriber chooses not to allow product interchange on a telephone order, the statement "Substitution not permitted by prescriber-telephone Rx" plus the pharmacist's full signature next to or below the statement, shall appear on the prescription order. A rubber stamp bearing the statement is acceptable.

(d) When a prescriber chooses to certify "Brand Medically Necessary" on a telephoned prescription for a product included on the Federal MAC list, a written signed prescription order containing the certification, shall be sent to the pharmacist within seven days of the date of the telephone order. The written prescription shall be retained by the pharmacist as the original prescription. Failure to comply will result in the payment for that prescription being reduced to the MAC reimbursement level.

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10:51-1.17 Changes or additions to the original prescription

Changes or additions to the original prescription, when approved by the prescriber, shall be clearly indicated (including date and time) and signed by the dispensing pharmacist. No changes (for example, dosage, quantity, number of refills, days supply, etc.) are permitted on the original prescription order after the claim is submitted for payment.

10:51-1.18 Prescription refill

(a) The provider shall submit a properly completed claim form to the fiscal agent for reimbursement of an allowable refill. An allowable refill shall comply with the following instuctions in order to be reimbursed as such:

1. Refill instructions must be indicated in writing by the prescriber on the original prescription or verbally when telephoning the original prescription to the pharmacist. Verbal instructions shall be reduced to writing by the pharmacist, in accordance with N.J.S.A. 45:14-14.

2. When the prescriber indicates a prescription refill(s) on the original prescription, the number of refills are limited to a maximum of five refills within a six month period.

3. Exception: Oral contraceptives originally prescribed for three ovulatory cycles may be refilled up to three times within one year if so indicated by the prescriber on the original prescription.

4. Refill instructions indicating "refill prn" or indicating more than five refills, shall be subject to the limits imposed in (a)2 above, and shall be reimbursed up to these limits only.

5. A telephone authorized refill for a prescription with no refill remaining must be assigned a new prescription number.

6. Prescription refills shall not be dispensed until a reasonable quantity (approximately 75 percent) of the medication originally dispensed or refilled could have been consumed in accordance with the prescriber's written directions for use.

i. Exception: When a prescription is lost or destroyed, requiring a replacement prescription to be dispensed before the original prescription could have been consumed in accordance with the prescriber's written directions for use, the replacement prescription must be a new prescription with a unique prescription number.

10:51-1.19 Prescription Drug Price and Quality Stabilization Act

(a) The Prescription Drug Price and Quality Stabilization Act, N.J.S.A. 24:6E-1 et seq., shall apply to the New Jersey Medicaid program. This law requires that every prescription blank contain the statements "Substitution Permissible" and "Do Not Substitute." The prescriber shall initial one of the statements in addition to signing the prescription blank.

1. When the prescriber does not initial "Substitution Permissible" or the "Do Not Substitute" statement on a prescription for a drug product listed in the DURC Formulary, the pharmacist shall substitute from the list of interchangeable products and bill Medicaid accordingly.

2. When the prescriber initials "Substitution Permissible," the pharmacist shall dispense and bill Medicaid for one of the less expensive products listed in the DURC Formulary as interchangeable with the brand name prescribed. The Medicaid recipient must accept the interchangeable product unless the recipient is willing to pay the pharmacy's full, usual and customary price. If that occcurs, the pharmacist shall so note on the prescription blank and no claim shall be submitted to Medicaid.

3. For non-MAC drugs (see N.J.A.C. 10:51-1.5), when the prescriber initials "Do Not Substitute," the pharmacist shall indicate the prescriber's preference by checking "Medical Certification" on the claim form and shall dispense and bill Medicaid for the prescribed product. Reimbursement will be the estimated acquisition cost (EAC) (see N.J.A.C. 10:51-1.5) plus applicable dispensing fee or the usual and customary charge, whichever is less for that product (see Appendix D, Fiscal Agent Billing Supplement for instructions about the claim form.)

4. When the prescriber orders by the generic name, the DURC Formulary (see N.J.A.C. 10:51-1.4) does not apply. The pharamacist shall dispense the least expensive, therapeutically effective product available to him or her at the time of dispensing. The product need not necessarily be from the list of interchangeable products.

(b) Federal regulations prescribe the aggregate upper limit, for which Federal Financial Participation (FFP) is available, that Medicaid may reimburse for certain multi-source drugs. The limit shall apply to all listed MAC drugs (see Appendix B) unless the prescriber indicates in his or her own handwriting on each written prescription or follow-up written prescription to a telephone rendered prescription (see N.J.A.C. 10:51-1.9) the phrase "Brand Medically Necessary." The Federal regulation requires a handwritten statement and does not permit the use of alternatives such as a check-off box, initials or prescriber's signature, next to a preprinted statement "Do Not Substitute," nor does it allow a handwritten statement "Do Not Substitute." For purposes of reimbursement, the physician's override capability under N.J.S.A. 24:6E-1 does not apply to drugs which have a Federal MAC limit.

(c) Blanket authorization denying substitutions shall not be permitted. Each prescription order shall state "Brand Medically Necessary" in the prescriber's own handwriting. For non-MAC drugs, each prescription order shall follow the requirements of N.J.S.A. 24:6E-1 et seq. (see (a) above).

(d) The dispenser must always report the actual labeler code and drug product code of the drug dispensed. The package size code reported may differ from the stock package size used to fill the prescription.

10:51-1.20 Drug Efficacy Study Implementation (DESI)

(a) "Less than effective drugs" are subject to a Notice of Opportunity for Hearing (NOOH) by the Food and Drug Administration (FDA).

1. Reimbursement is not available for the purchase or administration of any drug product that meets all of the following conditions:

i. The drug product was approved by the Food and Drug Administration (FDA) before October 10, 1962;

ii. The drug product is available only through prescription;

iii. The drug product is the subject of a notice of opportunity for hearing issued under Section 505(e) of the Federal Food, Drug, and Cosmetic Act and published in the Federal Register on a proposed order of FDA to withdraw its approval for the drug product because it has determined that the product is less than effective for all its labeled indications; and

iv. The drug product is at present not subject to a determination by FDA, made under its efficacy review study (see 21 CFR 310.6 including all subsequent amendments and supplements, for an explanation of this program), indicating there is a compelling justification of the drug product's medical need.

2. Reimbursement is not available for the purchase or administration of any drug product that is identical, related or similar, as defined in 21 CFR 310.6 (including all subsequent amendments and supplements), to a drug product that meets the conditions of (a) above.

3. The initial list of drugs and related drug products classified as "less than effective" by the FDA pending outcome of the NOOH appears at 21 CFR 310.6. Subsequent revisions to this list which are adopted, shall appear in the Federal Register.

10:51-1.21 Drug manufacturers' rebate agreement

(a) In order for legend drug products to be reimbursed by the New Jersey Medicaid program, manufacturers must have in effect a rebate agreement pursuant to Section 4401 of OBRA 1990 and Section 1927 et seq. of the Social Security Act.

(b) Price information is supplied from a reference drug file subcontracted for this purpose by the fiscal agent and accepted by the Division as the primary source of pricing information for the New Jersey Medicaid Management Information System (NJMMIS). The calculated price shall not exceed the lower of the average wholesale price (AWP) or the Federal Fund Participation Upper Limit (FFPUL) as supplied by the reference drug file contractor.

10:51-1.22 Bundled drug service

(a) "Bundled drug service" means a drug or service that is marketed or distributed by the manufacturer or distributor as a combined package which includes in the cost the drug product and

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ancillary services such as, but not limited to, case management services and laboratory testing.

(b) Bundled drug service shall not be eligible for reimbursement by the New Jersey Medicaid program.

1. This provision may be waived at the discretion of the Commissioner if he or she determines that a bundled drug service is less than or equal to the total cost of the unbundled components if reimbursed separately; or

2. The Commissioner may waive the provisions for reasons of medical necessity for a bundled drug or in accordance with terms approved by the Department as follows:

i. Those instances where discontinuation, withdrawal, or elimination of the use of the bundled drug by someone who has been receiving a bundled drug would result in the deprivation of the life saving or life prolonging benefits of the drug or would cause potential harm or serious exacerbation of the illness being treated; or

ii. Those instances where use of the bundled drug has shown marked improvement in the recipient's clinical status reflected in alleviation of symptoms, and elevation of level of function and independence.

(c) In order to determine eligibility for reimbursement, manufacturers or distributors of a bundled drug service shall submit complete product information, including the cost to the Program of the total bundled drug service, discrete costs of each component of the bundled drug service, cost benefit analyses, and other information as requested by the Department, to the Chief Pharmaceutical Consultant, Division of Medical Assistance and Health Services, CN 712, Trenton, New Jersey 08625-0712.

1. If the Commissioner determines that a bundled drug is eligible for reimbursement under this section, New Jersey Medicaid recipients shall receive or continue to receive the bundled drug service if prior authorization is requested and approved. Prior authorization shall be obtained by completing the appropriate "Request for Authorization Form" requesting medication management authorization and providing sufficient documentation to establish that it is medically necessary to continue the bundled drug services. Mail all the information to:

Medical Director
Division of Medical Assistance and
Health Services
CN 712
Trenton, NJ 08625-0712

10:51-1.23 Tape-to-tape incentive program

(a) An incentive payment instituted January 1, 1979, is available to approved pharmacies which submit Medicaid claims on magnetic tape. Incentive payments shall be made when the total volume of paid magnetic tape Medicaid/PAAD claims, submitted by pharmacy providers as a whole, equals or exceeds 20 percent of the total volume of paid Medicaid/PAAD claims.

(b) The reimbursement for incentive payments is based on the following schedule:

"Percent of Total Medicaid/PAAD Paid Claims"	"Amount of Incentive Payment"
20-29 percent	two cents/tape claim
30-39 percent	three cents/tape claim
40-55 percent	four cents/tape claim
over 55 percent	five cents/tape claim

(c) Claims volume figures shall be reviewed and averaged quarterly. The claim volume totals for the previous quarter shall determine the amount of incentive for the subsequent quarter. If the volume of paid tape claims is less than 20 percent of the total, no incentive payments shall be made. A pharmacy provider shall be eligible for incentive payments beginning with the month subsequent to the month in which the volume of tape claims reaches 20 percent of the total paid claims volume. A qualified tape-to-tape pharmacy provider shall receive a separate incentive payment check for all tape claims paid during the preceding month.

1. Incentive payment for a voided claim(s) shall be deducted from the subsequent month's total incentive payment, which follows the month in which the claim(s) was voided.

(d) The incentive payment for tape claims is an additional fee increment over and above the dispensing fee allowed by the New Jersey Medicaid program.

(e) In order to be eligible to submit magnetic tape claims for the Medicaid and/or PAAD programs, a pharmacy provider shall complete the "New Jersey Medicaid Provider Electronic Billing Agreement," submit the completed agreement to the fiscal agent, and receive approval by the Division of Medical Assistance and Health Services.

SUBCHAPTER 2. PHARMACEUTICAL SERVICES TO MEDICAID RECIPIENTS IN A NURSING FACILITY

10:51-2.1 Introduction

This subchapter of the Manual provides information about the provision of reimbursable pharmaceutical services provided to Medicaid recipients in Medicaid approved nursing facilities.

10:51-2.2 Participation of eligible providers

(a) A pharmacy, with a retail or institutional permit, may participate in the Medicaid program as a provider of pharmaceutical services, and as a provider of parenteral nutrition or intravenous therapy. The requirements for approval as a provider of pharmaceutical services are listed in (b) and (c) below.

(b) To be approved as a provider of pharmaceutical services, the pharmacy must:

1. Operate under a valid retail and/or institutional permit issued by the Board of Pharmacy of the State of New Jersey or by the board of pharmacy of the state in which the pharmacy is located. A pharmacy operating under an out-of-State institutional permit may not participate as an approved provider in the New Jersey Medicaid program; and

2. File an application and sign an agreement with the Division of Medical Assistance and Health Services.

i. Upon sale or other change of ownership of an approved pharmacy, the agreement is automatically terminated. To execute a new agreement to participate in the New Jersey Medicaid program, the new owner(s) shall apply to the Division of Medical Assistance and Health Services, Department of Human Services, by contacting the Medicaid Provider Enrollment Unit (see N.J.A.C. 10:49—Administration Chapter, Enrollment Process) or the fiscal agent Provider Enrollment Unit (see Appendix, Fiscal Agent Billing Supplement).

3. To enroll as a Medicaid provider of pharmaceutical services, a pharmacy shall contact the fiscal agent Provider Enrollment Unit (see Appendix, Fiscal Agent Billing Supplement).

(c) Requirements for approval as a provider of parenteral nutrition and/or intravenous therapy are as follows:

1. In addition to the requirements for approval as a pharmacy provider listed under (b) above, a pharmacy who supplies parenteral nutrition and/or intravenous therapy must:

i. Comply with the requirements of the N.J.A.C. 13:39-10, Sterile Admixture Services in Retail and Institutional Pharmacies; or

ii. Comply with similar applicable requirements of the state in which the applicant is located and submit a copy of the requirements of that state when applying for participation. A copy of the N.J.A.C. 13:39-10, Sterile Admixture Services in Retail and Institutional Pharmacies, is available, subject to copying charges, from OAL Publications, Office of Administrative Law, CN 301, Trenton, New Jersey 08625.

2. Parenteral nutrition and/or intravenous therapy may be provided by either a pharmacy/medical supplier or a medical supplier approved to provide these services by the New Jersey Medicaid program; however, billing for the ancillary supplies associated with parenteral nutrition and/or intravenous therapy are subject to the requirements of the Medical Supplier Manual, N.J.A.C. 10:59.

i. "Ancillary supplies" means medical supplies and/or durable medical equipment which are medically necessary to facilitate administration of parenteral or intravenous therapy.

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10:51-2.3 Conditions for participation as a provider of pharmaceutical services

(a) All participating pharmacies shall provide complete prescription services, including injectables and injectable anti-neoplastic agents and compounding services, when allowable. Prescriptions and in-patient medication orders must be dispensed in compliance with all current existing Federal and State laws.

(b) All drugs must be prescribed.

1. "Prescribed drugs" mean simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are:

i. Prescribed by a practitioner licensed or authorized by the state of New Jersey, or the state in which he or she practices, to prescribe drugs and medicine within the scope of his or her license and practice;

ii. Dispensed by licensed pharmacists in accordance with regulations promulgated by the New Jersey State Board of Pharmacy, N.J.A.C. 13:39; and

iii. Dispensed by licensed pharmacists on the basis of a written prescription and/or in-patient medication order that is recorded and maintained in the pharmacist's records.

(c) Participating pharmacies shall permit properly identified representatives of the Division of Medical Assistance and Health Services to:

1. Inspect written prescriptions and/or in-patient medication orders on file;

2. Audit records pertaining to covered persons;

3. Inspect private sector records, where deemed necessary to comply with the Federal regulations to determine a pharamacy's usual and customary charge to the public;

i. Information pertaining to the patient's name, address, and prescriber will remain confidential within the limits of the law. Only the following items may be reviewed:

(1) Drug name;

(2) Quantity dispensed;

(3) Price;

(4) Prescription number (for reference purposes only); and

(5) Date dispensed; and

4. Inspect records of purchases of covered drugs for which claims have been made for reimbursement.

10:51-2.4 Program restrictions affecting payment for prescribed drugs

(a) The choice of prescribed drugs shall be at the discretion of the prescriber within the limits of applicable laws. However, the prescriber's discretion is limited for certain drugs. Reimbursement may be denied if the requirements of the following rules are not met:

1. Covered and non-covered pharmaceutical services as listed in N.J.A.C. 10:51-2.10 and 2.11, respectively;

2. Quantity of medication (see N.J.A.C. 10:51-2.12);

3. Dosage and directions (see N.J.A.C. 10:51-2.13);

4. Prescriptions and in-patient medication orders rendered by telephone or technological devices (see N.J.A.C. 10:51-2.14);

5. Changes or additions to the original prescription or in-patient medication order (see N.J.A.C. 10:51-2.15);

6. Prescription refill (see N.J.A.C. 10:51-2.16);

7. Prescription Drug price and Quality Stabilization Act (N.J.S.A. 24:6E-1 et seq.) (see N.J.A.C. 10:51-2.17);

i. Products listed in the current New Jersey Drug Utilization Review Council (DURC) Formulary (hereafter referred to as "the Formulary"), and all subsequent revisions, distributed to all prescribers and pharmacists; and

ii. Non-proprietary or generic dispensing (see N.J.A.C. 10:51-2.9);

8. Federal regulations (42 CFR 447.301, 331-333) that set the aggregate upper limits on payment for certain multi-source drugs if Federal Financial Participation (FFP) is to be made available. The limit applies to all "maximum allowable cost" drugs (see N.J.A.C. 10:51-2.5, Basis of payment);

9. Drug Efficacy Study Implementation (DESI): "Less than effective drugs" subject to a Notice of Opportunity for Hearing (NOOH) by the Federal Food and Drug Administration (see N.J.A.C. 10:51-2.18 and listing of DESI drug in Appendix A); and

10. Drug Manufacturers' Rebate Agreement with the Health Care Financing Administration of the United States Department of Health and Human Services (see N.J.A.C. 10:51-2.18).

(b) A properly completed claim form must be submitted or a properly formatted electronic media claim (EMC) must be transmitted to the fiscal agent for claims processing.

1. The claim form may be completed manually or by computer, but only one prescription shall be billed on each claim form. See Appendix, Fiscal Agent Billing Supplement for instructions concerning the completion and submission of the specified claim form. A dispensing fee is not reimbursed to providers providing pharmaceutical services to nursing facility recipients (see N.J.A.C. 10:51-2.7).

2. All claim forms must contain the National Drug Code (NDC). The 11-digit NDC has three components. The first five digits are the manufacturer's labeler code, the next four digits are the product code, and the final two digits are the package size code. For claim submission, leading zeros must be included in all fields, for example, 00003-0234-01.

i. The Dispenser must always report the actual labeler code and drug product code of the drug dispensed. The package size code reported may differ from the actual stock package size used to fill the prescriptions.

10:51-2.5 Basis of payment

(a) This section provides a summary of the elements involved in the calculation of the payment of a legend or non-legend drug. The elements include the following:

1. Program restrictions affecting reimbursement for the dispensing of drugs as listed in N.J.A.C. 10:51-2.4;

2. Price information as supplied from a reference drug file subcontracted for this purpose by the fiscal agent and accepted by the Division as the primary source of pricing information for the New Jersey Medicaid Management Information System (NJMMIS). The drug price or ingredient cost shall not exceed the lower of the average wholesale price as supplied by the reference drug file contractor; the provider's usual and customary charge; or the drug's Maximum Allowable Cost, if applicable (see (b) below);

3. Federal regulations (42 CFR 447.301, 331-333) that set the aggregate upper limits on payment for certain covered drugs in the pharmaceutical program. The New Jersey Medicaid program refers to these upper limits as the "maximum allowable cost" (see (b) below); and

4. The provider's usual and customary charge for legend drugs (see (c) below), contraceptive diaphragms and legend devices.

(b) Payment for legend drugs, contraceptive diaphragms, and reimbursable legend devices, is based upon the maximum allowable cost. This means the lower of the upper payment limit price list (MAC price) as published by the federal government or the average wholesale price (AWP). See Appendix B for the listing of MAC drugs.

1. Maxium allowable cost is defined as:

i. The MAC price for listed multi-source drugs published periodically by the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services; or

ii. The Estimated Acquisition Cost (EAC), which is defined as the average wholesale price (AWP) listed for the package size (billed to the New Jersey Medicaid program), in current national price compendia or other appropriate sources (such as the First Data Bank (FDB) reference drug file contractor), and their supplements.

(1) Maximum cost for each eligible prescription claim not covered by (b)1i above is based on the lower of the AWP minus regression (discount) category, if applicable, plus dispensing fee. For information about the "regression (discount) categories," see N.J.A.C. 10:51-2.6.

2. If the published MAC price as defined in (b)1i above is higher than the average wholesale price which would be paid as defined in (b)1ii above, then (b)1ii above shall apply.

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10:51-2.6 Regression (Discount) Categories

(a) The maximum cost for each eligible prescription claim not covered by the maximum allowable cost price (see N.J.A.C. 10:51-2.5—basis of payment) is subject to the following fiscal conditions based upon six categories. The category, as determined by the New Jersey Medicaid program, is based on the previous year's total prescription volume for each participating pharmacy. The categories shall be reviewed annually and adjusted as appropriate.

1. Those pharmacy providers who have been in business for less than one calendar year shall have their prescription volume projected for the entire year, to determine the appropriate category.

(b) The pharmacy provider shall submit, in writing, an annual report on form FD-70 (see Appendix C, Pharmacy Provider Certification Statement) certifying its prescription volume. The Division shall determine a provider's total prescription volume, which includes all prescriptions filled (both new and refills), including nursing facility prescriptions, for private patients, Medicaid, PAAD, and other third party recipients for the previous calendar year. Failure to submit this report annually shall result in the provider being placed in the maximum discount category (category VI) for the year of non-compliance, or until the required report is received.

1. Category I: Pharmacies whose total prescription volume in the preceding calendar year was not more than 14,999 prescriptions.

i. Pharmacy providers in this category shall receive reimbursement for Medicaid prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-2.5—as the maximum.

2. Category II: Pharmacies whose total prescription volume in the preceding calendar year was at least 15,000 but not greater than 19,999 prescriptions.

i. Pharmacy providers in this category shall receive reimbursement for Medicaid prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-2.5, less two percent, as the maximum.

3. Category III: Pharmacies whose total prescription volume in the preceding calendar year was at least 20,000 but not greater than 29,999 prescriptions.

i. Pharmacy providers in this category shall receive reimbursement for Medicaid prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-2.5, less three percent, as the maximum.

4. Category IV: Pharmacies whose total prescription volume in the preceding calendar year was at least 30,000 but not greater than 39,999 prescriptions.

i. Pharmacy providers in this category shall receive reimbursement for Medicaid prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-2.5, less four percent, as the maximum.

5. Category V: Pharmacies whose total prescription volume in the preceding calendar year was at least 40,000 but not greater than 49,999 prescriptions.

i. Pharmacy providers in this category shall receive reimbursement for Medicaid prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-2.5, less five percent, as the maximum.

6. Category VI: Pharmacies whose total prescription volume in the preceding calendar year was 50,000 prescriptions or more.

i. Pharmacy providers in this category shall receive reimbursement for Medicaid prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-2.5, less six percent, as the maximum.

7. The appropriate calculated discount shall be automatically deducted, by the fiscal agent, from the cost of each covered drug or device during the claim processing by the New Jersey Medicaid Management Information System (NJMMIS).

8. For covered drugs or devices with an average wholesale price (AWP) of more than $24.99, there shall be no discount from the AWP.

10:51-2.7 Prescription Dispensing Fee (Capitation)

(a) The New Jersey Medicaid program capitates the dispensing fee for each prescription for recipients in Medicaid approved nursing facilities in accordance with the total number of Medicaid recipient days in the facility(ies) serviced by the pharmacy. Additional dispensing fees (add-ons) per prescription shall be given to pharmacy providers who provide the following levels of services:

Pharmacies with institutional permits shall be reimbursed as defined in (a) above, except that the daily per recipient capitation fee shall be 75 percent of the fee for pharmacies with retail permits.

1. Twenty-Four Hour Unit Dose Service: Pharmacies with retail permits dispensing medication in a dispensing system in which a 24-hour supply of unit dose oral medication, both solid (for example, tablets, capsules) and liquid formulations, is delivered for each recipient daily, shall be reimbursed the cost of all reimbursable legend medication plus a fee of $0.656 per recipient day.

i. Exception: Certain liquid medications that are supplied in concentrate form only and are administered by drop dosage cannot be supplied in a 24-hour dose.

2. Modified Unit Dose Service: Pharmacies with a retail permit dispensing medication in a dispensing system in which up to a one month supply of oral unit dose solid medication is delivered for each recipient (for example, unit dose solids, "bingo" card), shall be reimbursed the cost of all reimbursable legend medication plus a fee of $0.544 per recipient day.

3. Traditional Service: Pharmacies with a retail permit dispensing medication in a dispensing system in which a maximum one month supply of medication is delivered monthly for each recipient shall be reimbursed the cost of legend medication plus a fee of $0.487 per recipient day.

4. Computerized Service: Pharmacies which provide ancillary computerized services, such as, but not limited to, continuously updated computerized recipient profiles, clinical records (med sheets and physicians' orders on at least a monthly basis), etc., receive an added increment of $0.05 per recipient day, thereby making the total fee $0.706, $0.594 or $0.537 depending upon the dispensing system used.

(b) Price information is supplied from a reference drug file subcontracted for this purpose by the fiscal agent and accepted by the Division as the primary source of pricing information for the New Jersey Medicaid Management Information System. The calculated price shall not exceed the lower of the average wholesale price (AWP) or the Federal Fund Participation Upper Limit (FFPUL) as supplied by the reference drug file contractor.

(c) In order to receive any or all of the above increments, the provider shall certify annually to the Division on Form FD-70, that the service(s) as defined in (a) above, are being provided and/or that the provider is entitled to the impact increment as defined in (a) above.

1. Each claimed increment is subject to audit and retroactive recovery with appropriate penalties, if warranted, if the New Jersey Medicaid program determines that the provider was not entitled to reimbursement for them.

(d) When a nursing facility changes its servicing pharmacy provider, the new pharmacy provider must notify the fiscal agent so that the provider file of the New Jersey Medicaid Management Information System (NJMMIS) may be updated. The following information is required in writing:

1. A copy of the agreement between the servicing pharmacy provider and the nursing facility;

2. The provider number of the servicing pharmacy;

3. The effective date of the change in servicing pharmacy provider if not clearly indicated in the agreement between the servicing pharmacy provider and the nursing facility;

4. The name and address of the previous servicing pharmacy provider for the nursing facility;

5. The level of service to be provided (for example: traditional, modified unit dose, or 24-hour unit dose); and

6. A statement indicating the provision of ancillary computerized services or recordkeeping for the nursing facility.

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10:51-2.8 Compounded prescriptions

(a) Compounded prescriptions extemporaneously prepared and dispensed by approved pharmacy providers are reimbursable by the Medicaid program as follows:

1. Total ingredient cost is defined in N.J.A.C. 10:51-2.5. The provider may charge up to $0.25 for any ingredient whose "cost" is less than $0.25; plus

2. The maximum charge for a compounded prescription must not exceed the limits set forth in N.J.A.C. 10:51-2.12.

(b) Restrictions on payments for compounded prescriptions are as follows:

1. All legend and non-legend (OTC) ingredients which are contained in compounded prescriptions must be covered by a manufacturer rebate agreement (see N.J.A.C. 10:51-2.19). If the labeler code of any single ingredient is not manufactured by an approved manufacturer, the compounded prescription is not covered. Chemical ingredients without NDC codes are excluded.

2. All non-legend ingredients which are contained in compounded prescriptions must be covered by the Medicaid program. If a non-legend drug is not listed as covered in N.J.A.C. 10:51-2.10, the compounded prescription is not covered.

3. All legend ingredients which are contained in compounded prescriptions must be covered by the Medicaid program. If a legend drug is a DESI (Drug Efficacy Study Implementation, see N.J.A.C. 10:51-2.18) drug, the compounded prescription is not covered.

4. Compounded prescriptions containing drugs not eligible for reimbursement under N.J.A.C. 10:51-2.11 are not covered.

10:51-2.9 Non-proprietary or generic dispensing

When medication is prescribed by its non-proprietary or generic name, the pharmacist shall dispense the least expensive, therapeutically effective equivalent product available, preferably one listed in the DURC Formulary. The labeler code and drug product code of the actual product dispensed must be reported on the claim form. The package size code reported may differ from the stock package size used to fill the prescription.

10:51-2.10 Covered pharmaceutical services

(a) All covered pharmaceutical services shall be provided within the scope of N.J.A.C. 10:49 (Administration) and this Chapter, and billed to the fiscal agent on the claim form or other approved billing method. (See Appendix, Fiscal Agent Billing Supplement).

(b) Covered pharmaceutical services include:

1. Prescribed legend drugs (for their medically accepted indication) as defined in Section 1927(k)(6) of Social Security Act. "Legend drugs" mean those drugs whose labels include the legend statement "Caution: Federal Law Prohibits Dispensing Without a Prescription."

10:51-2.11 Non-covered pharmaceutical services

(a) The following classes of prescription drugs or conditions are not covered under the New Jersey Medicaid program:

1. Prescriptions which are not for medically accepted indications (as defined in Section 1927(k)(6) of the Social Security Act);

2. Antiobesics and anorexiants when used in treatment of obesity;

3. Drug products for which adequate and accurate information is not readily available, such as, but not limited to, product literature, package inserts and price catalogues;

4. Experimental drugs;

i. Exception: Drugs available only for treatment through an Investigational New Drug (IND) application may be prior authorized;

5. Medication furnished by a prescriber or an employee of a prescriber;

6. Medication prescribed for hospital inpatients;

7. Non-legend drugs;

8. Prescriptions and in-patient medication orders written and/or dispensed with nonspecific directions;

9. Food supplements, milk modifiers, infant formulas, therapeutic diets, special liquid or powdered diets used in the treatment of obesity;

10. Methadone in any form (tablets, capsules, liquid, injectables, or powder) when used for drug detoxification or addiction maintenance;

11. Drug products for which final orders have been published by the Food and Drug Administration, withdrawing the approval of their new drug application (NDA);

12. Drugs or drug products not approved by the Food and Drug Administration, when such approval is required by Federal law and/or regulation;

13. Radiopaque contrast materials (for example, Telepaque);

14. Drugs for which Federal Financial Participation (FFP) is not available, including:

i. Drug Efficacy Study Implementation (DESI) drugs and identical, similar and related drugs (see N.J.A.C. 10:51-2.18); and

ii. Drugs not covered by rebate agreements as defined in Section 4401 of OBRA '90 and Section 1927(a) of the Social Security Act (see N.J.A.C. 10:51-2.19); and

15. Any bundled drug service (see N.J.A.C. 10:51-2.20).

(b) Otherwise reimbursable products shall be excluded from payment, under the following condition(s):

1. Products whose costs are found to be in excess of defined costs outlined in N.J.A.C. 10:51-2.5, basis of payment;

2. Drug products in dosage forms whose labeling, prescription or promotional material indicate the primary use is cosmetic in nature; for example, hair restoration; and

3. Drug products available in unit-dose packaging and dispensed to residents in a boarding home or residential care setting.

i. Exception: Drug products available only in a unit dose package are covered.

10:51-2.12 Quantity of medication

When the quantity of a drug or medication is not indicated in writing by the prescriber, the pharmacy provider shall dispense an appropriate quantity of medication not to exceed a one month supply (see N.J.A.C. 10:51-2.16, Prescription Refill).

10:51-2.13 Dosage and directions

(a) Dosage and directions for use shall be included as part of all prescriptions or in-patient medication orders. Prescriptions or inpatient medication orders written and dispensed with no specific directions, such as "prn," "as directed" or "ad lib," etc. are not eligible for reimbursement. Specific directions such as "1 tablet 4 times a day PRN" are required.

1. Exceptions:

i. Topical preparations including ophthalmic and otic drops and ointments;

ii. Aerosol inhalers; and

iii. Nitroglycerin.

2. For all oral medication and injectables, the number of days the medication should last, based on the prescriber's directions for use, shall be entered in the "Days Supply" field on the pharmacy claim form.

(b) Dosage for the medications, under (a)1 above, cannot be related to number of days supply. The pharmacist shall enter a value of "1" in the "Days Supply" field on the pharmacy claim form.

10:51-2.14 Prescriptions and in-patient medication orders rendered by telephone or technological devices

(a) Telephone rendered and/or technologically transmitted (for example: Fax) original precriptions shall be permitted in accordance with all applicable Federal and State laws and regulations.

(b) For purposes of reimbursement, a telephone rendered and/or a technologically transmitted (for example: Fax) authorization to refill an original prescription is considered a new prescription or in-patient medication order and requires a new prescription number. Stamping or writing a new number on the original prescription or in-patient medication order does not constitute a new prescription under the Medicaid program.

(c) When a prescriber chooses not to allow product interchange on a telephone rendered original prescription or in-patient medication order, the statement "Substitution not permitted by prescriber-telephoned Rx" plus the pharmacist's full signature next to or below the statement, shall appear on the medication order. A rubber stamp bearing the statement is acceptable.

(d) When a prescriber chooses to certify "Brand Medically Necessary" on a telephone rendered original prescription or in-

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patient medication order for a product included on the Federal MAC list, a written signed prescription or in-patient medication order containing the certification, shall be sent to the pharmacist within seven days of the date of the telephone order. The written in-patient medication order shall be retained by the pharmacist as the original prescription. Failure to comply will result in the payment for that prescription being reduced to the MAC reimbursement level.

10:51-2.15 Changes or additions to the original prescription or in-patient medication order

Changes or additions to the original prescription or in-patient medication order, when approved by the prescriber, shall be clearly indicated (including date and time) and signed by the dispensing pharmacist. No changes (for example, dosage, quantity, number of refills, days supply, etc.) are permitted on the original prescription order after the claim is submitted for payment.

10:51-2.16 Prescription refill

(a) Refills are not allowed.

(b) For purposes of reimbursement, an order for continuation of medication shall be considered a new prescription requiring a new written prescription and new prescription number.

10:51-2.17 Prescription Drug Price and Quality Stabilization Act

(a) The Prescription Drug Price and Quality Stabilization Act, N.J.S.A. 24:6E-1 et seq., shall apply to the New Jersey Medicaid program. This law requires that every prescription blank contain the statements "Substitution Permissible" and "Do Not Substitute." The prescriber shall initial one of the statements in addition to signing the prescription blank.

1. When the prescriber does not initial "Substitution Permissible" or the "Do Not Substitute" statement on a prescription or in-patient medication order for a drug product listed in the DURC Formulary, the pharmacist shall substitute from the list of interchangeable products and bill Medicaid accordingly.

2. When the prescriber initials "Substitution Permissible" on the prescription blank, the pharmacist shall dispense and bill Medicaid for one of the less expensive products listed in the DURC Formulary as interchangeable with the brand name prescribed. The Medicaid recipient must accept the interchangeable product unless the recipient is willing to pay the pharmacy's full, usual and customary price. If that occurs, the pharmacist shall so note on the prescription blank and no claim shall be submitted to Medicaid.

3. For non-MAC drugs (see N.J.A.C. 10:51-2.5), when the prescriber initials "Do Not Substitute" on the prescription blank, or writes "Do Not Substitute" on the in-patient medication order, the pharmacist shall indicate the prescriber's preference by checking "Medical Certification" on the claim form and shall dispense and bill Medicaid for the prescribed product. Reimbursement will be the estimated acquisition cost (EAC) (see N.J.A.C. 10:51-2.5) plus applicable dispensing fee or the usual and customary charge, whichever is less for that product (see Appendix D, Fiscal Agent Billing Supplement for instructions about the claim form).

4. When the prescriber orders by the generic name, the DURC Formulary (see N.J.A.C. 10:51-2.4) does not apply. The pharmacist shall dispense the least expensive, therapeutically effective product available to him or her at the time of dispensing. The product need not necessarily be from the list of interchangeable products.

(b) Federal regulations prescribe the aggregate upper limits, for which Federal Financial Participation (FFP) is available, that Medicaid may reimburse for certain multi-source drugs. The limit shall apply to all listed MAC drugs (see Appendix B) unless the prescriber indicates in his or her own handwriting on each written prescription or in-patient medication order or follow-up written prescription or in-patient medication order to a telephone rendered prescription or technologically transmitted, (for example: Fax) (see N.J.A.C. 10:51-2.9) the phrase "Brand Medically Necessary." The Federal regulation requires a handwritten statement and does not permit the use of alternatives such as a check-off box, initials or prescriber's signature, next to a preprinted statement "Do Not Substitute," nor does it allow a handwritten statement "Do Not Substitute." For purposes of reimbursement, the physician's override capability under N.J.S.A. 24:6E-1 does not apply to drugs which have a Federal MAC limit.

(c) Blanket authorization denying substitutions shall not be permitted. Each prescription or in-patient medication order shall state "Brand Medically Necessary" in the prescriber's own handwriting. For non-MAC drugs, each prescription order shall follow the requirements of N.J.S.A. 24:6E-1 et seq. (see (a) above).

(d) The dispenser must always report the actual labeler code and drug product code of the drug dispensed. The package size code reported may differ from the stock package size used to fill the prescription.

10:51-2.18 Drug Efficacy Study Implementation (DESI)

(a) "Less than effective drugs" are subject to a Notice of Opportunity for Hearing (NOOH) by the Food and Drug Administration (FDA).

1. Reimbursement is not available for the purchase or administration of any drug product that meets all of the following conditions:

i. The drug product was approved by the Food and Drug Administration (FDA) before October 10, 1962;

ii. The drug product is available only through prescription;

iii. The drug product is the subject of a notice of opportunity for hearing issued under Section 505(e) of the Federal Food, Drug, and Cosmetic Act and published in the Federal Register on a proposed order of FDA to withdraw its approval for the drug product because it has determined that the product is less than effective for all its labeled indications; and

iv. The drug product is at present not subject to a determination by FDA, made under its efficacy review study (see 21 CFR 310.6 including all subsequent amendments and supplements, for an explanation of this program), indicating there is a compelling justification of the drug product's medical need.

2. Reimbursement is not available for the purchase or administration of any drug product that is identical, related or similar, as defined in 21 CFR 310.6 (including all subsequent amendments and supplements), to a drug product that meets the conditions of (a) above.

3. The initial list of drugs and related drug products classified as "less than effective" by the FDA pending outcome of the NOOH appears at 21 CFR 310.6. Subsequent revisions to this list which are adopted, shall appear in the Federal Register.

10:51-2.19 Drug manufacturers' rebate agreement

(a) In order for legend drug products to be reimbursed by the New Jersey Medicaid program, manufacturers must have in effect a rebate agreement pursuant to Section 4401 of OBRA 1990 and Section 1927 et seq. of the Social Security Act.

(b) Price information is supplied from a reference drug file subcontracted for this purpose by the fiscal agent and accepted by the Division as the primary source of pricing information for the New Jersey Medicaid Management Information System (NJMMIS). The calculated price shall not exceed the lower of the average wholesale price (AWP) or the Federal Fund Participation Upper Limit (FFPUL) as supplied by the reference drug file contractor.

10:51-2.20 Bundled drug service

(a) "Bundled drug service" means a drug or service that is marketed or distributed by the manufacturer or distributor as a combined package which includes in the cost the drug product and ancillary services such as, but not limited to, case management services and laboratory testing.

(b) Bundled drug service shall not be eligible for reimbursement by the New Jersey Medicaid program.

1. This provision may be waived at the discretion of the Commissioner if he or she determines that a bundled drug service is less than or equal to the total cost of the unbundled components if reimbursed separately; or

2. The Commissioner may waive the provisions for reasons of medical necessity for a bundled drug or in accordance with terms approved by the Department as follows:

i. Those instances where discontinuation, withdrawal, or elimination of the use of the bundled drug by someone who has been

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receiving a bundled drug would result in the deprivation of the life saving or life prolonging benefits of the drug or would cause potential harm or serious exacerbation of the illness being treated; or

ii. Those instances where use of the bundled drug has shown marked improvement in the recipient's clinical status reflected in alleviation of symptoms, and elevation of level of function and independence.

(c) In order to determine eligibility for reimbursement, manufacturers or distributors of a bundled drug service shall submit complete product information, including the cost to the Program of the total bundled drug service, discrete costs of each component of the bundled drug service, cost benefit analyses, and other information as requested by the Department, to the Chief Pharmaceutical Consultant, Division of Medical Assistance and Health Services, CN 712, Trenton, New Jersey 08625-0712.

1. If the Commissioner determines that a bundled drug is eligible for reimbursement under this section, New Jersey Medicaid recipients shall receive or continue to receive the bundled drug service if prior authorization is requested and approved. Prior authorization shall be obtained by completing the appropriate "Request for Authorization Form" requesting medication management authorization and providing sufficient documentation to establish that it is medically necessary to continue the bundled drug services. Mail all the information to:

Medical Director
Division of Medical Assistance and Health Services
CN 712
Trenton, NJ 08625-0712

10:51-2.21 Tape-to-tape incentive program

(a) An incentive payment instituted January 1, 1979, is available to approved pharmacies which submit Medicaid claims on magnetic tape. Incentive payments shall be made when the total volume of paid magnetic tape Medicaid/PAAD claims, submitted by pharmacy providers as a whole, equals or exceeds 20 percent of the total volume of paid Medicaid/PAAD claims.

(b) The reimbursement for incentive payments is based on the following schedule:

"Percent of total Medicaid/ PAAD Paid Claims"	"Amount of Incentive Payment"
20-29 percent	two cents/tape claim
30-39 percent	three cents/tape claim
40-55 percent	four cents/tape claim
over 55 percent	five cents/tape claim

(c) Claims volume figures shall be reviewed and averaged quarterly. The claim volume totals for the previous quarter shall determine the amount of incentive for the subsequent quarter. If the volume of paid tape claims is less than 20 percent of the total, no incentive payments shall be made. A pharmacy provider shall be eligible for incentive payments beginning with the month subsequent to the month in which the volume of tape claims reaches 20 percent of the total paid claims volume. A qualified tape-to-tape pharmacy provider shall receive a separate incentive payment check for all tape claims paid during the preceding month.

1. Incentive payment for a voided claim(s) shall be deducted from the subsequent month's total incentive payment, which follows the month in which the claim(s) was voided.

(d) The incentive payment for tape claims is an additional fee increment over and above the dispensing fee allowed by the New Jersey Medicaid program.

(e) In order to be eligible to submit magnetic tape claims for the Medicaid and/or PAAD programs, a pharmacy provider shall complete the "New Jersey Medicaid Provider Electronic Billing Agreement," submit the completed agreement to the fiscal agent, and receive approval by the Division of Medical Assistance and Health Services.

SUBCHAPTER 3. CONSULTANT PHARMACIST SERVICES

10:51-3.1 Introduction

All services required of a consultant pharmacist in nursing facilities (that is, a skilled nursing facility, an infirmary section of a home for the aged, or a public medical institution) as stipulated in Federal and State statutes, rules and regulations, including, but not limited to, those listed as this subchapter, shall be provided.

10:51-3.2 Definition of consultant pharmacist

The term "consultant pharmacist" shall mean a pharmacist licensed by the New Jersey State Board of Pharmacy, and who meets the qualifications in N.J.A.C. 10:51-3.3.

10:51-3.3 Qualifications

(a) Qualifications for a consultant pharmacist include the following:

1. Holding a valid license as a registered pharmacist from the New Jersey State Board of Pharmacy; and

2. Having received certification by the Joint Board for Certification of Consultant Pharmacists of New Jersey, or its equivalent. This requirement shall become effective (two years from the effective date of adoption of this rule).

10:51-3.4 Responsibilities

(a) The consultant pharmacist shall in cooperation and consultation with the nursing facility staff:

1. Assure that all drugs are dispensed, and in cooperation with the director of nursing, "shall assure all drugs" are administered in compliance with all Federal and State laws;

2. Establish and monitor the implementation of written policies and procedures, through the pharmaceutical services committee (pharmacy and therapeutics committee), to assure the safe use, storage, integrity, administration, control and accountability of drugs;

3. Assure that drug records are in order and an account of all controlled substances is maintained and reconciled;

4. Assure that the recipient's medication records are accurate, up to date, and that these records indicate that medications are administered in accordance with physicians' orders and established stop-order policies;

5. Assure that drugs, biologicals, laboratory tests, special dietary requirements and foods, used or administered concomitantly with other medication to the same recipient, are monitored for potential reverse reactions, allergies, drug interactions, contraindications, rationality, drug evaluation, and laboratory test modifications, and that the physician is advised promptly of any recommended changes;

6. Review the drug regiment (for example, dosage form, route of administration, time of administration) of each recipient at least monthly and report any irregularities pertaining to medications to the attending physician, medical director or director of nursing, as appropriate.

i. Irregularities in the administration of medications shall also be reported promptly to the director of nursing.

7. Report in writing at least quarterly to the pharmaceutical services committee (pharmacy and therapeutic committee) on the status of the facility's pharmaceutical services and staff performance as related to pharmaceutical services. This report shall include, but not be limited to, a summary of the review of each recipient's drug regimen and clinical record and the consultant pharmacist's findings and recommendations;

8. Assure there is maintained and available upon request from the Director of the New Jersey Medicaid program or his or her designee, documented records of the disposition, disposal or destruction of unused or discontinued drugs;

9. Serve as an active member of the pharmaceutical services committee (pharmacy and therapeutics committee) and infection control committee of the facility;

10. Provide, and document, in-service programs for the complete nursing staff. This training shall include, but not be limited to, registered nurses, licensed practical nurses, aides, and shall be given at least quarterly; and

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11. Devote a sufficient number of hours to carry out these responsibilities, maintain a written record of activities, findings and recommendations.

SUBCHAPTER 4. PHARMACEUTICAL ASSISTANCE TO THE AGED AND DISABLED PROGRAM (PAAD)

10:51-4.1 Introduction

This subchapter provides information about the provision of pharmaceutical services under the PAAD program which shall extend assistance to certain persons whose level of income disqualifies them for medical assistance under the Medical Assistance and Health Services Act, but who have significant needs for prescribed drugs and/or insulin, insulin needles, insulin syringes and diabetic testing materials and are unable to fully meet the cost of such items.

10:51-4.2 Participation of eligible providers

(a) A pharmacy, with a retail or institutional permit, may participate in the PAAD program as a provider of pharmaceutical services.

(b) To be approved as a provider of pharmaceutical services, the pharmacy must:

1. Operate under a valid retail and/or institutional permit issued by the Board of Pharmacy of the State of New Jersey. A pharmacy operating under an out-of-State institutional permit may not participate as an approved provider in the PAAD program.

2. File an application and sign an agreement with the Division of Medical Assistance and Health Services.

i. Upon sale or other change of ownership of an approved pharmacy, the agreement is automatically terminated. To execute a new agreement to participate in the PAAD program, the new owner(s) shall apply to the Division of Medical Assistance and Health Services, Department of Human Services, by contacting the Medicaid Provider Enrollment Unit (see N.J.A.C. 10:49, Administration Chapter, Enrollment Process) or the fiscal agent Provider Enrollment Unit.

3. To enroll as a Medicaid provider of pharmaceutical services, a pharmacy shall contact the fiscal agent Provider Enrollment Unit (see Appendix D, Fiscal Agent Billing Supplement).

10:51-4.3 Conditions for participation as a provider of pharmaceutical services

(a) All participating pharmacies shall provide complete prescription services, including injectables and injectable anti-neoplastic agents, compounding, and prescription refill services, when allowable. Prescriptions must be dispensed in compliance with all current existing Federal and State laws.

(b) All drugs must be prescribed.

1. "Prescribed drugs" mean simple or compounded substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are:

i. Prescribed by a practitioner licensed or authorized by the state of New Jersey, or the state in which he or she practices, to prescribe drugs and medicine within the scope of his or her license and practice;

ii. Dispensed by licensed pharmacists in accordance with regulations promulgated by the New Jersey State Board of Pharmacy, N.J.A.C. 13:39; and

iii. Dispensed by licensed pharmacists on the basis of a written prescription that is recorded and maintained in the pharmacist's records.

(c) Participating pharmacies shall permit properly identified representatives of the Division of Medical Assistance and Health Services to:

1. Inspect written prescriptions on file;

2. Audit records pertaining to covered persons;

3. Inspect private sector records, where deemed necessary to determine a pharmacy's ususal and customary charges to the public;

i. Information pertaining to the patient's name, address, and prescriber will remain confidential within the limits of the law. Only the following items may be reviewed:

(1) Drug name;

(2) Quantity dispensed;

(3) Price;

(4) Prescription number (for reference purposes only); and

(5) Date dispensed.

ii. The pharmacy shall provide sufficient information with regard to its contractual agreement(s) and payment history with other private third party prescription plans to identify and verify number of claims, amount paid, and dispensing fee paid by group contracts within the plan. Records and contracts shall be available on-site at the time of audit; or available within 10 working days of an on-site audit. Records shall include, but not be limited to:

(1) Payment vouchers;

(2) Contracts; and

(3) Agreements; and

4. Inspect records of purchases of covered drugs for which claims have been made for reimbursement.

10:51-4.4 Program restrictions affecting payment for prescribed drugs

(a) The choice of prescribed drugs shall be at the discretion of the prescriber within the limits of applicable laws. However, the prescriber's discretion is limited for certain drugs. Reimbursement may be denied if the requirements of the following rules are not met:

1. Covered and non-covered pharmaceutical services as listed in N.J.A.C. 10:51-4.12 and 4.13, respectively;

2. Quantity of medication (see N.J.A.C. 10:51-4.14);

3. Dosage and directions (see N.J.A.C. 10:51-4.15);

4. Telephone-rendered original prescriptions (see N.J.A.C. 10:51-4.16);

5. Changes or additions to the original prescription (see N.J.A.C. 10:51-4.17);

6. Prescription refill (see N.J.A.C. 10:51-4.18);

7. Prescription Drug Price and Quality Stabilization Act (N.J.S.A. 24:6E-1 et seq.) (see N.J.A.C. 10:51-4.19);

i. Products listed in the current New Jersey Drug Utilization Review Council (DURC) Formulary (hereafter referred to as "the Formulary"), and all subsequent revisions, distributed to all prescribers and pharmacists; and

ii. Non-Proprietary or generic dispensing (see N.J.A.C. 10:51-4.9);

8. Federal regulations (42 CFR 447.301, 331-333) that set the aggregate upper limits on payment for certain multi-source drugs if Federal Financial Participation (FFP) is to be made available. The limit applies to all "maximum allowable cost" drugs (see N.J.A.C. 10:51-4.5, Basis of payment); and

9. Drug Efficacy Study Implementation (DESI): "Less than effective drugs" subject to a Notice of Opportunity for Hearing (NOOH) by the Federal Food and Drug Administration (see N.J.A.C. 10:51-4.20 and listing of DESI drugs in Appendix A).

(b) A properly completed claim form must be submitted or a properly formatted electronic media claim (EMC) must be transmitted to the fiscal agent for claims processing.

1. The claim form may be completed manually or by computer, but only one prescription shall be billed on each claim form. See Appendix Fiscal Agent Billing Supplement for instructions concerning the completion and submission of the specified claim form;

2. All claim forms must contain the National Drug Code (NDC). The 11 digit NDC has three components. The first five digits are the manufacturer's labeler code, the next four digits are the product size code, and the final two digits are the package code. For claim submission, leading zeros must be included in all fields, for example, 00003-0234-01.

i. The dispenser must always report the actual labeler code and drug product code of the drug dispensed. The package size code reported may differ from the actual stock package size used to fill the prescriptions.

10:51-4.5 Basis of payment

(a) This section provides a summary of the elements involved in the calculation of the payment of legend or certain non-legend drugs. The elements include the following:

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1. Program restrictions affecting reimbursement for the dispensing of drugs as listed in N.J.A.C. 10:51-4.4;

2. Price information as supplied from a reference drug file subcontracted for this purpose by the fiscal agent and accepted by the Division as the primary source of pricing information for the New Jersey Medicaid Management Information System (NJMMIS). The drug price shall not exceed the lower of the average wholesale price as supplied by the reference drug file contractor; the provider's usual and customary charge; or the drug's maximum allowable cost, if applicable (see (b) below);

3. Federal regulations (42 CFR 447.301, 331-333) that set the aggregate upper limits on payment for certain covered drugs in the pharmaceutical program. The New Jersey Medicaid program refers to these upper limits as the "maximum allowable cost" (see (b) below); and

4. Provider's usual and customary charge for legend drugs (see (c) below), insulin, insulin needles and syringes, or diabetic testing materials.

(b) Payment for legend drugs is based upon the maximum allowable cost. This means the lower of the upper payment limit price list (MAC price) as published by the Federal government or the average wholesale price (AWP). See Appendix B for the listing of MAC drugs.

1. Maximum allowable cost is defined as:

i. The MAC price for listed multi-source drugs published periodically by the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services or established by the Division of Medical Assistance and Health Services; or

ii. The Estimated Acquisition Cost (EAC), which is defined as the average wholesale price (AWP) listed for the package size (billed to the New Jersey Medicaid program), in current national price compendia or other appropriate sources (such as the First Data Bank (FDB) reference drug file contractor), and their supplements.

(1) Maximum cost for each eligible prescription claim not covered by (b)1i above is based on the lower of the AWP minus regression (discount) category, if applicable, plus dispensing fee, or usual and customary charge. For information about the "regression (discount) categories," see N.J.A.C. 10:51-4.6 and for usual and customary charge, see N.J.A.C. 10:51-4.11.

2. If the published MAC price as defined in (b)1i above is higher than the average wholesale price which would be paid as defined in (b)1ii above, then (b)1ii above shall apply.

(c) The maximum charge to the PAAD program for a legend drug, including the charge for the cost of medication and the dispensing fee, shall not exceed the lowest of the following:

1. Maximum allowable cost (MAC) as determined in (b)1 above, plus dispensing fee (see N.J.A.C. 10:51-4.7); or

2. The provider's usual and customary and/or posted or advertised charge.

(d) The maximum allowance for the non-legend drugs, devices, or supplies under the PAAD program is:

1. The product AWP plus 50 percent; or

2. The usual over-the-counter (OTC) retail price charged to the other persons in the community, whichever is less.

10:51-4.6 Regression (discount) categories

(a) The maximum cost for each eligible prescription claim not covered by the maximum allowable cost price (see N.J.A.C. 10:51-4.5 Basis of payment) is subject to the following fiscal conditions based upon six categories. The category, as determined by the New Jersey Medicaid program, is based on the previous year's total prescription volume for each participating pharmacy. The categories shall be reviewed annually and adjusted as appropriate.

1. Those pharmacy providers who have been in business for less than one calendar year shall have their prescription volume projected for the entire year, to determine the appropriate category.

(b) The pharmacy provider shall submit, in writing, an annual report on form FD-70 (See Appendix C, Pharmacy Provider Certification Statement) certifying its prescription volume. The Division shall determine a provider's total prescription volume, which includes all prescriptions filled (both new and refills), including nursing facility prescriptions, for private patients, Medicaid, PAAD, and over third party recipients for the previous calendar year. Failure to submit this report annually shall result in the provider being placed in the maximum discount category (category VI) for the year of non-compliance, or until the required report is received.

1. Category I: Pharmacies whose total prescription volume in the preceding calendar year was not more than 14,999 prescriptions.

i. Pharmacy providers in this category shall receive reimbursement for PAAD prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-4.5—basis of payment, as the maximum.

2. Category II: Pharmacies whose total prescription volume in the preceding calendar year was at least 15,000 but not greater than 19,999 prescriptions.

i. Pharmacy providers in this category shall receive reimbursement for PAAD prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-4.5, less two percent, as the maximum.

3. Category III: Pharmacies whose total prescription volume in the preceding calendar year was at least 20,000 but not greater than 29,999 prescriptions.

i. Pharmacy providers in this category shall receive reimbursement for PAAD prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-4.5, less three percent, as the maximum.

4. Category IV: Pharmacies whose total prescription volume in the preceding calendar year was at least 30,000 but not greater than 39,999 prescriptions.

i. Pharmacy providers in this category shall receive reimbursement for PAAD prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-4.5, less four percent, as the maximum.

5. Category V: Pharmacies whose total prescription volume in the preceding calendar year was at least 40,000 but not greater than 49,999 prescriptions.

i. Pharmacy providers in this category shall receive reimbursement for PAAD prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-4.5, less five percent, as the maximum.

6. Category VI: Pharmacies whose total prescription volume in the preceding calendar year was 50,000 prescriptions or more.

i. Pharmacy providers in this category shall receive reimbursement for PAAD prescription claims for legend drugs, at average wholesale price (AWP), as defined in N.J.A.C. 10:51-4.5, less six percent, as the maximum.

7. The appropriate calculated discount shall be automatically deducted, by the fiscal agent, from the cost of each covered drug or device during claim processing by the New Jersey Medicaid Management Information System (NJMMIS).

8. For covered drugs or devices costing more than $24.99, there shall be no discount from the average wholesale price (AWP).

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10:51-4.7 Prescription drug dispensing fee

(a) The dispensing fee for legend drugs, dispensed by providers having retail permits to recipients other than those in nursing facilities, is $3.73. Additional dispensing fees (add-ons) per prescription shall be given to pharmacy providers who provide the following:

1. Twenty-four hour emergency service: $0.11. The provider shall have a 24-hour per day, 365 days per year prescription service available and shall have provided PAAD beneficiaries opportunities to utilize this service.

2. Patient consultation: $0.08. In addition to routinely monitoring recipient profiles for drug interactions, contraindications, allergies, etc., the provider shall, where appropriate, discuss the course of drug therapy with the recipient. This discussion must include emphasis on compliance with the prescriber's orders; proper drug utilization; cautions about possible side affects; foods to avoid; proper drug storage conditions; and any other information that will prove beneficial to the recipient while on drug therapy.

3. Impact area location: $0.15. The provider shall have a combined Medicaid and PAAD prescription volume equal to or greater than 50 percent of the provider's total prescription volume.

i. The nursing facility prescription volume shall be included for the determination of total prescription volume in determining entitlement to the impact allowance.

(b) Price information is supplied from a reference drug file subcontracted for this purpose by the fiscal agent and accepted by the Division as the primary source of pricing information for the New Jersey Medicaid Management Information System (NJMMIS). The calculated price shall not exceed the lower of the average wholesale price (AWP) or the Federal Fund Participation Upper Limit (FFPUL) as supplied by the reference drug file contractor.

(c) In order to receive any or all of the above increments, the provider shall certify annually to the Division on Form FD-70, that the service(s) as defined in (a) above, are being provided and/or that the provider is entitled to the impact increment as defined in (a) above.

1. Each claimed increment is subject to audit and retroactive recovery with appropriate penalties, if warranted, if the PAAD program determines that the provider was not entitled to reimbursement for them.

10:51-4.8 PAAD program copayment

(a) Beneficiaries in the PAAD program are responsible for a part of the cost of drugs and devices covered by the PAAD program. At the point of sale, a PAAD beneficiary shall render to a pharmacy provider a fixed or adjustable copayment of an amount determined appropriate by the Legislature.

(b) A copayment shall be rendered to a pharmacy provider for each original or refill prescription dispensed. The provider's usual and customary charge billed to the PAAD program shall be inclusive of the copayment amount which will be deducted by the New Jersey Medicaid Management Information System (NJMMIS).

1. Under no circumstances is the required rendered copayment amount to be waived for reasons of promotion, advertisement and/or competitive considerations. Failure to comply with PAAD program copayment requirements may result in a suspension of a provider's approval to participate in the PAAD program.

10:51-4.9 Compounded prescriptions

(a) Compounded prescriptions extemporaneously prepared and dispensed by approved pharmacy providers are reimbursable by the PAAD program as follows:

1. Total ingredient cost is defined in N.J.A.C. 10:51-4.5. The provider may charge up to $0.25 for any ingredient whose "cost" is less than $0.25; plus

2. The dispensing fee is allowed in N.J.A.C. 10:51-4.7; plus

3. The maximum charge for a compounded prescription must not exceed the limits set forth in N.J.A.C. 10:51-4.14.

(b) Restrictions on payments for compounded prescriptions are as follows:

1. All legend ingredients which are contained in compounded prescriptions must be covered by the PAAD program. If a legend drug is a DESI (Drug Efficacy Study Implementation, see N.J.A.C. 10:51-4.20) drug, the compounded prescription is not covered.

2. Compounded prescriptions containing drugs not eligible for reimbursement under N.J.A.C. 10:51-4.13 are not covered.

10:51-4.10 Non-proprietary or generic dispensing

When medication is prescribed by its non-proprietary or generic name, the pharmacist shall dispense the least expensive, therapeutically effective equivalent product available, preferably one listed in the DURC Formulary. The labeler code and drug product code of the actual product dispensed must be reported on the claim form. The package size code reported may differ from the stock package size used to fill the prescription.

10:51-4.11 Provider's usual and customary charge or advertised charge

(a) The provider's usual and customary charge or advertised charge is an element considered in the calculation of the basis of payment for legend drugs (see N.J.A.C. 10:51-4.5, Basis of payment).

(b) The usual and customary charge to the PAAD program is defined as the amount a provider charges the general public for a prescription for the same drug product (same NDC number) in the same quantity as the prescription being dispensed to a PAAD beneficiary. "Usual and customary charge" means the actual charge made to the majority (51 percent) of the total patient population served by the individual pharmacy.

1. The provider shall not charge the Program more than would be charged to a cash customer when the general public, including private third party plans, accounts for more than 50 percent of a provider's total prescription volume.

i. In the event Medicaid and/or PAAD represent more than 50 percent of a provider's total prescription volume, then, for reimbursement purposes, the provider's usual and customary charge may be considered the amount the Program would reimburse for the same services.

10:51-4.12 Covered pharmaceutical services

(a) All covered pharmaceutical services shall be provided within the scope of N.J.A.C. 10:49, Administration, and this Chapter, and billed to the fiscal agent on the claim form or other approved billing method (see Appendix, Fiscal Agent Billing Supplement).

(b) Covered pharmaceutical services include:

1. Prescribed legend drugs (for their medically accepted indication) as defined in Section 1927(k)(6) of the Social Security Act. "Legend drugs" mean those drugs whose labels include the legend statement "Caution: Federal Law Prohibits Dispensing Without a Prescription."

2. Non-legend drugs, as follows:

i. Diabetic testing materials;

ii. Insulin needles and/or syringes; and

iii. Insulin.

10:51-4.13 Non-covered pharmaceutical services

(a) The following classes of prescription drugs or conditions are not covered under the PAAD program:

1. Prescriptions which are not for medically accepted indications (as defined in Section 1927(k)(6) of the Social Security Act);

2. Drug products for which adequate and accurate information is not readily available, such as, but not limited to, product literature, package inserts and price catalogues;

3. Experimental drugs;

4. Medication furnished by a prescriber or an employee of a prescriber;

5. Medication prescribed for hospital inpatients;

6. Non-legend drugs other than diabetic testing materials; insulin; and insulin needles and/or syringes;

7. Prescriptions written and/or dispensed with nonspecific directions;

8. Food supplements, milk modifiers, infant formulas, therapeutic diets, special liquid or powered diets used in the treatment of obesity;

9. Drug products for which final orders have been published by the Food and Drug Administration, withdrawing the approval of their new drug application (NDA);

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10. Drugs or drug products not approved by the Food and Drug Administration, when such approval is required by Federal law and/or regulation;

11. Radiopaque contrast materials (for example, Telepaque);

12. Drugs for which Federal Financial Participation (FFP) is not available, including:

i. Drug Efficacy Study Implementation (DESI) drugs and identical, similar and related drugs (see N.J.A.C. 10:51-4.20);

13. Any bundled drug service, except drug product cost which is a component of a bundled drug service (see N.J.A.C. 10:51-4.21); and

14. If the provider has a delivery service, he or she may waive or discount delivery charges to the recipient but is prohibited from charging more than his or her usual and customary charge to the general public for delivery.

(b) Otherwise reimbursement products shall be excluded from payment, under the following condition(s):

1. Products whose costs are found to be in excess of defined costs outlined in N.J.A.C. 10:51-4.5, Basis of payment;

2. Covered diabetic testing materials which do not offer significant price and/or therapeutic advantage. The criteria shall be cost and improvement in accuracy over existing reimbursable products. Therapeutic advantage (in the case of diabetic testing materials improvement in accuracy) shall be determined by evaluation of literature and/or cost effectiveness data submitted in support of a request for admission of a diabetic testing material for inclusion in the list of reimbursable products; and

3. Manufacturers and distributors may request the review of a denial of reimbursement for products under this subsection by providing supportive information not previously submitted, within 30 days of the date of the denial. Agency decision after review of support material is final.

10:51-4.14 Quantity of medication

(a) The quantity of medication prescribed shall provide a sufficient amount of medication necessary for the anticipated duration of the illness or an amount sufficient to cover the interval between visits to the prescriber, but may not exceed a 60-day supply or 100 unit doses, whichever is greater. Any medication used continuously (that is, daily, three times daily, every other day, and so forth) for 14 days or more is considered a sustaining drug or maintenance medication and shall be prescribed in sufficient quantities to treat the recipient for at least 60 days or in 100 unit doses, whichever is greater. The pharmacist shall dispense the full quantity prescribed, within Program limits. Prescriptions shall not be split or reduced in quantity, unless the quantity prescribed exceeds Program limits, in which case the quantity shall be reduced to meet these limitations.

1. Exceptions:

i. Oral contraceptives may be prescribed and dispensed up to a supply of three ovulatory cycles; and

ii. When the full quantity prescribed (within Program limits) is not available at the time of dispensing, the pharmacist may dispense the quantity available and inform the PAAD beneficiary accordingly. The pharmacist shall retain the claim form until the balance of the medication is dispensed.

10:51-4.15 Dosage and directions

(a) Dosage and directions for use shall be indicated on all prescriptions. Prescriptions written and dispensed with no specific directions, such as "prn," "as directed" or "ad lib," etc. are not eligible for reimbursement. Specific directions such as "1 tablet 4 times a day PRN" are required.

1. Exceptions:

i. Topical preparations including ophthalmic and otic drops and ointments;

ii. Aerosol inhalers; and

iii. Nitroglycerin.

2. For all oral medication and injectables, the number of days the medication should last, based on the prescriber's directions for use, shall be entered in the "Days Supply" field on the pharmacy claim form.

(b) Dosage for the medications, under (a)1 above, cannot be related to number of days supply. The pharmacist shall enter a value of "1" in the "Days Supply" field on the pharmacy claim form.

10:51-4.16 Telephone-rendered original prescriptions

(a) Telephone orders from prescribers for original prescriptions shall be permitted in accordance with all applicable Federal and State laws and regulations.

(b) For purposes of reimbursement, telephone authorization to refill an original prescription with no refill remaining is considered a new order and requires a new written prescription with a new prescription number. Stamping or writing a new number on the original prescription order does not constitute a new prescription under the PAAD program.

(c) When a prescriber chooses not to allow product interchange on a telephone order, the statement "Substitution not permitted by prescriber-telephoned Rx" plus the pharmacist's full signature next to or below the statement, shall appear on the prescription order. A rubber stamp bearing the statement is acceptable.

(d) When a prescriber chooses to certify "Brand Medically Necessary" on a telephoned prescription for a product included on the Federal MAC list, a written signed prescription order containing the certification shall be sent to the pharmacist within seven days of the date of the telephone order. The written prescription shall be retained by the pharmacist as the original prescription. Failure to comply shall result in the payment for that prescription being reduced to the MAC reimbursement level.

10:51-4.17 Changes or additions to the original prescription

Changes or additions to the original prescription, when approved by the prescriber, shall be clearly indicated (including date and time) and signed by the dispensing pharmacist. No changes (for example, dosage, quantity, number or refills, days supply, etc.) are permitted on the original prescription order after the claim is submitted for payment.

10:51-4.18 Prescription refill

(a) The provider shall submit a properly completed claim form to the fiscal agent for reimbursement of an allowable refill. An allowable refill shall comply with the following instructions in order to be reimbursed as such:

1. Refill instructions must be indicated in writing by the prescriber on the original prescription or verbally when telephoning the original prescription to the pharmacist. Verbal instructions shall be reduced to writing by the pharmacist, in accordance with N.J.S.A. 45:14-14.

2. The original prescription is valid for the twelve month period beginning with the date of the original prescription. There is no limit to the number of refills dispensed during the twelve month period.

3. Exception: Oral contraceptives originally prescribed for three ovulatory cycles may be refilled up to three times within one year if so indicated by the prescriber on the original prescription.

4. Refill instructions indicating "refill prn" or indicating more than five refills, shall be subject to the limits imposed in (a)2 above, and shall be reimbursed up to these limits only.

5. A telephone authorized refill for a prescription with no refill remaining must be assigned a new prescription number.

6. Prescription refills shall not be dispensed until a reasonable quantity (approximately 75 percent) of the medication originally dispensed or refilled could have been consumed in accordance with the prescriber's written directions for use.

i. Exception: When a prescription is lost or destroyed, requiring a replacement prescription to be dispensed before the original prescription could have been consumed in accordance with the prescriber's written directions for use, the replacement prescription must be a new prescription with a unique prescription number.

10:51-4.19 Prescription Drug Price and Quality Stabilization Act

(a) The Prescription Drug Price and Quality Stabilization Act, N.J.S.A. 24:6E-1 et seq., shall apply to the PAAD program. This law requires that every prescription blank contain the statements "Substitution Permissible" and "Do Not Substitute." The prescriber shall initial one of the statements in addition to signing the prescription blank.

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1. When the prescriber does not initial "Substitution Permissible" or the "Do Not Substitute" statement on a prescription for a drug product listed in the DURC (reference here to where it is defined) Formulary, the pharmacist shall substitute from the list of interchangeable products and bill PAAD accordingly.

2. When the prescriber initials "Substitution Permissible," the pharmacist shall dispense and bill PAAD for one of the less expensive products listed in the DURC Formulary as interchangeable with the brand name prescribed.

3. For MAC drugs (see N.J.A.C. 10:51-4.5), when the prescriber initials "Do Not Substitute," the pharmacist shall indicate the prescriber's preference by checking "Medical Certification" on the claim form and shall dispense and bill PAAD for the prescribed product. Reimbursement will be the estimated acquisition cost (EAC) (see N.J.A.C. 10:51-4.5) plus applicable dispensing fee or the usual and customary charge, whichever is less for that product (see Appendix D, Fiscal Agent Billing Supplement for instructions about the claim form.)

4. When the prescriber orders by the generic name, the DURC Formulary (see N.J.A.C. 10:51-4.4) does not apply. The pharmacist shall dispense the least expensive, therapeutically effective product available to him or her at the time of dispensing. The product need not necessarily be from the list of interchangeable products.

(b) The dispenser must always report the actual labeler code and drug product code of the drug dispensed. The package size code reported may differ from the stock package size used to fill the prescription.

10:51-4.20 Drug Efficacy Study Implementation (DESI)

(a) "Less than effective drugs" are subject to a Notice of Opportunity for Hearing (NOOH) by the Food and Drug Administration (FDA).

1. Reimbursement is not available for the purchase or administration of any drug product that meets all of the following conditions:

i. The drug product was approved by the Food and Drug Administration (FDA) before October 10, 1962;

ii. The drug product is available only through prescription;

iii. The drug product is the subject of a notice of opportunity for hearing issued under Section 505(e) of the Federal Food, Drug, and Cosmetic Act and published in the Federal Register on a proposed order of FDA to withdraw its approval for the drug product because it has determined that the product is less than effective for all its labeled indications; and

iv. The drug product is presently not subject to a determination by FDA, made under its efficacy review study (see 21 CFR 310.6 including all subsequent amendments and supplements, for an explanation of this program), indicating there is a compelling justification of the drug product's medical need.

2. Reimbursement is not available for the purchase or administration of any drug product that is identical, related or similar, as defined in 21 CFR 310.6 (including all subsequent amendments and supplements), to a drug product that meets the conditions of (a) above.

3. The initial list of drugs and related drug products classified as "less than effective" by the FDA pending outcome of the NOOH appears at 21 CFR 310.6. Subsequent revisions to this list which are adopted, shall appear in the Federal Register.

10:51-4.21 Bundled drug service

(a) "Bundled drug service" means a drug or service that is marketed or distributed by the manufacturer or distributor as a combined package which includes in the cost the drug product and ancillary services such as, but not limited to, case management services and laboratory testing.

(b) Bundled drug service shall not be eligible for reimbursement by the PAAD program. The cost of the drug product which is a component of a bundled drug service (see N.J.A.C. 10:51-4.12, Covered Pharmaceutical Services) shall be covered by the PAAD program.

1. In order to determine eligibility for reimbursement, manufacturers or distributors of a bundled drug service shall submit complete product information, including the cost to the Program of the drug product component of the bundled drug service, and other information as requested by the Department, to the Chief Pharmaceutical Consultant, Division of Medical Assistance and Health Services, CN 712, Trenton, New Jersey 08625-0712.

10:51-4.22 Tape-to-tape incentive program

(a) An incentive payment instituted January 1, 1979, is available to approved pharmacies which submit PAAD claims on magnetic tape. Incentive payments shall be made when the total volume of paid magnetic tape Medicaid/PAAD claims, submitted by pharmacy providers as a whole, equals or exceeds 20 percent of the total volume of paid Medicaid/PAAD claims.

(b) The reimbursement for incentive payments is based on the following schedule:

"Percent of total Medicaid/PAAD Paid Claims"	"Amount of Incentive Payment"
20-29 percent	two cents/tape claim
30-39 percent	three cents/tape claim
40-55 percent	four cents/tape claim
over 55 percent	five cents/tape claim

(c) Claims volume figures shall be reviewed and averaged quarterly. The claim volume totals for the previous quarter shall determine the amount of incentive for the subsequent quarter. If the volume of paid tape claims is less than 20 percent of the total, no incentive payments shall be made. A pharmacy provider shall be eligible for incentive payments beginning with the month subsequent to the month in which the volume of tape claims reaches 20 percent of the total paid claims volume. A qualified tape-to-tape pharmacy provider shall receive a separate incentive payment check for all tape claims paid during the preceding month.

1. Incentive payment for a voided claim(s) shall be deducted from the subsequent month's total incentive payment, which follows the month in which the claim(s) was voided.

(d) The incentive payment for tape claims is an additional fee increment over and above the dispensing fee allowed by the New Jersey Medicaid program.

(e) In order to be eligible to submit magnetic tape claims for the PAAD program, a pharmacy provider shall complete the "New Jersey Medicaid Provider Electronic Billing Agreement," submit the completed agreement to the fiscal agent, and receive approval by the Division of Medical Assistance and Health Services.

10:51-4.23 Eligible PAAD beneficiary

(a) An eligible beneficiary is a permanent resident of the State of New Jersey, 65 years of age or older, or who is under 65 and over 18 years of age and is receiving Social Security Title II disability benefits with an annual income less than $15,700 for a single person and less than $19,250 in combined income for a married couple, and who possesses a current valid eligibility identification card.

1. Benefits are not payable in nursing facilities, hospitals or special hospitals by the PAAD program during any period recipients are covered for drug benefits by Medicaid, Medicare, Blue Cross and Blue Shield of New Jersey, Inc., or other insurance benefits or if such benefits are covered in the daily rate of the facility.

(b) An applicant shall be determined to be eligible for Pharmaceutical Assistance to the Aged and Disabled only if physically present in New Jersey at the time of application and utilization.

1. Exception: The PAAD program's determination of the continuing New Jersey residence of a person absent from the State of New Jersey shall be based upon whether the individual intends to return to New Jersey or remain indefinitely in the other jurisdiction. If a beneficiary leaves New Jersey with the intent to establish a place of abode elsewhere, he or she becomes ineligible under the PAAD program and shall notify the Bureau of Pharmaceutical Assistance to the Aged and Disabled of the address and return the PAAD eligibility card.

10:51-4.24 PAAD beneficiary identification

(a) Pharmacies should verify that the beneficiary is a PAAD covered person. This is done by checking the beneficiary's plastic PAAD identification card or the Temporary Validation Identification Letter.

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(b) The Division shall issue to all PAAD eligibles a Validation Identification Card. The document shall contain the patient's name, PAAD identification number, effective date and expiration date.

(c) The beneficiary is eligible only for the period of time indicated on the identification card.

APPENDIX A

DRUG EFFICACY STUDY IMPLEMENTATION (DESI)

(Update of Drug Products and Known Related Drug Products that Lack Substantial Evidence of Effectiveness)

Appendix A is a list of drugs that the Food and Drug Administration (FDA) has proposed to withdraw from the market which is updated periodically by the Health Care Financing Administration subsequent to published listing changes in the Federal register.

AGENCY NOTE: The Appendix A is filed as a part of this chapter/manual but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Appendix A, replacement pages will be distributed to providers and copies will be filed with the Office of Administrative Law. For a copy of the Appendix A, write to:

Paramax/Unisys
CN-4801
Trenton, New Jersey 08650

or contact:

Office of Administrative Law
Quakerbridge Plaza, Building 9
CN-049
Trenton, New Jersey 08625

APPENDIX B

UPPER PAYMENT LIMITS FOR MAXIMUM ALLOWABLE COST (MAC) DRUGS

Appendix B is a list of multiple source drugs which meets the criteria set forth in 42CFR 447.301, 331-333 which is updated periodically by the Health Care Financing Administration subsequent to published listing changes in the Federal register.

AGENCY NOTE: The Appendix B is filed as a part of this chapter/manual but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Appendix B, replacement pages will be distributed to providers and copies will be filed with the Office of Administrative Law. For a copy of the Appendix B, write to:

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or contact:

Office of Administrative Law
Quakerbridge Plaza, Building 9
CN-049
Trenton, New Jersey 08625

APPENDIX C

PHARMACY PROVIDER CERTIFICATION STATEMENT

Pharmacy Name_____ Provider ID #_____

Address_____

_____ Telephone ( )_____

Section I. ANNUAL CERTIFICATION OF TOTAL PRESCRIPTION VOLUME FOR 1991

Prescriptions Filled: New_____ + Refills_____ = TOTAL *

*Total: Include all third party and non-third party Rxs.
Combine totals for both regular and LTCF numbers, if applicable.

Section II. FEE INCREMENTS ADDED TO BASIC DISPENSING FEE

1. 24-Hour Emergency Service Availability $0.11

Provider certifies availability of 24 hours/day 365 days/year prescription service.

_____ Yes _____ No

If yes, service availability made known by:

_____ Sign in store window _____ Sign at prescription counter

_____ Other Note: If other is checked a complete description of how available must be given.

Telephone number for this service is ( )_____

Telephone number for this service must be a local call. If telephone number is not given, FD-70 will be returned.

2. Patient Consultation $0.08

Provider agrees to monitor all Medicaid and PAAD patient profiles for drug interactions, contraindications and adverse reactions. Provider will attempt to discuss therapy with the patient with emphasis on compliance and proper utilization of prescription. The pharmacist shall exercise good professional judgment at all times.

_____ Yes _____ No

NOTE: If provider discontinues any of the above services, he/she must notify Unisys CN 4804, Trenton, N.J. 08650 in writing within 72 hours of such discontinuance and must immediately cease adding the increments to the basic dispensing fee.

Each of the above claimed increments is subject to audit. If the New Jersey Medicaid Program determines that the provider has an error rate of 5% or more for either increment, the New Jersey Medicaid Program will recover the total reimbursement paid for that increment, plus interest, retroactive to the date of this agreement.

3. Impact Allowance $0.15

This provider has a combined Medicaid/PAAD prescription volume (including LTCF Rxs) equal to or greater than 50% of the total Rx volume & qualifies for "Impact Allowance".

_____ Yes _____ No

NOTE: If conditions for earning impact allowance change, provider must notify Unisys, CN 4804, Trenton, N.J. 08650 in writing within 30 days of change and must immediately cease adding the increment to the basic dispensing fee.

If the New Jersey Medicaid Program determines that the provider has not met the impact allowance requirements, the New Jersey Medicaid Program will recover the total reimbursement paid for this increment, plus interest, retroactive to the date of this agreement.

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Section III. OWNERSHIP DISCLOSURE STATEMENT

1. Chain Store (4 or more stores). _____ Yes _____ No
2. Do you or does your organization have any legal or professional relationships with any other health care organizations or facilities? _____ Yes _____ No

   If yes, list all such relationships on a separate page.
3. Does any person in your organization own or have an interest in or any relationship with any other corporation, partnership or other organization providing services under the New Jersey Medicaid Program? _____ Yes _____ No

   If yes, explain on a separate page.
4. Indicate the Legal Status of your organization:

   _____ Sole Proprietor _____ Partnership _____ Non-Profit Corporation

   _____ For Profit Corporation _____ Government _____ Other (If so, specify)
5. List names, **home** addresses, professional degree and percentage of ownership of individual(s) for:

   All partners, directors, officers and/or stockholders as applicable.

	NAME	DEGREE	HOME ADDRESS	% OWNERSHIP
1.				
2.				
3.				
4.				
5.				

I HAVE THOROUGHLY READ THE PHARMACY PROVIDER CERTIFICATION STATEMENT AND AGREE TO THE TERMS AND CONDITIONS SET FORTH HEREIN; I UNDERSTAND THAT THE MAXIMUM CHARGE TO THE NEW JERSEY MEDICAID PROGRAM FOR A MEDICAID OR PAAD PRESCRIPTION FOR A COVERED LEGEND DRUG, MAY NOT EXCEED THE LOWEST OF THE FOLLOWING:

A. Cost plus dispensing fee is outlined in the New Jersey Medicaid Pharmacy Manual.
B. Usual and customary and/or posted or advertised charge.
C. Average of other third party prescription plan charges or agreements.

THE MAXIMUM CHARGE TO THE NEW JERSEY MEDICAID PROGRAM FOR A COVERED NON-LEGEND PRODUCT, MAY NOT EXCEED THE LOWEST OF THE FOLLOWING:

A. The manufacturer's published suggested selling price to the consumer.
B. The usual and customary retail price charged to other persons in the community.

Legal Signature of Principal:_____ Date:_____

Print Name:_____ Title:_____

Pharmacy Name:_____

NOTE: All of the above statements are subject to audit and review by Division personnel, its contractors, or other state & federal agencies.

AFFIX
PHARMACY LABEL
HERE

FD-70 (REV. 12/91)

APPENDIX D
FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is filed as an incorporated Appendix of this chapter/manual but is not reproduced in the New Jersey Administrative Code. When revisions are made to the fiscal agent billing supplement, replacement pages will be distributed to providers and copies will be filed with the Office of Administrative Law. For a copy of the Fiscal Agent Billing Supplement, write to:

Paramax/Unisys
CN-4801
Trenton, New Jersey 08650
or contact:
Office of Administrative Law
Quakerbridge Plaza, Building 9
CN-049
Trenton, New Jersey 08625

(a)

DIVISION OF FAMILY DEVELOPMENT

Service Programs for Aged, Blind or Disabled Persons

Proposed Readoption: N.J.A.C. 10:83

Authorized By: Alan J. Gibbs, Commissioner, Department of Human Services.

Authority: N.J.S.A. 44:7-12, 44:7-13, 44:7-38 and 44:7-43.

Proposal Number: PRN 1992-373.

Submit comments by October 8, 1992 to:
Marion E. Reitz, Director
Division of Family Development
CN 716
Trenton, New Jersey 08625

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The agency proposal follows:

Summary

Pursuant to Executive Order No. 66(1978), N.J.A.C. 10:83 will expire on January 19, 1994. The Department's Division of Family Development has reviewed these rules and determined them to be adequate, necessary and effective for the purposes for which they were originally promulgated. The readoption of the rules becomes effective upon acceptance for filing by the Office of Administrative Law of the notice of readoption, if filed prior to the chapter expiration date.

N.J.A.C. 10:83 sets forth the rules and procedures concerning the provision of emergency assistance and the payment of burial and funeral expenses in cases of eligible aged, blind, and disabled individuals who are recipients of Supplemental Security Income (SSI). Medicaid Only recipients, while not eligible for emergency assistance, are eligible for payment of funeral and burial expenses.

N.J.A.C. 10:83-1.1 presents the purpose of the chapter and the remainder that all of the customary principles and concepts surrounding the provision of public assistance remain applicable. Those include the rights and procedures concerning fair hearings, safeguarding of information, non-discrimination, and matters relating to fraudulent receipt of assistance.

N.J.A.C. 10:83-1.2 contains the eligibility rules for payments of emergency assistance for persons who are receiving SSI benefits. A proposal published in the February 3, 1992 issue of the New Jersey Register (24 N.J.R. 326(a)) extensively revised N.J.A.C. 10:83-1.2 in order to expand emergency assistance services available to SSI recipients. The amendment provides a separate EA program for SSI recipients. Under current rules, an SSI recipient is subject to all the provisions that apply to Aid to Families with Dependent Children (AFDC) recipients since the SSI/EA rules are cross referenced to the AFDC/EA rules. By establishing separate SSI/EA rules, the special needs of SSI recipients are recognized. The proposed SSI/EA rules provide various remedies for avoiding or overcoming a state of homelessness. These include provision of emergency shelter, payment of rent, mortgage and utility arrearages and rental assistance.

N.J.A.C. 10:83-1.3 through 1.10 contain detailed rules which govern burial and funeral payments for deceased SSI or Medicaid Only recipients. Those sections include the identification of individuals who may be eligible for payment of burial and funeral expenses; limit the contracting authority of county agencies; discuss conditions under which burial or funeral payments will be authorized; and provide procedures to resolve disputed claims.

N.J.A.C. 10:83-1.11 shows the New Jersey SSI payment levels in accordance with Section 1618(a) of the Social Security Act, and is subject to periodic updating in accordance with that Act.

Social Impact

The rules set forth in this chapter provides SSI recipients with the personal security of knowing that should an emergency occur, they will not be left destitute, if the costs which result from such occurrence are beyond their own financial means. Similarly, they are assured that funds will be available to provide a decent and dignified funeral and burial. The social and economic damage that would be done to New Jersey's elderly and disabled, as well as their next of kin, by allowing this chapter to lapse would be significant. Without these rules, the Division would be unable to provide general assistance to SSI recipients who are not yet receiving SSI or who are not receiving enough SSI to provide for their basic shelter, medical, and/or subsistence needs. Also, without this chapter, funds would not be available for funerals and burials, placing a greater burden upon friends, and local charitable agencies. N.J.A.C. 10:83-1.11 has been periodically adjusted to provide an increase in SSI payment levels. This results in a significant social impact, since such annual increases in allowances provide SSI recipients with a greater amount of self-sufficiency in the face of increasing cost of living.

Economic Impact

The annual fiscal impact data is as follows:

1. Funerals and burials for SSI and Medicaid Only cases:

Fiscal Year	Expenditures
1991 (actual)	$ 5,057,062
1992 (projected)	$ 7,733,387
1993 (estimated)	$ 8,523,414

2. New Jersey's monetary share of the SSI maintenance payment:

Fiscal Year	Expenditures
1991 (actual)	$26,214,333
1992 (projected)	$37,987,342
1993 (estimated)	$41,348,613

3. SSI Emergency Assistance:

Fiscal Year	Expenditures
1991 (actual)	$ 2,319,676
1992 (projected)	$ 3,633,898
1993 (estimated)	$ 4,269,525

Regulatory Flexibility Statement

This chapter has been reviewed with regard to the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. These rules impose no reporting, recordkeeping or other compliance requirements on small businesses; therefore, a regulatory flexibility analysis is not required. The rules govern a public assistance program designed to certify eligibility to a low-income population by a governmental agency rather than a private establishment.

Full text of the proposed readoption can be found in the New Jersey Administrative Code at N.J.A.C. 10:83.

(a)

DIVISION OF FAMILY DEVELOPMENT

General Assistance Manual

Elimination of Inpatient and Outpatient Hospital Medical Services, Eligibility of Aliens, Employable/Unemployable Status, Time-limited Eligibility Periods for Employables, Pharmaceutical Payment Procedures, Time-limited Notice Previsions

Proposed Amendments: N.J.A.C. 10:85-1.1, 2.1, 3.1, 3.2, 3.3, 3.4, 3.5, 4.1, 4.2, 5.3, 5.4, 5.5, 5.6, 5.7, 5.8, 6.8 and 7.2

Proposed Repeals: N.J.A.C. 10:85-5.1 and 5.2

Proposed New Rule: N.J.A.C. 10:85 Appendix D

Authorized By: Alan J. Gibbs, Commissioner, Department of Human Services.

Authority: N.J.S.A. 44:8-111(d), Senate Bill 1000 as introduced June 18, 1992, enacted June 30, 1992 and effective July 1, 1992.

Proposal Number: PRN 1992-400.

Submit comments by October 8, 1992 to:
Marion E. Reitz, Director
Division of Family Development
CN 716
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The proposed amendments are initiated as a result of the budgetary constraints for State fiscal year (SFY) 1993, enacted in the State Budget, Senate No. 1000, as introduced June 18, 1992, enacted June 30, 1992 and effective July 1, 1992. The appropriations impact the General Assistance (GA) program in three primary areas.

The first area of change imposes a time-limited eligibility period which is a cumulative total of any six calendar months in a State fiscal year, for persons determined to be employable. A second significant change eliminates GA eligibility for illegal aliens and for those aliens admitted as students or visitors. The third program modification eliminates all text concerning eligibility for payments of inpatient and outpatient hospital medical services to GA clients.

The following is a description of the proposed amendments:

As proposed, due to the constraints placed on GA program funding, N.J.A.C. 10:85-1.1 is amended to stipulate that only United States citizens and those individuals who have eligible alien status are eligible to receive General Assistance. Additionally, N.J.A.C. 10:85-1.1(b)1, 2.1(a), 3.1(a),

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and 4.1(b) are amended to clarify that the provision of GA benefits is limited to "eligible" needy persons who meet GA eligibility criteria.

Language at N.J.A.C. 10:85-1.1(g)2 is deleted and relocated as N.J.A.C. 10:85-1.1(g)3 for purposes of clarity. The proposed text delineates specific circumstances of duplicative assistance. The rule provides that General Assistance benefits received during a sanction or during the ineligibility period, for employable clients, as set forth at N.J.A.C. 10:85-3.1 and 3.2 shall be considered duplicative assistance and subject to the penalty provisions stipulated in subsection (g).

N.J.A.C. 10:85-2.1 adds the phrase "as State resources permit" to establish that benefits are also contingent on the availability of State resources.

Text at N.J.A.C. 10:85-3.1(a)1i is added to exclude outpatient hospitalization and medical services rendered to an outpatient as payable excessive medical costs.

N.J.A.C. 10:85-3.1(a)1iii deletes text concerning inpatient hospital care for pending SSI applicants since payment for inpatient hospital care is no longer provided under GA.

Text is amended at N.J.A.C. 10:85-3.1(a)2 to stipulate that United States citizenship or lawful permanent residence, in accordance with the Immigration and Nationality Act (8 U.S.C. §1101 et seq.), is an eligibility requirement of the GA program.

N.J.A.C. 10:85-3.1(a)2i identifies aliens legally admitted as students or visitors as ineligible for GA.

N.J.A.C. 10:85-3.1(a)2ii is added to establish that legal alien status shall be verified and documented in accordance with new procedures at N.J.A.C. 10:85-3.2(c)6.

N.J.A.C. 10:85-3.1(a)2iii establishes a cross-reference to the provisions at N.J.A.C. 10:85-3.4(b)1 concerning sponsorship of aliens admitted for permanent residency.

N.J.A.C. 10:85-3.1(a)3 identifies two categories of eligible GA persons: employable and unemployable.

N.J.A.C. 10:85-3.1(a)4 provides a definition of an "employable" applicant/recipient, and stipulates that an "employable" person's eligibility for GA is limited to a cumulative total of any six calendar months in any State fiscal year.

Text at N.J.A.C. 10:85-3.1(a)5 is relocated and revised from N.J.A.C. 10:85-3.2(g)2v to establish the criteria for the determination of an unemployable GA applicant/recipient.

N.J.A.C. 10:85-3.1(a)5i lowers the age for the designation of a person as unemployable from age 65 to age 55 years or older.

Text at N.J.A.C. 10:85-3.1(a)6 establishes criteria for the time-limited eligibility period for employable GA recipients. The provisions count all or part of any month that an individual receives GA benefits as a full calendar month for the purpose of the cumulative six-month total. Accordingly, examples are also provided to illustrate that the total months of eligibility in a State fiscal year may be less than the maximum of six months.

N.J.A.C. 10:85-3.1(a)6iii stipulates that employable clients who incur any penalty of ineligibility shall have those months of penalty counted toward the SFY eligibility period.

N.J.AC. 10:85-3.1(a)6v establishes that the limited eligibility period for employable GA clients also applies to GA Emergency Assistance and Temporary Rental Assistance (TRA) benefits as well, since such benefits are contingent on GA eligibility.

N.J.A.C. 10:85-3.1(a)6vii indicates that the MWD shall advise the employable client at time of expiration of the time-limited eligibility period that he or she may reapply for GA if circumstances render them unemployable.

N.J.A.C. 10:85-3.1(c)1ii deletes obsolete text concerning aliens.

N.J.A.C. 10:85-3.2(c)1iv was deleted in its entirety and rewritten for purposes of clarity and to include the new Form GA-53 (Notice of Time-limited Availability of General Assistance for Employable Clients) that is to be signed at time of application by employable clients.

N.J.A.C. 10:85-3.2(c)5 eliminates obsolete text concerning Social Security accounts and undocumented aliens.

N.J.A.C. 10:85-3.2(c)6 is added to describe the documentation and verification procedures for aliens.

N.J.A.C. 10:85-3.2(g)2 adds language to further clarify the distinction between the two categories of persons eligible for GA benefits, that is, those who are employable and those who are not employable.

N.J.A.C. 10:85-3.2(g)3v is relocated, in part, as mentioned previously, to N.J.A.C. 10:85-3.1(a)5 and text added for cross-reference purposes.

N.J.A.C. 10:85-3.2(g)7ii(l) is amended to comport with statutory language at N.J.S.A. 44:8-114 concerning the 90 day penalty period for refusal or failure to comply with the work provisions without good cause.

At N.J.A.C. 10:85-3.3(g)1, a reference to elimination of payment for outpatient hospital services is added.

At N.J.A.C. 10:85-3.3(g)3 and 4, text is deleted in its entirety concerning inpatient hospitalization.

At N.J.A.C. 10:85-3.4(b)1i, obsolete text concerning illegal aliens is deleted.

N.J.A.C. 10:85-3.5(b) adds text to clarify that redeterminations for long term care clients are to be conducted annually.

N.J.A.C. 10:85-4.2(a)6 adds language which stipulates that the employable recipient's eligibility for General Assistance is limited to a cumulative total of any six calendar months in a State fiscal year.

N.J.A.C. 10:85-5.1 and 5.2 are repealed as obsolete. Text at N.J.A.C. 10:85-5.1 is obsolete due to the changes made at N.J.A.C. 10:85-3.1(a) and 3.3(g), and is being deleted to conform with these changes. N.J.A.C. 10:85-5.2 is obsolete due to the elimination of inpatient hospital care for GA clients.

N.J.A.C. 10:85-5.3 is amended, reorganized and recodified as N.J.A.C. 10:85-5.1 for clarification purposes. All references to inpatient and outpatient hospital services are deleted, as well as a reference to physician recertification by means of annual completion of Form GA-18.

N.J.A.C. 10:85-5.4 is recodified as N.J.A.C. 10:85-5.2. Also, text is relocated from N.J.A.C. 10:85-5.2(c) to N.J.A.C. 10:85-5.1(f).

N.J.A.C. 10:85-5.6 is recodified as N.J.A.C. 10:85-5.4 and obsolete text deleted.

N.J.A.C. 10:85-5.8 is recodified and amended as N.J.A.C. 10:85-5.6 to remove an obsolete process concerning pharmaceutical claims processing and to replace with updated operational procedures.

N.J.A.C. 10:85-6.8 is amended to clarify fiscal procedures for the updated pharmaceutical claims process.

N.J.A.C. 10:85-7.2 is amended to include the new Form GA-33C (Time-limited Benefit Period Expiration Notice for General Assistance Employables) and issuance requirements.

Additional minor technical changes, as well as recodification and integration of certain text for clarity, are also included as proposed amendments.

Social Impact

Current recipients of General Assistance who are aliens not admitted for permanent residence will lose program eligibility upon implementation of these amendments. This fact, along with the time-limited eligibility period for GA employable individuals, will likely cause an increase in homelessness and other social problems associated with poverty. Additionally, the shortened and sometimes intermittent periods of GA eligibility will serve as a disincentive to efforts of training and other employment-directed activities that are designed to lead such individuals to self-sufficiency. It should be noted that clients whose circumstances change and who are later unemployable, may reapply at any time for benefits. The elimination of inpatient and outpatient hospital services is expected to have a significant impact on GA recipients and places an increased burden on the already over-extended Health Care Trust Fund-Charity Care provisions as well as increased fees for paying patients served. Financially, the "poorest of the poor" who may not make appropriate application or who are found ineligible for assistance through the Charity Care Fund, will be rendered liable for payment of services provided to them by hospitals, which in all cases, will most probably result in referrals to collection agencies for nonpayment.

It is estimated that approximately 440 aliens will be removed from the Statewide General Assistance population by these proposed amendments. It is also estimated that as of January 1, 1993, approximately 2,500 employable General Assistance recipients Statewide will become ineligible for GA benefits due to the time-limited eligibility period provisions. In subsequent months, it is estimated that approximately 690 recipients per month will lose eligibility due to this same requirement.

The proposed amendment which lowers the age of a GA client considered unemployable from age 65 to age 55 appears to be a positive measure for GA clients, since that age group cannot readily find employment in the currently depressed job market.

Economic Impact

The projected savings for State fiscal year 1993 are as follows:

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	Annual Savings	Avg Monthly Clients
Six Month Limitation—Employable	$ 9,116,131	2,099
Out-patient Medical Services*	$ 5,089,000	34,103
Stop payments to illegal aliens	$ 750,000	150
Total Projected Savings	$14,955,131	

*Average monthly recipients reflect the entire projected caseload whether or not such individuals currently avail themselves of out-patient medical services.

Regulatory Flexibility Statement

The proposed amendments have been reviewed with regard to the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The amendments impose no reporting, recordkeeping or other compliance requirements on small businesses; therefore, a regulatory flexibility analysis is not required. The rules govern a public assistance program designed to certify eligibility for the General Assistance program to a low-income population by a governmental agency rather than a private business establishment.

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

10:85-1.1 Purpose of the General Assistance program

(a) General Assistance is a program under which financial and medical aid is provided by municipal departments of welfare to persons **who are citizens of the United States or who have eligible alien status and are** currently ineligible for participation in any other public assistance program in New Jersey.

(b) Each municipality in New Jersey is required by law (Chapter I of Title 44, Revised Statutes) to provide financial assistance and medical care to all eligible persons residing in the community at the time of application and not otherwise provided for under the laws of this State and to such other persons who may be in the municipality and require emergency assistance. (See N.J.A.C. 10:85-3.2(f) for definition of resident and N.J.A.C. 10:85-4.6 for emergency assistance.)

1. The General Assistance Manual is a compilation of rules based on State law (Chapter 8 of Title 44, Revised Statutes) which govern the provision of assistance to **eligible** needy persons by all municipalities and authorize 100 percent State funding for non-administrative costs incurred by those municipalities in the administration of the General Assistance program.

(c)-(f) (No change.)

(g) Financial assistance for maintenance requirements or other needs, including medical assistance, shall not be authorized through General Assistance when, during the same period, such needs are actually being provided by any other source.

1.(No change.)

2. Receipt of duplicate assistance from more than one MWD in any one month shall render the client ineligible for General Assistance benefits for a period of 90 days beginning with the month subsequent to the month in which the benefit infraction was identified. [General Assistance benefits received from any MWD during any sanction period, such as set forth at N.J.A.C. 10:85-3.2(g)7, shall be viewed as having received duplicative assistance within the meaning of the penalty provisions stipulated herein.] Sanctions imposed are for additional/cumulative periods of ineligibility for each infraction.

i. (No change.)

3. The following situations shall be included as duplicative assistance within the meaning of the penalty provisions stipulated in this subsection:

i. General Assistance benefits received from any MWD during any imposed sanction period, such as set forth at N.J.A.C. 10:85-3.2(g)7; and

ii. General Assistance benefits received from any MWD during the ineligibility period for employable clients in a State fiscal year as set forth at N.J.A.C. 10:85-3.1(a)4i and 3.1(a)6;

10:85-2.1 Statutory obligation to provide assistance

[(a)] It is the basic obligation of every municipality in the State to provide financial assistance and medical care, to the extent established by State regulations **and as State resources permit,** for all **eligible** persons living in that community who are in need. This essential obligation is embodied in N.J.S.A. chapter 1 of Title 44.

10:85-3.1 Persons eligible for General Assistance

(a) General assistance shall be provided to all **eligible** needy persons who, while in the State, are entitled to receive such assistance. Entitlement does not extend to persons who have been found eligible for or are recipients of public assistance programs administered by the county welfare agency, or who have been found ineligible for such programs due to voluntary refusal to comply with program requirements. (See also [subsections] (c) and (d) [of this section] **below**.)

1. Exceptions relevant to medical care:

i. Individuals and families who are ineligible for public assistance (General Assistance, AFDC, [Cuban or Indochinese refugee assistance] **Refugee Resettlement Program**) or for SSI payments because their income exceeds the standards established for the applicable program may apply to the MWD on a monthly basis for assistance in paying excessive medical costs. The provisions of this section are not applicable to the payment of bills for inpatient **or outpatient** hospitalization or for medical services rendered to an inpatient **or outpatient**;

ii. (No change.)

[iii. When an individual, whose application for SSI is pending, requires in-patient hospital care or care in a long term facility, the MWD shall withhold payment for such care in accordance with N.J.A.C. 10:85-5.7.]

2. Citizen/alien status: [Eligibility for General Assistance is not related to citizenship. No inquiry about citizenship need be made except for purposes of obtaining support from the sponsor of an alien admitted for permanent residence in accordance with N.J.A.C. 10:85-3.4(b)1.] **To be eligible for GA an individual shall be either a citizen of the United States or an otherwise lawful permanent resident of the United States. Such lawful permanent residents include individuals admitted under color of law or any alien who is lawfully present in the United States as a result of the application of the following sections of the Immigration and Nationality Act, 8 U.S.C. §1101 et seq.: Section 207(c) concerning refugees; Section 203(a)(7) (prior to April 1, 1980) related to conditional entrants; Section 208 concerning asylees; and Section 212(d)(5) covering parolees.**

i. An alien who is legally admitted as a student or visitor shall not be eligible for GA.

ii. Legal alien status shall be verified and documented in accordance with provisions set forth at N.J.A.C. 10:85-3.2(c)6.

iii. Sponsorship of an alien admitted for permanent residency shall be pursued in accordance with provisions at N.J.A.C. 10:85-3.4(b)1.

3. In the GA program, there are two distinct categories of persons eligible for financial assistance, those who are "employable" and those who are "unemployable."

4. An "employable" person is any person applying for or receiving assistance who is able-bodied and does not meet any one of the criteria of "unemployable" delineated in (a)5 below.

i. Eligible individuals determined "employable" shall be eligible to receive benefits for up to a maximum cumulative total of any six calendar months in a State fiscal year (SFY) (July 1-June 30) (see (a)6 below).

5. An "unemployable" person is any person who meets any of the unemployable criteria below:

i. Persons who are 55 years of age or older;

ii. Persons receiving inpatient hospital care and treatment who were receiving an unemployable grant prior to entering the hospital. (Persons who were listed as employable shall retain such employable status until hospital discharge);

iii. Persons who are residents in long term care facilities;

iv. Persons in the first 12 months of residential treatment in centers licensed by the New Jersey Department of Health for the treatment of drug abuse, when medical evidence exists that the residential treatment is necessary. The 12 month period starts anew for each commencement of treatment, previous incomplete or unsuccessful courses of treatment notwithstanding;

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v. Persons normally eligible to receive RSDI (Title II benefits), SSI or Railroad Retirement benefits on the basis of disability, but due to recovery of overpayments or administrative delays in that respective program, payments are being withheld;

vi. Persons who have been determined to be legally blind by the New Jersey Commission for the Blind and Visually Impaired;

vii. Persons in the third trimester of pregnancy when an examining physician certifies to both the pregnancy and its term;

viii. Pregnant persons when an examining physician certifies that employment poses a threat to the mother or the fetus;

ix. Persons whose presence is required at home to care for one or more children under age six or for disabled family member(s). No more than one person in a household may be considered unemployable for this reason without written authorization from the Division of Family Development (DFD)/GAP Unit; and/or

x. Persons determined to be incapacitated by the MWD are unemployable when such determination of incapacity is supported by any of the following circumstances:

(1) Written certification by an examining physician that the individual is, by reason of an identified physical or mental defect, disease, or impairment, unable to engage in any useful occupation. Such certification shall include the date of examination, diagnosis, length of incapacity, functional limitations, prescribed treatment, an indication of whether or not reevaluation will be necessary, and the examining physician's signature;

(2) An obvious disability or impairment which makes employment unrealistic at the time of application/redetermination. A determination on this basis shall be valid for up to three months or such longer period as may be specified under (a)5x(4) below;

(3) The individual's history of unemployment and lack of vocational training and/or education, combined with medical evidence of the existence of a mental or physical disability or impairment, negates all possible employment. Facts leading to such determination must be recorded in the case file. A determination on this basis shall be valid for three months or such longer period as may be specified under (a)5x(4) below; and/or

(4) Written Record of Action (Form GA-38) from DFD/GAP Unit. The record may be applied for by MWD submission of such documentary material as the MWD finds appropriate. This may include, but is not limited to, medical or hospital reports and the MWD's own statement of specific observations and recommendations with reasons. Form PA-5/DRS-1, Examining Physician's Report, may be used in this process. Social information submitted by the MWD should include at a minimum, the client's age, educational level attained, experience, and general description of the individual, especially as the description may relate to employment. The DFD/GAP Unit shall consider the individual's age, experience, education, vocational training, and work history as well as physical or mental defects, diseases or impairments in determining whether an individual is able to engage in any useful occupation for which he or she has competence, or his or her ability to engage in retraining.

6. Criteria concerning the eligibility period for receipt of GA benefits of employable persons, up to a maximum cumulative total of any six calendar months in a State fiscal year (SFY) (July 1-June 30), are as follows:

i. All or any part of a month for which assistance is provided shall be considered a calendar month for the purpose of determining the eligibility period for employable clients.

ii. The eligibility period in a SFY for the receipt of assistance for employables shall be determined based on when the months of GA eligibility fall within the SFY.

(1) Example 1: A GA employable client receives four months of GA benefits in September, October, November, and December. The case is terminated by the MWD in January due to receipt of earned income. The individual reapplies in April and is determined GA eligible and employable. This individual may be eligible to receive assistance benefits for up to two months of the three remaining months in the SFY, which would constitute his or her maximum six calendar month eligibility period. If instead, the individual reapplied in June, that individual's eligibility period for that SFY would only be five months, not the maximum six months.

(2) Example 2: A GA employable client who receives six months of GA benefits from July through December shall have exhausted his or her eligibility period for receipt of assistance for that SFY and shall not be eligible for any further GA assistance benefits for the remaining months of January through June.

iii. Employable clients who incur any penalty of ineligibility shall be considered to be in receipt of assistance during the penalty month(s) and those penalty month(s) shall be counted when determining the SFY eligibility period for such clients.

iv. Employable recipients who terminate benefits at their own request, or for whom benefits are terminated by the MWD due to a determination of ineligibility for a reason other than a sanction penalty, shall be considered to have been in receipt of assistance only for those months in which assistance benefits were actually provided.

v. The limited eligibility period for GA employable clients shall also apply to the period of eligibility for Emergency Assistance (EA) and Temporary Rental Assistance (TRA) benefits, since such benefits are contingent on GA eligibility.

vi. Appropriate timely and time-limited notices shall be provided to employable GA clients whose SFY eligibility period ends in accordance with the notice provisions for GA at N.J.A.C. 10:85-7 and for EA at N.J.A.C. 10:85-4.6.

vii. At the time of expiration of the time-limited eligibility period for employables, the MWD shall advise the client verbally and in writing that if his or her circumstances change to an unemployable status before the end of that State fiscal year, he or she may reapply for assistance.

(b) (No change.)

(c) Rules concerning persons found ineligible by CWA are as follows:

1. Families:

i. (No change.)

ii. Families determined by the CWA to be ineligible for AFDC due to eligibility factors other than financial need (such as age of children [or alien status]) may be eligible for general assistance. Applications will be accepted and processed in accordance with the [regulations] **rules** stated in this manual.

(1) (No change.)

iii. (No change.)

2. (No change.)

(d)-(f) (No change.)

10:85-3.2 Application process

(a)-(b) (No change.)

(c) Rules concerning taking applications are:

1. Application/affidavit: Any person who indicates a wish to apply for General Assistance shall be recognized as an applicant. Such individual will be assisted by an MWD worker in completing the application (Form GA-1). [He/she] **He or she** shall then be required to sign under oath the attached affidavit attesting to the correctness of [his/her] **his or her** statements.

i.-iii. (No change.)

[iv. At the time of application the MWD shall advise the applicant(s) of his/her obligation to promptly report changes in income, resources or other circumstances. The applicants shall be required to sign two copies of Form GA-51 (Important Reminder of Your Obligation to Report Changes). The applicant shall retain one copy and the original shall be filed in the case record. In addition, the applicant(s) shall be provided with the pamphlet, Your Rights and Responsibilities (Form GA-197) and any oral explanations the individual(s) may request.]

iv. The following procedures apply at the time of application:

(1) All applicants shall be required to sign two copies of Form GA-51 (Important Reminder of Your Obligation to Report Changes). The applicant shall retain one copy and the original shall be filed in the case record. The MWD shall explain to the applicant(s) that it is his or her obligation to promptly report changes in income, resources or other circumstances.

(2) Employable applicant(s) shall be required to sign two copies of Form GA-53 (Notice of Time-limited Availability of General Assistance for Employable Clients), incorporated herein by reference

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as Appendix D, Exhibit 3. The applicant shall retain one copy and the original shall be filed in the case record. The MWD shall fully explain to the employable applicant(s) that the eligibility period for assistance benefits provided to employable individuals shall be time-limited up to a maximum of six calendar months during the State fiscal year which is from July 1-June 30.

(3) All applicants shall be provided with a copy of Form GA-197, Your Rights and Responsibilities in the General Assistance Program. The MWD shall provide any oral explanations the applicant(s) may request.

v. (No change.)

2.-4. (No change.)

5. Social Security number: The Social Security number of every recipient of General Assistance must be recorded on the application form (Form GA-1) and elsewhere in the record as may be appropriate to the facts of the case. Any person who has a number and whose number is not disclosed and recorded is not eligible for assistance. [This paragraph is not applicable to undocumented aliens because they are not permitted to have Social Security accounts.)]

i.-ii. (No change.)

6. If at the time of application a client indicates on Form GA-1, Application and Affidavit for General Assistance, that he or she is not a United States citizen, he or she shall be required to provide the MWD documentation from the Immigration and Naturalization Service (INS) which indicates his or her alien status and the corresponding Alien Registration Number ("A" Number) as soon as possible but no later than 10 calendar days from the date of application. A copy of such documentation shall be retained in the case file.

i. Upon receipt of alien status documentation (which must indicate the "A" Number), the MWD shall complete and submit (faxed or mailed) Form GA-26 (Alien Verification Form), incorporated herein by reference as Appendix D, Exhibit 1, to the Division of Family Development, Bureau of Integrity Control, CN 716, Trenton, New Jersey 08625. Information supplied in the GA-26 shall be used for verification purposes of the "A" Number through an INS automated system in the Bureau of Integrity Control (BIC).

ii. When the "A" Number has been verified, the BIC will fax or mail the verification information to the MWD.

iii. When the INS system indicates that additional verification is required, the MWD will be so advised on the returned Form GA-26 (Alien Verification Form) and the MWD shall be required to complete and submit INS Form G-845 (Document Verification Request) to the Regional INS office.

iv. All information concerning alien status shall be kept confidential and secure in the case file.

v. Requests for alien verification shall at no time be made for anyone who is not an applicant or current recipient of GA.

[6.]**7.** (No change in text.)

(d)-(e) (No change.)

(f) Resident defined: A resident of a municipality is a person who maintains a permanent customary home in the municipality, a person who is in the municipality with intention to remain, or a person who enters a New Jersey [medical] **long-term care** facility from out-of-State and qualifies as a resident in accordance with (f)1i below. No time intervals are relevant so long as the home is not established for a temporary purpose such as for a visit or vacation. A resident may live in his or her own home, a rented home or apartment, the home of a friend or relative, in a boarding home or in a residential medical facility.

1.-2. (No change.)

3. College students: An individual age 18 or over who is attending school or college may be found eligible for General Assistance only when all of the following conditions are present:

i. (No change.)

ii. [He/she] **He or she** is [financially] eligible[,] in accordance with the **eligibility** provisions of [N.J.A.C. 10:85-3.3] **the GA program.**

iii.-iv. (No change.)

4. (No change.)

(g) Work requirement: Eligibility for public assistance in New Jersey is directly related to an individual's willingness to work when he or she is able to do so. It is, therefore, a part of the application process to explain the work requirement to the applicant and to record in the case file the reasons for any exemption from this requirement.

1. (No change.)

2. Elements of the work requirement: Unless specifically exempt, all **employable** recipients of General Assistance benefits [must] **shall** comply with all parts of this section:

i. Maintain current registration with the New Jersey Division of Employment Services. No **employable** person who is subject to this requirement [is] **shall be** eligible for any General Assistance payment until after he or she has completed Form NJES-1A and submitted it to the MWD. The MWD will, within one working day thereafter, submit the form to the appropriate Special Programs Office of the New Jersey Division of Employment Services. Once registered, a GA recipient remains registered as long as he or she remains on assistance.

ii.-vi. (No change.)

3. Exemptions from work requirement: An individual shall be exempt from the work requirement if any of the following exist[s]:

i.-iv. (No change.)

v. The individual is **determined to be** unemployable. **See N.J.A.C. 10:85-3.1(a)5 for those groups of individuals that are considered to be "unemployable."** [: For purposes of General Assistance, unavailability of employment cannot be the basis of a determination of unemployability. Only persons included in any of the following groups are unemployable:]

[(1) Persons age 65 or over;

(2) Persons whose presence is required at home to care for one or more children under age six or for disabled family member(s). No more than one person in a household may be exempt for this reason without written authorization from the DEA/GAP Unit;

(3) Persons receiving inpatient hospital care and treatment who were or would have been classified as unemployable prior to entering the hospital (persons who were or would have been listed as employable shall retain such status until hospital discharge);

(4) Patients in long term care facilities;

(5) Persons normally eligible to receive RSDI (Title II benefits), SSI or Railroad Retirement benefits on the basis of disability, but due to recovery of overpayments or administrative delays, payments are being withheld;

(6) Persons who have been determined to be legally blind by the New Jersey Commission for the Blind and Visually Impaired;

(7) Pregnant persons when an examining physician certifies that employment poses a threat to the mother or the fetus;

(8) Persons in the third trimester of pregnancy when an examining physician certifies to both the pregnancy and its term;

(9) Persons determined by the MWD to be unemployable when such determination is supported by any of the following:

(A) Written certification by an examining physician that the individual is, by reason of an identified physical or mental defect, disease, or impairment, unable to engage in any useful occupation for which he/she has competence. Any time period or termination date included in the written certification shall be observed. A time period of "indefinite" shall be construed to mean three months unless renewed by the examining physician or extended under (g)3v(9)(D) below. When no date or time period is indicated, the certification shall be renewed monthly or such longer period as may be specified under (g)3v(9)(D) below.

(B) An obvious disability or impairment which makes employment unrealistic. A determination on this basis shall be valid for up to three months or such longer period as may be specified under (g)3v(9)(D) below.

(C) The individual's history of unemployment and lack of vocational training and/or education, combined with medical evidence of the existence of a mental or physical disability or impairment, negates all possible employment. Facts leading to such determination must be recorded in the case file. A determination on this basis shall be valid for three months or such longer period as may be specified under (g)3v(9)(D) below.

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(D) Written Record of Action (Form GA-38) from the DEA/GAP Unit. Such may be applied for by MWD submission of such documentary material as the MWD finds appropriate. This may include medical or hospital reports and the MWD's own statement of specific observations and recommendations with reasons. Form PA-5 may be used. Social information submitted should include as a minimum the client's age, education, experience, and general description of applicant, especially as it may relate to employment. The DEA/GAP Unit will consider the individual's age, experience, education, vocational training, and work history as well as physical or mental defects, diseases or impairments in determining whether an individual is able to engage in any useful occupation for which he or she has competence or ability to engage in retraining.

(10) Persons in the first 12 months of residential treatment in centers licensed by the New Jersey Department of Health for the treatment of drug abuse when medical evidence exists that the residential treatment is necessary. The 12 month period starts anew for each commencement of treatment, previous incomplete or unsuccessful courses of treatment notwithstanding.]

4. Action in [Situations of Exemption] **situations of exemption**:

i. Action by MWD:

(1)-(2) (No change.)

(3) When appropriate, the MWD will make referral of the recipient to the Division of Vocational Rehabilitation Services (see N.J.A.C. 10:85-8.4[(h)] **(g)**) and/or to the Social Security Administration for RSDI and/or SSI benefits (see N.J.A.C. 10:85-8.3(c)).

ii. (No change.)

5.-6. (No change.)

7. Failure to comply: [Persons] **Employable persons** who are not exempt (see (g)3 above) and who fail or refuse without good cause (see (g)6 above) to comply with applicable parts of this work requirement section are considered to be unwilling to work and are subject to penalty as indicated in (g)7ii below.

i. (No change.)

ii. Penalties:

(1) Any **employable** person who fails or refuses without good cause to comply with any part of [(g)2i-iii] **(g)2i through vi above** or [any person] who voluntarily ceases employment without good cause or [any person] who has been involuntarily terminated from employment for reasons attributable to [his/her] **his or her** own negligence, shall be considered unwilling to work for [the 90 day period immediately following such failure, refusal, or termination] **a period of 90 days which shall commence at the end of the month during which the person last received GA benefits**. The MWD [will deny or] **shall** terminate (with notice) all assistance to or for such person for the 90 day period [or the remainder of it].

8.-9. (No change.)

(h)-(i) (No change.)

10:85-3.3 Financial eligibility

(a)-(f) (No change.)

(g) Medical care: Persons found eligible for General Assistance maintenance payments in accordance with the procedures and standards established in this subchapter (N.J.A.C. 10:85-3) are likewise eligible for medical care (see N.J.A.C. 10:85-5 regarding provision of medical care). In addition, certain other individuals and families are eligible for medical assistance from the MWD or for referral to the county welfare agency.

1. Medically needy: Individuals and families who are ineligible for [the] General Assistance, AFDC [or] **, the** Refugee Resettlement Program **or SSI,** because their income exceeds the standards established for the applicable program may apply to the MWD on a monthly basis for assistance in paying excessive medical costs. The provisions of this subsection are not applicable to the payment of bills for inpatient **or outpatient** hospitalization or for medical services rendered to an inpatient **or outpatient by a hospital or hospital clinic**. The MWD shall refer to the county welfare agency those persons who appear to be potentially eligible for the Medically Needy Program administered by that agency. Except as stated in (g)1i below, any person found eligible under the provisions of that program is not eligible for benefits under this subsection.

i.-vi. (No change.)

2. (No change.)

[3. Inpatient hospitalization: Eligibility for payment of inpatient hospital costs described in N.J.A.C. 10:85-5.2 is limited to situations which exist in (g)3i, ii, and iii below.

i. Notice in writing of the admission of the person to the hospital was received by the MWD within two weeks of the admission date. The notice must contain, at a minimum, the name, address (if any), any other available identifying information, and the estimated length of hospital stay. The notice may be in any convenient form or format. The notice may, when appropriate, also serve as an application for assistance, provided that the requirements and deadlines for both are met (see paragraph (g)3iii(3) below).

ii. The hospital bill was received by the MWD within one year of the date of discharge.

iii. The individual was in income maintenance eligibility status during at least some part of the hospital stay. This requirement is met by persons:

(1) Who, at the time of admission, were receiving General Assistance maintenance payments other than medical payments.

(2) Who, at the time of admission, had an application for General Assistance pending and were subsequently found eligible for maintenance payments other than medical payments.

(3) Who, after admission but before discharge from the hospital, applied for General Assistance and were subsequently found eligible for maintenance payments other than medical payments. Form PA-1C or any substantially similar document shall be recognized as establishing the date of an application for this purpose. The application may also serve as the notice required under subparagraph (g)3i above, provided that the requirements and deadlines for both are met.

iv. Any disputes with respect to the above which cannot be resolved between the parties involved are to be referred to the General Assistance Program (GAP) Unit, DEA for adjudication.

4. Payment for hospitalization being provided by a third party at the time of application is not considered as income in establishing eligibility.

i. The MWD will, via Form PA-14, refer all GA recipients under age 21 and all pregnant recipients to the county welfare agency for Medicaid Special. Referral of those who have income marginally above GA eligibility standards is also indicated. The CWA will advise as to the eligibility determination made.

ii. Persons found eligible for Medicaid Special are not thereby disqualified for grant of General Assistance but the MWD will make no medical payments for such persons.]

10:85-3.4 Resources

(a) (No change.)

(b) Identification: The person(s) applying for assistance shall identify all his or her resources, shall assist in their evaluation, and, where indicated, shall participate in planning and carrying out their liquidation. The failure of any individual to identify a resource and to participate in its evaluation and/or liquidation shall render that individual ineligible for assistance.

1. Each alien admitted for permanent residence is required to have a sponsor who has certified that he or she will provide support to prevent the alien from becoming a public charge. Therefore, an alien admitted for permanent residence shall supply the name and address of his or her sponsor to the MWD or, if unable to do so, must cooperate in the agency's efforts to obtain the information from the Immigration and Naturalization Service (INS). The alien shall also cooperate in the agency's efforts to obtain support from the sponsor.

[i. Aliens other than those admitted for permanent residence do not have sponsors and are not subject to this section.]

[ii.]**i.** Communication between the MWDs and the INS for purposes other than obtaining support for an alien admitted for permanent residence is permitted only to the extent authorized [in] **at** N.J.A.C. 10:85-1.5(b) **and 3.1(a)2.**

Recodify iii. through viii. as **ii. through vii.** (No change in text.)

(c)-(g) (No change.)

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10:85-3.5 Continuing eligibility

(a) (No change.)

(b) Redetermination of eligibility: In order to continue granting assistance, the MWD shall make a complete redetermination for each case at least once every six months except that for [the chronically ill, recertification by a physician via Form GA-18 shall be made at time intervals in accordance with N.J.A.C. 10:85-5.3(e)1i] **long term care clients, redetermination shall be completed annually.**

1.-5. (No change.)

(c)-(d) (No change.)

10:85-4.1 State and local responsibilities

(a) (No change.)

(b) The municipal welfare director is responsible for determining the eligibility of persons applying for General Assistance and for providing assistance, based on the established standards, necessary to prevent needy **eligible** persons from suffering from cold, hunger, lack of shelter or sickness. He or she has specific authority to issue payments to or on behalf of such persons and to expedite investigation of the circumstances of each case.

1.-2. (No change.)

(c)-(d) (No change.)

10:85-4.2 Periods for which assistance is granted

(a) General assistance is granted to meet needs of individuals in a variety of situations. The director of welfare shall determine which of the following is appropriate:

1.-4. (No change.)

5. Emergency [grant] **assistance**: [An emergency grant] **Emergency assistance benefits** may be [made] **provided** to **eligible GA** individuals under the conditions stated in N.J.A.C. 10:85-4.6. Emergency [grants] **assistance** made in accordance with such regulations [qualify] **qualifies** for State aid.

6. GA recipients determined to be employable shall be limited to a cumulative total of any six calendar months of eligibility for GA benefits in each State fiscal year (July 1-June 30) (see N.J.A.C. 10:85-3.1(a)3 and 4).

[6.]**7.** (No change in text.)

[10:85-5.1 General provisions

(a) The municipal director of welfare shall authorize payment for medical and hospital care and services to General Assistance recipients and eligible applicants when such care and services are deemed necessary and appropriate. The MWD may seek the advice of the DEA/GAP Unit in determining whether particular elements or programs of care or service are necessary and appropriate.

1. In no instance will the rate exceed that payable under the Medicaid Program. Payment for services not provided for under the Medicaid Program shall not be authorized.

2. Medical bills which have been paid by the client or on his or her behalf are not subject to reimbursement by the MWD.

3. In the event that payment is obtained from a third party by or for any client for whom the MWD has made medical payments, the welfare agency shall seek recovery of such payment from the beneficiary.

10:85-5.2 Inpatient hospital care

(a) When inpatient care in a general hospital licensed by the New Jersey Department of Health has been prescribed by a fully licensed physician, dentist, or podiatrist for medical, surgical or psychiatric treatment, diagnosis, and/or rehabilitation and the conditions of N.J.A.C. 10:85-3.3(g)3 are met, payment authorization shall be governed by the following:

1. If the hospital is located in a county of the first class, the director shall authorize the payment.

2. If the hospital is located in a county other than a county of the first class and is operated or controlled by the State or any county, municipal or other public entity, the director shall not authorize any payment.

3. In all other instances the director shall either authorize or deny the payment in accordance with municipal policy. Such municipal policy shall have been previously determined and shall be consistently applied in all cases of inpatient hospitalization in nonpublic hospitals in counties other than those of the first class.

(b) The director of welfare may authorize payment of Blue Cross or other hospital insurance premiums.

(c) Hospital all-inclusive rate: To the extent that they are prescribed by a physician, dentist or podiatrist as necessary for the diagnosis and/or treatment of the condition for which hospitalization is required, the following hospital care and services are included in the hospital all-inclusive rate:

1. Bed and board: The cost of bed, board, meals and dietary service in "semi-private" (two to four beds per room) accommodations.

i. Private accommodations: Should the patient or the hospital, for whatever reason, decide on patient utilization of a private room, the payment of additional charges resulting from the occupancy of such room shall not be authorized.

2. Special facilities: Use of the operating room, recovery room, intensive care unit, and coronary care unit, etc., including their respective facilities and equipment;

3. Medical supplies: Therapeutic solutions, all types of anesthetics, oxygen, serums, dressings, bandages, and plaster casts;

4. Medications: Drugs and medications supplied during the period of hospitalization;

5. Restorative services: Physical, occupational or speech therapy;

6. Radiology services: Therapeutic or diagnostic service;

7. Inhalation therapy services;

8. Laboratory services: Clinical and pathological laboratory services;

9. Other services: Any service not specifically excluded under (d) below.

(d) Expenses not covered: The MWD shall not authorize payments for any of the following:

1. Services rendered in a nonapproved hospital.

2. Rest cures and other care: Hospital services, in whole or in part incurred for the purposes of obtaining bed rest or a rest cure; cosmetic surgery not incidental to accidental injury; and convalescent, custodial, or sanatorium care.

3. Miscellaneous expenses: Private duty nursing; services and supplies not directly related to the care of the patient (for example, guest meals and accommodations, travel expense, TV and telephone charges, take-home supplies, and so forth); and all charges incurred during temporary absence of the patient from the hospital premises prior to actual discharge from the hospital.

4. Services covered under other laws or appropriations: Hospital services to the full extent, if any, that are covered under any foreign, Federal, or State law (other than the New Jersey General Assistance Law) or by county appropriations. The amount to which the patient is entitled, when identifiable, whether or not he or she asserts right to that coverage, shall be deducted from the total amount incurred for hospitalization and the remainder, if any, may be paid.

i. Hospital services paid for by the municipality with money appropriated by any foreign, Federal, State, or county government and paid to the municipality either directly or indirectly shall not be considered as a General Assistance program expense.

5. Employment related injury or disease: Hospital services for the treatment of any condition, disease, ailment, or accidental injury stemming from or incurred in the course of employment, for which benefits (in whole or in part) are payable under the provisions of any Workmen's Compensation Law, Temporary Disability Benefits Law, Occupational Disease Law, or similar foreign, Federal, or State law. It makes no difference whether a person actually receives benefits for hospital services under any of the aforementioned laws, nor does it matter whether any recovery is made by the patient against a third party for damages resulting from such condition, disease, ailment, or accidental injury.

6. Otherwise collectable costs: Hospital services to the extent, if any, that they are or may be collectable by the hospital or by the patient through civil suit against a third party.

7. Services covered by health insurance: Hospital services to the extent, if any, that such costs are or may be payable under a policy which insures the patient.

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i. Medicare program: Persons eligible for Medicare benefits must have health services billed to the appropriate carrier (Prudential Insurance Company or Hospital Service Plan, Blue Cross of New Jersey) by the provider before submitting bills to the MWD for consideration. The amount of the Medicare deductible may be paid by the MWD.

ii. Any benefits which are or may be provided through no-fault insurance.

iii. Any benefits provided through the Medical Assistance Program (Medicaid) of the State of New Jersey or any other state.

8. Death benefits (life insurance): Hospital services to persons who subsequently die and have life insurance, death benefits, or estate assets sufficient to cover burial and hospitalization.

9. Routine physical examinations: Hospital services for research studies, screening, routine physical examinations or any examination not incident to or necessary for the diagnosis and/or treatment of an illness or injury.

(e) Out-of-state hospitalization: In cases where the type of treatment required is not available in a New Jersey hospital or in which a hospital beyond State borders is more accessible to the patient, the director may authorize payment for hospital services to the same extent authorized under the provisions of (a) through (d) above. Payment shall not exceed the appropriate Blue Cross or Medicaid rate, whichever is less.

(f) Payment for hospitalization: Upon certification of hospitalization, the director of welfare shall approve payment as approved by the DEA/GAP Unit which shall cover all items listed in (c) above.

1. Method of payment: Payment shall be made directly to the hospital by the municipal department of welfare from the Public Assistance Trust Fund Account.

2. Amount of payment: Payment for hospital services by the municipal department of welfare shall be at the Diagnosis Related Group (DRG) rate if such a rate is applicable. The MWD shall submit all inpatient hospital bills to the DEA/GAP Unit for costing before making payments. If a DRG rate is not applicable, payment shall be authorized at the least of the following:

i. The current Medicaid rate, future retroactive changes notwithstanding;

ii. The current Blue Cross all-inclusive per diem rate, future retroactive changes notwithstanding;

iii. A rate not in excess of actual charges which has been negotiated between the MWD and the hospital.

3. Reporting requirements: Each month the municipal director of welfare shall submit Form GA-6 (Report of Assistance Commitments) to the Division of Economic Assistance, recording actual payments to hospitals for inpatient care made from the Public Assistance Trust Fund Account. Starting July 1, 1988, State Aid matching will be available for the payment of inpatient hospital bills for a period not to exceed six months from the date in which the General Assistance Program (GAP) Unit approval is granted. Payments made after six months from the approval date will be denied General Assistance State Aid matching unless an extension for good cause has been granted. Written requests for extension may be directed to the DEA.

i. Date of submission of form: Form GA-6 shall be submitted by the 10th of the month following the month for which activity is being reported.]

10:85-[5.3]**5.1** [Other medical payments] **Medical service payment**

(a) The director of welfare shall authorize payment for medical care and professional practitioner services if such care and services are deemed necessary and appropriate and, for services rendered after July 1, 1988, if the bill for each such service reaches the municipal welfare office within one year after the date of the service. For services rendered after July 1, 1991, the bill for each such service must reach the municipal welfare office within six months after the date of the service. **The MWD may seek the advice of the Division of Family Development (DFD) GAP Unit in determining whether particular elements or programs of care or service are necessary and appropriate.**

1. In no instance will the rate exceed that payable under the Medicaid Program. Only services covered by the Medicaid Program shall be authorized under this program for payment.

i. Payment of medical bills which is or may be paid from any benefits provided through the Medical Assistance Program (Medicaid) of the State of New Jersey or any other state shall not be authorized.

2. Medical bills, which have been paid by the client or on his or her behalf, are not subject to reimbursement by the MWD.

3. In the event that payment is obtained from a third party by or for any client for whom the MWD has made medical payments, the welfare agency shall seek recovery of such payment from the beneficiary.

[1.]**4.** The director of welfare may authorize payment of [Blue Cross or] other medical insurance premiums.

5. Persons eligible for Medicare benefits must have health services billed to the appropriate carrier (Pennsylvania Blue Cross/Blue Shield) by the provider before submitting bills to the MWD for consideration. The amount of the Medicare deductible may be paid by the MWD.

6. Payment for medical bills which are or may be paid through no-fault insurance benefits shall not be authorized.

(b) (No change.)

[(c) Outpatient facility services are as follows:

1. Hospital emergency room: The director of welfare shall authorize payment at the rate regularly charged by the hospital or a lesser rate if such has been negotiated between the MWD and the hospital.

2. Hospital clinics: The director of welfare shall authorize payment at the rate regularly charged by the hospital or a lesser rate if such has been negotiated between the MWD and the hospital.]

[3.]**(c)** (No change in text.)

[4.]**(d)** Mental health services: For all mental health services, the payment shall be deemed to cover all services of the provider. It does not cover prescription costs. If the MWD has negotiated a rate with the mental health agency or provider which is no higher than the rate which would otherwise be payable and which takes into account any funding by the municipality or county, that rate shall be used for all participants receiving services from that provider. In all other instances, [payment to hospital-based mental health facilities shall be at the rate regularly charged and] payment to [all] other providers shall be at the Medicaid rate.

[i.]**1.** (No change in text.)

[(1)]**i.** (No change in text.)

Recodify (A) through (C) as **(1) through (3)** (No change in text.)

[(2)]**ii.** (No change in text.)

[(3)]**iii.** (No change in text.)

Recodify (A) through (B) as **(1) through (2)** (No change in text.)

[(4)]**iv.** Service periods are as follows:

[(A)]**(1)** The MWD will not authorize payment for any services rendered more than five days prior to notice (see [(c)4i(3)(A)] **(d)1iii(1)** above) nor more than 30 days prior to submittal of Form FD-07 (see [(c)4i(3)(B)] **(d)1iii(2)** above).

[(B)]**(2)** (No change in text.)

[ii.]**2.** [Other] **Payment for other** mental health services [are] **is** as follows:

[(1)]**i.** Mental health clinics: **Payment shall be authorized as described in (d) above for an initial period of 30 days or until receipt by the MWD of a completed Medicaid Form FD-07, whichever occurs first. The MWD will record receipt of the form and forward it promptly to the DFD/GAP Unit. The DFD/GAP Unit will return the form indicating any further services which are approved. For services beyond the initial period, payment shall be authorized only for services approved by the DFD/GAP Unit.**

[(A) For hospital-based mental health clinics, payment shall be authorized as described in (c)4 above.

(B) For all other clinics, payment shall be authorized as described in (c)4 above for an initial period of 30 days or until receipt by the MWD of a completed Medicaid Form FD-07, whichever occurs first. The MWD will record receipt of the form and forward it promptly to the DEA/GAP Unit. The DEA/GAP Unit will return

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the form indicating any further services which are approved. For services beyond the initial period, payment shall be authorized only for services approved by the DEA/GAP Unit.]

[(2)]**ii.** Private practitioners: If no local clinic offers services which are necessary, the MWD shall authorize payment to a private psychologist or psychiatrist in accordance with the provisions and limitations specified in [(c)4ii(1)(B)] **(d)2i** above [for clinics which are not hospital-based].

[(3)]**(1)** (No change in text.)

[(d)]**(e)** (No change in text.)

[(e)]**(f)** Care [for the chronically ill] **of individuals in long term care facilities**: The director of welfare shall authorize payments for patient care and **allow for** a personal [incidental] **needs** allowance **(PNA)** in a skilled nursing home or intermediate care facility when a physician certifies that a client has a defect, disease, or impairment (other than psychosis) which necessitates such care, the client is not eligible for Medicaid, and there is no person available who will provide such care without cost to the client. **In the event that a person who is determined ineligible for Medicaid Only benefits by the county welfare agency applies promptly, and is found eligible for GA, payment of eligible medical expenses shall be made retroactive to the date of application for Medicaid Only.**

1. Physician certification (completion of GA-18): Physician certification shall be accomplished by means of Form GA-18, Certification of Need for Patient Care in Facility Other than Public or Private General Hospital. This form shall be completed in duplicate, by the attending, or staff physician and the operator or superintendent of the appropriate facility. One copy shall be submitted to the DFD/GAP Unit for level-of-care determination and subsequently, filed in the case record and the other copy shall be retained by the nursing home or institution.

[i. Physician recertification by means of a new Form GA-18 shall be completed annually.]

2. Maximum fees: Payment to the facility shall not exceed the rates for such facility as established by Medicaid or, for non-Medicaid facilities, by the DFD/GAP Unit. The MWD [may] **shall** contact the DFD/GAP Unit to obtain the per diem rate for room, board and nursing care. A personal [incidental] **needs** allowance of $35.00 per month shall be allowed to the patient.

i.-iii. (No change.)

[(f)]**(g)** The director of welfare shall authorize payment for physical, occupational, or speech therapy under the conditions and in the amounts indicated in [(f)] **(g)**1 through 2 below.

1.-2. (No change.)

Recodify (g) through (h) as **(h) through (i)** (No change in text.)

[(i)]**(j)** [Resident] **Residential** treatment for drug or alcohol abuse: When the director of welfare authorizes **the GA grant,** payments for room and board **shall be made by the client**, and [personal incidentals] **a PNA** in amounts as specified in N.J.A.C. 10:85-3.3(f)4iv[, the] **shall be retained by the client. The** payment **for room and board by the GA client** shall be considered as inclusive of all goods and services.

1. (No change.)

10:85-[5.4]**5.2** Procedure for payment of medical bills

(a)-(b) (No change.)

[(c) Retroactive medical eligibility: In the event that a person who is determined ineligible for Medicaid Only benefits by the county welfare agency applies promptly and is found eligible for General Assistance, payment of medical expenses shall be made retroactive to the date of application for Medicaid Only.]

10:85-[5.5]**5.3** (No change in text.)

10:85-[5.6]**5.4** Medical care for recipients with chronic renal failure

(a) Most patients with chronic renal failure requiring dialysis or transplantation are eligible for Medicare coverage the first day of the third month following the first dialysis treatment, or immediately upon hospitalization for transplantation. Medicare provides payment for the hospitalization. Medicare Part B shall be purchased to provide payment for 80 percent of the cost of outpatient care, including dialysis treatment. Drugs not prescribed as part of the dialysis treatment are not eligible for payment by Medicare.

1. (No change.)

2. MWD responsibility: When utilization of benefits from other sources leaves a medical cost deficit, the municipal welfare director will determine eligibility [for hospitalization payment through General Assistance, if needed, in accordance with N.J.A.C. 10:85-5.2. The MWD will determine eligibility for payment] for other medical costs, if needed, in accordance with N.J.A.C. 10:85-[5.3] **5.1** with due regard for the medically needy provisions of N.J.A.C. 10:85-3.3(g)1. Maximum fees will be determined by the DFD/GAP Unit in accordance with N.J.A.C. 10:85-[5.3(b)1] **5.1(b)1**.

i. (No change.)

10:85-[5.7]**5.5** (No change in text.)

10:85-[5.8]**5.6** Pharmaceutical payments through DMAHS

(a) Prescription bills, except for medical supplies and equipment, incurred on behalf of recipients in [certain] **all** municipalities [will] **shall** be processed through the New Jersey Division of Medical Assistance and Health Services (DMAHS).

(b) A General Assistance recipient who requires a pharmaceutical product will take [his/her] **his or her** prescription to a Medicaid participating pharmacy. The pharmacist will procure [an] authorization [number] **from the MWD** (see (d) below), complete [Form MC-24] **Form MC-6**, and supply the product. Payment will be as provided in (e) below.

(c) [Form MC-24, GA prescription claim form: Each MWD will maintain in a secure location a supply of Form MC-24. Forms are available from the Bureau of Management Services, Division of Economic Assistance. The MWD will enter its four-digit municipality code in the first four of the 10 blocks over "Patient's First Name" on each form upon receipt and record the receipt of the serially numbered forms on a MC-24 Record Log (Form GA-20). In cases which cover the needs of more than one person, the "Person No." blocks on the MC-24 Form must be completed. The number 01 shall apply to adult males; 02 to adult females; the numbers 20, 21, 22, etc. shall apply to children. All person numbers must be recorded by the MWD to ensure that the assigned numbers are applied consistently to the same individual. The MWD will supply forms without charge to pharmacies which provide services to GA recipients, recording on a separate MC-24 Control Log (Form GA-20A), the serial numbers of forms supplied to each pharmacy.] **All GA pharmaceutical claims shall be processed via Form MC-6 or any other system utilized by the participating pharmacies. Supplies of the MC-6 claim form are provided to the pharmacies by the Unisys Corporation.**

(d) [Participating pharmacies have been instructed to obtain an authorization number before dispensing a product to a GA recipient. This is a 10-digit number, the first four of which were entered by the MWD. The last six digits are those of the agency-assigned case number preceded by zeroes, if necessary, to fill all spaces. Pharmacies may obtain the last part of the number through either one or a combination of the following two ways at the option of the agency:] **It should be noted that in all instances the "Person No." block on the claim form shall be completed with a code of "01." Each MWD shall provide, in writing, its unique four-digit identification number to each participating pharmacy. In addition, each MWD shall be required to provide the pharmacy with verification that a particular individual is an active GA recipient and has an agency assigned case number. The pharmacy shall require the MWD to provide a six-digit case number in order to process the claim. If a client's case number has less than six digits, the MWD shall add zeros in front of the case number to exact the required six-digit case number. The MWD shall provide the above information to the pharmacies through either one or a combination of the following:**

1. The pharmacy will contact a MWD representative by telephone prior to dispensing the prescription. [The person providing the authorization (which includes provision of the four-digit municipality code and six-digit (maximum) case number) shall record the date of authorization, the recipient's name and case number, and his/her

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own name as the official authorizing the service next to the applicable MC-24 serial number on the Form GA-20A maintained for that pharmacy.] Agencies using this method only must maintain procedures whereby pharmacies can obtain authorizations outside of agency business hours.

2. The recipient presents a current validation card **or letter issued by the MWD** to the pharmacist who completes the transaction without additional contact with the agency. Agencies using this method must supply a card **or letter** to each recipient at each opening or reopening of a case and at least monthly thereafter with dates [such as] to ensure validity throughout all periods of assistance eligibility. [With this method, the agency will complete the GA-20A record, except for the name of the official authorizing service and date authorization was provided, upon receipt of the detailed statement provided by Blue Cross (see N.J.A.C. 10:85-6.8(b)).] The size and layout of the validation card **or the letter** are optional with the agency. Each card **or letter** must contain as a minimum:

i. Name, address, phone number and four-digit municipality code of the agency[.];

ii. First and last name(s) of client(s) for whom card **or letter** applies[.];

iii. **The required** [Six] **six**-digit [(maximum)] case number[.] **(see (d) above);**

iv. Expiration date[.];

v. Notice to client as follows: This validation form indicates eligibility for General Assistance benefits and is to be presented to the pharmacist when having a prescription filled[.];

vi. Notice to pharmacist as follows: Please complete [MC-24 (green) General Assistance Prescription Claim Form] **Form MC-6** according to Medicaid policies and procedures and forward to [Blue Cross] **the Unisys Corporation** for payment.

(e) The MWD will make no payment directly to a pharmacy for any prescription charge other than those for medical supplies or equipment. Payment at the Medicaid rate will be made by [Blue Cross] **the Unisys Corporation** and reported and charged as described in N.J.A.C. 10:85-6.8(d).

10:85-6.8 Pharmaceutical payments

(a) The provisions of this section apply [only] to [those] **all** municipalities [in which certain] **concerning** pharmacy charges [are] paid by [Blue Cross] **the Unisys Corporation** as described in N.J.A.C. 10:85-[5.8] **5.6**.

(b) Each month [Blue Cross] **the Unisys Corporation** will provide to **the Division of Family Development (DFD), Bureau of Business Services (BBS)**, through DMAHS, a [detailed statement] **computer printout** of pharmacy bills paid for General Assistance recipients. The [DFD] **BBS** will forward this [report] **printout** to the respective municipal welfare departments. The monthly [statement] **printout** will show:

Municipal Code	Amount dispensed
Provider (Medicaid I.D. No.)	Number of days supply
Sequential claim No.	Prescription (Rx) No.
Recipient No.	Individual Medicaid
National Drug Co.	Practitioner (IMP) No.
Name of Drug	Date of Service
Metric quantity	Amount paid

1. Upon receipt of [its statement] **the computer printout** each month the MWD [will reconcile it with the GA-20A forms maintained for the various pharmacies] **shall be responsible to check the printout to determine if all claims charged to the municipality are for eligible GA recipients. All identified errors shall be highlighted and the MWD shall provide a copy of the highlighted printout to the BBS.** Payments may be recorded in individual case records if desired.

[i. MWDs giving authorization via telephone only, will have completed all columns of Form GA-20A at the time authorization is given.

ii. MWDs using an identification card system only, will at this time complete each GA-20A, except the columns for "Official Authorizing the Service" and "Authorization Date".

iii. MWDs using a combination of these systems will have completed all columns on the GA-20A for prescriptions authorized via telephone, but must at this time complete the GA-20A as in (b) above for all authorizations made via identification card.]

2. [Monthly statements] **Computer printouts** shall be retained for the same periods applicable to Form GA-6.

(c) The [monthly statement will] **computer printout shall** serve as a supplementary Form GA-6. It will therefore be unnecessary to transfer the [statement] **printout** listings to a regular Form GA-6. However, because the Bureau of Business Services will have retained a copy for charging purposes, it will be necessary to notify that bureau of any adjustments made in the reconciliation process **(see (b)1 above)**.

(d) Periodically, the administrative costs of processing the [MC-24] **MC-6** forms up to that time will either be billed to or deducted from payments of State aid to the respective municipalities.

1. For municipalities that maintain a zero balance Public Assistance Trust Fund II Account, a check shall be drawn from the municipal account used for administrative expenses and made payable to the Public Assistance Trust Fund II Account for the total amount billed the municipality for the processing of each Form [MC-24] **MC-6**, the prescription processing form. The amount of the check must be recorded on GA-12, Statement of Refunds, as administrative costs of the pharmaceutical (Rx) program (abbreviate as "Admin Rx Pgm").

2. For municipalities that receive [either monthly or] quarterly advance payments of State aid for deposit into the municipality's Public Assistance Trust Fund II Account, the total amount of the administrative costs of processing the [MC-24] **MC-6** forms will be deducted from one State aid advance payment. Therefore, a check shall be drawn on the municipal account used for the payment of administrative expenses, made payable and deposited to the Public Assistance Trust Fund II Account, and recorded as a refund on Form GA-12, Statement of Refunds, to the Public Assistance Trust Fund II Account for "Admin RX Pgm."

10:85-7.2 Notices to applicants or recipients

(a) (No change.)

(b) Exceptions to timely notice are:

1. (No change.)

2. Time-limited assistance: When it is mutually understood between the applicant and the MWD that assistance is requested for and will be granted to cover only a limited period of time, or is limited to a specific purpose or an emergency grant (see N.J.A.C. 10:85-4.2(a)4 and 5) or when other circumstances warrant the MWD to grant assistance to cover a limited period of time, the MWD will send a time-limited notice promptly when such assistance is granted. No further notice will be required.

i. Employable GA recipients shall be notified of the expiration date of their time-limited, six-month period of eligibility for receipt of assistance benefits (see N.J.A.C. 10:85-3.1(a)6) via Form GA-33C (Time-limited Benefit Period Expiration Notice for General Assistance Employables), incorporated herein by reference as Appendix D, Exhibit 2.

(1) The MWD shall send Form GA-33C to the employable client the month prior to the month in which the time-limited period of eligibility expires.

(2) If, due to intermittent periods of GA eligibility throughout a State fiscal year, Form GA-33C cannot be provided in accordance with (b)2i(1) above, the MWD shall send Form GA-33C to the employable client no later than 10 calendar days prior to the end of the month in which the time-limited period of eligibility actually expires.

[i.]**ii.** [The] **All** time-limited [notice] **notices** shall include information regarding the client's right to appeal (see [paragraph] (c)2 [of this section] **below**).

(c) (No change.)

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APPENDIX D
Exhibit 1

GA-26
(New 7/92)

ALIEN VERIFICATION REQUEST FORM

MUNICIPALITY #_____ PHONE #_____ FAX #_____
(If applicable)

Client Name	Date of Application	"A" Number	Requested By (GA Staff)

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APPENDIX D
Exhibit 2

GA-33C
(New 7/92)

AGENCY LETTERHEAD

TIME-LIMITED BENEFIT PERIOD EXPIRATION NOTICE FOR GENERAL ASSISTANCE EMPLOYABLES FOR STATE FISCAL YEAR (SFY): July 1, 1992-June 30, 1993

TO: _____ CASE NO.:_____

_____ DATE MAILED:_____

_____

IMPORTANTE: ESTA ES UNA NOTICIA IMPORTANTE. SI USTED NO ENTIENDE LA INFORMACIÓN CONTENIDA EN ESTA NOTICIA O NO LEE INGLÉS, PÓNGASE EN CONTACTO CON UN REPRESENTANTE DEL DEPARTAMENTO DE BIENESTAR PÚBLICO DEL MUNICIPIO.

IMPORTANT: The information checked below shows action taken on your General Assistance case. If you do not understand, or if you disagree, you should contact your General Assistance worker for an explanation. You also have a right to appeal this matter at a fair hearing. Please read the reverse side of this form which explains fair hearings.

TIME-LIMITED SFY BENEFIT PERIOD. Your specific benefit period for entitlement to General Assistance benefits will end on the last day of _____ for this SFY.
(month/year)

Check one of the blocks below, if applicable:

☐ Your Emergency Assistance (EA) benefits will end as of the above date since such benefits are contingent on continuing GA eligibility.

☐ Your Temporary Rental Assistance (TRA) benefits will end as of the above date since such benefits are contingent on continuing GA eligibility.

If your circumstances change, and due to illness, injury or other incapacity you think that you may be eligible for assistance as an unemployable person, you should come to the municipal welfare department to reapply for benefits.

The reason this action has been taken:

_____

_____

_____

DATE_____ _____ DIRECTOR

_____, MUNICIPAL WELFARE DEPARTMENT

New Jersey Department of Human Services—Division of Family Development

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GA-33C (Reverse)
(New 7/92)

REQUEST FOR A LOCAL HEARING
IF YOU DISAGREE WITH THE ACTION TAKEN REGARDING THE EXPIRATION OF YOUR TIME-LIMITED ELIGIBILITY PERIOD, YOU HAVE THE RIGHT TO REQUEST A LOCAL HEARING BEFORE A MUNICIPAL WELFARE DEPARTMENT REPRESENTATIVE.

TIME LIMITS
A REQUEST FOR A LOCAL HEARING MUST BE MADE WITHIN TEN (10) DAYS OF THE MAILING DATE OF THIS NOTICE. SINCE TIME-LIMITED ASSISTANCE IS BASED ON AVAILABLE FUNDING LEGISLATION, YOU WILL NOT BE ENTITLED TO CONTINUED BENEFITS PENDING THE FINAL HEARING DECISION.

HOW TO REQUEST A LOCAL HEARING
IF YOU WISH A HEARING, PLEASE CONTACT IN PERSON, BY TELEPHONE OR WRITE THE _____ MUNICIPAL WELFARE DEPARTMENT AT

_____ OR CALL _____.
(Address) (Phone Number)

YOUR RIGHTS
Concerning the hearing, you have the right to:

- Present your own case or have a friend, relative or attorney make the presentation.
- Submit any evidence and/or bring any witnesses that have knowledge of your case.
- Question or challenge any witness or evidence presented by the municipal welfare department.
- Examine at a reasonable time before the date of the hearing, as well as during the hearing, the contents of your file and all the documents and records to be used at the hearing.
- Review a complete and up-to-date copy of the General Assistance Manual.

STATE FAIR HEARINGS
IF YOU WISH TO APPEAL THE LOCAL HEARING DECISION YOU MAY REQUEST A STATE FAIR HEARING WITHIN TEN (10) DAYS OF THE MAILING DATE OF THE LOCAL DECISION. YOU MAY ALSO REQUEST A STATE FAIR HEARING IF THE LOCAL FAIR HEARING IS NOT CONVENED WITHIN FIFTEEN (15) DAYS OF THE DATE OF THE HEARING REQUEST. A WRITTEN REQUEST FOR A STATE FAIR HEARING MUST BE MADE EITHER TO THE MUNICIPAL WELFARE DEPARTMENT (LISTED ABOVE) OR DIRECTLY TO THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF FAMILY DEVELOPMENT, CN 716, TRENTON, NEW JERSEY 08625.

IF YOU WISH FURTHER INFORMATION ON THE FAIR HEARING PROCESS, YOU MAY CALL THE STATE TOLL FREE HOTLINE NUMBER 800-792-9774.

LEGAL SERVICES
You have a right to pursue legal consultation in your area, if you wish.

Legal Services projects are private, nonprofit organizations that are not connected in any way with any local or county welfare agencies or any other government agencies, and they provide free legal services to poor people in most civil matters.

New Jersey Department of Human Services—Division of Family Development

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APPENDIX D
Exhibit 3

GA-53
(New 7/92)

NOTICE OF TIME-LIMITED AVAILABILITY OF GENERAL ASSISTANCE
FOR EMPLOYABLE CLIENTS

This is to advise you that the eligibility period for receipt of assistance benefits for individuals considered to be employable in the General Assistance (GA) program is limited to a maximum cumulative total of any six calendar months in State fiscal year 1993. State fiscal year 1993 is the period of time from July 1, 1992 through June 30, 1993.

In addition, you are further advised that eligibility for Emergency Assistance (EA) or Temporary Rental Assistance (TRA) benefits in the General Assistance program is also limited to a cumulative total of any six calendar months in State fiscal year 1993, since eligibility for such benefits is contingent on your period of eligibility for General Assistance.

The above benefit limitations have been fully explained to me (us) and I (we) understand that since I (we) am considered to be an employable individual(s) in accordance with the provisions of the General Assistance program, assistance benefits afforded to me (us) will be limited to a maximum cumulative total of six calendar months in State fiscal year 1993. I (we) further understand that a notice (Form GA-33C) will be provided to me (us) in the month prior to, or when necessary in the actual month of the expiration of my (our) GA eligibility period.

(Employable GA Client's Signature)	(Date)
(Employable GA Client's Signature)	(Date)
(MWD Representative's Signature)	(Date)

Municipal Welfare Department

(a)

DIVISION OF YOUTH AND FAMILY SERVICES

Social Services Program for Individuals and Families
Personal Needs Allowance: Residential Health Care Facilities and Boarding Homes
Annual Adjustment
Proposed Amendment: N.J.A.C. 10:123-3.4

Authorized By: Alan J. Gibbs, Commissioner, Department of Human Services.
Authority: N.J.S.A. 44:7-87.
Proposal Number: PRN 1992-374.

Submit comments by October 8, 1992 to:
Kathryn A. Clark, Esq.
Administrative Practice Officer
Division of Youth and Family Services
CN 717
Trenton, New Jersey 08625-0717

The agency proposal follows:

Summary

The proposed amendment to N.J.A.C. 10:123-3.4, Amount, sets forth the mechanism for the annual adjustment in the personal needs allowance for certain residents of residential health care facilities and boarding houses. This mechanism is in use currently by the Division of Youth and Family Services. After the adoption of this proposed amendment, the personal needs allowance rate for each new year thereafter will be published as a Public Notice in the New Jersey Register and, additionally, will be publicized by other appropriate means.

Presently, the Division of Youth and Family Services uses the normal rulemaking process of proposal and adoption to effectuate the annual adjustment in the personal needs allowance. This has resulted in the adjustment becoming effective no earlier than the fifth month of each year. To compensate, the Division has pro-rated the full yearly amount of the adjustment over the remaining months of the year, so as to assure the residents the full benefit of any increase. However, some residential health care facility and boarding house operators have raised the issue of whether this pro-ration artificially increases the base amount for the next year's calculation. The Division does not agree with this concern, but to avoid this appearance, and to provide the personal needs allowance to the residents of the residential health care facilities and boarding houses as soon as possible, the formula currently in use for setting the personal needs allowance is being proposed as an amendment to the rules. This will allow the annual adjustment to take place through the publication of a notice in the New Jersey Register, and by other appropriate means of publication.

The amount of the personal needs allowance to be reserved by owners and operators of residential health care facilities and boarding houses, for the use of Supplemental Security Income or General Public Assistance recipient residents, for the year 1992, is $65.00. Any future annual increases will be equal to the percentage of the Federal cost of living increase, rounded to the nearest dollar, in the Federal Supplemental Security Income (SSI) rate (which was this year published at 55 Fed. Reg. 55325 (October 25, 1991)), multiplied by the current year's personal needs allowance.

Social Impact

This mechanism for providing for the annual adjustment in the personal needs allowance will respond to the concern raised by William Abrams, Vice President of the New Jersey Association of Health Care Facilities (see the response to the comment of Mr. Abrams, in the adoption of the 1992 personal needs allowance increase, 24 N.J.R. 1503(a), April 20, 1992). Mr. Abrams expressed his Association's concern over the base that is used for the annual calculation of the PNA increase. The PNA increase usually goes into effect in May of the year, and the aggregate increase for the year is prorated over the remaining eight months of the year. The eight-month base is then used to calculate the increase for the next year, not the non-prorated 12 month base. The Association stated that this causes each annual increase to be inflated.

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The Association suggested that the 12 month base be used, and that the PNA be put into effect on January 1 of each year.

The Division of Youth and Family Services and the Department of Human Services have developed this method for putting the personal needs allowance increase into effect on January 1 of each year, the same date as the Federal cost of living increase in the SSI. This new procedure will be in place for the personal needs allowance increase for the year 1993, and will eliminate the concern identified by Mr. Abrams and the Association.

The annual personal needs allowance adjustment has a beneficial impact on certain residents of residential health care facilities and boarding houses in that it allows those residents who rely on Supplemental Security Income or General Public Assistance to maintain their spending power in equilibrium with the cost of living. The personal needs allowance may be used at the resident's discretion to purchase clothing and incidentals that the residential health care facilities and boarding homes do not provide. The mechanism proposed in these amendments will assure that the residents receive any increase at the earliest possible date.

Economic Impact

The approximately 8,000 residents in over 500 New Jersey residential health care facilities and boarding houses who are eligible to receive a personal needs allowance will benefit by having their spending power adjusted annually, to keep pace with the cost of living. There will be no negative impact on facility owners, since they also will benefit from the annual Federal cost of living adjustment in the Supplemental Security Income rate.

Regulatory Flexibility Statement

The proposed amendment will not result in any increase in the amount or type of reporting, recordkeeping or compliance requirements relating to personal needs allowances. It provides a mechanism for the annual adjustment of the dollar amount of the personal needs allowance for certain residents of residential health care facilities and boarding houses. Fewer than 500 facilities Statewide serve Supplemental Security Income or General Public Assistance residents. It is estimated that the majority of these are small businesses, as defined in N.J.S.A. 52:14B-16 et seq. Mr. William Abrams, on behalf of the New Jersey Association of Health Care Facilities, asked for these amendments following the proposal of the 1992 increase in the personal needs allowance. The proposed amendments are in response to Mr. Abrams' comments, and are not expected to have any adverse or additional economic impact on these facilities or on any small businesses, as the term is defined in N.J.S.A. 52:14B-16 et seq., the Regulatory Flexibility Act.

Full text of the proposal follows (additions indicated in boldface **thus**):

10:123-3.4 Amount

(a) The owner or operator of each residential health care facility or boarding home shall reserve to each Supplemental Security Income recipient residing therein, and the owner or operator of each residential health care facility shall reserve to each General Public Assistance recipient residing therein, a personal needs allowance in the amount of at least $65.00 per month. **The amount of the personal needs allowance shall be adjusted annually according to the provisions of (b) below, and noticed in the New Jersey Register and otherwise publicized, in accordance with the provisions of (c) below.** No owner or operator or agency thereof shall interfere with the recipient's retention, use, or control of the personal needs allowance.

(b) The personal needs allowance shall be adjusted annually by multiplying the percentage figure of the cost of living increase in the Federal Supplemental Security Income rate, as published in the Federal Register in or about October of each year, by the current personal needs allowance (see (c) below), rounded up or down to the nearest dollar.

(c) The personal needs allowance for each calendar year set forth in (a) above shall be revised through a notice of administrative correction in the New Jersey Register on or about January 1 of that year, and shall be considered the current personal needs allowance for that calendar year. Additional notice of the revision shall be provided in at least three newspapers of general circulation in the State of New Jersey before January 1 of that year, and by other means reasonably calculated to inform those persons most likely to be affected by or interested in the personal needs allowance increase for that calendar year.

(a)

DIVISION OF YOUTH AND FAMILY SERVICES

Manual of Standards for Children's Shelter Facilities and Homes

Proposed Readoption: N.J.A.C. 10:124

Authorized By: Alan J. Gibbs, Commissioner, Department of Human Services.

Authority: N.J.S.A. 30:1-14 and 15, 30:4C-4, 2A:4A-37 and 2A:4A-20 et seq.

Proposal Number: PRN 1992-371.

Submit comments in writing by October 8, 1992 to:
Richard Crane, Acting Chief
Bureau of Licensing
Division of Youth and Family Services
CN 717
Trenton, New Jersey 08625

The agency proposal follows:

Summary

Pursuant to Executive Order No. 66(1978), N.J.A.C. 10:124, the Manual of Standards for Children's Shelter Facilities and Homes, expires on December 7, 1992. The Department of Human Services and the Division of Youth and Family Services have reviewed these rules and have determined them to be necessary, reasonable, and proper for the purpose to which they were originally promulgated. The Department proposes to readopt these rules without change. During the last five years, the Division has used these rules without amendment. While the rules have effectively served the Division during that time, an evaluation, in cooperation with the regulated public and other interested parties, will be undertaken.

Pursuant to N.J.S.A. 30:1-14 and 15, 30:4C-4, 2A:4A-37, and 2A:4A-20 et seq., the Department of Human Services is authorized to inspect, evaluate and approve publicly and privately operated shelter facilities and/or homes that provide services to children under 18 years of age who are abused, abandoned, dependent, neglected, in need of temporary emergency care, are runaways or charged as juvenile delinquents.

Subchapter 1 (N.J.A.C. 10:124-1) cites the legal authority of the rules (N.J.A.C. 10:124-1.1), defines the terms used in this chapter (N.J.A.C. 10:124-1.2), identifies the population of children served in the shelter facilities and homes (N.J.A.C. 10:124-1.3), specifies the capacities and locations of shelter facilities and homes (N.J.A.C. 10:124-1.4), outlines the approval requirements (N.J.A.C. 10:124-1.5), notes the administrative hearings process (N.J.A.C. 10:124-1.6) and specifies the rules for public access to the Division's records for shelter facilities and homes (N.J.A.C. 10:124-1.7).

Subchapter 2 (N.J.A.C. 10:124-2) requires that a shelter facility or home maintain a written statement of purpose (N.J.A.C. 10:124-2.1), describes the intake and admission procedures a shelter facility or home must follow (N.J.A.C. 10:124-2.2), delineates the reporting requirements when there are fires, closings, injuries, legal actions and changes in staffing (N.J.A.C. 10:124-2.3) and outlines the records that must be maintained (N.J.A.C. 10:124-2.4).

Subchapter 3 (N.J.A.C. 10:124-3) deals with staffing requirements, including: basic information that must be maintained on staff members (N.J.A.C. 10:124-3.1), health requirements for staff (N.J.A.C. 10:124-3.2), qualifications that shelter facility staff must meet (N.J.A.C. 10:124-3.3), qualifications for the shelter home coordinator and shelter home parent (N.J.A.C. 10:124-3.4), staff to child ratios that shelter facilities must meet (N.J.A.C. 10:124-3.5), requirements for staff development and evaluation for shelter facilities (N.J.A.C. 10:124-3.6) and requirements for governing body/citizens board for shelter facilities (N.J.A.C. 10:124-3.7).

Subchapter 4 (N.J.A.C. 10:124-4) outlines the various program requirements including: the health requirements/services for children (N.J.A.C. 10:124-4.1), rules that address the child's clothing and personal belongings needs (N.J.A.C. 10:124-4.2), food and nutrition requirements (N.J.A.C. 10:124-4.3), the requirements for rest, bedroom and sleep (N.J.A.C. 10:124-4.4), education requirements that ensure that children

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receive appropriate education services (N.J.A.C. 10:124-4.5), social services requirements (N.J.A.C. 10:124-4.6), recreation requirements (N.J.A.C. 10:124-4.7), rules that specify religion requirements (N.J.A.C. 10:124-4.8), rules that govern the work and employment of the children (N.J.A.C. 10:124-4.9), routines and house rules for shelter facilities (N.J.A.C. 10:124-4.10), rules that specify acceptable means of discipline and control (N.J.A.C. 10:124-4.11), the visitation requirements (N.J.A.C. 10:124-4.12), the rules that govern mail and telephone communications (N.J.A.C. 10:124-4.13), the rules that outline the prohibition of firearms and weapons (N.J.A.C. 10:124-4.14) and the rules that address search and seizure with regards to weapons, drugs and contraband.

Subchapter 5 (N.J.A.C. 10:124-5) specifies the physical facility and life-safety requirements for shelter facilities/homes, references the local government physical facility requirements for shelter facilities that are a prerequisite to State approval (N.J.A.C. 10:124-5.1), references the State government physical facility requirements for shelter facilities (N.J.A.C. 10:124-5.2), outlines the State government physical facility requirements for shelter homes (N.J.A.C. 10:124-5.3), specifies the life-safety and maintenance requirements shelter facilities/homes must meet that are not addressed by the State Uniform Construction or Uniform Fire Codes (N.J.A.C. 10:124-5.4) and specifies that the Bureau may require shelter facilities/homes to correct any conditions in the physical plant that endanger the health, safety and well-being of the children served (N.J.A.C. 10:124-5.5).

Subchapter 6 (N.J.A.C. 10:124-6) specifies the transportation requirements, including rules for vehicles used by the shelter facility/home (N.J.A.C. 10:124-6.1), driver requirements (N.J.A.C. 10:124-6.2), safety practices when children are in the vehicles or being discharged from vehicles (N.J.A.C. 10:124-6.3), rules that require the shelter facility to maintain records (N.J.A.C. 10:124-6.4), insurance requirements (N.J.A.C. 10:124-6.5) and special rules that address the transportation of non-ambulatory children (N.J.A.C. 10:124-6.6).

Social Impact

This chapter has provided standards for shelter facilities and homes which serve children under 18 years of age who are experiencing crises in their families, such as abuse, abandonment or neglect, or who are in need of temporary emergency care, are runaway, or are charged as juvenile delinquents. During the past year, an average of 2,985 children in crisis situations were served and 1,485 were served as a result of runaway or juvenile delinquent behavior, for a total of approximately 4,500 served in one year throughout the 31 facilities in the State. The rules set minimum requirements in the areas of administration, staffing, social services, recreation, education, discipline, nutrition, search and seizure, health, life-safety, maintenance and transportation. The readoption of these rules will enable the State of New Jersey to assure the health, safety and well-being of the children who are served in shelter facilities/homes.

Economic Impact

The 31 shelter facilities/homes in New Jersey which are regulated by this chapter are funded by a variety of sources: DYFS, county, private and Federal. The Federal funding is primarily directed to special-purpose programs, while the other sources cover the full range of services. The use of these funds to help children in crisis situations can have a positive long-term economic effect; however, that effect cannot be specifically determined. The Department anticipates that the prevention of a portion of the social and financial cost of incarcerations, hospitalizations, crimes against the general population and other similar situations would create a positive economic impact.

The specific economic impact of these rules upon the facilities regulated cannot be determined exactly, since there are different ways the facilities can comply with the rules, some more expensive than others. Those requirements include staffing, recordkeeping, training, shelter, food, clothing, medical care and environmental/milieu requirements, as well as specification of the rights of the children served. The current impact of the rules will essentially continue unchanged with this readoption.

Regulatory Flexibility Analysis

The proposed readoption will affect approximately 31 facilities which serve children under 18 years of age, as indicated in the Summary. All of these facilities can be considered small businesses, as the term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The facilities are required to meet minimum standards in the areas outlined in the Summary. These standards can be implemented in several ways, some of which may be more economical for small businesses. While per-facility costs cannot be determined, the cost areas include staffing, recordkeeping, training, shelter, food, clothing, medical care and costs associated with the environment/milieu of the facility. Every effort has been made by the Division to accommodate the needs of the service providers; however, the need to protect the children of New Jersey requires that certain minimum standards be maintained. Therefore, no differential requirements based upon business size have been provided in this chapter.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 10:124.

LABOR
(a)

DIVISION OF WORKERS' COMPENSATION
Notice of Extension of Public Comment Period
Investigation of Discrimination Complaints
Appeal Procedures
Proposed Amendment: N.J.A.C. 12:235-9.4

Take notice that the Department of Labor has extended the public comment period for the proposed amendment to N.J.A.C. 12:235-9.4, published in the May 4, 1992 New Jersey Register at 24 N.J.R. 1684(a), from June 3, 1992 in the notice of proposal, to September 28, 1992.

Submit comments, in duplicate, by September 28, 1992 to:

Linda Flores, Special Assistant
External and Regulatory Affairs
Department of Labor
CN 110
Trenton, New Jersey 08625-0110; and

Mark E. Litowitz, Director and Chief Judge
Division of Workers' Compensation
Department of Labor
CN 381
Trenton, New Jersey 08625-0381

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RULE ADOPTIONS

ADMINISTRATIVE LAW

(a)

OFFICE OF ADMINISTRATIVE LAW

Special Hearing Rules
Special Education Program
Adopted New Rules: N.J.A.C. 1:6A-9.2 and 14.4
Adopted Amendments: N.J.A.C. 1:6A-14.1, 18.1 and 18.3
Adopted Repeal: N.J.A.C. 1:6A-18.5

Proposed: June 1, 1992 at 24 N.J.R. 1936(a).
Adopted: July 30, 1992 by Jaynee LaVecchia, Director, Office of Administrative Law.
Filed: July 30, 1992 as R.1992 d.331, **without change.**
Authority: N.J.S.A. 52:14F-5(e), (f) and (g).
Effective Date: September 8, 1992.
Expiration Date: March 19, 1995.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows.

1:6A-9.2 Adjournments
(a) The judge may grant an adjournment at the request of either party. Any adjournment shall be for a specific period of time. When an adjournment is granted, the deadline for a decision will be extended by an amount of time equal to the adjournment.
(b) No adjournment or delay in the scheduling of the hearing shall occur except at the request of a party.

1:6A-14.1 Procedures for Hearing
(a)-(b) (No change.)
Recodify existing (d)-(e) as (c)-(d) (No change in text.)

1:6A-14.4 Transcripts
(a) In addition to any stenographic recording, each hearing shall be sound recorded by tape recording. A parent may receive a copy of the tape recording at no cost by making a request to the Clerk.
(b) Transcripts of any hearing may be obtained pursuant to the procedures in N.J.A.C. 1:1-14.11.

1:6A-18.1 Deadline for decision
Subject to any adjournments pursuant to N.J.A.C. 1:6A-9.2, a written decision shall be issued by the judge and mailed by the Office of Administrative Law no later than 45 days from the date of the hearing request.

1:6A-18.3 Appeal, use of hearing record, obtaining copy of record, and contents of record
(a) (No change.)
(b) A party intending to appeal the administrative law judge's decision or an authorized representative is permitted to use, or may request a certified copy of, any portion or all of the original record of the administrative proceeding, provided a copy remains on file at the Office of Administrative Law. The requesting party shall bear the cost of any necessary reproduction provided, however, that requesting parents shall not be charged or assessed costs. Written requests for this material should be directed to the Clerk, Office of Administrative Law, 185 Washington Street, Newark, New Jersey 07102.
(c) (No change.)

PERSONNEL

(b)

MERIT SYSTEM BOARD

Reinstatement Following Disability Retirement
Adopted Amendments: N.J.A.C. 4A:4-3.7 and 7.10
Adopted New Rule: N.J.A.C. 4A:4-7.12

Proposed: June 15, 1992 at 24 N.J.R. 2107(a).
Adopted: July 28, 1992 by the Merit System Board; Anthony J. Cimino, Commissioner, Department of Personnel.
Filed: August 12, 1992 as R.1992 d.338, **without change.**
Authority: N.J.S.A. 11A:4-1 et seq.
Effective Date: September 8, 1992.
Expiration Date: June 6, 1993.

Summary of Public Comments and Agency Responses:
A public hearing on the proposed amendments and new rule was held on Wednesday, July 8, 1992. Mr. Henry Maurer served as hearing officer. **No comments were received** at that time and no recommendations were made by the hearing officer.
No written comments received.

Full text of the adoption follows.

4A:4-3.7 Priority of eligible lists
(a) (No change.)
(b) Reinstatement of a permanent employee following disability retirement shall have priority over appointment from any eligible list, except a special reemployment list. See N.J.A.C. 4A:4-7.12.

4A:4-7.10 Regular reemployment
(a) (No change.)
(b) Seniority commences as of the date of regular reemployment.

4A:4-7.12 Reinstatement following disability retirement
(a) A permanent employee who has been placed on disability retirement may be reinstated following a determination from the Division of Pensions that the retiree is no longer disabled.
(b) The employee's reinstatement shall have priority over appointment from any eligible list, except a special reemployment list.
(c) Seniority for an employee who is reinstated following a period of disability retirement shall be the aggregate of permanent service in the employee's permanent title prior to retirement and following reinstatement. Seniority shall not be granted for the period of retirement.

HIGHER EDUCATION

(c)

BOARD OF DIRECTORS OF THE EDUCATIONAL OPPORTUNITY FUND

Financial Eligibility for Undergraduate Grants
Adopted Amendment: N.J.A.C. 9:11-1.5

Proposed: May 18, 1992 at 24 N.J.R. 1859(a).
Adopted: August 17, 1992 by the Board of Directors of the Educational Opportunity Fund, Delbert Payne, Chairperson.
Filed: August 17, 1992 as R.1992 d.353, **without change.**
Authority: N.J.S.A. 18A:71-33.
Effective Date: September 8, 1992.
Expiration Date: April 17, 1994.

Summary of Public Comments and Agency Responses:
Comments on the proposed revisions to the Financial Eligibility Criteria were received from Stockton State College.

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COMMENT: Stockton State College supports the eligibility criteria increases proposed as they keep pace with the inflation and acknowledges annual salary increases.

RESPONSE: The Board concurs with Stockton State College's comments.

COMMENT: Stockton State College believes that the proposed language would eliminate an institution's ability to exercise the 10 percent limit for discretionary admission; and, therefore, limit access to this population of students. They also indicated that the establishment of a threshold criterion would automatically limit an institution's ability to consider extenuating circumstances for students who fall above the established threshold, thus denying access.

RESPONSE: Follow-up discussions suggest Stockton misinterpreted the nature and intent of the changes. That, in fact, the changes will not eliminate the 10 percent discretion, or ability to appeal to the Executive Director to exceed this limit. It was pointed out that the purpose of this additional language is not designed to limit access but to provide consistent criteria for discretionary decisions. However, whenever a threshold is established, there will be a student or family who falls just above that line. The regulations continue to provide sufficient avenues for appeal and the consideration of exceptional individual cases.

Full text of the adoption follows.

9:11-1.5 Financial eligibility for undergraduate grants

(a) A dependent student is financially eligible for an initial EOF grant if the gross income of his or her parent(s) or guardian(s) does not exceed the applicable amount set forth below in the EOF Income Eligibility Scale. Where the dependent student's parent(s) or guardian(s) are receiving welfare as the primary means of family support, the student is presumed to be eligible without regard to the amount of primary welfare support.

1. EOF Dependent Student Eligibility Scale:

Applicants With a Household of:	Gross Income (Not to Exceed):
2 persons	$15,480
3	17,970
4	20,460
5	22,950
6	25,440
7	27,930

2. For each additional member of the household, an allowance of $2,490 shall be added to this amount in order to determine eligibility for EOF for the 1992-93 Academic Year. This allowance shall be adjusted annually to reflect changes in the Standard Maintenance Allowance as published by the College Scholarship Service. In addition, the gross income level for each household size also shall be adjusted to reflect the change in the annual Standard Maintenance Allowance.

3. (No change.)

(b)-(c) (No change.)

(d) An independent student is financially eligible for an EOF grant providing his or her gross annual income (including spouse) for the calendar year prior to the academic year for which aid is requested and the calendar year during which aid is received does not exceed the following schedule:

1. $9,610 family size (including student) 1;
2. $12,100 family size (including spouse) 2;
3. $14,590 family size (including spouse) 3;
4. $17,080 family size (including spouse) 4;
5. Add $2,490 for each additional dependent. This amount should be adjusted annually to reflect changes in the Independent Student Allowance as published by the College Scholarship Service.
6. (No change.)

(e) Where there is evidence that strict adherence to the maximum income eligibility cut-offs will not serve the purpose of the EOF Program, the campus EOF director may admit up to a maximum of 10 percent of the annual freshman class under a waiver pursuant to the provisions of this section. Students admitted under this provision must have family incomes that do not exceed 175 percent of the official national poverty threshold as published annually by the Federal Government adjusted to reflect New Jersey's cost of living and meet one of the following criteria:

1. The student attends(ed) a District Factor Group A or B school district as certified by the New Jersey Department of Education.
2. The student has resided in a municipality defined as a "high distress" area. A high distress area, as defined by the New Jersey Office of Management and Budget, is one which, in comparison to the rest of the state, is characterized by old or substandard housing and/or low real estate value, low per capita income, high unemployment, population decline, and a high percentage of residents receiving welfare and other benefits targeted for low-income families.
3. The student has resided in an area of a municipality that is historically populated by low-income families; such an area is commonly known as a "pocket of poverty" as characterized by criteria outlined in (e)2 above.
4. The student has a sibling who was, or is currently, enrolled in an EOF Program.
5. The student (or family) is eligible for government assistance and educational programs targeted toward low-income and disadvantaged populations (TRIO programs, free and reduced breakfast/lunch programs, food stamps) and is a first-generation college student.

(f)-(g) (No change.)

HUMAN SERVICES

(a)

DIVISION OF FAMILY DEVELOPMENT

Assistance Standards Handbook

Division of Youth and Family Services Monthly Foster Care Rates

Adopted Amendment: N.J.A.C. 10:82-4.9

Proposed: June 15, 1992 at 24 N.J.R. 2160(a).

Adopted: August 13, 1992 by William Waldman, Deputy Commissioner, Department of Human Services.

Filed: August 17, 1992 as R.1992 d.340, **without change.**

Authority: N.J.S.A. 44:7-6 and 44:10-3.

Effective Date: September 8, 1992.

Expiration Date: August 24, 1994.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows.

10:82-4.9 Division of Youth and Family Services

(a)-(b) (No change.)

(c) The basic monthly rates for foster care as established by the Division of Youth and Family Services are as follows:

Age	New Base Rate/Child
0-5	$256.00 per month
6-9	$272.00 per month
10-12	$301.00 per month
13 and over	$320.00 per month

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CORRECTIONS

(a)

THE COMMISSIONER
Notice of Administrative Correction
Security and Control
Office of Interstate Services
N.J.A.C. 10A:3-9.11

Take notice that within the Department of Corrections, the Office of Interstate Services has been transferred from the Division of Policy and Planning to the Division of Adult Institutions. By this notice of administrative correction, published pursuant to N.J.A.C. 1:30-2.7, the change is being incorporated into the text of N.J.A.C. 10A:3-9.11(c).

Full text of the corrected rule follows (addition indicated in boldface **thus**; deletions indicated in brackets [thus]):

10A:3-9.11 Office of Interstate Services
(a)-(b) (No change.)
(c) The Office of Interstate Services shall develop specific guidelines governing the transporting of inmates by aircraft. These guidelines shall be approved by the Assistant Commissioner, Division of [Policy and Planning] **Adult Institutions**, prior to implementation. Current Federal Aviation Administration rules applicable to any phase of aircraft use in transporting inmates shall be maintained by **the** Office of Interstate Services.

COMMERCE AND ECONOMIC DEVELOPMENT

(b)

NEW JERSEY DEVELOPMENT AUTHORITY FOR SMALL BUSINESSES, MINORITIES', AND WOMEN'S ENTERPRISES
Direct Loan Program
Loan Guarantee Program
Adopted Amendments: N.J.A.C. 12A:31-1 and 12A:31-2

Proposed: June 15, 1992 at 24 N.J.R. 2131(a).
Adopted: July 21, 1992 by the New Jersey Development Authority for Small Businesses, Minorities', and Women's Enterprises, Jerome C. Harris, Jr., Acting Chair.
Filed: July 29, 1992 as R.1992 d.330, **without change.**
Authority: N.J.S.A. 34:1B-50(t).
Effective Date: September 8, 1992.
Expiration Date: July 16, 1995.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows.

SUBCHAPTER 1. DIRECT LOAN PROGRAM

12A:31-1.1 Applicability and scope
(a)-(b) (No change.)
(c) Applications and questions concerning participation in the program should be directed to:

New Jersey Development Authority for Small
Businesses, Minorities' and Women's Enterprises
200 South Warren Street
CN 990
Trenton, New Jersey 08625

12A:31-1.2 Definitions
The words and terms in this subchapter shall have the following meanings, unless the context clearly indicates otherwise:
...
"Authority" means the New Jersey Development Authority for Small Businesses, Minorities' and Women's Enterprises established pursuant to N.J.S.A. 34:1B-47 et seq., or the staff thereof.
...

12A:31-1.4 Allocation of direct loan assistance
(a)-(b) (No change.)
(c) The Authority may provide direct loans to an eligible business for the purpose of fixed asset acquisition, working capital, or contract financing. The term of the direct loan shall not exceed 15 years. The maximum amount of the loan shall not exceed $1,000,000. The interest rate shall be as described in (e) below.
(d) The Authority may provide one direct loan to an eligible business which applies to the Authority pursuant to N.J.A.C. 12A:31-1.3(d) for the purpose of fixed asset acquisition, working capital, or contract financing. The term of the direct loan shall not exceed six months. The maximum amount of the loan shall not exceed $20,000. The interest rate shall be as described in (e) below.
(e) The interest rate on direct loans shall be equal to:
1. For fixed asset loans, the lower of the Federal Discount Rate at the time of approval or at the time of the loan closing, with a minimum of five percent;
2. For working capital loans and contract financing, the lower of the Federal Discount Rate plus 200 basis points at the time of approval or at the time of the loan closing, with a minimum of five percent.

12A:31-1.6 Evaluation of applications for direct loans
(a) The Authority shall evaluate each application for a direct loan considering the following factors:
1.-5. (No change.)
(b) After evaluation of the application, the Authority shall forward the application to the Loan Review Committee for its consideration.
(c)-(e) (No change.)

12A:31-1.9 Information confidentiality
(a) All records of the Authority such as minutes, annual reports, program guidelines, regulations, applications for financial assistance and other information not classified as nonpublic information shall be deemed public information available for examination and copying upon request. If the above information is requested by the public and is not readily available and must be photocopied or otherwise reproduced by the Authority, the Authority shall charge a fee of $.50 for pages 1 to 10, $.25 for pages 11 to 20 and $.10 for pages 21 and above. The public may obtain general information concerning Authority programs by contacting the New Jersey Development Authority for Small Businesses, Minorities' and Women's Enterprises, CN 990, Trenton, New Jersey 08625.
(b) (No change.)

SUBCHAPTER 2. LOAN GUARANTEE PROGRAM

12A:31-2.1 Applicability and scope
(a)-(b) (No change.)
(c) Applications and questions concerning participation in the program should be directed to:

New Jersey Development Authority for Small
Businesses, Minorities' and Women's Enterprises
200 South Warren Street
CN 990
Trenton, New Jersey 08625

12A:31-2.2 Definitions
The words and terms in this subchapter shall have the following meanings, unless the context clearly indicates otherwise:
...

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"Authority" means the New Jersey Development Authority for Small Businesses, Minorities' and Women's Enterprises established pursuant to N.J.S.A. 34:1B-47 et seq., or the staff thereof.

. . .

12A:31-2.4 Allocation of loan guarantee assistance

(a)-(b) (No change.)

(c) The Authority may provide loan guarantees to an eligible business in the following manners:

1. For the purpose of fixed asset acquisition for an eligible business, the term of the loan guarantee shall not exceed a period of 10 years. The maximum amount of the guarantee shall not exceed $1,000,000 or 90 percent of the loan balance, whichever is less.

2. For the purpose of acquiring working capital for an eligible business, the term of the loan guarantee shall not exceed a period of 10 years. The maximum amount of the guarantee shall not exceed $600,000 or 90 percent of the loan balance, whichever is less.

12A:31-2.6 Evaluation of applications for loan guarantees

(a) The Authority shall evaluate each application for a loan guarantee considering the following factors:

1.-4. (No change.)

(b) After evaluation of the application, the Authority shall forward the application to the Loan Review Committee for their review.

(c)-(e) (No change.)

12A:31-2.9 Information confidentiality

(a) All records of the Authority such as minutes, annual reports, program guidelines, regulations, applications for financial assistance and other information not classified as nonpublic information shall be deemed public information available for examination and copying upon request. If the above information is requested by the public and is not readily available and must be photocopied or otherwise reproduced by the Authority, the Authority shall charge a fee of $.50 for pages 1 to 10, $.25 for pages 11 to 20 and $.10 for pages 21 and above. The public may obtain general information concerning Authority programs by contacting the New Jersey Development Authority for Small Businesses, Minorities' and Women's Enterprises, CN 990, Trenton, New Jersey 08625.

(b) (No change.)

LAW AND PUBLIC SAFETY

(a)

DIVISION OF CONSUMER AFFAIRS
BOARD OF MEDICAL EXAMINERS

Certified Midwife Practice

Adopted Repeal: N.J.A.C. 13:35-2.6 through 2.12
Adopted New Rules: N.J.A.C. 13:35-2A
Adopted Recodification: N.J.A.C. 13:35-2.14 as 13:35-2A.10

Proposed: December 2, 1991 at 23 N.J.R. 3632(a).

Adopted: July 22, 1992 by the Board of Medical Examiners, Sanford Lewis, M.D., President.

Filed: August 6, 1992 as R.1992 d.332, **with substantive changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 45:9-2.

Effective Date: September 8, 1992.

Expiration Date: September 21, 1994.

The Board of Medical Examiners afforded all interested parties an opportunity to comment on the proposed repeal of N.J.A.C. 13:35-2.6 through 2.12, and proposed new rules, N.J.A.C. 13:35-2A, relating to certified midwife practice. The proposed repeal, new rules and recodification were published in the New Jersey Register on December 2, 1991 at 23 N.J.R. 3632(a). The official comment period ended on January 1, 1992. Announcement of the opportunity to respond to the Board was forwarded to the Star Ledger, the Camden Courier Post, the Trenton Times, the Medical Society of New Jersey and 21 county medical societies, the New Jersey Obstetrics and Gynecological Society, the Neurological Society of New Jersey, the Federation of State Medical Boards of the United States, the University of Medicine and Dentistry of New Jersey, the Department of Health of New Jersey, the New Jersey Hospital Association, the New Jersey Association of Osteopathic Physicians and Surgeons, the American College of Nurse Midwives, and a number of certified nurse midwives and other individuals.

A full record of this opportunity to be heard can be inspected by contacting the Board of Medical Examiners, 28 West State Street, Trenton, N.J. 08608.

Summary of Public Comments and Agency Responses:

The following submitted written comments:

Mamie S. Bowers, M.D.
Peter S. Pyatak, M.D.
Corrado J. Altomare, M.D.
Judith Catenacci, CNM
Elaine K. Diegmann, CNM, M.Ed., Program Director, Nurse-Midwifery Program, University of Medicine & Dentistry of New Jersey
Barbara Scanlon, CNM
Ruby P. Huttner, M.D.
Barbara La Brie, CNM
Anthony P. Salerno, M.D.
Marianne DiGiovanni, D.O.
Jennifer K. Nogrady
Wendy Marchesi, CNM
Karen Criss Moniz, CNM, President, New Jersey Chapter ACNM
Abraham Risk, M.D., Chief of OB/GYN, Morristown Memorial Hospital
Diane Kane Erwin, CNM, MSN, Asst. Professor of Clinical Midwifery, UMDNJ
Kathleen A. Latshaw
Gerald S. Barad, M.D.
Irene A. Pedersen, M.D.
Ruth Monchek, CNM, Asst. Professor, UMDNJ/SHRP Nurse Midwifery Program
Mary K. Powderly, M.D., Director, Plainfield Women's Center
Bianca Aniski, CNM
Susan Wiedaseck, CNM
Lonnie C. Morris, CNM, MS, Director, the Childbirth Center
Robert P. Kamrin, M.D., Medical Director, Mercer Medical Center
Gwenne Baile, CNM
Diane Hargis-Reynold, CNM
Laura Martin, CNM
Gary R. Brickner, M.D.
Gigi Bauduin-Morgan
Maria McLaughlin
Merry L. Quick
Christine Todd, CNM
Lee S. Clay, CNM

The Board considered a total of 32 written communications from the persons listed above. Twenty-two of the letters were substantially identical, and expressed enthusiastic support for the proposal, with the general exception of N.J.A.C. 13:35-2A.3(a)3. The letters suggested that this section should be expanded to reflect the legislative authorization in 1991 for certified nurse midwives ("CNM"s) to prescribe drugs. The remaining letters, while equally supportive, addressed other concerns.

In response to comments, three changes from the proposal were made: (1) wording has been added in N.J.A.C. 13:35-2A.3 to clarify that periodic conferences are to take place with the affiliated physician; (2) insulin dependence is now included in the list of medical conditions determining patient classification; and (3) the recently-created American College of Nurse-Midwives Certification Council has been added in N.J.A.C. 13:35-2A.2, since actual certification of successful examinees is now delegated to that body by the American College of Nurse-Midwives.

A summary of the specific issues raised by the commenters, as well as the Board's responses, follows:

COMMENT: N.J.A.C. 13:35-2A.3(a)3 should reflect the provisions of P.L. 1991, c.97, approved April 9, 1991, which Act permits qualified CNMs to prescribe drugs, medicine and devices, as determined by the State Board of Medical Examiners.

RESPONSE: The Board notes that this section does not prohibit CNM prescribing. However, the statute requires the Board to promulgate rules and regulations necessary to carry out the purposes of the Act, and a regulatory proposal directly aimed at CNM prescribing will be published in the near future. It is the Board's expectation that the new regulatory proposal will help clarify the issues concerning CNM prescribing and thereby effectuate the legislative intent underlying P.L. 1991, c.97.

COMMENT: The requirement of N.J.A.C. 13:35-2A.2(a)3 to demonstrate continuing competency may be overly burdensome on certain CNMs engaging in part-time practice.

RESPONSE: The Board is of the opinion that the requirements in N.J.A.C. 13:35-2A.3 are necessary to ensure the public that CNMs

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licensed to practice in this State are qualified to do so. The section in essence adopts the standards of the American College of Nurse Midwives.

COMMENT: Various terms and conditions set forth in the rules need definition or clarification. One commenter suggested that N.J.A.C. 13:35-2A.3(c) and (d) were too vague. A second commenter stated that terms such as "direct supervision," "readily available," and "operative" required clarification.

RESPONSE: The Board, upon review, has determined to add the phrase "with an affiliated physician" to N.J.A.C. 13:35-2A.3(c) in order to make clear that the conferences referred to in the rule are to take place with the affiliated physician. However, the Board does not find that any further clarification is necessary, and it is satisfied that the wording throughout the rules is generally clear and understandable.

COMMENT: One commenter opposed the deletion of the requirement, previously imposed, that CNMs demonstrate a minimum of two years of obstetrical clinical experience.

RESPONSE: The Board believes that by requiring all CNMs in New Jersey to be certified by the American College of Nurse Midwives or the American College of Nurse Midwives Certification Council ("ACC"), the public is adequately protected.

COMMENT: The remaining comments concerned the inclusion or exclusion of certain conditions in Schedule "A" or Schedule "B" patients, under N.J.A.C. 13:35-2A.7(a)4 and 6.

RESPONSE: The Board continues to support these lists of conditions that determine whether a patient shall be classified as Schedule "A" or "B," except that the Board has decided to add insulin dependency as a Schedule "A" (documented problems in maternal medical history) condition. While some commenters suggested that liberalization of certain of the requirements for physician involvement might be appropriate, the Board has attempted to act in a cautious manner in fashioning these regulations in its desire to safeguard the public health, safety and welfare. The Board notes that the list of risk factors set forth in Schedules "A" and "B" will have to be reviewed in any case, with the passage of time and likely changes in medical knowledge and conditions. The Board points out that pursuant to N.J.A.C. 13:35-2A.9, the Certified Nurse Midwive Liaison Committee is to engage in periodic and ongoing review of the categorizations of at-risk patients set forth within N.J.A.C. 13:35-2A.7 and 2A.8.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

SUBCHAPTER 2A. LIMITED LICENSES: CERTIFIED NURSE MIDWIFERY

13:35-2A.1 Certified Nurse Midwife practice

(a) A Certified Nurse Midwife ("CNM") shall mean a registered professional nurse licensed in the State of New Jersey who, by virtue of added knowledge and skill gained through an organized program of study and clinical experience, is qualified to manage the care of women and/or newborns during the antepartum, intrapartum and postpartum periods and to provide well-woman health care as expressly limited and set forth below.

(b) A CNM shall maintain current registration with the Board of Medical Examiners (hereinafter the "Board") in order to discharge those responsibilities set forth in this subchapter.

(c) The CNM shall not work alone (that is, in an individual or independent practice) but shall function within a health care system which provides for consultation, collaborative management and referral with a physician licensed to practice medicine and surgery in the State of New Jersey.

13:35-2A.2 Qualifications

(a) A CNM shall demonstrate the following qualifications in order to be registered by the Board:

1. A diploma from a legally chartered school of nurse midwifery accredited by the American College of Nurse Midwives (hereinafter, the "ACNM");

2. Current registration as a professional nurse in the State of New Jersey;

3. Certification by the ACNM ***or the American College of Nurse Midwives Certification Council (the "ACC")*** and evidence of continuing competency as required by the ACNM; and

4. Proof of age of at least 18 years.

13:35-2A.3 Minimum conditions of practice

(a) The CNM shall establish written agreements with one or more physicians licensed in the State of New Jersey (hereinafter, the "affiliated physician(s)") who practice obstetrics and/or gynecology and who have hospital privileges in obstetrics and/or gynecology. The written agreements shall delineate the scope of practice of the CNM. In no instance, however, may the scope of practice of the CNM in any way exceed the scope of practice of the affiliated physician (as limited by the physician's privileges). All agreements shall include a written protocol setting forth:

1. All procedures and routine orders, including specific tests and treatment regimens, to be performed or provided by the CNM;

2. The circumstances under which consultation, co-management, referral and transfer of care of women and/or newborns between the CNM and the affiliated physician are to take place, and the mechanics by which each is to occur;

3. A list of all medications the CNM may dispense, administer, order and/or prescribe. Under no circumstances may the agreement provide for the use of controlled dangerous substances outside of a licensed hospital except upon prescription of the physician; and

4. A schedule setting forth or a mechanism for determining the availability of the physician (or a designated qualified substitute physician responsible for back-up care) for consultation and emergency assistance or medical management when needed.

(b) The CNM shall file with the Board a notice listing the name(s) and address(es) of the affiliated physician(s) with whom the CNM establishes written agreements and the effective date of the agreement(s) at the time of application for registration with the Board. In the event of any change of physician(s), the CNM shall notify the Board in writing within seven days of the change.

(c) The CNM shall participate in periodic conferences ***with the affiliated physician*** for review of patient records and for quality assurance.

(d) The CNM shall demonstrate a satisfactory peer review by a Peer Review Committee of the ACNM.

(e) The CNM shall function in accordance with the published Standards for the Practice of Nurse-Midwifery of the ACNM.

13:35-2A.4 Normal antepartum management

(a) Certified Nurse Midwife practice during normal antepartum stages shall include, but is not necessarily limited to, the following:

1. The CNM may order medical, therapeutic and diagnostic measures for women not classified as being at risk (see N.J.A.C. 13:35-2A.7) in accordance with the CNM protocol;

2. The CNM may administer, dispense, order and/or prescribe medications provided said medications are included within the list of approved medications in the CNM protocol; and

3. The CNM shall consult, refer or collaborate with the affiliated physician in situations where women present with significant medical problems in accordance with the CNM protocol.

13:35-2A.5 Normal intrapartum management

(a) Certified Nurse Midwife practice during normal intrapartum periods shall include, but is not necessarily limited to, the following:

1. The CNM may manage the labor and delivery of the patient not classified as being at risk (see N.J.A.C. 13:35-2A.8) at any location as long as such management is in accordance with mutually agreed upon protocols that comply with both the published standards of the ACNM and current practice standards. These protocols shall include the medical, therapeutic and diagnostic measures that may be utilized by the CNM;

2. The CNM shall perform immediate screening of the newborn. When necessary, the CNM shall initiate immediate resuscitation of the newborn. In accordance with the written protocol with the affiliated physician, the CNM shall refer problems with the newborn to a physician. When practicing outside the hospital setting, the CNM shall establish a written protocol for transfer of the newborn to a hospital;

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3. When labor and delivery take place at the home, the CNM may use a local anesthetic and may perform and repair episiotomies; and

4. When labor and delivery take place in a licensed health care facility (which may include a licensed birthing center), the CNM may administer and/or order medications in accordance with the mutually agreed upon protocols, may perform and repair episiotomies and may use local or pudendal block anesthesia. Additionally, the CNM may repair third degree lacerations upon the direction of the affiliated physician and fourth degree lacerations under the direct supervision of a plenary-licensed physician who has obstetrical privileges.

13:35-2A.6 Postpartum and well-woman health care

The CNM may provide postpartum care and well-woman health care, which may include family planning, reproductive health care counseling and reproductive systems health care screening. The CNM's participation in periodic well-woman health care shall be in accord with written protocol(s) which shall require the prompt referral of women with medical or gynecological abnormalities to the appropriate physician.

13:35-2A.7 Management of antepartum women at risk

(a) The CNM may participate in the management of antepartum patients at risk under the following conditions:

1. The physician/CNM team shall have both agreed to include the patient at risk in the caseload.

2. The physician/CNM team shall have established a management plan for all patients identified as at risk, which plan shall delineate the role of both the physician and the CNM in the care of the patient. The management plan shall set forth the following:

i. Frequency of physician visits;

ii. Timing of appropriate diagnostic and evaluative procedures;

iii. Parameters for consultation; and

iv. A proposed plan for the delivery, including the type, place and provider.

3. All patients at risk shall be classifed as either Schedule "A" or Schedule "B" patients, in accordance with the schedules set forth in (a)4 and 6 below. The minimum standards of physician participation in the management of the at risk patient shall vary dependent upon whether the patient is classified as Schedule "A" or Schedule "B." The minimum standards of physician participation for Schedule "A" patients are set forth in (a)5 below and for schedule "B" patients in (a)7 below.

4. Patients with the following risk factors shall be deemed to be "Schedule A" patients:

i. Documented problems in maternal medical history:

(1) Acute and/or chronic hypertension;

(2) Congenital or acquired heart disease;

(3) Deep vein thrombosis (current or recent history);

(4) HIV positive, AIDS or AIDS Related Complex;

(5) Renal disease;

(6) Severe urinary tract infection;

(7) Seizure disorder requiring medications; *[or]*

(8) Hemolytic anemia; ***or***

(9) Insulin dependence.

ii. Documented problems in past maternal obstetrical history:

(1) Incompetent cervix;

(2) Two or more second or third trimester fetal losses; or

(3) Preterm delivery; or

iii. Documented problems in present maternal obstetrical history:

(1) Significant uterine myomata;

(2) Hydramnios or oligohydramnios;

(3) Isoimmunization;

(4) Multiple gestation;

(5) Intrauterine growth retardation; or

(6) Current evidence of fetal chromosome or other disorder confirmed by amniocentesis or ultrasound.

5. For all patients classified within Schedule "A", the physician shall be in the office on each patient visit and shall review the care of the patient on each visit. Prior to the Schedule "A" patient's discharge from each scheduled visit, the physician shall review and sign the chart. The physician shall examine the Schedule "A" patient at least once during each trimester and, at that time, the management plan shall be reviewed and revised as necessary by the Physician/CNM team.

6. Patients with the following risk factors shall be deemed to be Schedule "B" patients:

i. Documented problems in maternal medical history:

(1) Drug addiction;

(2) Psychotic episode;

(3) Controlled asthmatics currently on medication; or

(4) Hematologic disease;

ii. Documented problems in past maternal obstetrical history:

(1) Parity of six or more;

(2) Previous cesarean delivery;

(3) Surgery involving the uterine wall;

(4) Previous placental abruption;

(5) Previous significant postpartum hemorrhage; or

(6) Preterm labor; or

iii. Documented problems in present maternal obstetrical history:

(1) Any recent history or visible evidence of genital herpes;

(2) Gestational diabetes;

(3) No prenatal care prior to the 28th week;

(4) Maternal age less than 16 years or more than 35 years; or

(5) Significantly abnormal PAP smear.

7. For all patients classified within Schedule "B", the affiliated physician or his or her designee shall be available for consultation during hours of prenatal visits. The physician shall evaluate the management plan and current status of the Schedule "B" patient at least once each trimester. The plan shall be reviewed and revised as necessary by the physician/CNM team.

8. The patient at risk shall receive all scheduled prenatal care in a licensed ambulatory care clinic, a licensed hospital clinic or a professional office.

13:35-2A.8 Care of intrapartum women at risk

(a) The CNM may participate in the management of labor and delivery of patients in the following circumstances, providing the physician is readily available:

1. Abnormal fetal heart rate tracing responsive to conservative measures;

2. Premature labor at less than 37 weeks, but more than 34 weeks with appropriate pediatric coverage;

3. Premature rupture of membranes more than 24 hours before onset of regular contractions;

4. Failure to progress normally in labor;

5. Assessment of infant less than 2,000 gms or more than 4,000 gms;

6. Vaginal birth after previous cesarean delivery;

7. Soft tissue problems such as severe vulvar varicosities or marked edema of the cervix; or

8. Pitocin infusion.

(b) The CNM may participate in the management of the labor and delivery of patients in the following circumstances, providing the physician is present in the hospital:

1. Development of pregnancy-induced hypertension or signs of preeclampsia;

2. Evidence of active infection;

3. Premature labor at less than 34 weeks; or

4. Significant meconium staining.

(c) Conditions which require immediate physician presence in the delivery suite include, but are not limited to, the following:

1. Abnormal fetal heart rate tracing unresponsive to conservative measures;

2. Prolapse of the cord;

3. Intrapartum hemorrhage;

4. Severe medical/surgical problems;

5. Need for cesarean section/forceps delivery;

6. Multiple gestation;

7. Malpresentation; or

8. Any other condition requiring operative intervention.

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13:35-2A.9 Certified Nurse Midwife Liaison Committee

(a) A Certified Nurse Midwife Liaison Committee shall be established by the Board of Medical Examiners. The Committee shall consist of six members who shall serve as consultants to the Board and who shall be appointed by the Board. The Committee shall include at least three certified nurse midwives and at least two physicians, one of whom shall be a member of the Board of Medical Examiners and one of whom shall be Board-certified by the American Board of Obstetrics and Gynecology. The Committee shall meet no less than four times per year but may meet more frequently as needed.

(b) Functions of the Committee shall include, but are not limited to, the following:

1. Advising and assisting the Board in the evaluation of applicants for certified nurse-midwifery registration, investigation of unlawful conduct and approval of professional training programs;

2. Advising and assisting the Board in establishing a formulary of drugs that may be ordered, administered, dispensed or prescribed by CNMs;

3. Periodic and ongoing review of the appropriateness and viability of all rules concerning CNM practice in the State of New Jersey, specifically to include (but not necessarily limited to) periodic review of the categorizations of at risk patients set forth within N.J.A.C. 13:35-2A.7 and 2A.8. In the event the Committee should determine that any changes in any regulations or in any schedules within said rules are appropriate, the Committee may report said recommendations to the Board and may recommend that the Board seek to revise the rules accordingly; and

4. Ongoing review of CNM practice in the State of New Jersey.

Recodify existing N.J.A.C. 13:35-2.14, Limited privileges and conditions of practice permitted for a graduate nurse midwife pending results of certifying examination and licensure, as N.J.A.C. 13:35-2A.10 (No change in text.)

TRANSPORTATION

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID

BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS

Restricted Stopping and Parking Exception for Religious Services Route U.S. 206 in Mercer County

Adopted Amendment: N.J.A.C. 16:28A-1.57

Proposed: July 6, 1992 at 24 N.J.R. 2342(a).

Adopted: August 7, 1992 by Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.

Filed: August 7, 1992 as R.1992 d.336, **without change.**

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 39:4-138.1 and 39:4-198.

Effective Date: September 8, 1992.

Expiration Date: June 1, 1993.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows.

16:28A-1.57 Route U.S. 206

(a) The certain parts of State highway Route U.S. 206 described in this subsection shall be designated and established as "no stopping or standing" zones. In accordance with the provisions of N.J.S.A. 39:4-198, proper signs must be erected.

1.-6. (No change.)

7. No stopping or standing in Lawrence Township, Mercer County:

i. Along both sides:

(1) 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 approved parking restrictions and during religious services at the following locations:

(A) Along the easterly side between a point 35 feet north of the northerly curb line of Fairfield Avenue to approximately 35 feet south of the southerly curb line of Gedney Road.

(B) Along the easterly side between a point 100 feet north of the northerly curb line of Gordon Avenue to a point 35 feet south of the southerly curb line of Cold Soil Road.

(C) Along the westerly side between a point 35 feet south of the southerly curb line of Manning Lane and a point 100 feet north of the northerly curb line of Gordon Avenue.

8.-16. (No change.)

Recodify 19.-23. as 17.-21. (No change in text.)

(b)-(c) (No change.)

(b)

DIVISION OF CONSTRUCTION AND MAINTENANCE ENGINEERING SUPPORT

BUREAU OF MAINTENANCE SUPPORT

Permits

Adopted New Rules: N.J.A.C. 16:41

Proposed: June 15, 1992 at 24 N.J.R. 2237(a).

Adopted: July 16, 1992 by Kathy Stanwick, Deputy Commissioner, Department of Transportation.

Filed: August 17, 1992 as R.1992 d.341, **without change.**

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 27:1A-7, 27:7A-11 and 27:7A-17.

Effective Date: September 8, 1992.

Expiration Date: September 8, 1997.

Summary of Public Comments and Agency Responses:
No comments received.

N.J.A.C. 16:41 expired on July 28, 1992, in accordance with Executive Order No. 66(1978). Pursuant to N.J.A.C. 1:30-4.4(f), these expired rules are being adopted as new rules.

Full text of the adopted new rules can be found in the New Jersey Administrative Code at N.J.A.C. 16:41.

(c)

DIVISION OF TRANSPORTATION ASSISTANCE OFFICE OF REGULATORY AFFAIRS

Zone of Rate Freedom

Adopted Amendment: N.J.A.C. 16:53D-1.1

Proposed: July 6, 1992 at 24 N.J.R. 2343(a).

Adopted: August 12, 1992, by Kathy A. Stanwick, Deputy Commissioner.

Filed: August 18, 1992 as R.1992 d.355, **without change.**

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 48:2-21 and 48:4-2.20.

Effective Date: September 8, 1992.

Expiration Date: May 3, 1994.

Summary of Public Comments and Agency Responses:
No comments received.

A public hearing was held on July 21, 1992, before Hearing Officer Randye Bloom, Esquire, of the Office of Administrative Law, in the Hearing Room, Office of Administrative Law, 9 Quakerbridge Plaza, Quakerbridge Road, Mercerville, New Jersey 08625. There were no commentators or participation from the public. Ms. Bloom, in her hearing report of August 5, 1992, recommended that proposal N.J.A.C. 16:53D-1.1 be adopted.

Full text of the adoption follows.

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16:53D-1.1 General provisions

(a) Any regular route autobus carrier operating within the State which seeks to revise its rates, fares or charges in effect as of the time of the promulgation of this rule shall not be required to conform with N.J.A.C. 16:51-3.10 (Tariff filings or petitions which do not propose increases in charges to consumers) or N.J.A.C. 16:51-3.11 (Tariff filings or petitions which propose increases in charges to customers) provided the increase or decrease in the rate, fare or charge, or the aggregate of increases and decreases in any single rate, fare or charge is not more than the maximum percentage increase or decrease as promulgated below upgraded to the nearest $.05.

1. The following chart sets forth the 1993 percentage maximum for increases to particular rates, fares or charges and the resultant amount as upgraded to the nearest $.05:

Present Fare	% Of Increase	Increase Upgraded To Nearest $.05
$1.10 or less	4.5%	$.05
$1.15-$2.20	4.5%	$.10
$2.25-$3.30	4.5%	$.15
$3.35 upward	4.5%	$.20+

2. The following chart sets forth the 1993 percentage maximum for decrease to particular rates, fares or charges and the resultant amount as upgraded to the nearest $.05:

Present Fare	% Of Decrease	Decrease Upgraded To Nearest $.05
$ .50 or less	10%	$.05
$ .55-$1.00	10%	$.10
$1.05 upward	10%	$.15+

TREASURY-GENERAL

(a)

OFFICE OF THE STATE TREASURER

Lottery Prize Offset for Child Support and Public Assistance Payments

Adopted New Rules: N.J.A.C. 17:42

Proposed: July 6, 1992 at 24 N.J.R. 2343(b).
Adopted: August 10, 1992 by Samuel Crane, State Treasurer.
Filed: August 11, 1992 as R.1992 d.337, **without change.**

Authority: N.J.S.A. 5:9-13.1 et seq.

Effective Date: September 8, 1992.
Expiration Date: September 8, 1997.

Summary of Public Comments and Agency Responses:
There were **no comments** received.

Full text of the adoption follows.

CHAPTER 42
OFFSET OF STATE LOTTERY PRIZES
TO SATISFY OVERDUE CHILD SUPPORT PAYMENTS
AND OVERPAYMENTS IN CERTAIN PUBLIC ASSISTANCE
PROGRAMS

SUBCHAPTER 1. GENERAL PROVISIONS

17:42-1.1 DEA's responsibility

The Division of Economic Assistance in the Department of Human Services (DEA) shall maintain a list of individuals covered by P.L.1991, c.384 (N.J.S.A. 5:9-13.1 et seq.). The list shall include the individual's name and social security number, plus the amount of the alleged support arrears or public assistance overpayment. The list shall be updated at least monthly to show new individuals or obligations and to show payment or satisfaction of amounts outstanding.

17:42-1.2 Lottery's responsibility

The Division of State Lottery (Lottery) shall maintain a list of winners of prizes in amounts in excess of $2,500. The list shall include the winners' names, addresses, social security numbers and amounts won. The list shall be updated weekly.

17:42-1.3 OTIS' responsibility

On a weekly basis, the Office of Telecommunications and Information Services (OTIS) shall perform a computer match of the data on the two lists to ascertain the existence of a social security number match and shall notify both DEA and Lottery of the existence of any such match or of the fact that no matches were found from the given comparison. If matches are found, OTIS shall transmit a list to each agency including the individual's name, address, social security number, lottery prize and outstanding arrearage or overpayment. No Lottery prize in excess of $2,500 shall be disbursed by the Department of the Treasury (Treasury) until results of a match involving that prize payment have been determined. In case of annuity prizes where the first installment has not been paid, the match will be conducted on an expedited basis, directly between DEA and Lottery. If the first installment exceeds the lien, a net check can be given to the winner immediately, with the procedures elaborated under these rules to apply to the amount withheld from immediate distribution.

17:42-1.4 Prize disbursement restriction

Upon receipt of notice from OTIS that a social security number match has been made, neither Lottery nor Treasury shall disburse the lottery prize (except a first annuity installment as described in N.J.A.C. 17:42-1.3) until notified that the hearing procedures set forth in this subchapter have been completed or that no hearing has been timely requested. Lottery prizes of $5,000 or more shall first be subjected to Federal income tax withholding before any other setoffs, deductions or set-asides under these rules.

17:42-1.5 Notice of prize withholding

Within 14 days of notification by OTIS that a social security number match has been found to exist, DEA shall cause written notice to be sent to the subject of the match by first class mail. Such notice shall inform the individual that the match has been found to exist, that payment of the lottery prize is being withheld, that he or she has the right to make a request, within 10 business days of the date of the notice, for a hearing on the alleged debt and the proposed setoff and that, if no such request is timely received, Treasury will transmit the withheld money, up to the amount owed, to DEA or to the Office of Child Support and Paternity Programs in the Department of Human Services (OCSPP) for transmission to the appropriate county probation department.

17:42-1.6 Treasury action following notice of prize withholding

(a) No later than 15 business days from the date of the notice to the alleged debtor, DEA shall notify Treasury and Lottery of any request by the alleged debtor for a hearing, of the failure of the debtor to make such request or of the satisfaction of the alleged debt. Such information shall allow Treasury to:

1. Maintain the account on a hold status if a hearing has been requested;

2. Transmit the alleged debt to DEA or OCSPP where the alleged debtor has not made a timely request for a hearing or where a hearing request is made but subsequently withdrawn; or

3. Release the prize check to the winner if the debt has been satisfied.

(b) Treasury shall extend the hold status of an affected check until a final decision by DEA, in order to accommodate the hearing process, where Treasury has been notified that a hearing has been requested pursuant to N.J.A.C. 17:42-1.7. Following the hearing, N.J.A.C. 17:42-1.8 shall apply. If the request for the hearing is withdrawn, the provisions of (a)2 and 3 above shall apply.

17:42-1.7 Right to hearing

(a) Any person whose lottery prize has been withheld pursuant to P.L.1991, c.384 (N.J.S.A. 5:9-13.1 et seq.) may request a hearing by serving a written request on DEA within 10 business days of the notice of match described in N.J.A.C. 17:42-1.5.

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(b) When an alleged debtor makes a timely request for a hearing in a case where DEA is seeking to recoup arrears of child support payments, DEA shall notify the appropriate county probation department, which shall conduct an administrative review of the matter. The issues to be resolved shall include whether the claimed sum asserted is due and owing. If the matter cannot be resolved, then the alleged debtor may appeal to the Superior Court of New Jersey, Chancery Division, Family Part.

(c) If there is a judgment against the alleged debtor in a case where DEA is seeking to recoup an overpayment of Aid to Family with Dependent Children benefits, food stamp benefits or low-income home energy assistance benefits, the alleged debtor must seek relief in the court where judgment was entered. If there is no judgment against the alleged debtor, he or she may request a contested case hearing pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and 52:14F-1 et seq., through the county welfare agency which issued the benefits.

17:42-1.8 Transmission of prize offset to DEA or OCSPP

(a) Upon either final determination of the debt due and owing and exhaustion of time in which an appeal may be filed, or upon the debtor's default for failure to make timely request for review of the asserted setoff, or upon payment (in whole or in part) of the outstanding debt, DEA shall forthwith notify Treasury and Lottery, following which the amounts withheld from distribution, up to the amount owed, shall be transmitted to DEA or OCSPP, as appropriate. In cases of multiple or conflicting claims, DEA will provide internal dispute resolution or apportionment according to its own procedures.

(b) Where judicial review is sought from the administrative review, DEA shall advise Treasury and Lottery of such appeal within three days of receiving notice of the filing of the request for review. Upon resolution of judicial review (including any appeal which may be taken) like notice shall be provided by DEA to Treasury and Lottery.

17:42-1.9 Notice and disbursement of prize after setoff

Upon the finalization of setoff through administrative or judicial action, DEA shall notify the debtor in writing of the action taken and of any outstanding balance remaining due after the setoff. If there is an outstanding prize balance remaining after the setoff, it shall be disbursed with the notice described in this section.

17:42-1.10 Confidentiality

Apart from notice to affected individuals and to county probation departments for purposes of administrative review, personally identifiable information compiled under this chapter regarding any person shall be confidential and shall not be disseminated or used for any purpose other than as set forth in N.J.S.A. 5:9-13.1 et seq. and this chapter.

OTHER AGENCIES

(a)

CASINO CONTROL COMMISSION

Gaming Schools
Equipment
Adopted Amendment: N.J.A.C. 19:44-9.4

Proposed: April 20, 1992 at 24 N.J.R. 1471(a).
Adopted: August 5, 1992 by the Casino Control Commission, Steven P. Perskie, Chairman.
Filed: August 7, 1992 as R.1992 d.333, **without change.**
Authority: N.J.S.A. 5:12-63(c) and 70(i).
Effective Date: September 8, 1992.
Expiration Date: September 29, 1993.

Summary of Public Comment and Agency Response:
COMMENT: One comment was received from the Division of Gaming Enforcement, which supported the proposal.
RESPONSE: Accepted.

Full text of the adoption follows.

19:44-9.4 Equipment

(a) (No change).

(b) Unless the Commission shall otherwise determine, each gaming table shall have the name of the gaming school, or some other identifying attribute as approved by the Commission, permanently imprinted thereon in letters at least one inch in height and shall, as shall each slot machine, also have permanently affixed on it a serial number which, together with the location of the table or machine, shall be filed with the Commission.

(b)

CASINO CONTROL COMMISSION

Internal Controls
Personnel Assigned to the Operation and Conduct of Gaming and Slot Machines
Adopted Amendment: N.J.A.C. 19:45-1.12

Proposed: June 15, 1992 at 24 N.J.R. 2136(a).
Adopted: August 5, 1992 by the Casino Control Commission, Steven P. Perskie, Chairman.
Filed: August 7, 1992 as R.1992 d.334, **without change.**
Authority: N.J.S.A. 5:12-70(f) and 70(j).
Effective Date: September 8, 1992.
Expiration Date: March 24, 1993.

Summary of Public Comments and Agency Responses:
The Division of Gaming Enforcement submitted comments in general support of the proposed amendment to N.J.A.C. 19:45-1.12(c).

Full text of the adoption follows.

19:45-1.12 Personnel assigned to the operation and conduct of gaming and slot machines

(a)-(b) (No change.)

(c) Each casino licensee shall maintain the following standard levels of staffing:

1. (No change.)

2. One dealer shall be assigned to each blackjack, roulette, minibaccarat, sic bo, red dog and big six table;

3. Three dealers shall be assigned to each craps and baccarat table;

4.-6. (No change.)

(d)-(i) (No change.)

(c)

CASINO CONTROL COMMISSION

Internal Controls
Personnel Assigned to the Operation and Conduct of Gaming and Slot Machines
Adopted Amendment: N.J.A.C. 19:45-1.12

Proposed: April 6, 1992 at 24 N.J.R. 1249(b).
Adopted: August 5, 1992 by the Casino Control Commission, Steven P. Perskie, Chairman.
Filed: August 7, 1992 as R.1992 d.335, **without change.**
Authority: N.J.S.A. 5:12-70(f) and 70(j).
Effective Date: September 8, 1992.
Expiration Date: March 24, 1993.

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Summary of Public Comments and Agency Responses:

Comments were received from Bally's Park Place; Caesar's Atlantic City; the Sands Hotel, Casino & Country Club; TropWorld Casino and Entertainment Resort; Trump's Castle Casino Resort; and the Division of Gaming Enforcement (Division) in general support of the proposed amendments to N.J.A.C. 19:45-1.12(a) and (g). The Division also submitted comments in general support of the proposed amendment to N.J.A.C. 19:45-1.12(c).

COMMENT: The Division noted that the elimination of the sunset provision in N.J.A.C. 19:45-1.12(g) would allow casino licensees optimum utilization of supervisory personnel beyond the initial six-month trial period.

RESPONSE: The Commission agrees that extension of the revised supervision rules will continue to provide beneficial staffing flexibility to the casino industry.

Full text of the adoption follows.

19:45-1.12 Personnel assigned to the operation and conduct of gaming and slot machines

(a) Each casino licensee shall be required to employ the personnel herein described in the operation of its casino, regardless of the position titles assigned to such personnel by the casino licensee in its approved jobs compendium. Functions described in this section shall be performed only by persons holding the appropriate license and position endorsement required by the casino licensee's approved jobs compendium to perform such functions, or by persons holding the appropriate license and position endorsement required by the casino licensee's approved jobs compendium to supervise persons performing such functions, subject to the limitations imposed by N.J.A.C. 19:45-1.11(a). Each casino licensee shall at all times maintain a level of staffing which ensures the proper operation and effective supervision of all table games in the casino.

(b)-(c) (No change.)

(d) Notwithstanding the provisions of (c) above, a casino licensee may implement a plan for revised supervision by floorpersons or pit bosses. In any plan for revised supervision:

1.-3. (No change.)

(e)-(f) (No change.)

Recodify existing (h)-(i) as (g)-(h). (No change in text).

HEALTH

(a)

HEALTH FACILITIES EVALUATION AND LICENSING DRUG CONTROL

Registration of Wholesale Distributors of Prescription and Nonprescription Drugs; Registration of Manufacturers and Wholesalers of Devices

Adopted New Rules: N.J.A.C. 8:21-3A

Proposed: July 6, 1992 at 24 N.J.R. 2410(b)

Adopted: August 18, 1992, by Frances J. Dunston, M.D., M.P.H., Commissioner, Department of Health.

Filed: August 18, 1992 as R.1992 d.354, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3), **and with portions not adopted but still pending** (repeal of N.J.A.C. 8:21-3.13 and portions of N.J.A.C. 8:21-3A shown as "Reserved").

Authority: N.J.S.A. 24:2-1; 21 U.S.C. 351, 353, 371 and 374; and 21 C.F.R. 205.

Effective Date: September 8, 1992.

Expiration Date: October 23, 1995.

Summary of Public Comments and Agency Responses:

Comments were received from Arnold D. Marcus, Ph.D., J.D., Director of Regulatory Affairs, Bristol-Myers Products; Robert W. Cockren, of Satterlee, Stephens, Burke and Burke, representing the Wholesale Druggists Association of New Jersey, Inc; Edwin H. Allen, Vice President of Government Affairs and General Counsel, Health Industry Manufacturers Association; and Peter D. Bewley, Associate General Counsel, Johnson and Johnson.

There was a general concern expressed by the commenters regarding the adoption of those portions of the proposed rules which dealt with areas other than the wholesale distribution of prescription drugs, the focus of the Federal Prescription Drug Marketing Act and the associated Federal regulatory activity. Due to the concerns expressed, and because the members of the regulated public requested further opportunity for discussion and input, the Department is adopting, at this time, only those portions of the proposed rules which are required by Federal law to be in place by September 14, 1992. After further evaluation, the Department may adopt the balance of the rules proposed, or may propose alternate requirements. The comments regarding those portions of the rules which are pending will be addressed at that time.

COMMENT: One commenter noted that the Federal requirements include, at 21 C.F.R. 205.5(c), a requirement that any changes in the information submitted for licensure or registration be submitted to the licensing authority within 30 days of the change.

RESPONSE: The Department agrees that this provision belongs in the rules, but notes that the addition of such a requirement is too substantive to make upon adoption. However, an amendment to that effect will be proposed in the next available issue of the New Jersey Register.

COMMENT: N.J.A.C. 8:21-3A.4(b)4 and 5 seem to indicate that the Department will issue a single license for multiple facilities operated by a manufacturer or wholesale distributor. The commenter recommends that the requirement be changed so that each individual facility operated by a wholesale distributor be licensed separately, so that, in the event a problem at one facility caused the suspension of revocation of a license, other facilities which are not in violation would not be affected.

RESPONSE: As the rules currently require, the license is issued to the company, for a specific number of sites, not to the sites themselves. The Department believes that, since the company is the license holder, it is the company, not the distribution site, which should be penalized for any violations. The Department will consider further information from, and/or discussion with, the regulated public on this subject, but has adopted the provision as proposed.

COMMENT: The information sought by N.J.A.C. 8:21-3A.5(a)8 should be included on the application filed by those seeking registration, rather than as stated in the rule, which could be construed as a requirement for submission of an additional, separate statement.

RESPONSE: The commenter is correct in the perception that the requirement may involve an additional, separate statement. The circumstances of a particular application may suggest additional factors related to the public health and safety, and the Department may, in such a case, require the submission of an additional statement in order to evaluate such factors. In order to carry out its duties to protect the public health and safety, the Department has included the provision at N.J.A.C. 8:21-3A.5(a)8, and does not elect to change it at this time.

COMMENT: The commenter asked that the term "drug laws" in N.J.A.C. 8:21-3A.20 be specified further, to avoid an apparent ambiguity.

RESPONSE: The Department intends that only a violation of those Federal, State, or local drug laws, rules or regulations which are applicable to the wholesale distribution of prescription drugs be considered in the suspension or revocation of any registration granted under the provisions of N.J.A.C. 8:21-3A, as adopted. The Department has included the term "applicable" in the adoption of the rule, in order to make this clear.

COMMENT: The provisions of N.J.A.C. 8:21-3A.6 are too broad and do not show what factors will result in a denial of an application. At a minimum, the rule should refer to N.J.A.C. 8:21-3A.5.

RESPONSE: The factors which will result in the denial of an application are those which are "directly related to the protection of the public health and safety." A reference to N.J.A.C. 8:21-3A.5 would not be inconsistent with this standard; therefore, it has been added to the rule on adoption.

COMMENT: A commenter objected to the requirement that records kept on site or immediately accessible by computer must be readily available for authorized inspection during the period of their retention, and that records kept off-site be available in two days. The Commenter suggests that time should be allowed to permit consultation with legal counsel, and that standards of five days for on-site records and eight days for off-site records be applied.

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RESPONSE: The Department believes that allowing the time periods suggested by the commenter would not be in the public interest, and that data should be available as quickly as indicated in the rule, for public health and safety reasons. The rule has been adopted as proposed; however, further comments are invited from the regulated public on this issue.

Full text of the adoption follows (additions indicated in boldface with asterisks ***thus***; deletions indicated in brackets with asterisks *[thus]*) (Office of Administrative Law Note: Those portions of the proposed new rules not being adopted at this time do not appear in the following text, which only sets forth text now adopted, and revisions thereto):

SUBCHAPTER 3A. REGISTRATION OF WHOLESALE DISTRIBUTORS OF PRESCRIPTION DRUGS

8:21-3A.1 Scope

This subchapter sets forth standards for the registration and operation of any person, partnership, corporation or business firm engaging in the wholesale distribution of human prescription drugs.

8:21-3A.2 Purpose

The purpose of this subchapter is to implement the requirements of the Federal Prescription Drug Marketing Act of 1987, 21 U.S.C. 351, 353, 371 and 374, and 21 C.F.R. 205, and for the benefit of the health and safety of the ultimate consumers of prescription drugs.

8:21-3A.3 Definitions

The words and terms used in this subchapter shall have the following meanings, unless the context clearly indicates otherwise:

"Blood" means whole blood collected from a single donor and processed either for transfusion or further manufacturing.

"Blood component" means that part of blood separated by physical or mechanical means.

"Department" means the New Jersey Department of Health.

"Drug sample" means a unit of a prescription drug that is not intended to be sold and is intended to promote the sale of the drug.

"Manufacturer" means anyone who is engaged in the manufacturing of drugs or devices, as defined in N.J.S.A. 24:6B-12, or engaged in the manufacturing, preparing, propagating, compounding, processing, packaging, repackaging, or labeling of a prescription drug.

"Non-prescription" or "Non-legend" or "O.T.C." drugs mean drugs directly available to the consumer over the counter, without a physician's prescription.

"Prescription drug" means any human drug required by Federal law or regulation to be dispensed only by a prescription, including dosage forms and active ingredients subject to section 503(b) of the Federal Food, Drug and Cosmetic Act.

"Wholesale distribution" means the distribution of drugs or devices to persons other than a consumer or patient, but does not include:

1. Intracompany sales;

2. The purchase or other acquisition by a hospital or other health care entity that is a member of a group purchasing organization, of a drug or device for its own use from the group purchasing organization or from other hospitals or health care entities that are members of such organizations;

3. The sale, purchase, or trade of a drug or device or an offer to sell, purchase, or trade a drug or device by a charitable organization described in section 501(c)(3) of the Internal Revenue Code of 1954 to a nonprofit affiliate of the organization to the extent otherwise permitted by law;

4. The sale, purchase, or trade of a drug or device or an offer to sell, purchase, or trade a drug or device among hospitals or other health care entities that are under common control; for purposes of this definition "common control" means the power to direct or cause the direction of the management and policies of a person or an organization, whether by ownership of stock, voting rights, by contract, or otherwise;

5. The sale, purchase or trade of a drug or device or an offer to sell, purchase, or trade a drug or device for emergency medical reasons; for purposes of this definition, "emergency medical reasons" includes transfers of prescription drugs by a retail pharmacy to another retail pharmacy to alleviate a temporary shortage;

6. The sale, purchase, or trade of a drug, an offer to sell, purchase, or trade a drug, or the dispensing of a drug pursuant to a prescription;

7. The distribution of drug or device samples by manufacturers' representatives or distributors' representatives; or

8. The sale, purchase, or trade of blood and blood components intended for transfusion.

"Wholesale distributor" means anyone engaged in wholesale distribution of prescription drugs including, but not limited to, manufacturers; repackagers; own-label distributors; private label distributors; jobbers; brokers; warehouses, including manufacturers' and distributors' warehouses, chain drug warehouses, and wholesale drug warehouses; and independent wholesale drug traders, but does not include a retail pharmacy whose sales of prescription drugs to other than the ultimate user, including physicians for office use, nursing homes, institutions, etc. does not exceed five percent of the total gross annual sales of prescription drugs of the pharmacy.

8:21-3A.4 Application requirements; reciprocity

(a) The Department may permit an out-of-State wholesale distributor to satisfy the registration requirements of *[N.J.A.C. 8:21-3.14]* ***this subchapter*** on the basis of reciprocity provided that:

1. Such out-of-State wholesale distributor possesses a valid license or registration granted by another state pursuant to legal standards comparable to those which must be met by a registrant of this State as prerequisites for satisfying the registration requirements under the laws of this State; and

2. Such other state extends reciprocal treatment under its own laws to wholesale distributors of this State.

(b) Every wholesale distributor ***of prescription drugs*** shall apply to the Department in accordance with the provisions of N.J.S.A. 24:6B-2 using forms supplied by the Department. In addition, every applicant shall complete the appropriate sections of the application, which shall include:

1. Name, full business address and telephone number of the applicant;

i. All trade or business names used by the registrant;

ii. Addresses, telephone numbers and name of the contact person for all facilities used by the registrant for the storage, handling and distribution of prescription drugs;

2. The type of ownership or operation (that is, partnership, corporation, or sole proprietorship);

3. The name(s) of the owner and/or operator of the applicant, including:

i. If a person, the name of the person;

ii. If a partnership, the name of each partner, and the name of the partnership;

iii. If a corporation, the name and title of each corporate officer and director, the corporate names, and the name of the State of incorporation, and

iv. If a sole proprietorship, the full name of the proprietor and the name of the business entity;

4. The address of each location in New Jersey at which the business is to be conducted. If an applicant's business is not to be conducted within the State, the application shall give the name and address of an agent resident of this State on whom process against the applicant may be served;

5. If the business is to be conducted at more than one location in this State, the name and address of the individual in charge of each such location;

6. A description of the business;

7. The name and address of the individual or individuals on whom orders of the Commissioner may be served; and

8. A statement as to whether the registrant engages in the manufacturing, compounding, processing, wholesaling, jobbing, distribution of any controlled dangerous substances as defined pursuant to N.J.S.A. 24:21-2.

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8:21-3A.5 Evaluation criteria

(a) In considering any application for registration, the Department shall consider, at a minimum, the following factors in reviewing the qualifications of those persons applying for registration as a ***wholesale prescription*** drug distributor:

1. Any convictions of the applicant under any Federal, state, or local laws relating to drug samples, wholesale or retail drug distribution, or distribution of a controlled substance;

2. Any felony conviction under Federal laws, or the equivalent (under whatever statutory term) conviction under state or local laws;

3. The applicant's past experience in the manufacturing or distribution of prescription drugs or controlled substances;

4. The furnishing of false or fraudulent material in any application made in connection with drug or device manufacturing or distribution;

5. Suspension or revocation by Federal, state or local government of any registration currently or previously held by the applicant for the manufacture or distribution of any drugs, including controlled substances;

6. Compliance with license and/or registration requirements under any previously granted license or registration, if any;

7. Compliance with requirements to maintain and/or make available to the Department or Federal or local law enforcement officials those records required by this subchapter; and

8. Any other factors or qualifications the Department considers relevant to and consistent with the public health and safety.

(b) Wholesale drug distributors shall operate in compliance with applicable Federal, State and local laws and regulations and where the wholesale drug distributor also deals in controlled dangerous substances, it shall also register with the Department and Drug Enforcement Administration (DEA) and also comply with all applicable State rules and DEA regulations.

(c) A retail pharmacy wishing to conduct a wholesale business shall operate the wholesale business under a separate name and at a separate location, other than that of the pharmacy name and address and the wholesale business will be subject to all of the requirements of a wholesale distributor.

8:21-3A.6 Denial of application

The Department shall have the right to deny an application for registration if it determines the granting of such registration would not be in the public interest. Public interest considerations shall be based upon factors and qualifications that are directly related to the protection of the public health and safety ***as delineated in N.J.A.C. 8:21-3A.5***.

8:21-3A.7 Personnel requirements

Personnel employed by a wholesale distributor shall have appropriate education and/or experience to assume responsibility for positions that would affect compliance with registration requirements.

8:21-3A.8 Facility

(a) All facilities at which prescription drugs are stored, warehoused, handled, held, offered, marketed, or displayed shall:

1. Be of suitable size and construction to facilitate cleaning, maintenance, and proper operations;

2. Provide storage areas which include adequate lighting, ventilation, temperature, sanitation, humidity, space, equipment, and security conditions;

3. Provide a quarantine area for storage of outdated, damaged, deteriorated, misbranded or adulterated prescription drugs, or drugs that are in immediate or sealed secondary containers that have been opened;

4. Be maintained in a clean and orderly condition; and

5. Be free from infestation by insects, rodents, birds, or vermin of any kind.

8:21-3A.9 Security

(a) All facilities used for wholesale distribution shall be secure from unauthorized entry and shall provide the following additional security measures:

1. Access from outside the premises shall be kept at a minimum and shall be well controlled;

2. The outside perimeter of the premises shall be well-lighted; and

3. Entry into areas where prescription drugs are held shall be limited to authorized personnel.

(b) All facilities shall be equipped with an alarm system to detect entry after hours.

(c) All facilities shall be equipped with a security system that will provide suitable protection against theft and diversion, and shall provide, when appropriate, protection against theft or diversion that is facilitated or hidden by tampering with computers or electronic records.

8:21-3A.10 Storage

(a) All prescription drugs shall be stored at appropriate temperature and conditions in accordance with the requirements set forth in the labeling of such drugs or with the requirements of the current edition of an official compendium, such as the United States Pharmacopoeia/National Formulary (USP/NF).

(b) If no storage requirements are established for a prescription drug, the drug may be held at controlled room temperature, as defined in an official compendium, to help ensure that its identity, strength, quality, and purity are not adversely affected.

(c) Appropriate manual, electromechanical or electronic temperature and humidity recording equipment, devices and/or logs shall be utilized to document proper storage of prescription drugs.

8:21-3A.11 Examination of materials

(a) Upon receipt, each outside shipping container shall be visually examined for identity and to prevent the acceptance of contaminated prescription drugs or prescription drugs that are otherwise unfit for distribution, and such examination shall be adequate to reveal container damage that would suggest possible contamination or other damage to the contents;

(b) Each outgoing shipment of prescription drugs shall be carefully examined for the identity of the prescription drug products and to ensure that there is no delivery of prescription drugs that have been damaged in storage or held under improper conditions.

8:21-3A.12 Returned, damaged and outdated prescription drugs

(a) Prescription drugs that are outdated, damaged, deteriorated, misbranded, or adulterated shall be quarantined and physically separated from other prescription drugs until they are destroyed or returned to their supplier.

(b) Prescription drugs whose immediate or sealed outer or sealed secondary containers have been opened or used shall be identified as such, and shall be quarantined and physically separated from other prescription drugs until they are either destroyed or returned to the supplier.

(c) If the conditions under which a prescription drug has been returned cast doubt on the drug's safety, identity, strength, quality or purity, then the drug shall be destroyed or returned to the supplier, unless examination, testing or other investigation proves the drug meets appropriate standards of safety, identity, strength, quality and purity. The wholesale distributor of prescription drugs shall consider, among other things, the conditions under which the drugs were held, stored, or shipped before or during their return and the condition of the drug and its container, carton, or labeling as a result of storage and shipping when considering that there is any doubt of the drug's safety, identity, strength, quality or purity.

8:21-3A.13 Recordkeeping

(a) Wholesale distributors of prescription drugs shall establish and maintain inventories and records of all transactions regarding the receipt and distribution or other disposition of prescription drugs. Such records shall include the following information:

1. The source of the drugs, including the name and principal address of the seller or transferor, and the address of the location from which the drugs were shipped;

2. The identity and quantity of the drugs received and distributed or disposed of and;

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3. The dates of receipt and distribution or other disposition of the drugs.

8:21-3A.14 (Reserved)

8:21-3A.15 Availability of records and inventories

(a) Records and inventories, including those related to any prescription drug salvage or reprocessing procedure, shall be made available for inspection and photocopying by Federal, State or local law enforcement agencies and shall be maintained for a period of two years following the disposition of the drugs.

(b) The records that are kept at the inspection site or that can be immediately retrieved by computer or other electronic means shall be readily available for authorized inspection during the retention period, and records kept at a central location apart from the inspection site and not electronically retrievable shall be made available for inspection within two working days of a request by an authorized official of a Federal, state or local enforcement agency.

8:21-3A.16 Policies and procedures

(a) Wholesale ***prescription drug*** distributors shall establish, maintain, and adhere to written policies and procedures which shall be followed for the receipt, security, storage, inventory, and distribution of prescription drugs, including policies and procedures for identifying, recording, and reporting losses or thefts, and for correcting all errors and inaccuracies in inventory. Wholesale drug distributors shall include in their policy and procedures the following:

1. A procedure whereby the oldest approved stock of a prescription drug is distributed first. The procedure may permit deviation from this requirement if the deviation is temporary and appropriate;

2. A procedure to be followed for, and which shall be adequate for, handling recalls and withdrawals due to:

i. Any action initiated by the request of the Food and Drug Administration or other Federal, state, local law enforcement or other government agency, including the State registering agency;

ii. Any voluntary action by the manufacturer to remove defective or potentially defective drugs from the market; or

iii. Any action undertaken to promote public health, and safety by replacing existing merchandise with an approved product or new package design.

3. A procedure, to ensure that a wholesale distributor prepares for, protects against, and handles any crisis that affects security or the operation of any facility in the event of strike, fire, flood, or other natural disaster, or other situations of a local, State or national emergency; and

4. A procedure to ensure that outdated prescription drugs shall be segregated from other drugs and either returned to the manufacturer or destroyed. Such procedure shall provide for written documentation of the disposition of the outdated prescription drugs and shall be maintained for two years after disposition of the outdated drugs.

8:21-3A.17 List of responsible persons

Wholesale drug distributors shall establish and maintain a list of officers, directors, managers, and other persons in charge of wholesale distribution, storage, and handling of prescription drugs that shall include a description of their duties and a summary of their qualifications.

8:21-3A.18 Inspection and auditing

Wholesale drug distributors shall permit the Department and authorized Federal, State and local law enforcement officials to enter and inspect their premises and delivery vehicles, and to audit their records and written operating procedures, at reasonable times and in a reasonable manner, to the extent authorized by law.

8:21-3A.19 Salvage; reprocessing

Wholesale drug distributors shall be subject to the provisions of any applicable Federal, State or local laws, rules or regulations that relate to prescription drug product salvaging or reprocessing.

8:21-3A.20 Suspension; revocation

The Department shall suspend or revoke any registration granted under this subchapter upon conviction of the registrant of a violation of ***applicable*** Federal, State or local drug laws, rules or regulations and may suspend or revoke any registration granted hereunder if the registrant willfully and seriously violated the requirements of this chapter.

8:21-3A.21 Penalties

The Department may provide for fines, imprisonment, or civil penalties as set forth in N.J.S.A. 24:6B-11 or 24:17.1.

8:21-3A.22 Appeals

Prior to the suspension or revocation of a registration issued in accordance with this subchapter, the registrant shall have a right to prior notice and a hearing pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules N.J.A.C. 1:1.

(a)

HEALTH FACILITIES RATE SETTING

Notice of Administrative Correction

Standard Hospital Accounting and Rate Evaluation (SHARE) Manual

Cost Center Record

N.J.A.C. 8:31A, Appendix A

Take notice that the Department of Health has discovered an error in the text of N.J.A.C. 8:31A, Appendix A. In the August 5, 1991 New Jersey Register, at 23 N.J.R. 2242(a), the Department proposed to change the Units of Service for Ancillary Service, OPPM, III, Statewide, from "Patient Days" to "Admissions." However, in response to comments received on this amendment from Methany School Hospital and Children's Specialized Hospital, the Department elected to retain "Patient Days" as the unit of service upon adoption. While this intention is reflected in the Summary of Public Comments and Agency Responses in the notice of adoption (see 23 N.J.R. 2648(a)), the adopted text of Appendix A inadvertently failed to indicate the change. This error is corrected through this notice of administrative correction, published pursuant to N.J.A.C. 1:30-2.7.

Full text of the corrected rule follows (addition indicated in boldface **thus**; deletion indicated in brackets [thus]):

APPENDIX A
Cost Center Record

Function	Cost Center (Abbr.)	Level	Peer Group	Units of Service	Reasonableness Limit	Cost Increase Analysis Variability Personnel	Factor Supplies
...							
Ancillary Service	...						
	OPPM	III	Statewide	[Admissions] **Patient Days**	1.3	50	–
...							

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(a)

DIVISION OF HEALTH PLANNING AND RESOURCES DEVELOPMENT

Certificate of Need
Application and Review Process
Adopted Repeals: N.J.A.C. 8:33-1 through 4
Adopted Recodification: N.J.A.C. 8:33-5.1 to 6.1
Adopted New Rules: N.J.A.C. 8:33-1 through 5

Proposed: June 15, 1992 at 24 N.J.R. 2222(a).

Adopted: August 14, 1992 by Frances J. Dunston, M.D., M.P.H., Commissioner, Department of Health (with approval of Health Care Administration Board).

Filed: August 17, 1992 as R.1992 d.342, **with substantive and technical changes** not requiring additional public notice (see N.J.A.C. 1:30-4.3) and **with portions of the proposal not adopted but still pending (N.J.A.C. 8:33-3.11(a))**.

Authority: N.J.S.A. 26:2H-1, 26:2H-5, 26:2H-8, 26:2H-9.

Effective Date: September 8, 1992.

Expiration Date: July 27, 1995.

Summary of Public Comments and Agency Responses:

The proposal appeared in the New Jersey Register for Monday, June 15, 1992 at 24 N.J.R. 2222(a). Public comment was received on the proposal through July 15, 1992. Written comments were received from: James E. Cunningham, president, New Jersey Association of Health Care Facilities; Michael A. Samach, M.D., F.A.C.P.; Jon Vick, vice president, Surgicenter Development Corporation; Christine V. Bator, Esq.; Jon Vick, vice president, Endoscopy Center Affiliates; Theodosia A. Tamborlane, Esq.; Dan Moles, L.N.H.A., R.N., administrator, Ashbrook Nursing Home; Cheryl J. Tice, associate vice president for issues management and strategic planning, University of Medicine and Dentistry of New Jersey; Solomon Goldberg, D.D.S., M.P.H.; Raymond R. Groller, Interstate Health Planning Corporation; Carole Stapleton Rhodes, chief planning officer, University Hospital; Thomas E. Terrill, Ph.D., executive vice-president, University Health System of New Jersey; Pamela B. Rayvid, director of planning, Dover General Hospital; Maxine H. Neuhauser, Epstein, Becker, & Green, P.C., attorneys at law; Michael S. Steiner, vice president for planning, Jersey City Medical Center; Neil E. Weisfeld, director of education, research and regulatory affairs, Medical Society of New Jersey; David A. Wagner, senior vice president for strategic planning and corporate development, Saint Barnabas Medical Center; Leonard H. Adoff, Esq.; Paul A. Mertz, vice president for general services, The Hospital Center at Orange; John L. Tweed, executive director, Medical Transportation Association of New Jersey, Inc.; Louis P. Scibetta, FACHE, president, New Jersey Hospital Association; Barbara Ann Slagg, director of planning, Hackensack Medical Center; Richard P. Oths, president, Morristown Memorial Hospital; Sister Patricia Lynch, CSJP, president, Holy Name Hospital; Timothy O. Patschke, Ed.D, chairman of the board, Region One Health Planning Advisory Board, Inc.; Joan P. Furman, director of planning, St. Joseph's Hospital and Medical Center; Marci A. Shapiro-Goldman, corporate manager for planning services, Kennedy Memorial Hospitals University Medical Center; Dale J. Florio, Princeton Public Affairs Group, Inc.; David Kostinas, HealthTeam, Inc.; Victoria Wicks, president, HIP Rutgers Health Plan; Robin Wilcox, Executive Director, Health Visions, Inc.

In an effort to articulate a process for reviewing certificate of need applications for demonstration projects which is responsive to concerns voiced during the public comment period, the Department wishes to reserve subsection N.J.A.C. 8:33-3.11(a) (see the response to Comment 8).

1. COMMENT: N.J.A.C. 8:33-1.3 Definitions Mr. Groller stated that the term "medically underserved" is qualified by various Federal designations as medically underserved areas, health manpower shortage areas, and medically underserved groups and suggested that the definition of medically underserved groups noted at N.J.A.C. 8:33-1.3 be cross-referenced to include these Federal designations.

RESPONSE: The definition referenced at N.J.A.C. 8:33-1.3 refers specifically to medically underserved groups and defines such groups as segments of the population which currently fail to use health care services in numbers approximately proportionate to their presence in the population as adjusted to account for their need for such services. As such, not all segments of a medically underserved area or health manpower shortage area, as defined by Federal rules, are medically underserved within the context of the definition set forth in this rule. Rather, the definition references the use of health services by segments of the population anywhere in the State, not just in Federally designated medically underserved areas or health manpower shortage areas.

2. COMMENT: N.J.A.C. 8:33-3.9 Changes in cost/scope/financing Mr. Groller objected to the restriction noted at N.J.A.C. 8:33-3.9(b)3 that a change of site for an approved but unimplemented certificate of need project outside of the county for which it was originally approved will not be accepted for processing and that the failure of the applicant to implement the project within the county for which it was originally approved will result in nullification of the approved certificate of need. He suggested that when a project is regional in scope, such as an AIDS nursing home or a transplant center such relocations should be considered.

RESPONSE: Certificates of need are issued because they respond to public health need in specific areas. That need is very often established on a county basis, as evidenced in the need methodologies reflected in or referenced by many historically adopted health planning regulations. Where it is established on a larger geographic basis, the selection of the approved application results from a consideration of the qualifications of the applicant as well as a decision that the delivery of the service in the proposed area will provide important quality of care and access benefits to people to be served by the approved applicant. The Department does not want that need subsequently vacated by a relocation of the proposed project outside of the area approved for its location. Because the relocation of the service outside of the county in which it was approved for location offers significant consequences for the public that was to be served by the approval, the Department believes that such a change warrants the nullification of the approval and the subsequent resubmission of an entirely new application open to full review by local and state health planning bodies.

3. COMMENT: N.J.A.C. 8:33-4.1 Request for certificate of need applications Mr. Groller objected to the proposed provision at N.J.A.C. 8:33-4.1(a) that the full review process for certificate of need applications will be activated upon notice by the Commissioner inviting certificate of need applications in response to specific needs identified in the State Health Plan. He claimed that this procedure is "both poor planning and worse practice" and difficult to accommodate because site control can take months to negotiate.

RESPONSE: The Department does not agree with the writer's claim that the process noted at N.J.A.C. 8:33-4.1(a) is indicative of poor planning. Quite the opposite is the case. This section of the rule implements a recommendation of the Governor's Commission on Health Care Costs. The Commission felt strongly that the planning process should direct the certificate of need process and that once the planning process established a public health need, the Commissioner of Health should invite applications to fill that need. This approach to decision-making concerning the distribution of needed health care services and facilities is rational and efficient and offers the benefit of concentrating efforts on meeting public need rather than in defending denials of applications. The process identified in these rules requires that public need be established via pro-active planning efforts and that once the need of the public for health care facilities and services is defined in areas of the state that the certificate of need process can be employed to advance the filling of those service gaps. The Department believes that this process advances sound planning, focuses provider and staff resources in meeting the needs of the public we serve, and reduces waste in the health care system.

4. COMMENT: N.J.A.C. 8:33-3.2 Termination of Service and Reduction of Bed Capacity Ms. Stapleton Rhodes noted that subsection N.J.A.C. 8:33-3.2(b) gives the Commissioner authority to reduce a facility's license, since the two year period noted has already expired. She suggested that the language regarding the Commissioner's review of utilization be changed to reflect any two-year period after January 1, 1991 "because of statewide nursing shortages that may have only temporarily resulted in reduction of operating beds during the three years prior".

RESPONSE: The language of N.J.A.C. 8:33-3.2(b) has its authority in P. L. 1991, c.187, section 38. In passing this law, the Legislature specifically authorized the Commissioner of Health to amend a facility's license to reduce that facility's licensed bed capacity to reflect actual utilization at the facility if the Commissioner determines that 10 or more

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licensed beds in the health care facility have not been used for at least two succeeding years beginning on January 1, 1990. While Ms. Stapleton Rhodes offered no explanation for recommending that the two year period begin with January 1, 1991 and not January 1, 1990, as prescribed in statute, the Department must reject her suggestion because it is inconsistent with law. In making these determinations for adjustments in a facility's license, the Commissioner will consider actual utilization for a minimum of two consecutive years. Significant underutilization of beds for this time period would appear to be indicative of a situation which is not temporary, as Ms. Stapleton Rhodes suggested. Nevertheless, where a facility believes that a bed reduction of the scope noted in this subsection is not warranted, it will be given an opportunity to present its case.

5. COMMENT: Ms. Stapleton Rhodes has commented that there is an inconsistency between subsection N.J.A.C. 8:33-3.2(c) and (d), the former noting that the voluntary closure of a facility (other than a general acute care hospital) or the discontinuance of all of its services requires only notification to the Department and does not require a certificate of need and the latter requiring a certificate of need for the discontinuance of a component service facility, which in the case of a hospital service would follow full-review proceedings and in the case of a non-hospital would be reviewed via expedited procedures.

RESPONSE: N.J.A.C. 8:33-3.2(c) and (d) do not reflect inconsistent policies when applied to practical situations. In practice there is little that the Department can do if a non-hospital health care facility elects to voluntarily close and to discontinue all of its services. Most often this occurs either because the services offered have historically been severely underutilized or because the facility cannot continue operation in a financially solvent manner. In practical terms, the denial of the certificate of need would have no bearing on the outcome. One cannot force an insolvent facility to continue operation. Rather, what the Department seeks in such instances is adequate notification so that patients can be properly directed to or placed in alternative health care settings. The same is not true where a provider elects to discontinue a component service it provides without discontinuing full operation. In such instances, the decision is often based on the fact that the service targeted for closure is a lost-leader. The loss of revenue in one service component, however, can often be made up by the profits generated in other service areas. Where this occurs, and particularly where the service is meeting a local need, it is entirely consistent with the Department's responsibility to promote needed and accessible care to examine the basis for the proposed closure, the impact that the service proposed for closure is having on the overall financial health of the facility, and the consequences of the proposed closure on the patients who have been or would otherwise be receiving care.

6. COMMENT: N.J.A.C. 8:33-1.1 Purpose/Scope Dr. Goldberg noted that N.J.A.C. 8:33-1.1(d) encourages certificate of need applicants to consult with the local advisory boards (LABs) in the planning regions which will be served by their proposed health care service or facility prior to submitting their certificate of need applications. He asked that the Department identify any adverse action which might accrue if an applicant failed to contact the LAB prior to submitting an application.

RESPONSE: The Department's recommendation that potential applicants contact their local advisory board(s) in advance of submitting a certificate of need application is just that, a recommendation. It is not intended to be mandatory and there are no penalties associated with a failure to do so. The suggestion is made in order to provide assistance to applicants. The LAB will be able to provide an understanding of how the proposal relates to the LAB plan and the State Health Plan, can identify what regulatory requirements will have to be satisfied by the application, and can answer technical questions that applicants may have in the course of developing their applications.

7. COMMENT: N.J.A.C. 8:33-3.11 Demonstration projects Ms. Tice, Associate Vice President for Issues Management and Strategic Planning at the University of Medicine and Dentistry of New Jersey, and Dr. Terrill, Executive Vice President for University Health Systems of New Jersey have offered an important distinction between a "research" and a "demonstration" project. They noted that research projects are those which involve investigation and experimentation into new modalities, clinical trials of new equipment or therapeutic regimen, require approval of an Institutional Review Board, and do not involve billings to or reimbursement from patients or third party payors. In essence, any service, modality, or intervention offered through a research project is limited to the study subjects and does not involve charges to those subjects. A "demonstration" project, on the other hand, according to Ms. Tice, generally involves established patient care modalities for which there is a need to examine systematically and conclusively such variables as demand, cost, and outcome. Given this context and the distinctions she offered, Ms. Tice suggested that where a project is exclusively for research purposes and while it is operating as an exclusively experimental or research modality and not billing for any service provided that it should be exempted from certificate of need. Ms. Stapleton Rhodes advised the Department that she fully supported the views expressed by Ms. Tice.

RESPONSE: The Department agrees that it is important for this rule to distinguish between a purely "research" project and a "demonstration" and that a project which is purely research in nature, does not offer services to persons who are not the subjects of research protocols approved by Institutional Review Boards in accordance with all rules and regulations established by the Federal and State governments as well as the institutional sponsor, does not bill for or receive reimbursement from patients or third party payors for the services provided to the research subjects, and does not otherwise compete with or affect any other health care provider in the State can and should be exempted from certificate of need requirements while operating in an exclusively research status. The Department wishes to be absolutely explicit in stating that while it can support exemption from certificate of need for projects which are exclusively "research" in nature that the Commissioner of Health reserves the right to require a certificate of need of that same project once it is no longer operating as an exclusively research activity, once the services it provides qualify for reimbursement, once it offers its services to persons who are not the subjects of research protocols duly approved by Institutional Review Boards or if it attempts to market its services to the general public or otherwise impacts on licensed providers of health care services in the State or once its activities could reasonably be concluded as falling within the scope of adopted regulations as well as this rule, as determined by the Commissioner. Where there is any doubt whether a particular project is "research" in nature and, therefore, exempt from certificate of need requirements or a "demonstration", as reference at N.J.A.C. 8:33-3.11, and subject to these rules, the Commissioner shall make a determination and her decision in this matter will be a final decision of the Department. Accordingly, the Department proposes a change in the rule at N.J.A.C. 8:33-1.3 and at N.J.A.C. 8:33-3.11 to accommodate the distinction noted herein.

8. COMMENT: A number of other comments related to N.J.A.C. 8:33-3.11 concerning demonstration and research projects were received. The New Jersey Association of Health Care Facilities suggested that the applicant originally requesting the incorporation of a demonstration project should be given priority in consideration of awarding certificates of need for demonstrations. Dr. Goldberg expressed concern that the rule did not require that applicants for demonstration and research projects submit operational and research protocols indicating how they will proceed to insure the health and safety of the public during the demonstration phase. A number of commentors, including Dr. Terrill, Sister Patricia Lynch and Mr. Oths represented that the process outlined at N.J.A.C. 8:33-3.11 for considering demonstration projects was too cumbersome and would delay the initiation of new demonstrations. Sister Patricia Lynch, CSJP suggested that the rule be redrafted so that the applicant can present a demonstration project to the local advisory board and the State Health Planning Board simultaneously with the presentation to the Department staff "and it can be reviewed on its own merits, not in competition with any other applicant, and be either approved or rejected by the Commissioner in a timely fashion."

RESPONSE: As indicated above, there were many commentors who noted that the process for demonstration projects was too cumbersome and could result in unnecessary delays. The Department acknowledges that these concerns are significant enough to warrant a re-examination of the certificate of need process for demonstration projects. Therefore, in an effort to articulate a process for reviewing certificate of need applications for demonstration projects which is responsive to public health needs, the Department wishes to reserve subsection N.J.A.C. 8:33-3.11(a), until such time that a further review of the process has been completed, at which time the Department will take action, in accordance with the Administrative Procedure Act, to adopt the pending subsection (a) or to propose and adopt new requirements.

9. COMMENT: N.J.A.C. 8:33-1.3 Definitions A number of commentors asked that definitions be added to N.J.A.C. 8:33-1.3 to define terms that are already well described in statute and in health planning regulations. Among these terms are: Health Care Administration Board, State Health Planning Board, rehabilitation center. In other instances, they

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took issue with the definition of "service area" contained in this rule, noting that a service area may extend beyond county borders. Some found a given definition too broad and others found the same definition too restrictive.

RESPONSE: In many instances writers identified a given definition as too broad or too narrow without explaining the basis for their representations. In other instances, writers asked that this rule spell out the functions of the Health Care Administration Board and the State Health Planning Council in relation to certificate of need applications. Since the Health Care Cost Reduction Act, P. L. 1991, c.187, carefully articulates the functions of these public bodies in matters related to certificate of need, the Department does not believe that it is necessary to repeat those aspects of the law in this rule. While it is true that a "service area" may extend beyond a county, the definition noted in the rule clearly establishes that, since it states that a "service area" is a geograhic area, generally a county, within which the facility or service is located. This is a generic definition. The rule also states that definitions of service areas specified in approved planning rules shall take precedence over the general definition used in this rule. Other commenters asked for the inclusion of definitions at N.J.A.C. 8:33-1.3 for terms that are not used in this rule. One such example is the term "subacute." Where a specific definition may not be included in this rule, the definition offered in the enabling statute, the State Health Plan, and the specific health planning rules will apply for certificate of need purposes. For terms not used in this rule but where a definition was requested by a commenter and where the term is not defined in statute, the State Health Plan or a particular planning rule, the Department will refer the comment to its planning staff so that operationalized definitions are developed, where appropriate, in future iterations of the State Health Plan or appropriate health planning rules.

10. COMMENT: Ms. Tamborlane represented that the definition of "major moveable" equipment used at N.J.A.C. 8:33-1.3 is different from the definition used at N.J.A.C. 8:33-3.7 and Mr. Weisfeld claimed that the language of N.J.A.C. 8:33-3.7(a) should explicitly state that major moveable equipment which has been grandfathered pursuant with section 30 of the Health Care Cost Reduction Act shall not require a certificate of need for replacement.

RESPONSE: The Department does not agree with Ms. Tamborlane that the use of term "major moveable" in the referenced sections is definitionally different. N.J.A.C. 8:33-1.3 simply identifies what the Department will consider as constituting "major moveable equipment" for certificate of need purposes. N.J.A.C. 8:33-3.7 goes on to state that the acquisition, replacement, expansion or transfer of major moveable equipment by any person will require a certificate where the major moveable equipment costs over $1 million, is the subject of a health planning regulation or where the equipment is proposed by the Commissioner to be the subject of a health planning regulation. This section also goes on to note that while a certificate of need is required for the acquisition, replacement, expansion or transfer of major moveable equipment, a physician or a Health Maintenance Organization may petition for a waiver of the certificate of need requirements in accordance to Section 30 of P. L. 1991, c.187.

Moreover, the Department does not agree that equipment grandfathered under section 30 of the Health Care Cost Reduction Act is exempted from certificate of need requirements for its replacement or transfer. It is the understanding of the Department that the intention of the Legislature is enacting the grandfathering provision at section 30 of P. L. 1991, c.187 was to protect a physician from financial harm if he or she had ordered major moveable equipment pursuant to subsection c of section 30 prior to July 1, 1991, the date that most of the provisions of the Health Care Cost Reduction Act became effective. The requirement to obtain a certificate of need was waived for the specific purchase of the equipment only. The argument that the grandfathered equipment is exempt from certificate of need requirements for transfers, replacements, and expansions, as has been expressed by a number of commenters, has no statutory basis. It is clear from the language of the statute that the intent of the Legislature was to create an even playing field so that all providers would compete equally and by the same standards, for certificates of need for regionalized services which are the subject of adopted health planning rules and for expensive major moveable equipment. There is no basis to the claim that the law exempted anyone from the requirements of subsection c of section 30 of the Health Care Cost Reduction Act for acquisitions made after July 1, 1991.

11. COMMENT: N.J.A.C. 8:33-2.2 Determination of a Health Care Facility or Service Ms. Tamborlane referred to the provisions of N.J.A.C. 8:33-2.2 as a "new regulation" which "would allow the Commissioner the right to determine whether a proposed or existing system or modality of health care delivery constitutes a health care service or health care facility subject to certificate of need requirements". She went on to state that "if this regulation is adopted as written, the Commissioner will be able to make such determinations when there is no certificate of need applications pending or when the individual has not asked the Department to make such a determination regarding his/her medical program or practice". Ms. Tamborlane asked that the regulation be amended to allow the Commissioner to make such determinations only if she is asked for a determination, but offered no reason for her suggested change.

RESPONSE: The proposed rule sets forth at N.J.A.C. 8:33-2.2 is not strictly a "new regulation." The provisions of this section were, for many years, contained at N.J.A.C. 8:33-6.1 in substantially the same form. The Commissioner of Health has the responsibility to insure that providers of health care services in this State comply with the laws of this State, including the provisions of the Health Care Facilities Planning Act (N.J.S.A. 26:2H-1 et seq.) and the amendments to that law as set forth in P. L. 1991, c.187. Most potential providers of health care services are compliant with the law and where there is a question of whether a planned health care facility or service is subject to certificate of need requirements will contact the Department of Health for a determination in this regard. Where existing rules do not explicitly answer the question raised by inquiry, the provisions of this section are intended to assist in making a determination of whether a certificate of need will or will not be required. The Department disagrees with Ms. Tamborlane's claim that this type of determination should be made only if the Commissioner is asked to make a determination. The Department very frequently receives complaints from health care providers, who have properly applied for and received certificates of need, that a service is illegally operating in its area because it has not received the required certificate of need and license. To protect the public from unlicensed operators, to insure that the laws of the State are upheld, and to prevent illegal intrusions into established health care markets, the Department is obligated to investigate and to make a determination whether the operation is acting illegally for failing to have obtained the required certificate of need. The factors noted at N.J.A.C. 8:33-2.2 are offered to assist in these determinations. The Department disagrees with those commenters who claim that the factors noted in this section are either too broad or are irrelevant to such determinations. As mentioned, these factors were substantially included in a prior regulation, N.J.A.C. 8:31-6.1 and effectively served the process for making these determinations both in practice and upon challenge.

12. COMMENT: N.J.A.C. 8:33-2.3 Waivers to certificate of need requirements for physicians; and N.J.A.C. 8:33-2.4 Waivers to certificate of need requirements for Health Maintenance Organizations In reference to N.J.A.C. 8:33-2.3 concerning waivers of certificate of need requirements for physicians and N.J.A.C. 8:33-2.4 concerning similar waivers for health maintenance organizations, Health Visions, Inc. has asked that the Department notify local advisory boards of final determinations by the Commissioner of all such waiver petitions. Region One Health Planning Advisory Board, Inc. has asked that a review by the local advisory board occur for each such petition for a waiver. Dover General Hospital argued that the inclusion of waiver opportunities for physicians and health maintenance organizations "does not treat all applicants equally" and requested that waivers be considered for different services, not based on type of provider. The Medical Society of New Jersey supported the changes in the language of this section that occurred from the initial working draft that they reviewed to the formal proposal promulgated by the Commissioner and approved by the Health Care Administration Board for initial publication. Ms. Tamborlane interpreted N.J.A.C. 8:33-2.3 to mean that "if the State Plan does not identify a need for the service that is the subject of the waiver request that the physician will not be permitted to present a waiver application". St. Barnabas Medical Center asked that the language of N.J.A.C. 8:33-2.4(c) be changed to require that the Commissioner be required to consult with existing providers when considering a waiver request submitted by a health maintenance organization. No similar requirement was sought for waivers submitted by physicians.

RESPONSE: N.J.A.C. 8:33-2.3(a) and 2.4(a) properly articulate the circumstances under which a physician or a health maintenance organization may petition the Commissioner for a waiver of certificate of need requirements. These sections are consistent with section 30 of P.L. 1991, c. 187, in which waiver provisions for physicians and health maintenance

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organizations are established. To correct any misunderstanding of these provisions, the Department advises as follows. Where a physician's or a health maintenance organization's right to consideration of a waiver of certificate of need requirements is established in law, a physician or health maintenance organization will be permitted to file a waiver request and those opportunities for waiver consideration are not conditioned on whether the State Health Plan identifies a need for the service which is the subject of the request. Also, in response to the comments summarized above, the Department will notify local advisory boards of waiver determinations made by the Commissioner. While the Department wishes to and, to the extent practical, will consult with the local advisory boards on specific waiver requests, the time constraints established in the statute appear to make an automatic review of all such petitions by the local advisory board impractical. Section 30 of P. L. 1991, c.187 gives the Commissioner only 45 days from the date of receipt of a waiver request from a health maintenance organization to make a determination on the request. Because the language change requiring the Commissioner to make inquiries of existing providers will not always be necessary nor will it be practical given the very limited time constraints, the Department cannot accept the amendment recommended by St. Barnabas Medical Center.

13. COMMENT: N.J.A.C. 8:33-3.1 Initiation of health care service Ms. Stapleton Rhodes commented that it is unclear at N.J.A.C. 8:33-3.1 how expansion of a service is defined as it relates to minor moveable equipment, "which is proposed for deregulation." She indicated that while she assumed that the acquisition of general radiology equipment does not require a certificate of need, since it is an example of minor moveable equipment, that such an acquisition could constitute an expansion of radiology services, thereby requiring a certificate of need. She asked that the inconsistency be clarified. In addition, she suggested that while the initiation of a new health care service should require a certificate of need application processed via full review procedures that the modification or expansion of an existing service should be processed via expedited review.

RESPONSE: In responding, the Department would like to clarify that where a certificate of need is not required for a particular acquisition, the expansion of the unregulated service generally does not require a certificate of need. For example, a certificate of need is not required for the acquisition by a hospital of minor moveable equipment, an example of which is certain radiology equipment not the subject of adopted health planning regulations. If a hospital elects to purchase this type of minor moveable equipment, it may do so without a certificate of need whether it is an initial installation of that equipment or an expansion of it. However, if the hospital elects to purchase that equipment and house it in a renovated, modernized or newly constructed space, the cost of which exceeds the capital threshold of $1 million, it would have to apply for and receive a certificate of need for the modernization, renovation or new construction project. Moreover, while this proposed rule allows certain modifications in projects to be processed via expedited review procedures (See section 5.1), it is not practical in all instances to do so for a variety of reasons including the fact that many hospital projects are subject to the Statewide capital cap created at section 32 of P.L. 1991, c.187. These types of projects, unless they are of an emergent or mandatory nature, should be comparatively reviewed within the capital allowance.

14. COMMENT: N.J.A.C. 8:33-3.4 Bed Capacity, medical day care slot capacity The New Jersey Association of Health Care Facilities, Dr. Solomon Goldberg, and Mr. Dan Moles, Administrator of Ashbrook Nursing Home, recommended that the Department amend the certificate of need requirement at N.J.A.C. 8:33-3.4(a)2 for a decrease in the number of licensed beds by licensure and/or health planning category. A suggestion was made that a reduction of licensed beds only require notification to the Department "unless the original application contained a promise for said beds."

RESPONSE: The Department agrees that, where a reduction in licensed beds can be accomplished without capital expenditures or with capital expenses below the monetary thresholds noted at N.J.A.C. 8:33-3.6, that it should not require a certificate of need. Accordingly, the Department changed N.J.A.C. 8:33-3.4(a)2 which would require that where a reduction in licensed beds can occur below the referenced monetary threshold that the licensed entity merely has to notify the Certificate of Need Program and the Division of Health Facilities Evaluation in writing at least 120 days prior to the effective date of the reduction. Where the reduction in licensed beds would violate a prior condition of certificate of need approval or where the monetary threshold identified at N.J.A.C. 8:33-3.6 would be exceeded in the course of reducing the licensed beds or where the beds are proposed for conversion to another use rather than closure, a certificate of need would be required and the application will be processed in accordance with the procedures set forth in N.J.A.C. 8:33. The Department believes that this change will provide an incentive to close underutilized beds.

15. COMMENT: N.J.A.C. 8:33-3.5 Buildings A number of commenters asked for a clarification of whether the certificate of need requirements set forth at N.J.A.C. 8:33-3.5 require review by full review or expedited review procedures. Still others asked for a clarification of the term "component service" as used at N.J.A.C. 8:33-3.5(a)5.

RESPONSE: In order to provide clarification on the issues raised with regard to N.J.A.C. 8:33-3.5, the Department changed requirements in N.J.A.C. 8:33-3.5 to specifically state the type of review process that applies with regard to establishment of a new facility, replacement of a health care facility at the same site, relocation or replacement of a health care facility at a new site, establishment of a satellite location and relocation of a component service of an existing health care facility. This was done to assure that applicants can readily determine if a certificate of need is required and the process to follow. Therefore, the Department established a subsection for each of the aforementioned situations and identified the specific criteria that are applicable in determining when a certificate of need is required and, if so, the type of review process that will apply. This modification is not substantive since it clarifies certificate of need requirements previously addressed in the rule which were ambiguous or inconsistent.

16. COMMENT: Holy Name Hospital represented that the relocation and replacement of an existing non-bed related facility, referenced at N.J.A.C. 8:33-3.5(a)4 and the relocation and replacement of a component service of an existing health care facility, noted in N.J.A.C. 8:33-3.5(a)5 should not require a certificate of need unless the Department of Health determines that access to the relocated facility or service will be curtailed.

RESPONSE: While the impact of relocations on access to care is a critical factor influencing the decision to require certificates of need for the actions noted at N.J.A.C. 8:33-3.5, it is not the only important issue. The relocation of component services of a facility can have dramatic effects on the cost of health care, especially where the services are corporately unbundled, or where the replacement is unneeded. Moreover, the impacts of such relocations can have major impacts in improving or offending a continuum of care. The certificate of need requirements for such actions are warranted, in light of the impacts on the quality and cost of health care as well as on access to care.

In the rule as proposed, information regarding the certificate of need requirements for buildings was limited and did not provide sufficient information to address all situations. Specifically, it stated that a certificate of need was required for the establishment of a new health care facility. However, it did not identify the type of process that would be followed. In addition, it stated that replacement of an existing bed related health care facility required a certificate of need, regardless of cost. This was inconsistent with the rule at N.J.A.C. 8:33-3.6, which requires a certificate of need for construction in excess of $1,000,000. In addition, the proposed rule indicated that a certificate of need is required for relocation and replacement of an existing non-bed-related health care facility to a new site outside of the municipality. It did not identify the type of process and did not address a relocation of a facility without replacement, for example, lease of a building rather than construction. With regard to the relocation and replacement of a component service, again, the type of process was not identified and relocation and replacement was erroneously combined rather than more appropriately addressed as separate requirements. In order to provide clarification on the issues raised with regard to N.J.A.C. 8:33-3.5, the Department changed requirements in N.J.A.C. 8:33-3.5 to specifically state the type of review process that applies with regard to establishment of a new facility, replacement of a health care facility at the same site, relocation or replacement of a health care facility at a new site, establishment of a satellite location and relocation of a component service of an existing health care facility. This was done to assure that applicants can readily determine if a certificate of need is required and the process to follow. Therefore, the Department established a subsection for each of the aforementioned situations and identified the specific criteria that are applicable in determining when a certificate of need is required and, if so, the type of review process that will apply. This modification is not substantive since it clarifies certificate of need requirements previously addressed in the rule which were ambiguous or inconsistent.

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17. COMMENT: N.J.A.C. 8:33-3.6 New construction/modernization/renovation Ms. Tamborlane's comments in reference to N.J.A.C. 8:33-3.6(a) summarize the substance of this subsection but go on to state that the Department has failed to state that if a physician expends less than $1 million on the modernization, renovation or construction of a facility-type which is the subject of a health planning regulation, he or she is exempt from the certificate of need requirements articulated in this subsection.

RESPONSE: N.J.A.C. 8:33-3.6(a) restates the provisions of Section 7 of P.L. 1971, c.136 (N.J.S.A. 26:2H-7), as amended by Section 30 of P.L. 1991, c.187, subsections 7d and 7e. These subsections of the statute obligate a physician to obtain a certificate of need for the modernization, renovation or construction of a facility only where the facility-type is the subject of an adopted health planning regulation and only when the total project cost for the modernization, renovation or construction exceeds $1 million. Where the total project costs do not exceed $1 million or where the modernization, renovation or construction is not for a facility-type which is the subject of an adopted health planning regulation, a physician is not required to obtain a certificate of need. Licensed health care facilities must obtain a certificate of need whenever the total project costs for modernization or renovation of its physical plant or construction of a new health care facility exceeds $1 million.

18. COMMENT: A number of commenters, including Region One Health Planning Advisory Board, Inc., Morristown Memorial Hospital, the New Jersey Hospital Association, The Hospital Center at Orange, Saint Barnabas Medical Center, Dover General Hospital, and University Hospital, represented that the provision of N.J.A.C. 8:33-3.6(a) are too restrictive because of the cumulative nature of the capital thresholds. They believe that small, unrelated building acquisition, renovation, modernization, and construction projects should not be linked so as to create the requirement for a certificate of need when their total project costs exceed $1 million within a fiscal year.

RESPONSE: As noted above, the requirements of subsection N.J.A.C. 8:33-3.6(a) implement provisions of section 30 of P.L. 1991, c.187 to require a certificate of need when a licensed health care facility expends more than $1 million for the modernization or renovation of its physical plant or for the construction of a new health care facility or where any person, including a physician, expends more than $1 million in total project costs for the modernization, renovation or construction of a facility-type which is the subject of a health planning regulation adopted by the Department of Health. Clearly, the scope of regulatory coverage established in the statute was intended to avoid the unnecessary proliferation of health care facilities and services and to constrain unwarranted expenditures, which lead to unnecessary increases in health care costs. The cumulative nature of the capital threshold referenced at N.J.A.C. 8:33-3.6(a) is essential in safeguarding the intent of the legislation and in avoiding what could become a major loophole allowing for avoidance of regulatory responsibility specifically mandated in the law. If the Department were to accept the recommendation that unrelated renovation projects under $1 million should not require a certificate of need, a health care facility could then engage in a multi-million dollar renovation project and argue that it should not be subject to certificate of need requirements because the components are not related and the renovation costs associated with each component is less than the capital threshold. Surely such an interpretation would be violative of statutory requirements. It could argue, for example, that the renovation of the inpatient psychiatric service is not related to the renovation of the obstetrics service, which similarly is not related to the renovation of the radiology department. Clearly such an interpretation would violate the statutory mandate of section 30 of P.L. 1991, c.187, which requires a certificate of need for the expenditures by a licensed health care facility of over $1 million for modernization or renovation of its physical plant. The Department would like to achieve a responsible accommodation with providers on this issue and will continue a dialogue relative to this issue, but the recommendation offered that costs associated with the certificate of need scope coverage noted in N.J.A.C. 8:33-3.6(a) not be cumulative is fraught with problems as noted herein.

19. COMMENT: N.J.A.C. 8:33-3.7 Major moveable equipment Mr. Weisfeld advised that the Medical Society of New Jersey agrees with the wording of N.J.A.C. 8:33-3.7(a) so far as it goes but asked that a sentence be added to state explicitly that certificate of need are not needed to replace grandfathered equipment "that is intended and used for the same diagnostic and/or therapeutic purposes as the grandfathered equipment."

RESPONSE: See Comment Number 10 and Response noted above.

20. COMMENT: N.J.A.C. 8:33-3.9 Changes in cost/scope/financing A variety of comments were received in response to N.J.A.C. 8:33-3.9 concerning changes in cost/scope/financing. The New Jersey Association of Health Care Facilities asked that the words "including any" be deleted from N.J.A.C. 8:33-3.9(a)1 and replaced with the words "plus the annual." It argued that as currently proposed, any certificate of need applicant would have to file for a change of cost because it interprets the cost change to reflect an increase of 10 percent above the certificate of need approved cost and not 10 percent above the most recently approved adjustment to the certificate of need approved cost, which reflects the annual constuction factor approved by the Department. Region One Health Planning Advisory Board, Inc., stated that the change of cost review should allow for both the 10 percent increase and the annual construction cost factor.

RESPONSE: As a point of clarification, a certificate of need for a change of cost is required pursuant to N.J.A.C. 8:33-3.9(a)1 only when the project costs exceed the total certificate of need approved project cost, adjusted by the approved construction factor. For example, if project X were originally approved for $2 million and received an approved inflation factor in year One for Five percent and in year Two for Five percent, the adjusted approved cost of the project would be $2,200,000. If the cost of the project exceeds $2,200,000 in the instance case, a certificate of need for a change of cost would be required. Thus if a project can be completed for the total originally approved project cost adjusted by the Department for inflation during project implementation, no change of cost certificate of need would have to be submitted because the project will have been implemented at its approved costs. To clarify this matter, the Department accepts the recommendation of the New Jersey Association of Health Care Facilities and has changed N.J.A.C. 8:33-3.9(a)1 accordingly.

Some commenters argued that a 10 percent contingency be built into the cost of each project so that the approved applicant would not have to file for a change of cost unless the project cost exceeded 110 percent of the originally approved costs plus the construction cost factor. The Department rejects this suggestion believing that if the project had been properly planned it could reasonably be implemented at the originally approved costs plus the approved construction cost factors and if it had not, it should be reexamined at its new costs. Moreover, it has been the experience of the Department that to allow the contingency in addition to the construction cost factor is to assure that the contingency amount will be spent. Doing so would not be in the public interest given the high cost of health care. The Department believes the standard established at N.J.A.C. 8:33-3.9(a)1 is reasonable and does not place excessive burdens on project developers. It does require that they plan carefully up front.

21. COMMENT: A number of commenters opposed the absolute cap of 10 percent for changes in costs established at N.J.A.C. 8:33-3.9(a)1 arguing that it would bring valuable projects to a stand-still.

RESPONSE: The Department does not agree that the 10 percent cap would bring irreparable harm to the implementation of approved projects. What the cap requires is careful and complete planning up front and more accurate application submissions. This subsection states that the Department will review certificate of need applications for changes in cost only where the required cost change does not exceed the originally approved project cost plus the approved construction cost factor by 10 percent. If the costs exceed this standard, the certificate of need application will not be accepted for processing and any costs in excess of the approved certificate of need will not be eligible for reimbursement. It does not appear unreasonable to say that everyone has to live within a budget, particularly when the rules are established up front, the proposed costs are included in the applicant's often competitively reviewed application, and the approved applicant has been granted a construction cost factor to account for inflation. The rule holds the applicant to the proposal it submitted and for which approval was granted. If the applicant finds that in the course of project development the cap will be exceeded, there are other provisions in this rule which allow the applicant to scale the project back.

In addition, the Department believes that the provisions of this subsection will result in more accurate application submissions and will create a fairer situation when applications are competitively reviewed. It will absolutely discourage applicants from submitting applications which underrepresent anticipated project costs so as to experience a competitive advantage when the costs of similarly batched projects are comparatively reviewed. In essence, the provisions of this subsection protect other applicants in a competitively reviewed batch against the applicant who

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may deliberately underestimate project costs in order to experience a competitive advantage in the batch and who subsequently file for a major cost change after the original certificate of need is granted. By requiring the applicant to live with the budget that was submitted, the process will seriously discourage deliberate underrepresenting project costs.

22. COMMENT: A criticism was received of the requirement of N.J.A.C. 8:33-3.9(a)3, which prohibits the processing of certificate of need applications after the scope and/or cost changes have been implemented and the costs incurred. The commenter argued that project implementation cannot stop while the provider goes through a certificate of need process. He closed by accusing the Department of micromanagement.

RESPONSE: The Department intends for the application of the provisions of this subsection to be reasonable and responsible and for that reason the subsection includes language stating that the prohibition will not apply where the Commissioner determines that the changes arose from extraordinary circumstances outside the applicant's control. Admittedly rules cannot be written for every conceivable circumstance that may surface during project implementation and the Department wants to fully cooperate in addressing real and practical problems that do arise. As an example, there is a big difference between the conduct of an approved applicant who runs into an asbestos problem during construction that may cause additional costs beyond those approved and advises the Department accordingly and one that incurs costs of several millions of dollars beyond those approved and does not advise the Department until the project is complete or nearly complete. There have been instances where these enormous cost excesses have occurred without informing the Department and then after the fact, sometimes years after the fact, the provider has sought to submit a change of cost application fully expecting these costs excesses to be fully reimbursable. All the Department can say in response to the commenter's criticism is that it has no interest in micro-managing, as suggested; it fully intends to cooperate with reasonable accommodations for reasonable requests, and believes that the provisions of the subsection allow for that accommodation while protecting the public and all who pay for health care from excessive project cost increases that have been incurred without approval by the Department.

23. COMMENT: Mr. Moles has recommended that N.J.A.C. 8:33-3.9(g) should not apply to refinancing which would lower existing indebtedness or total project costs.

RESPONSE: The Department agrees that when market conditions result in lowered interest rates, it should encourage refinancing that would reduce debt service burdens on the state's health care facilities. Accordingly, N.J.A.C. 8:33-3.9(g) has been changed to exempt from certificate of need requirements the refinancing of projects that would result in lower debt service to the provider.

24. COMMENT: While there were few comments concerning the provisions of N.J.A.C. 8:33-3.9(b)1 through 3 regarding the relocation of approved but not yet implemented projects, a comment was received that certificate of need applications for relocations of unimplemented projects should not be required unless the relocation is in a new service area or an area that creates access problems.

RESPONSE: The Department believes that the provisions of N.J.A.C. 8:33-3.9(b)1 through 3 advance access protections without creating unnecessary burdens on approved applicants. If the relocation is within the same municipality, notification to the Department alone is necessary. If, however, the relocation is to another municipality, a reexamination of the project is warranted to insure that the relocation will not cause access barriers that the original project was intended to address. Relocations of approved projects outside of the county in which they were originally approved offer sufficient access concerns that the Department believes that they should either be barred or that the applicant should submit a new application for review by both local and state planning bodies. When a certificate of need is issued, it is with the expectation that it will provide an important service to persons in the area where it will be located. The public expects that in time that service will be available to them. If in the course of project implementation the approved applicant decides to relocate the service out of the municipality or out of the county, that decision will have impact not only for the public that was to be served but also on providers of the service at the new location. Such impacts can be significant and can be severely negative to the system of health delivery and to the public it serves. As a result, the Department believes the purposes for which the project was initially approved should be reexamined within the context of the proposed change.

25. COMMENT: N.J.A.C. 8:33-3.10 Duration of certificate of need Considerable support was voiced for the provision of N.J.A.C. 8:33-3.10(a)1 and 2, which generally establishes a five year "life" for a certificate of need unless the Commissioner grants a longer "life" for complex hospital projects that need to be phased. One hospital commenter believed the five year standard was too generous for regionalized services which involve competitive review. Two commenters claimed that zoning litigation and sewer moratoria, referenced at N.J.A.C. 8:33-3.10(a)1i, should result in automatic extensions and another commeter claimed that hospitals implementing complex projects requiring phasing should be allowed to seek extensions at any time during the first five years.

RESPONSE: Support for the provisions of N.J.A.C. 8:33-3.10 were voiced by people who thought the five year standard was reasonable, who applauded eliminating the present extension of time policy, and who believed that establishing a life for a certificate of need, as recommended by the Governor's Commission of Health Care Costs, would reduce the inventory of approved but not yet built beds in the State. The Department believes that the five year standard is reasonable and that the provisions of this section adequately respond to the needs of hospitals implementing complex projects requiring phasing by allowing them to propose a longer period for implementation for these complex projects based upon the implementation schedule the hospital proposed in its certificate of need application. The provisions do not constrain hospitals in this regard. They only require that the hospital prepare a detailed implementation schedule and make that clear in its certificate of need application. Where a hospital or non-hospital approved applicant finds that the project cannot be implemented in the agreed to time-frames for circumstances beyond the applicant's control, N.J.A.C. 8:33-3.10(a)1i allows the applicant to present his case to the Commissioner. While the Commissioner will give serious attention to such factors as zoning litigation through the first court decision and sewer moratoria, each case should be considered on its merits. Rather than grant automatic extensions, as suggested, the Department believes that it should review the facts specific to each case and intends to do so with the full intention of cooperating with applicants for whom delays in project implementation resulted from extraordinary factors over which they had no control.

26. COMMENT: N.J.A.C. 8:33-4.1 Request for certificate of need applications Few commenters expressed concern with the provisions of N.J.A.C. 8:33-4.1, which set forth the procedures by which certificate of need applications, subject to full review procedures specified in this rule, will be filed with the Department of Health and the local advisory board in response to a call for applications made by the Commissioner of Health. One concern that was expressed is that the Commissioner's calls for applications occur at least three months prior to the due date for submission of the applications. Another commenter suggested that the rule be modified to establish a schedule for the submission of certificate of need applications requiring full review for certificate of need applications that are not competitively reviewed, are not the subject of regionalization activities, are not the subject of an adopted health planning regulation, and do not involve hospital capital construction and major moveable equipment projects which are subject to the annual Statewide capital cap established in section 32 of P.L. 1991, c.187 and articulated in this rule at N.J.A.C. 8:33-4.9(e).

RESPONSE: The Department agrees that it is important to give timely notice of the anticipated schedule for receipt of certificate of need applications. Accordingly, beginning in calendar year 1993, and in accordance to the provisions of N.J.A.C. 8:33-4.1, the Commissioner of Health shall give notice of the schedule for receipt of certificate of need applications for the full calendar year. The notice shall be published in the New Jersey Register on or before its last publication date in February each year as well as in newspapers of general circulation throughout the State and shall include the calendar for submission of applications for full review for the calendar year. In addition, the Commissioner may announce additional or special calls for applications beyond those identified in the yearly notice or delete a scheduled call. Wherever practical, the Commissioner shall allow a minimum of 90 days between the date of publication of the call for applications and the date for submission of applications in response to the call by the Commissioner. N.J.A.C. 8:33-4.1 has been changed to respond to the concern that adequate and timely notice of calls for certificate of need applications occur.

27. COMMENT: N.J.A.C. 8:33-4.3 Submission of applications One commenter pointed out a technical error in the proposal at N.J.A.C. 8:33-4.3(b) concerning the certificate of need application filing fee

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schedule. The first item in the fee schedule immediately under the words "Total Project Cost (TPC)" should read $1,000,000 or less," not $1,000 or less.

RESPONSE: The Department acknowledges the technical error noted above and has changed this subsection to correct the error and in so doing to bring the fee schedule into compliance with the fee schedule set forth in section 36 of P.L. 1991, c.187.

28. COMMENT: A number of commenters objected to the certificate of need application fee schedule established at N.J.A.C. 8:33-4.3(b) claiming that the fees were excessive. Others suggested that different fee schedules be developed for applications that are to be processed via full review as opposed to expedited review procedures. In objecting to the fees, Mr. Groller claimed that "the fees shown here are prejudicial to small facilities with a limited resource base." He also argues that applicants who filed certificate of need applications prior to July 1, 1991 should be permitted to have any subsequent change of cost/scope/or financing processed under the fee schedule that pre-dated the enactment of the Health Care Cost Reduction Act.

RESPONSE: The fee schedule for certificates of need was established at section 36 of P.L. 1991, c.187. A minimum fee of $5,000 was set for the filing of a certificate of need application and the law does not authorize the Commissioner to set a fee below the minimum noted. N.J.A.C. 8:33-4.3(b) merely sets forth the fee schedule established in statute. Applications submitted prior to July 1, 1991 paid the previous fee of not more than $1,000 established in law in 1971. The continued processing of those previously filed applications will not require an additional fee, but all applications submitted subsequent to enactment of P.L. 1991, c.187 will be required to comply with the fee schedule established in that law.

29. COMMENT: N.J.A.C. 8:33-4.5 Review for Completeness It was suggested that for applications determined to be incomplete, the Department should refund the application fee or not require an additional fee when the application is resubmitted. It was also recommended that the filing fee be returned minus a reasonable filing fee and penalty, in the case of an application which is withdrawn. LAB I commented that the rule is silent on whether fees for incomplete applications will be returned.

The New Jersey Association of Health Care Facilities as well as other commenters recommended that this section allow for the completeness review process currently in place whereby an applicant can submit additional information as requested by the Department and have his or her application processed in that same cycle so that an applicant is not forced into a subsequent cycle especially since the need may have dissipated through certificate of need awards in the current cycle. Clarification was requested with regard to subsection (c) which indicates that once an application has been submitted, no subsequent submission of information will be accepted, unless specifically requested. LAB I commented that for an incomplete application, it is not clear when the "next appropriate cycle" will occur and what recourse an applicant has. In addition, they noted that substantive issues which disqualify the application should be identified. LAB I as well as one other commenter suggested that criteria for completeness be specified in the regulations to insure that applications meet Department expectations and streamline the CN process.

A representative of University Health System of New Jersey recommended that the LABs be given the opportunity to appeal those applications that have not ben accepted for processing by the Department to place more responsibility and authority with the local advisory boards and to insure responsiveness to local needs.

RESPONSE: The application fee is required to fund staffing and administration to carry out planning and certificate of need functions. Prior to an application being deemed incomplete, the application is reviewed by staff, correspondence is sent to the applicant providing an opportunity to provide additional information, and a review of the response is completed by the Department. Therefore, it is not feasible to refund an application fee due to the time and resources allocated to the planning for and review of an application before it may be deemed incomplete or withdrawn by an applicant. N.J.A.C. 8:33-4.3 specifies that an application fee is non-returnable, except where an application is declared not accepted for processing.

The proposed completeness review process is essentially the same as the current completeness review process, that is, no application for certificate of need shall be modified or altered after the deadline date for application submission and additional information shall be permitted only in direct response to written questions submitted to the applicant by the Department. The current as well as proposed completeness review process does not permit the modification or alteration of an application to change the number or category of inpatient beds or any services after the application submission deadline date, but allows for unsubstantive changes such as changes in square footage and cost. The completeness review process will provide an opportunity for the applicant to provide information to supplement their application in response to questions by the Department and/or LAB before a determination is made on the completeness status of the application. A change in N.J.A.C. 8:33-4.5(a) has been made in response to comments.

If an application is determined to be incomplete, the application will not be processed in the current cycle. The applicant may file a new application in next cycle calling for the particular health care service which is the subject of the application.

The completeness review process allows for input by the LABs if they so choose to comment on the completeness status of applications. A decision by the Department as to the completeness status of applications is made only after consideration of the entire record. An appeal process for the LABs to appeal decisions by the Department not to accept an application would result in unnecessary delays of all applications in a batch.

N.J.A.C. 8:33-4.2 states that "Application for a certificate of need shall be made to the Department, in accordance with the requirements of this chapter, and shall be in such form and contain such information as the Department may prescribe." In addition to the requirements identified in this rule, specific criteria are addressed in the appropriate health planning regulation for a particular type of health care service. Furthermore, the certificate of need application forms for a particular health care facility and subsequent completeness review process identifies specific requirements for a complete application.

30. COMMENT: N.J.A.C. 8:33-4.6 Modifications of applications Mr. Oths commented that N.J.A.C. 8:33-4.6(b), which states that "under no circumstances may an application be modified or altered to change the number or category of inpatient beds, proposed services, equipment subject to a planning regulation, or change in site after the application submission deadline date," is overly restrictive and would not result in effective health planning. He noted that historically, the Department of Health staff have "negotiated" with applicants regarding the number and category of inpatient beds, proposed services, etc. in order to meet the needs of a patient population. He suggested that modifications or alterations to a certificate of need application should be allowed if the change is acceptable to the Department of Health.

RESPONSE: This provision is not new, but is a continuation of the requirement as specified in the current certificate of need rules. Historically, "negotiations" during the certificate of need review process which resulted in reduction of beds or services would continue in the process with a Department recommendation for partial approval and partial denial. "Negotiations" which resulted in increases in beds and services were not permitted during the certificate of need review process. The goal of the Department is to work with an applicant in developing a certificate of need application prior to submission of an application. This is essential in light of the $225 million cap which requires all acute care hospitals to compete for construction and major moveable equipment project.

31. COMMENT: N.J.A.C. 8:33-4.7 Deferral of applications LAB V commented that more detail is necessary with regard to N.J.A.C. 8:33-4.7 to clarify if a deferred applicant will be required to wait for a call for the next applicable cycle and if there will be a timeframe.

One commenter objected to N.J.A.C. 8:33-4.7(a) which requires the submission of a new application if the applicant does not notify the Department to reactivate a deferred application. Others were confused about whether an entire competitive batch would be deferred or only one application which was part of the batch and whether the applicants must agree to deferral.

The New Jersey Association of Health Care Facilities suggested that the words "a certificate of need application" should be deleted from N.J.A.C. 8:33-4.7(b) since an entire batch should be deferred if any are to be deferred without approval of the applicant so that an applicant is not deferred while total available need is granted to others. LAB I also commented that it seems unfair to defer a single applicant in a batch while allowing others to go forward. Deferral should be for the entire batch to preserve the competitive nature of the CN process.

LAB I suggested that the basis for deferrals should be identified in regulation to avoid arbitrary or capricious decisions when it is not the applicant requesting the deferral.

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Mr. Oths also suggested that the rule be changed to indicate that once projects have been acted upon by the Local Advisory Board and the State Health Planning Board, no deferrals should be permitted.

LAB I and other commenters requested clarification of N.J.A.C. 8:33-4.7(b) as to whether the LAB, SHPB and DOH may each defer an application for 6 months (resulting in a total delay of 18 months) or if the total deferral period is 6 months.

RESPONSE: If an applicant requests deferral for a project that is subject to a call, that deferral necessarily would have to be into the next cycle called for that type of health care service.

With regard to N.J.A.C. 8:33-4.7(a), if the applicant does not notify the Department of an intent to reactivate a deferred application within the regulatory timeframe, it will be assumed that the applicant is no longer interested in proceeding with the application. Therefore, a new application will be required at a future date if the applicant renews interest in proceeding with the project.

The LAB and SHPB have the authority to defer an individual certificate of need application or a batch of applications, except that for an application(s) which is reviewed by more than one LAB, all LABs must agree to the deferral. Furthermore, for applications subject to the capital cap, only the SHPB may recommend deferral of the batch which is subject to approval by the Commissioner. If the Commissioner agrees with the recommendation of the SHPB, all such applications must be deferred, albeit without the consent of the applicant. This provision allows for a fair and equitable treatment of all applications which are competing within the limitations of a competitive batch. In response to comments, N.J.A.C. 8:33-4.7(b) has been revised to more clearly set forth the time frame and process for deferral of certificate of need applications.

32. COMMENT: N.J.A.C. 8:33-4.9 General criteria for review It was suggested that the January 1, 1992 effective date of the State Health Plan be changed to reflect the final adoption of the phases of the Plan.

LAB I objected that N.J.A.C. 8:33-4.9(a) as written reserves for the State Health Planning Board (SHPB) the exclusive right to accept or reject LAB revisions to the State Health Plan since it appears to be too narrow a basis to prevent against a local solution compromising a positive statewide approach. They suggested that any SHPB rejection of a LAB recommendation should be reviewed by the Commissioner and HCAB and the LAB should be granted the right to a fair hearing with the Office of Administrative Law.

The New Jersey Hospital Association, LAB I and numerous other commenters recommended elimination of the capital cap specified at N.J.A.C. 8:33-4.9(e). Reasons cited as to why the cap should be eliminated were that the amount of money allocated for capital projects will not be sufficient to cover the backlog of projects which has resulted from the moratorium, and that application of the cap will create a number of process or regulatory problems and in the long run will inevitably create higher costs. It was noted that the exclusion of projects which can be funded totally by equity gives an unfair advantage to the wealthier suburban hospitals. An objection was made to the language which provides that the capital cap shall apply to all capital construction projects that are or would be financed by the Health Care Facilities Financing Authority if the project is deemed eligible for such financing by the Authorty. It was suggested that the regulation be changed to exclude from the cap projects financed by equity or other sources. A commenter also stated that there is inconsistency regarding the monies that are used in the calculation of the $225 million since the rule refers to projects that could be "deemed eligible" for financing by the Health Care Facilities Financing Authority, but goes on to state that the cap shall not apply to a certificate of need application that is funded totally by cash equity. In addition, it was suggested that the regulations be amended to include only the financed portion of the project in the $225 million cap calculation. An objection was also raised to the designation of the capital cap monies to $205,000,000 for construction and $20,000,000 for major moveable equipment which may result in some projects which require both types of funding not being approved if the major moveable equipment amount was already expended.

RESPONSE: The provisions outlined at N.J.A.C. 8:33-4.9(a) were established at Section 34 of P.L. 1991, c.187. A revision to N.J.A.C. 8:33-4.9(a) was made by the Department which identifies the State Health Plan as an advisory document and outlines the action to be taken by the State Health Planning Board if any recommendations of the local advisory boards are not incorporated into the plan. This modification is consistent with P.L. 1991, c.187, as amended by Assembly Bill 1144.

The $225,000,000 capital cap was established at Section 32 of P.L. 1991, c.187. The allocation between construction and major moveable was established to assure that a portion of the cap would be available for major moveable equipment and was developed as a result of an analysis of historical information on certificate of need applications.

The Health Care Cost Reduction Act established a Statewide cap for hospital construction and major moveable equipment certificates of need in direct response to a recommendation of the Governor's Commission on Health Care Costs. The Commission concluded that a "major determinant of the rise in health care costs includes the amount that the insured are paying for bricks and mortar." They commented that "this [cap] forces the system to consider overall affordability, ..." and "... ends the current practice of assuming an unlimited affordability for capital investment." Applying the cap only to those projects which actually finance through the Health Care Facilities Financing Authority would not adequately address the concern with and proposed solution to rising health care costs expressed by the Commission which subsequently resulted in the Health Care Cost Reduction Act. An exception to the cap for those projects which fund through total cash equity has been included as an exception providing the project will not result in any future increase in capital reimbursement under Chapter 83.

33. COMMENT: N.J.A.C. 8:33-4.10 Specific criteria for review Mr. Steiner commended the State Health Department for requiring certificate of need applicants to include (1) how the proposed project promotes access to low income persons, racial and ethnic minorities, women, disabled persons, the elderly and persons with HIV infections and other persons who are unable to obtain care and (2) the extent to which medically underserved populations currently use the applicant's service in comparison to the percentage of the population in the applicant's service area which is medically underserved and the extent to which medically underserved populations are expected to use the proposed services if approved. However, with respect to the populations noted above he questioned what numerical targets will be deemed acceptable and how will compliance with these targets be monitored on an ongoing basis.

Mr. Wagner stated the law defines the issue of need well and subsequent regulations over the years have done more than an adequate job. Subsection (b) and what follows define need and cost. It used to be that within the definition, as outlined in subsection (b), the issue of access was appropriately addressed. In these regulations, access takes on a life of its own and leads one to expect that tinkering with the CN regulations will, in itself, lead to improvements in access. In fact, the only breakthroughs in improving access have been through legislation and rate regulations. He further commented that the only thing N.J.A.C. 8:33-4.10 will do is increase friction between inner city, suburban and rural hospitals in competitive batches. Hospital services are not the issue, as the Department of Health studies and data have indicated: it is the lack of primary and preventive care which are the most critical issues. If all the requirements devoted to the promotion of access would really improve that situation, then N.J.A.C. 8:33-4.10 would be a major contribution.

Several individuals expressed concern with the requirements of N.J.A.C. 8:33-4.10(b)6v which indicates that evaluation of the certificate of need applications will include a review of whether the applicant has demonstrated that the project will result in an excess of revenue within two years after completion of the project. One commenter stated that after two years, an application should be expected to demonstrate at least a break-even status on operating expenses. It was also mentioned that many providers institute services, not because the project will generate an excess of revenues over expenses, but because it meets an unmet need in the community and is consistent with the organization's not-for-profit mission. Furthermore, one individual commented that to require an excess of revenue may contravene Federal requirements for 501(c)(3) organizations.

It was also suggested that the provisions of N.J.A.C. 8:33-4.10 will result in longer narrative and statistical submissions in applications and noted that such increased costs to applicants should be referenced in the Economic Impact section of the proposal for these rules.

The New Jersey Association of Health Care Facilities, LAB I and others requested that the equity requirement be changed to 10 percent instead of the required 15 percent. It was noted that historically the equity requirement has been 10 percent for all health care facilities except hospitals and that a 15 percent equity could create a hardship for these health care providers. It was suggested that this rule specify the equity reductions that will be allowed at N.J.A.C. 8:33-4.10(b)6(vi)v,

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and suggested that it should be more specific so as to be fair and equitable.

Mr. Mertz stated that the provision of N.J.A.C. 8:33-4.10(e)2 may disallow a certificate of need to be filed to correct licensure violations and deficiencies mentioned in the regulation.

One commenter indicated that the term "history" should be specifically defined at N.J.A.C. 8:33-4.10(e)2 and clarification should be provided as to who must be in compliance with this provision. It was also suggested that the one year waiting period should be changed so that an application can be submitted when all deficiencies are corrected and the facility is found to be back in full compliance.

RESPONSE: The intent of N.J.A.C. 8:33-4.10 is to specifically identify criteria which will be used in the review of certificate of need applications. Provisions of this section include criteria from the current regulations, as well as information previously requested during completeness review of certificate of need applications. Therefore, the costs associated with providing this information should not be significantly greater than the current process. It is acknowledged that the costs will be greater for small businesses not previously regulated. However, the Regulatory Flexibility Analysis for this proposal addressed the impact of the reporting, recordkeeping and other compliance requirements on small businesses. Certificate of need approval letters include conditions which refer to the commitments to access made by the applicant. In addressing the criteria, the applicant shall be guided by current utilization data of the facility and the health planning rules appropriate to the service which is the subject of the application. Monitoring is carried out by Health Facilities Evaluation Licensing Program and failure to comply with the conditions of approval may result in assessment of penalties.

All projects must demonstrate financial feasibility. However, for those projects that are new or additional to a currently operating health care facility, the total financial viability of the health care institution will be examined incorporating the new and/or additional project.

The equity requirement has been set at 15 percent to provide greater assurances that the applicant will have sufficient resources for start-up costs to proceed with the project if approved and to reduce the amount of debt associated with health care facility/service development which should result in lower costs for the delivery of health care services.

The intention of N.J.S.A. 8:33-4.10(b)6vi(4) is to allow the Commissioner to reduce the equity requirement for projects which will primarily serve a medically underserved population. To specify some formulistic method for the equity reduction would be violative of the intent of this section and would deny the Commissioner, the State Health Planning Board, and the Local Advisory Board discretion in considering the merits of a given application in meeting the needs of the medically underserved populations as well as the financial feasibility of the project. As the proposed rule states, ordinarily applicants will be required to provide a minimum equity contribution of 15 percent to the proposed project. There will be occasions, however, where meritorious proposals which offer promise in meeting the health care needs of medically underserved populations may not be able to satisfy this equity contribution but may otherwise be financially feasible. An example might be an inner city ambulatory care center which may not have the 15 percent equity in liquid assets at the time of filing but may have grant money available to it contingent upon the receipt of the certificate of need. It is the intent of this provision to consider these factors and not to automatically eliminate such a project from eligibility because it could not meet the 15 percent equity contribution at the time of filing.

N.J.A.C. 8:33-4.10(e)3 states "An exception will be in the case of applications submitted for the purpose of correcting recognized major licensure deficiencies."

The "history of noncompliance" is defined within the provisions of N.J.A.C. 8:33-4.10(e)2 where it states that an applicant cannot file a certificate of need application until a period of at least one year has elapsed measured from the time of the last licensure or certification action indicating full compliance. Once an applicant has been out of compliance, it is not sufficient to permit the applicant to file when all deficiencies are corrected. The applicant must demonstrate a record of continuous compliance with licensing or regulatory standards for a period of time before being considered for a certificate of need to expand its services.

34. COMMENT: N.J.A.C. 8:33-4.11 Notification of review cycles LAB I expressed concern with the "exclusive" nature of its responsibility for providing notification of certificate of need applications given the limited resources available to the LAB and questioned if an inability to comprehensively notify the public will be cause for a legal action. They commented that not only does the LAB has a legitimate responsibility in this area, but the Department of Health does as well.

It was suggested that the Department establish biannual submission dates for various subject/chapters of the State Health Plan, so that applicants will be able to prepare the certificate of need in a timely manner.

RESPONSE: The responsiblity for notification of certificate of need applications to members of the public can most efficiently and effectively be carried out by the LABs because they will have an ongoing direct working relationship with not only the health care facilities in their areas, but also with interested parties and members of the general public. Therefore, they will be in the best position to assure appropriate notification.

A revision to this rule at N.J.A.C. 8:33-4.1 sets forth that the call for applications which will be accepted during the year will be announced shortly after the State Health Plan has been adopted.

35. COMMENT: N.J.A.C. 8:33-4.12 Functions of local advisory boards; and 4.13 Role of the State Health Planning Board It was commented that these rules do not set forth criteria for LABs or the SHPB to recommend endorsement of waiver applications when a project may not meet standards in the Plan or in planning rules but may meet an identified community or regional need. The commenter recommended that a section allowing LABs and the SHPB to endorse waiver applications be added to allow for more flexibility in the review process.

RESPONSE: Criteria for waiver are more appropriately addressed in the applicable health planning rules.

36. COMMENT: N.J.A.C. 8:33-4.14 Procedures for review by local advisory boards and the State Health Planning Board. The New Jersey Hospital Association, LAB I and several individual commentors objected to the provisions of N.J.A.C. 8:33-4.14 which require at least 25 percent of the quorum of voting members of a local advisory board and State Health Planning Board to vote affirmatively before an application is moved to the next level of review. It was noted that this provision appears to defeat the intent of the Cost Reduction Act by installing a process that could counteract streamlining measures included in the legislation by adding to the complexity and delays of the certificate of need process. It was also suggested that a provider may intentionally submit an application to delay or sabotage a competing applicant. It was recommended that all projects submitted in a given batch not be deferred for review in the case of an individual project appeal since significant delays could be encountered and also suggested that this rule be revised to limit the right of appeal only to final decisions made by the Commissioner or the HCAB.

It was also commented that the regulations improperly seek to limit the Administrative Law Judge as to what the standard of review is to be for this expedited hearing and what documents can be received into evidence.

RESPONSE: The requirement for 25 percent affirmative votes is a statutory requirement of P.L. 1991, c.187, section 37 and an amendment to the legislation would be necessary to eliminate this requirement. To permit other applicants to proceed while one competing applicant is under appeal, does not provide due process for an applicant under appeal. If the other applicants were to proceed, the limited needed beds, services or dollars might be fully allocated to the applicants moving forward. The provisions included in paragraph (c)2 allow for a timely hearing process for an applicant not receiving at least 25 percent affirmative votes by the LAB and/or SHPB and were reviewed with the Office of Affirmative Law.

37. COMMENT: N.J.A.C. 8:33-4.15 Procedures for Commissioner of Health review The New Jersey Association of Health Care Facilities objected to the language at N.J.A.C. 8:33-4.15(d) since it appears to preclude settlement talks.

With regard to N.J.A.C. 8:33-4.15(f), Ms. Tamborlane commented that in accordance with N.J.A.C. 8:33-4.5(b) an application which is unresponsive to the Notice or which inappropriately requests an expedited review will not be accepted for processing by the Department. She further noted that the Health Care Cost Reduction Act gave the Commissioner the right to approve or deny applications contrary to the State Health Plan and states that it is not clear how an application would get before the Commissioner if she wants to approve or deny an application that is contrary to the Plan.

LAB I objected to the language in N.J.A.C. 8:33-4.15(f) which states, "where the State Health Plan is silent on an issue(s) related to a service or facility proposed in a certificate of need application, the Commissioner shall rely on appropriate departmental policies and planning rules, as

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well as any appropriate recommendations of the State Health Planning Board and local advisory board, in making a determination on the application." They indicated that the State Health Plan alone is not an effective tool to utilize as a basis for statewide planning decisions. They suggest that the basis for decision making be specified when the State Health Plan is silent on an issue and the criteria to be utilized by the Commissioner be specified.

It was noted that N.J.A.C. 8:33-3.10(a)1 indicates that a certificate of need shall be valid for a period of five years. Clarification was requested with regard to N.J.A.C. 8:33-4.15(h) as to whether the Commissioner may null and void a certificate of need prior to the five year period if it is determined that the applicant is not making a good faith effort to implement the project. A definition of "good faith effort" was also requested.

It was also noted by other commenters that, since the State Health Plan is now an advisory document based on amendments to P.L. 1991, c.187, the Department should carefully reconsider references to the State Health Plan throughout the entire document.

RESPONSE: The provisions of N.J.A.C. 8:33-4.15(d) do not preclude settlement talks, which are consistent with the Administrative Procedure Act and the Uniform Administrative Procedures Rules.

N.J.A.C. 8:33-4.15(f) has been deleted, consistent with amendments to P.L. 1991, c.187 (A.1144).

Whereas N.J.A.C. 8:33-3.10(a)1 states that a certificate of need shall be valid for a period of five years, it is expected that the applicant will actively pursue the timely implementation of the project. However, in any instance where an applicant received certificate of need approval, but does not make a good faith effort, that is, demonstrate appropriate active progress, toward implementation of the project, the Commissioner may take action through N.J.A.C. 8:33-4.15(h) to null and void the certificate of need. In response to comments, a change to N.J.A.C. 8:33-4.15 was made by the Department which states that the Commissioner may approve or deny an application for a certificate of need upon consideration of the State Health Plan. This is consistent with P.L. 1991, c.187, as amended.

38. COMMENT: N.J.A.C. 8:33-4.16 Conditions on approval/monitoring Clarification was requested as to what is meant by the statement that the SHPB and the LABs may not recommend the inclusion of conditions which are not consistent with the provisions of this subchapter since this subchapter is a procedural set of rules and conditions are usually substantive. The commenter also expressed concern with N.J.A.C. 8:33-4.16(b) which gives the Commissioner the right to modify a condition with agreement of the applicant after the 30 days and prior to licensing in order to respond to changes in the health care system. The commenter noted that if an applicant does not agree to a change in condition, the Department can refuse to license the facility or service and suggested that this section be modified or deleted. She further suggested that a section should be added to give the applicant the right to petition the Commissioner to change a condition of approval prior to or after licensure when "unforeseen circumstances arise which will impact the project or program negatively if the condition is not changed or modified."

With regard to N.J.A.C. 8:33-4.16(c) several commenters requested clarification as to what information is to be provided to comply with conditions, timetable or mechanism for notification to the applicant if the Department determines that a condition is not being met, the applicant's right to appeal or to cure such alleged deficiency before imposition of licensure or rate penalties.

RESPONSE: The provisions of N.J.A.C. 8:33-4.16 make reference to criteria and rules which form the basis for conditions.

In response to the issues and concerns expressed by commenters, the Department has deleted language at N.J.A.C. 8:33-4.16(b) which permitted the Commissioner to modify a condition after the 30 day contest period.

Conditions of certificate of need approval vary according to the type of health care facility, service, etc. The terms of the conditions are included in the certificate of need approval letter.

39. COMMENT: N.J.A.C. 8:33-5 Expedited review process LAB I expressed concern that there is no role for the LAB in the expedited review process nor in the decision making by the Commissioner as to whether the expedited review process may be used in lieu of the full review process. They concluded that it is essential that local advice become a formal part of the process especially for community based primary care and ambulatory mental health services. They suggested that criteria be specified as to when the expedited process may be used in lieu of full review process and that definition and guideline criteria for "minimal impact" be included in the rule. One commenter suggested that the expedited review process be streamlined in terms of time frames and information required.

It was suggested that mandatory renovations, mandatory replacement of fixed or major moveable equipment and changes in cost of 10 percent or less be deregulated.

It was stated that minimum utilization thresholds identified at N.J.A.C. 8:33-5.5(a) should not be established for selected services and programs, but should apply to all health care providers. Furthermore the threshold should be based on the percent of the community that is served.

Comments from the Medical Transportation Association of New Jersey requested that consideration be given to a change in ownership to be processed as an expedited review and a change of ownership less than 10 percent should not require a certificate of need. They also commented that they agree with the requirement for ambulance/invalid coach provider applicants to become a Medicaid provider as along as there is no requirement on the percent of Medicaid recipients accommodated.

The New Jersey Association of Health Care Facilities commented that since the proposed N.J.A.C. 8:33H as published allows for expedited review for adult day health care, N.J.A.C. 8:33-5.1(a) should be amended to include "adult day health care."

It was suggested that N.J.A.C. 8:33-5.4(a)4ii be amended to incorporate track record language from N.J.A.C. 8:33H and that "record of non-compliance" should be clarified.

RESPONSE: The types of certificate of need applications to be processed as expedited review are considered to be those types of projects which require limited resources and are not subject to need methodology criteria. Therefore, in order to assure an expedited process, the review is limited to the Department. The expedited review process is similar to the administrative review process described in the previous regulations governing the certificate of need review process. The criteria specified for expedited review process are identified to the extent possible. For specific situations not identified, it is appropriate for the Commissioner to make determinations regarding projects which have a minimal impact when they are in the best interest of public health.

The expedited review process is shorter than the full review process. In addition, the information required in many cases is generally less than that which is required for a full review application.

Mandatory renovations, replacement of major moveable equipment and changes in cost are subject to the statutory provisions of P.L. 1991, c.187.

Health planning rules generally include requirements for utilization by the medically underserved. The utilization thresholds identified in this rule are for services for which there are no planning rules. The thresholds are included so that applicants for these services will provide a commitment to provide services to the medically underserved.

Transfer of ownerships of all health care facilities except general acute hospitals are processed in accordance with the expedited review process. Furthermore, the rule does not require a certificate of need for the purchase or sale of less than 10 percent of outstanding stock.

N.J.A.C. 8:33-5.5(a)3 requires that an ambulance/invalid coach applicant must agree to become a Medicaid provider. It does not identify a percentage requirement.

N.J.A.C. 8:33H allows for expedited review for adult day health care programs that propose to eliminate or reduce the capacity of an existing program. N.J.A.C. 8:33-5.1(a)17 is consistent with this requirement.

N.J.A.C. 8:33-5.4(a)4ii identifies the information that must be addressed in an application for a transfer of ownership and is not inconsistent with the track record requirements at N.J.A.C. 8:33H, wherein requirements regarding a record of non-compliance are identified.

40. COMMENT: Appendix, Exhibit 2 Lab I recommends that item A6, "Rehabilitation," should be revised to read "Comprehensive rehabilitation". It was suggested that subacute services be added to the bed-related category.

LAB I requested that the subcategory listing in the current rule be added to the new rule to encourage the initiation of ambulatory services and further development of existing services without additional regulatory impediments.

RESPONSE: Exhibit 2, item A 6 was revised to read "comprehensive rehabilitation," since this terminology is consistent with the health planning rules. Exhibit 2a was added which identifies component services of outpatient clinic services which would not require certificate of need review. This information was included in the previous certificate of need rules. It has been added to the new rules to assist applicants in determin-

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ing when a certificate of need may or may not be required for the establishment of a component service of an existing licensed outpatient and clinic service.

Summary of Agency-Initiated Changes:

N.J.A.C. 8:33-1.2(c): In view of the advisory status of the State Health Plan effectuated by the passage of A.1144 which amended P.L. 1991, c.187, the Department has amended N.J.A.C. 8:33-1.2(c) by deleting the following language:

[consistent with the health care needs identified in the State Health Plan and the action is]

N.J.A.C. 8:33-1.2(f): In view of the advisory status of the State Health Plan effectuated by the passage of A.1144 which amended P.L. 1991, c.187, the Department has amended N.J.A.C. 8:33-1.2(f) by deleting the following language:

[The Commissioner may approve or deny an application for a certificate of need if the approval or denial is consistent with the State Health Plan.]

N.J.A.C. 8:33-3.7(d): In order to make this section consistent with the requirements identified in N.J.A.C. 8:33-3.7(a), the following language was added:

or which is the subject of a health planning regulation

N.J.A.C. 8:33-3.7(e): In order to make this section consistent with the requirements identified in N.J.A.C. 8:33-3.7(a), the following language was added:

or which is the subject of a health planning regulation

N.J.A.C. 8:33-4.1(a): The definition of full review process at N.J.A.C. 8:33-1.3 identifies who has responsibility for the review of certificate of need applications. This information has been added to N.J.A.C. 8:33-4.1(a) within its proper context, so that all aspects of the review process are identified in one section as follows:

The full review process involves the review of a certificate of need application by the local advisory board(s) and the State Health Planning Board, as well as the Department of Health.

N.J.A.C. 8:33-4.1(b): The definition of expedited review process at N.J.A.C. 8:33-1.3 identifies who has responsibility for the review of certificate of need applications. This information has been added to N.J.A.C. 8:33-4.1(b) within its proper context, so that all aspects of the review process are identified in one section as follows:

The expedited review process involves review of a certificate of need application by the Department of Health. It does not include a review by the local advisory board(s) or State Health Planning Board.

N.J.A.C. 8:33-4.3(a): During the review of a draft of the new certificate of need rules, representatives of local advisory boards requested that 15 copies of the certificate of need applications be submitted to them so they would have sufficient copies for their board members. The Department changed N.J.A.C. 8:33-4.3(a) as follows:

[Three] ***Fifteen***

N.J.A.C. 8:33-4.9(a): In view of the amendments to P.L. 1991, c.187, effectuated by the passage of A.1144, the Department has amended N.J.A.C. 8:33-4.9(a) as follows:

[the basis upon which all full review certificate of need applications shall be approved. The plan shall be effective beginning January 1, 1992.] ***an advisory document which may be considered when certificate of need applications are reviewed for approval.***

If any recommendations of the local advisory boards are not incorporated into the plan, the State Health Planning Board shall identify those recommendations, which shall be listed separately for each local health planning region, in an addendum to the plan and shall state the specific reason that each recommendation is in conflict with the best interests of Statewide health planning.

N.J.A.C. 8:33-4.14: At N.J.A.C. 8:33-4.14(c), the reference to "the hearing examiner" was changed to "the Administrative Law Judge," in order to conform to N.J.A.C. 8:33-4.14(c)2. At N.J.A.C. 8:33-4.14(c)2, the basis for the Administrative Law Judge's review of the reasonableness of the LAB's or SHPB's denial was clarified as follows (see also change upon adoption at N.J.A.C. 8:33-4.15(c)):

"... based on the documenting evidence that was *[considered by]* ***presented to*** the LAB or SHPB."

N.J.A.C. 8:33-4.15(a): In view of the amendments to P.L. 1991, c.187, effectuated by the passage of A.1144, the Department has amended N.J.A.C. 8:33-4.15(a) as follows:

upon consideration of the State Health Plan and

[the State Health Plan and]

N.J.A.C. 8:33-4.15(c): To clarify that the contest of a record at an administrative hearing contesting the recommended denial of a certificate of need is subject to the same limitations as the record of an administrative hearing earlier in the process as described at N.J.A.C. 8:33-4.14(c), the Department modified N.J.A.C. 8:33-4.15(c) as follows:

(c) A request for a fair hearing shall be made to the Department within 30 days of receipt of notification of the Commissioner's decision. The fair hearing shall be conducted according to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1 ***and the record shall be limited to the documentary evidence presented to the reviewing agencies below.***

N.J.A.C. 8:33-5.1(a)6: In response to comments (see Comment No. 14), the Department agrees that where a reduction in licensed beds can be accomplished without capital expenditures or with capital expenses below the monetary thresholds, it should not require a certificate of need. To be consistent with the requirements at N.J.A.C. 8:33-3.4, N.J.A.C. 8:33-5.1(a)6 has been deleted:

[6. Decrease in licensed beds with a total project cost less than the threshold;]

N.J.A.C. 8:33-5.1(a)10v, 11 and 12: In response to comments (see Comment No. 15), the Department provided the required clarification and consistency with regard to relocation or replacement of existing health care facilities. To be consistent with the requirements at N.J.A.C. 8:33-3.5, N.J.A.C. 8:33-5.1(a)10 and 11 have been modified as follows:

10. Relocation ***or replacement*** of *[a]* ***an existing*** health care facility within *[the same municipality or within]* the same county ***providing the relocation or replacement complies with N.J.A.C. 8:33-3.5***;

11. ***Replacement at the same site of an existing health care facility which exceeds the dollar threshold set forth at N.J.A.C. 8:33-3.6 providing the replacement complies with N.J.A.C. 8:33-3.5.***

N.J.A.C. 8:33-5.1(a)12 has been grammatically corrected, and the reference to continuing care retirement community clarified by the predicate "new."

N.J.A.C. 8:33 Exhibit 2, C14: Extracorporeal shock wave lithotripsey service has been added to the list of special services which require a certificate of need. This should have been included in the original proposal, but was an oversight. This is not a substantive change since an extracorporeal shock wave lithotripter is listed as an example of major moveable equipment which requires a certificate of need; therefore, establishment of the service would also require a certificate of need.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

CHAPTER 33
CERTIFICATE OF NEED APPLICATION AND REVIEW PROCESS

SUBCHAPTER 1. GENERAL PROVISIONS

8:33-1.1 Purpose; scope

(a) The purpose of these rules is to implement the provisions of the Health Care Facilities Planning Act, P.L. 1971, c.136, as amended by P.L. 1978, c.83 and the Health Care Cost Reduction Act, P.L. 1991, c.187. These rules may be amended as necessary to best implement the statutory provisions and to reflect changing economic and systemic conditions within the health care system.

(b) The Health Care Facilities Planning Act provides that no health care facility shall be constructed or expanded, and no new health care service shall be instituted, except upon application for and receipt of a certificate of need. It further provides that no agency of the State or of any county or municipal government shall approve any grant of funds for, or issue any license to, a health care facility which is constructed or expanded, or which institutes a new health care service, in violation of the provisions of this act, N.J.S.A. 26:2H-7. Finally, the Act states:

"No government agency and no hospital service corporation organized under the laws of the State and no other purchasers of health care services shall purchase, pay for or make reimbursement or grant-in-aid for any health care services provided by a health care facility unless at the time the service was provided, the health care facility possessed a valid license or was otherwise authorized to provide such service." N.J.S.A. 26:2H-18.

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(c) All inquiries regarding certificate of need matters should be directed to:

Certificate of Need Program
New Jersey State Department of Health
CN 360, Room 604
Health-Agriculture Building
John Fitch Plaza
Trenton, New Jersey 08625-0360
(609) 292-6552

(d) In addition, before filing a certificate of need application, prospective applicants are encouraged to contact the local advisory board (LAB) in the service area(s) in which their proposed health care service(s) or facility is planned to examine the relationship of the proposed project with the LAB's plans and the State Health Plan. If the proposed service area overlaps more than one planning region, the applicant should consult with each of the affected LABs.

8:33-1.2 General statements of public policy and rules of general application

(a) It is the public policy of the State that hospital and related health care services of the highest quality, of demonstrated need, efficiently provided, properly utilized, and at a reasonable cost are of vital concern to the public health. As provided by N.J.S.A. 26:2H-1, in order to provide for the protection and promotion of the health of the 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 related health care services planning, and health care facility cost containment programs, as well as planning with all public and private institutions whether State, county or municipal, incorporated or not incorporated, serving principally as nursing or maternity homes, residential health care facilities, or as facilities for the prevention, diagnosis, or treatment of human disease, pain, injury, deformity or physical condition(s). All such institutions shall be subject to the provisions established herein.

(b) The Commissioner, to implement the provisions and purposes stated above, shall have the power to inquire into the accessibility to and availability of health care services and the operation of health care facilities and to conduct periodic inspections of such facilities with respect to the fitness and adequacy of the premises, equipment, personnel, rules and bylaws and the adequacy of financial resources and resources of future revenues.

(c) No certificates of need shall be issued unless the action proposed in the application for such certificate is consistent with the health care needs identified in the State Health Plan and the action is necessary to provide required health care in the area(s) to be served, can be economically accomplished and maintained, will not have an adverse economic or financial impact on the delivery of health care services in the region or Statewide, and will contribute to the orderly development of adequate and effective health care services. In making such determinations there shall be taken into consideration the availability of facilities or services which serve as alternatives or substitutes, the need for special equipment and services in the area, the possible economies and improvement in services to be anticipated from the operation of joint central services, the adequacy of financial resources and sources of present and future revenues, the availability of sufficient health personnel supply in the several professional disciplines, the accessibility to and availability of health care services to low income persons, and such other factors as may be established by regulation. In the case of an application by a health care facility established or operated by any recognized religious body or denomination, the needs of the members of such religious body or denomination for care and treatment in accordance with their religious or ethical convictions may be considered to be public need.

(d) Certificate of need applications shall be reviewed for conformance with the rules in effect on the date the application is deemed complete for processing.

(e) Recommendations concerning certificates of need shall be governed and based upon the principles and considerations set forth in these rules, as well as applicable State laws, rules and policies.

(f) Certificates of need shall be issued by the Commissioner based upon criteria and standards promulgated by the Commissioner and the State Health Planning Board and approved by the Health Care Administration Board. The Commissioner may approve or deny an application for a certificate of need if the approval or denial is consistent with the State Health Plan. If any application is denied, the applicant may appeal the decision to the Health Care Administration Board.

(g) No decision shall be made by the Commissioner contrary to the recommendations of the State Health Planning Board or the local advisory board concerning a certificate of need application or any other matter, unless the State Health Planning Board and the applicant shall have been granted the opportunity for a fair hearing in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

8:33-1.3 Definitions

The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

"Accepted for processing" means an application has been determined to be complete by the Department and has been entered into the applicable review cycle.

"Applicant" means an individual, a partnership, a corporation (including associations and joint-stock companies), a State, or a political subdivision or instrumentality (including a municipal corporation) of a State that will be the licensed operator of the proposed service, facility or equipment, which will have overall responsibility for the health care service to be provided.

"Bed capacity" means the total number of beds, listed by health care service within the facility, which are recognized on the facility's current license.

"Capital-related operating costs" means costs pertaining to buildings, fixtures, and moveable equipment, including depreciation, interest, rent/lease and property taxes.

"Change in cost" means any cost in excess of the total approved capital cost in the most recent certificate of need approval for the project.

"Change in financing" means an increase in financing related charges for the project or an increase in the annual interest rate for the financing.

"Change in the method of financing" means a change in the source of financing for a project (for example a change from tax-exempt bonds to taxable bonds), or a change in the amount of project costs which are to be paid from cash, fund raising, grants or other sources other than mortgages, loans or leases.

"Change in project scope" is defined as a deviation from the approved certificate of need which results in a change in any one of, but not limited to, the following:

1. Number of beds by service;
2. Change in complement of major movable equipment;
3. Array of services;
4. Service area;
5. Access or availability to the approved project;
6. Population served including the percentage of Medicaid and medically indigent required to be served as a condition of certificate of need approval; or
7. Square footage.

"Commissioner" means the State Commissioner of Health.

"Construction" means the erection, building, alteration, reconstruction, improvement, renovation, extension or modification of a health care facility, including fixed equipment, the inspection and supervision thereof; and the studies, surveys, designs, plans, working drawings, specifications, procedures, and other actions necessary thereto.

"Construction cost factor" means the inflation factor calculated by the Department and added to the certificate of need approved project cost. This construction cost factor is calculated as a factor

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of the time between certificate of need submission and initiation of construction, and is based on a standardized industry measurement of construction cost inflation.

"Deferral" means a suspension of the review of a submitted application for a limited period of time.

"Demonstration/research project" *[means a health care service, technology, equipment or modality not currently available in the State.]* ***generally refers to a health care service, technology, equipment or modality not currently available in the State. A demonstration project requires a certificate of need as specified at N.J.A.C. 8:33-3.11. The services provided through a demonstration project are not generally available in the State; consequently, the demonstration project does not compete with or affect other health care providers in the State. For purposes of this chapter, "demonstration projects" are distinguishable from "research projects" in that technologies offered as demonstrations have premarket approval from the United States Food and Drug Administration and are not considered investigational or experimental; services provided through demonstration projects may be billed for and receive reimbursement from patient and third party billings; the recipients of services provided at a demonstration are not limited to the subjects of research, as is the case with "research projects," (See also the definition of "research project" below, as well as N.J.A.C. 8:33-3.11 concerning demonstration and research projects.)***

"Department" means the New Jersey State Department of Health.

"Discontinuance" means any health care facility which has closed or substantially ceased operation of any of its beds, facilities, services, or equipment for a period of two succeeding years.

"Equipment system" means a group of equipment units, which operate together to perform a function. For example, the central processing unit of a computer and its peripheral equipment comprise an equipment system. The bedside cardiac monitor units and the nursing console form an equipment system.

"Equipment unit" is an apparatus that can perform its designated function by itself without the addition of any other component.

"Expedited review process" means the review by the Department of Health of a certificate of need application meeting certain specified criteria. Such a review process does not include a review by the local advisory board or the Statewide Health Planning Board.

"Financing charges" means charges, fees and costs incurred by a health care facility in connection with obtaining financing for a project, including, but not limited to: points, discount, financing fees and other charges by the financing agency, authority, bank or trustee; interest on borrowings during construction, net of any interest earnings derived from the investment of borrowed funds; fees of bond counsel, counsel to the lender and counsel to the trustee, if any; fees of accountants and feasibility or other financial consultants; a reserve for debt service equal to one year's principal and interest; charges for title insurance, mortgage insurance, bond insurance or other insurance required in connection with the financing; and rating service fees, printing costs and other costs incurred in connection with the financing; provided that where financing is being provided with tax exempt bonds, an application for a certificate of need will be deemed to include a reserve for debt service of one year's principal and interest and a reasonable underwriter's discount or financing fee, as approved by the bond issuing authority.

"Fixed equipment" means equipment which is attached to the physical plant of a facility.

"Full review process" means the review of an application by the local advisory board(s) and the Statewide Health Planning Board, as well as the Department of Health.

"Health care facility" means the facility or institution, whether public or private, engaged principally in providing services for health maintenance organizations, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, including, but not limited to, a general hospital, special hospital, mental hospital, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled nursing home, nursing home, intermediate care facility, tuberculosis hospital, chronic disease hospital, maternity hospital, outpatient clinic, dispensary, home health care agency, residential health care facility and bioanalytical laboratories (except as specifically excluded hereunder) or central services facility serving one or more such institutions but excluding institutions that provide healing solely by prayer and excluding such bioanalytical laboratories as are independently owned and operated, and are not owned, operated, managed or controlled in whole or in part, directly or indirectly by any one or more health care facilities and the predominant source of business of which is not by contract with health care facilities within the State of New Jersey and which solicit or accept specimens and operate predominantly in interstate commerce.

"Health care service" means the preadmission, outpatient, inpatient, and postdischarge care provided in or by a health care facility, and such other items or service as are necessary for such care, which are provided by or under the supervision of a physician for the purpose of health maintenance or diagnosis or treatment of human disease, pain, injury, disability, deformity, or physical condition, including, but not limited to nursing service, home care nursing and other paramedical service, ambulance service, service provided by an intern, resident in training or physician whose compensation is provided through agreement with a health care facility, laboratory service, medical social service, drugs, biologicals, supplies, appliances, equipment, bed and board, but excluding services provided by a physician in his or her private practice, unless the service is the subject of a health planning regulation adopted by the Department of Health or involves the acquisition of major moveable equipment as specified herein, and services provided by volunteer first aid, rescue and ambulance squads as defined in the New Jersey Highway Safety Act of 1971, P.L. 1971, c.351.

"Health maintenance organization" or "HMO" means an entity which has received a certificate of authority to provide prepaid health care services pursuant to the Health Maintenance Organizations Act, P.L. 1973, c.337 (N.J.S.A. 26:2J-1 et seq.) inclusive of any amendments which may be made thereto.

"Local advisory board" means an independent, private non-profit corporation which is not a health care facility, a subsidiary thereof or an affiliated corporation of a health care facility, that is designated by the Commissioner of Health to serve as the regional health planning agency for a designated region in the State.

"Major moveable equipment" means equipment, including installation and renovation, which is the subject of a health planning rule or which is proposed by the Commissioner to be the subject of a health planning rule. For purposes of this chapter, major moveable equipment shall include all equipment which receives premarketing approval from the U.S. Food and Drug Administration unless the Health Care Administration Board explicitly excludes a specific piece of equipment or a specific technology from the classification of major moveable equipment. Examples of major moveable equipment are identified in the chapter Appendix, Exhibit 3, incorporated herein by reference.

"Mandatory replacement of equipment and/or mandatory renovations to facilities" means replacement of equipment or renovation for one or more of the following reasons:

1. Replacement or renovation is required as a result of a mandate from any Federal, State, county or municipal governmental agency; or

2. Replacement or renovation is required to operate the licensed health care facility without harm or major disruption to the care of patients or to the health and safety of patients, providers, or employees of the health care facility. Examples of this type of replacement would include a breakdown of a heating and/or cooling plant within a facility or a malfunction rendering inoperable the power plant of a facility.

"Medically underserved" groups refer to segments of the population which currently fail to use health care services in numbers approximately proportionate to their presence in the population as adjusted to account for their need for such services.

"Medical arts building" or "medical office building" means a building whose primary function is to provide office space for a person or persons engaged in the private practice of medicine.

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"Minor moveable equipment" means equipment which does not fall within the definition of major moveable equipment stated herein.

"Modernization/renovation" means the alteration, expansion, major repair, remodeling, replacement, and renovation of existing buildings, and the replacement of obsolete equipment of existing buildings.

"Null and void," "nullification," and "nullify" means the revocation of a certificate of need by the Commissioner prior to the expiration of the certificate.

"Operator" of a health care facility means the person or entity which is the holder of the facility license and which has the ultimate responsibility for the provision of health care services in the facility in accordance with applicable legal and professional standards.

"Optional replacement of equipment" means replacement equipment which will perform more analyses, operate more efficiently, economically or reliably or in some manner improve operations in a unit, but which maintains existing capability and does not include upgrading to a newer technology that expands the range of service.

"Person" shall include a corporation, company, association, society, firm, partnership and joint stock company, as well as an individual.

"Principal" means any individual, partnership, or corporation with an ownership interest in a health care facility or service, or a general or managing partner in a limited partnership.

"Project cost" means costs submitted in those dollars which would be needed to complete the project over the anticipated period of construction, if construction were to begin at the time of certificate of need submission.

"Provider of health care" means an individual:

1. Who is a direct provider of health care service in that the individual's primary activity is the provision of health care services to individuals or the administration of health care facilities in which such care is provided and, when required by State law, the individual has received professional training in the provision of such services or in such administration; or

2. Who is an indirect provider of health care in that the individual:

i. Holds a fiduciary position with, or has a fiduciary interest in, any entity described in subparagraph 2ii(2) or subparagraph 2ii(4) below; provided, however, that a member of the governing body of a county or any elected official shall not be deemed to be a provider of health care unless he is a member of the board of trustees of a health care facility or a member of a board, committee or body with authority similar to that of a board of trustees, or unless he participates in the direct administration of a health care facility; or

ii. Received, either directly or through his or her spouse, more than one-tenth of his or her gross annual income for any one or more of the following:

(1) Fees or other compensation for research into or instruction in the provision of health care services;

(2) Entities engaged in the provision of health care services or in research or instruction in the provision of health care services;

(3) Producing or supplying drugs or other articles for individuals or entities for use in the provision of or in research into or instruction in the provision of health care services; or

(4) Entities engaged in producing drugs or such other articles.

"Research projects" are projects whose scope of inquiry and activity are exclusively limited to the execution of a research protocol which when it involves human subjects must be approved by an Institutional Review Board; whose services and interventions are provided to approved study subjects alone; who do not bill for or receive reimbursement for the services, equipment, or interventions provided through the research; and whose services, equipment, or interventions are not competing with and do not negatively impact upon licensed providers of health care services in the State, as determined by the Commissioner of Health. (See also the definition of "demonstration project" above and N.J.A.C. 8:33-3.11.)

"Service area" means a geographic area, generally a county, within which the facility or service is located. However, definitions of service areas specified in approved planning rules shall take precedence over this general definition.

"Similar equipment units" means pieces of equipment which are similar in function and appearance. For example, a manually operated bed and an electrically operated bed are similar units. A 1,000 power microscope and 500 power microscope are similar units. A coulter counter and a microscope are not similar units.

"State Health Planning Board" means the board established pursuant to section 10 of P.L. 1991, c.187, to prepare and review the State Health Plan and to conduct certificate of need review activities.

"Termination" means a certificate of need is not extended by the Commissioner beyond its expiration date.

"Total capital cost" means all costs associated with the proposed project including studies and/or surveys; architect, engineer, legal fees; plans and specifications; supervision and inspection of site and buildings; demolition, renovation, construction; fixed and major moveable equipment, purchase of land and buildings; lease and/or rentals; developmental and/or start up costs, but excluding carrying and financing cost and/or fees, interest and debt service reserve fund. Total capital cost excludes any contingency amounts.

"Total project cost" means all costs associated with the proposed project, including all capital costs, carrying and financing costs, net interest on borrowings during construction, debt service reserve fund. Total project cost excludes any contingency amounts.

"Withdrawal" means a voluntary written request by a certificate of need applicant to the Department to cease any further review of a submitted application submitted before the Commissioner acts on the application. Such a request shall be considered final by the Department and no further consideration or review shall be given to the "withdrawn" application.

SUBCHAPTER 2. APPLICABILITY OF CERTIFICATE OF NEED REQUIREMENTS

8:33-2.1 Types of review

There will be two types of review of certificate of need applications: full review, as described in N.J.A.C. 8:33-4.1(a), and expedited review, as described in N.J.A.C. 8:33-4.1(b). The full review process applies to all certificate of need applications not specifically identified herein as meeting the criteria for expedited review.

8:33-2.2 Determination of a health care facility or service

(a) It is incumbent upon all health care facilities and services to comply with the certificate of need requirements set forth in statute and rules promulgated pursuant thereto. If such automatic compliance is not forthcoming, the Commissioner, consistent with the "public policy of the State that hospital 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" (N.J.S.A. 26:2H-1) and in accordance with the definitions of a health care facility and a health care service, as specified in N.J.S.A. 26:2H-2 and 26:2H-7, shall determine whether a proposed or existing system or modality of health care delivery constitutes a health care service or health care facility subject to certificate of need requirements. If so designated, such facility shall be subject to all of the provisions of the Health Care Facilities Planning Act (N.J.S.A. 26:2H-1 et seq.) and rules promulgated pursuant thereto.

(b) In making this determination, the Commissioner may choose to request the advice and comment of the State Health Planning Board and/or the local advisory board within whose boundaries the proposed or existing health care modality in question originates.

(c) Those factors which shall be considered relevant to the determination of a health care facility or service shall include, but not be limited to:

1. The types of health care service and facilities, and changes thereto, which are required to obtain certificate of need approval by the provisions of this subchapter;

2. The type of health care service delivered or to be delivered, its impact on existing health care facilities and providers and its potential effect on the health care delivery system;

3. The apparent costs of equipping, staffing and operating the health care service and the resultant cost to all payors and consumers of health care;

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4. The degree of complexity in terms of medical technology, equipment, and the medical, para-medical and administrative staffing required to provide the health care service;

5. The evaluation of how historically established referral patterns will be impacted upon by the proposed service; and

6. The financial arrangements for the payment or reimbursement of health care services available to both the service entity in question and to those persons receiving such care.

(d) When a determination is made that a health care service/health care facility is deemed to require certificate of need review, the person(s) involved shall be so notified by the Commissioner. The Commissioner's decision shall be a final agency decision.

8:33-2.3 Waivers to certificate of need requirements for physicians

(a) A physician who initiates a health care service which is the subject of a health planning requirement, or purchases major moveable equipment whose total cost is over $1,000,000, may apply to the Commissioner for a waiver of the certificate of need requirement.

(b) The application by a physician for a waiver of the certificate of need requirement may be made if the following criteria are met:

1. The equipment or health care service is such an essential, fundamental and integral component of the physician's practical specialty, that the physician would be unable to practice his or her specialty according to the acceptable medical standards of that specialty without the health care service or equipment;

2. The physician bills at least 75 percent of his or her total amount of charges in the practice specialty which uses the health care or equipment; and

3. The health care service or equipment is not otherwise available and accessible to patients pursuant to standards identified in the State Health Plan or in specific health planning regulations guiding the review of the proposed service or equipment. However, where these standards are not identified in either the State Health Plan or the relevant health planning rules, a physician may satisfy this criteria by documenting to the satisfaction of the Commissioner, that the proposed service or equipment is not otherwise available or accessible for geographic, financial or other reasons to patients at a health care facility which has received certificate of need approval for the health care service or equipment within 30 minutes travel time of the physician's proposed site for the planned service or equipment.

(c) The physician's documentation in support of his or her petition for a waiver shall include, but may not be limited to, a detailed description of the service or equipment, a statement of the costs related to the implementation, a detailed explanation of patients to be served, detailed assessment of the costs, risks and benefits to patients and an assessment of the impact that the subject of the petition will have on the health care delivery system in general, and on the specific providers of that service in the area in which the service will be located. The Commissioner may make inquiries of existing providers in the area proposed to be served to determine the impact of those providers. In addition, the physician shall identify how his or her service will provide access to persons who are unable to pay the full cost of care and how the service will advance the principles of P.L. 1991, c.187 concerning access, quality and cost containment.

(d) The satisfaction of (b)1, 2, and 3 above will be judged according to the following standards:

1. In assessing a physician's petition for a waiver of the certificate of need requirements, the Commissioner shall be guided by the principles set forth in P.L. 1991, c.187.

2. The certificate of need requirement will not be waived for any health care service proposed to be provided by a physician to inpatients.

3. The certificate of need requirement will not be waived for any diagnostic or therapeutic health care service proposed to be offered by a physician in an outpatient setting when the Commissioner finds that the service as proposed represents an unnecessary risk to patients (for example, services that can only be offered by Department regulation in acute care settings with appropriate backup).

4. A petition for a waiver may not be made concurrently with the submission by the physician seeking the waiver of a certificate of need application for the service. If such an application has been submitted, it will be deferred automatically into the first available batch following a determination on the waiver.

(e) The Commissioner shall make a determination about whether to grant or deny the waiver based upon the criteria set forth at (b)1 through 3 above within 120 days from the date the request for the waiver is received by the Commissioner and shall so notify the physician who requested the waiver. If the request is denied, the Commissioner shall include in that notification the reason for denial of the waiver. If the request is denied, the proposed health care service or the proposed acquisition of major moveable equipment shall be subject to certificate of need requirements pursuant to this chapter. The Commissioner's determination whether to grant or deny the waiver shall be a final agency decision.

8:33-2.4 Waivers to certificate of need requirements for health maintenance organizations

(a) A health maintenance organization which furnishes at least basic comprehensive care health services on a prepaid basis to enrollees either through providers employed by the health maintenance organization or through a medical group or groups which contract directly with the health maintenance organization may apply to the Commissioner for a waiver of certificate of need requirements for:

1. The initiation of any health care service as provided in section 2 of P.L. 1971, c.136 (N.J.S.A. 26:2H-2);

2. The initiation by any person of a health care service which is the subject of a health planning regulation adopted by the Department;

3. The expenditure by a licensed health care facility of over $1,000,000 for modernization or renovation of its physical plant, or for construction of a new health care facility; or

4. The modernization, renovation or construction of a facility by any person, whose total project cost exceeds $1,000,000, if the facility-type is the subject of a health planning regulation adopted by the Department.

(b) The application by a health maintenance organization for a waiver of the certificate of need requirements may be made if the following criteria are met:

1. The initiation of the health care service or the modernization, renovation or construction is in the best interests of State health planning; and

2. The health maintenance organization is in compliance with the provisions of P.L. 1973, c.337 (N.J.S.A. 26:2J-1 et seq.) and complies with the provisions of subsection d of section 3 of P.L. 1973, c.337 (N.J.S.A. 26:2J-3) regarding notification to the Commissioner.

(c) In its petition for a waiver, the health maintenance organization must provide sufficient information, which shall include, but need not be limited to, a detailed description of the service or equipment, statement of the costs related to the implementation, detailed explanation of patients to be served, detailed assessment of the costs, risks and benefits to patients and an assessment of the impact that the subject of the petition will have on the health care delivery system in general, and on the specific providers in the area in particular. The Commissioner may make inquiries of existing providers in the area proposed to be served to determine the impact on those providers.

(d) The satisfaction of (b)1 and 2 above will be judged according to the following standards:

1. In assessing a health maintenance organization's petition for a waiver of the certificate of need requirements, the Commissioner shall be guided by the principles set forth in P.L. 1991, c.187.

2. The certificate of need requirement will not be waived for any health care service proposed to be provided by a health maintenance organization to inpatients.

3. The certificate of need requirement will not be waived for any diagnostic or therapeutic health care service proposed to be offered by a health maintenance organization in an outpatient setting where the Commissioner finds that the service as proposed represents an

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unnecessary risk to patients (for example, services that can only be offered by Department regulation in acute care settings with appropriate backup).

4. A petition for a waiver may not be made concurrently with the submission by the health maintenance organization seeking the waiver of a certificate of need application for the service. If such an application has been submitted, it will be deferred automatically into the first available batch following a determination on the waiver.

(e) The Commissioner shall make a determination about whether to grant or deny the waiver within 45 days from the date the request for the waiver is received by the Commissioner and shall so notify the health maintenance organization requesting the waiver. If the request is denied, the Commissioner shall include in that notification the reason for denial of the waiver. If the request is denied, the proposed health care service or the proposed acquisition of major moveable equipment shall be subject to certificate of need requirements pursuant to this chapter. The Commissioner's determination whether to grant or deny the waiver shall be a final agency decision.

SUBCHAPTER 3. TYPES OF CERTIFICATE OF NEED APPLICATIONS

8:33-3.1 Initiation of health care service

Initiation of any of the specified standard categories of health care services identified in the chapter Appendix, Exhibit 2, incorporated herein by reference, or the modification, replacement or expansion of any health care service or facility, regardless of the amount of capital or operating expenditures requires a certificate of need.

8:33-3.2 Termination of service and reduction of bed capacity

(a) Any health care facility which has closed or substantially ceased operation of any of its beds, facilities, services, or equipment for any consecutive two-year period shall require a certificate of need before reopening such beds, facilities, services, or equipment.

(b) The Commissioner may amend a facility's license to reduce that facility's licensed bed capacity to reflect actual utilization at the facility if the Commissioner determines that 10 or more licensed beds in the health care facility have not been used for any consecutive two-year period. For the purposes of this subsection, the Commissioner may retroactively review utilization at a facility for any two-year period beginning on or after January 1, 1990.

(c) Voluntary closure of a facility or discontinuance of all of its services does not require a certificate of need, except that the closure of a general acute hospital requires a certificate of need and shall follow the full review process. Where a certificate of need is not required pursuant to this section, written notification shall be filed, with the Department's Division of Health Facilities Evaluation and Licensing and with the Certificate of Need Program, 120 days prior to the proposed closure of a facility or discontinuance of all of its services and full compliance with all applicable regulations for closure/discontinuance is required.

(d) Discontinuance of a component service of a hospital requires a certificate and shall follow the full review process. Discontinuance of a component service of any other health care facility requires a certificate of need and shall follow the expedited review process.

8:33-3.3 Transfer of a health care service/facility

(a) A certificate of need is required for a transfer of ownership of operating health care facilities, beds, services, or equipment, that are the subject of health planning regulation according to the rules in this chapter. Applications for transfer of ownership shall follow the expedited review process, except for those involving general acute hospital facilities or services, which shall follow the full review process.

(b) If a transfer of ownership occurs without a required certificate of need subsequent to licensure, then a daily penalty as established in licensing rules promulgated by the Department may be assessed on the "new" owner and/or operator from the date of the unapproved transfer to the date the Department grants formal ownership approval to the "new" owner and/or operator.

(c) In the review of a transfer of ownership application, the prospective owner(s)/operator(s) will be evaluated by the Department on the basis of character and competence and track record with regard to past and current compliance with state licensure, applicable Federal and certificate of need requirements, as specified in N.J.A.C. 8:33-4.9 and 4.10.

(d) A prospective owner approved for any transfer of ownership shall be subject to the same Department of Health certificate of need, licensure, and reimbursement requirements as the current owner, including continuing compliance with any applicable certificate of need conditions, except that the Commissioner may amend the requirements to relate to changes in the health care system.

(e) These rules apply to ownership by any individual, partnership, corporation, or other entity in any entity which is the licensed operator of a facility or which owns the facility's real property. Except as otherwise provided in (g) below, a transfer of ownership which requires a certificate of need is defined as an acquisition or transfer which will increase or establish an ownership interest in a health care facility, as defined in N.J.A.C. 8:33-1.3, through purchase, lease, purchase or lease option, gift, donation, exchange, or by any other means. Types of ownership interests to which these rules apply include, but are not limited to, the following:

1. Shares of stock or any other type of security in a private business corporation;

2. Partnership interests in a general or limited partnership;

3. Ownership of a proprietorship or any other entity which operates a health care facility; and

4. Holding title to real property which is used to operate health care facility, or having a leasehold interest in such real property.

(f) Applications for transfer of ownership shall specify each and every principal in the entity which is the prospective owner and shall account for 100 percent of the ownership of the facility, except that if the ownership and operation is a publicly held corporation, each and every principal who has a 10 percent or greater interest in the corporation must be identified by name, home address and percentage of interest.

(g) The following types of changes by operating health care facilities do not require certificate of need approval by the Department as transfers of ownership, but do require prior written notice to the Division of Health Facilities Evaluation and Licensing of any such sale and identification of ownership changes.

1. The purchase or sale of less than 10 percent of the outstanding stock (preferred or common) in a business corporation, except that any purchase of stock which results in an individual holding 10 percent or more of the corporation's outstanding stock when the individual previously held less than 10 percent of the stock shall require certificate of need approval;

2. The purchase or sale of limited partnership interests in a limited partnership, where a written limited partnership agreement prohibiting participation in management of the partnership by limited partners has been submitted to the Department. This exception shall not apply to general or managing partners or to any partner who participates in management;

3. A change in the membership of a nonprofit corporation, where the members are individuals or nonprofit corporations, and there is no purchase or sale of assets.

4. A change in ownership which does not involve acquisition of an ownership interest by a new principal; that is, the change involves only the percentage owned by the principals in the entity which is the licensed operator of the facility or involves withdrawal of one or more principals from ownership in the facility;

5. The death of a principal in a health care facility, which shall be reported to the Department's Licensure Program, together with the identity of the heir(s) to the ownership interest of the deceased principal. If the heir(s) intends to retain the ownership interest, the heir(s) shall be subject to investigation of licensure track record. Otherwise, the Department may accept an application to transfer the heir's ownership interest. Any other transfer ownership which occurs by operation of law shall be reported in the same manner; and

6. A transfer, which involves a change in the controlling legal entity, but not in individuals with ownership interests, including, but not limited to:

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i. A change in the type of organizational entity owning the facility only, with no change in the principals with ownership interests (for example, a change from a corporation to a partnership or vice versa);

ii. The merger or consolidation of a corporation with or into its wholly-owned subsidiary;

iii. The merger or consolidation of a corporation with or into a corporation with identical common ownership;

iv. A transfer of assets to an entity with identical common ownership;

v. A transfer of assets to a wholly-owned subsidiary corporation;

vi. A transfer of assets from a wholly-owned subsidiary corporation to its parent;

vii. A transfer of stock to a wholly-owned subsidiary; or

viii. A transfer of stock to an entity with identical common ownership.

(h) Any person or entity which loans money for the construction of, capital improvements to, or operation of a health care facility may hold as security therefore such liens, mortgages, pledges, and other encumbrances on the assets, real property, or stock or other ownership interests in the health care facility as provided in any loan or security agreement with the borrower and to the fullest extent permitted by law. If a lender acquires an interest in all of the assets or ownership of a health care facility upon foreclosure of any such security interest upon default, such lender shall promptly make application for a certificate of need in accordance with this subchapter and will be permitted to operate the facility pending review of said application provided that such lender shall demonstrate to the satisfaction of the Department that the health, safety and welfare of the patients will be maintained in the interim.

(i) Except as otherwise provided in (j) below, the transfer of approved certificates of need prior to licensure is prohibited. Proceeding with any such transfer shall nullify the certificate of need and preclude licensure as a health care facility.

(j) At the discretion of the Department, an exception to the prohibition, at (i) above, on the sale of certificates of need prior to licensure may be permitted and the certificate of need process for transfer of ownership may be allowed to proceed on an unimplemented certificate of need if the types of changes set forth at 1 through 6 above apply. Applicants for transfers of unimplemented certificates of need demonstrate in the application that the transfer will not adversely affect the financial feasibility of the project.

(k) If a lender or creditor acquires an ownership interest in the physical assets of an unlicensed certificate of need project through foreclosure on a mortgage, lien, or other security interest, the certificate of need ordinarily will be automatically nullified. However, the Commissioner may consider the transfer of the certificate of need to the new owner of the site where the certificate of need approved project has been substantially completed as determined by the Commissioner, and where the Commissioner finds that the completion of the project would be in the best interest of the population to be served. The Commissioner must seek the recommendation of the State Health Planning Board and the State Health Planning Board may seek the recommendation of the local advisory board. The State Health Planning Board may appeal a decision of the Commissioner which is contrary to its recommendation.

(l) If the facility being transferred has any partially implemented or unimplemented certificate of need approvals, an application for transfer of ownership will not be accepted for processing until the unimplemented components of the certificate of need have been completed. The Commissioner can waive this requirement where he or she determines it is consistent with the needs of the health care system reflected in the State Health Plan.

(m) Applications for transfer of ownership of home health agencies will be processed according to the rules in this chapter and must meet the criteria identified at N.J.A.C. 8:33L-2.6.

8:33-3.4 Bed capacity, medical day care slot capacity

(a) The following criteria apply to changes in bed capacity:

1. Any increase in the number of licensed beds by licensure and/or health planning category requires a certificate of need and shall follow the full review process, except as follows:

i. Long-term care facilities proposing to increase their total number of licensed long-term care beds by no more than 10 beds or 10 percent of their licensed long-term care capacity, whichever is less, within a period of five years shall not require a certificate of need, but shall apply to the Department's Division of Health Facilities Evaluation and Licensing for authorization pursuant to N.J.S.A. 26:2H-7.2.

ii. Any increase in the total number of residential health care beds requires a certificate of need and shall follow the expedited review process.

2. Any decrease in the number of licensed beds by licensure and/or health planning category requires a certificate of need and shall follow the full review process, *[except that an application for decrease in the number of licensed beds by licensure and/or health planning category which will result in a capital expenditure less than the monetary threshold outlined in N.J.A.C. 8:33-3.6 shall follow the expedited review process.]* ***where the reduction in the licensed beds will result in a capital expenditure greater than the monetary threshold specified in N.J.A.C. 8:33-3.6 or where the bed reduction would violate a condition of certificate of need approval imposed upon the provider, as determined by the Commissioner. A certificate of need will not be required for any decrease in the number of licensed beds by licensure and health planning category where the reduction can be accomplished at a total capital expenditure less than the monetary threshold specified in N.J.A.C. 8:33-3.6 and where the reduction will not violate a condition of approval of a certificate of need provided to or on behalf of the provider or the organization of which the provider entity is a part. In these instances the licensed entity will be required to notify in writing by certified mail the Certificate of Need Program and the Division of Health Facilities Evaluation in the State Department of Health at least 120 days prior to the effective date of the bed reduction identifying by number and licensure and/or health planning category the beds to be removed from the facility's license and shall specify both the total capital costs associated with the planned reduction of licensed beds and the specific plans the provider has made to relocate any and all patients occupying the beds proposed for closure. The Department will notify the provider in writing within 20 days of receipt of written notification of the proposed bed reduction whether the proposed reduction shall require a certificate of need. The provisions of this subsection shall apply exclusively to a reduction of licensed beds which results in the permanent closure of the subject beds and their removal from the facility's license. The provisions of this subsection do not apply in the case of an applicant proposing the reduction or elimination of residential health care beds or the closure of a residential health care facility. The rules guiding such bed reductions or residential health care facility closures are set forth at N.J.A.C. 8:33H-1.12. Conversions of licensed beds to other uses shall be treated as increases in the number of beds by licensure or health planning category and the provisions of (a)1 above shall apply.***

3. The relocation of licensed beds from one physical facility or site to another requires a certificate of need and shall follow the expedited review process, except that if the relocation is from one county to another, the application shall follow the full review process.

(b) The following criteria apply to medical day care slots:

1. The establishment or expansion of an adult day health care facility requires a certificate of need and shall follow the full review process.

2. The reduction of adult day health care slots from an existing facility requires a certificate of need and shall follow the expedited review process.

3. The establishment of or change in the number of pediatric day care slots requires a certificate of need and shall follow the expedited review process.

8:33-3.5 Buildings

(a) *[Regardless of cost, a certificate of need is required for]* ***The following criteria apply to buildings***:

1. *[Establishment]* ***Regardless of cost, a certificate of need is required for the establishment*** of a new health care facility ***and shall follow the full review process***;

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2. Replacement ***at the same site*** of an existing *[bed-related]* health care facility ***which exceeds the dollar threshold set forth at N.J.A.C. 8:33-3.6 requires a certificate of need and shall follow the expedited review process, providing it meets the following criteria:**

i. The facility proposed for replacement is not licensed as a general acute care hospital or subject to the capital cost restrictions noted at N.J.A.C. 8:33-4.9(e);

ii. The existing facility proposed for replacement is not adding beds to its total licensed bed inventory and is not adding beds within any licensure and/or health planning category at the proposed replacement facility beyond those identified on its license at the time the certificate of need application is submitted;

iii. All direct patient services in the existing facility will cease operation once the replacement facility is licensed; and

iv. The replacement facility shall be located at the existing site or at a new site either within the same municipality or within the same county as the existing facility. Where the new site is in a county other than the county in which the existing facility is located, a certificate of need will be required and will follow the full review process.*

3. *[Establishment of a satellite location for an existing health care facility;]* ***Replacement at the same site of an existing health care facility which does not meet the criteria set forth above requires a certificate of need and shall follow the full review process;***

4. Relocation *[and]* ***or*** replacement of an existing *[non-bed related]* health care facility to a new site *[outside of the municipality]* ***within the same county*** in which it is located ***shall follow the expedited review process. A relocation or replacement of an existing health care facility within the same municipality which does not exceed the dollar threshold set forth at N.J.A.C. 8:33-3.6 will not require a certificate of need. However, notification of the change must be submitted to the Certificate of Need Program. If the facility's plan for relocation or replacement includes any proposed new service not previously offered by the applicant at the existing location or involves a relocation to a county other than the one in which the facility to be relocated or replaced is located at the time the certificate of need application for relocation or replacement is submitted to the Department, the application shall follow the full-review process. In addition, if the relocated or replacement facility is a licensed general acute care hospital or is subject to the capital requirements noted at N.J.A.C. 8:33-4.9(e), the certificate of need application shall follow the full review process in the appropriate batch;*** *[and]*

5. Establishment of a satellite location by an existing health care facility requires a certificate of need and shall be subject to full-review requirements set forth at N.J.A.C. 8:33-4.1(a); and

*[5.]***6.*** Relocation and replacement of a component service of an existing health care facility ***shall follow the expedited review procedure noted at N.J.A.C. 8:33-5.1 unless the service is a component of an acute care hospital in which case the application shall be processed via full review procedures in the appropriate batch*.**

8:33-3.6 New construction/modernization/renovation

(a) Acquisition of a building and/or new construction, modernization or renovation of a health care facility which, under generally accepted accounting principles, results in cumulative total project costs for all projects within a fiscal year in excess of $1,000,000, requires a certificate of need and shall follow the full review process. If the new construction, modernization or renovation is for a facility which is the subject of a health planning regulation adopted by the Department, then any person, including a physician or group of physicians must also obtain a certificate of need.

(b) Acquisition of fixed equipment and/or renovations to facilities dealing exclusively with energy conservation and management in excess of the cost thresholds for optional replacements or renovations requires a certificate of need and shall follow the expedited review process.

(c) Mandatory replacement of fixed equipment and/or mandatory renovations to facilities in excess of the monetary thresholds for equipment replacement or renovations requires a certificate of need and shall follow the expedited review process.

(d) Regardless of capital cost, a certificate of need is not required for new construction, modernization or renovation of a medical arts building or parking garage.

1. The costs of purchase, construction, renovation, expansion and operation of the proposed parking garage shall be fully underwritten by charges to users, as the costs will not be financed, directly or indirectly, in whole or in part, by charges to patients. An exception may be made for components of cost which are reasonable and necessary and conform to the reimbursement definitions and procedures for employee benefits related to patient care set forth in reimbursement regulations.

2. The costs of the purchase, construction, renovation, expansion and operation of a proposed medical arts building shall be wholly underwritten by charges to users. An exception can be made when documentation is provided and the Department determines that it is cost effective to locate health care services in the building.

8:33-3.7 Major moveable equipment

(a) Acquisition, replacement, expansion, or transfer by any person, including a physician, of major moveable equipment whose total cost exceeds $1,000,000, as well as any major moveable equipment for the provision of a service which is the subject of a health planning regulation or which is proposed by the Commissioner to be the subject of a health planning regulation, requires a certificate of need except where the Commissioner has granted a waiver to a physician or to a Health Maintenance Organization pursuant to section 30 of P.L.1991, c.187.

(b) Acquisition of an equipment unit that is part of an equipment system, through purchase, lease, or donation, if the system's cost or value, including installation and renovation under generally accepted accounting principles, results in a cumulative total project cost or value of $1,000,000 or more or is expected to be $1,000,000 or more, within a fiscal year, requires a certificate of need and shall follow the full review process in the appropriate batch.

(c) Any major moveable equipment acquisition which is subject to certificate of need batching requirements shall be processed in the appropriate batch and cannot be included as part of another application, such as a facility modernization/renovation/construction project.

(d) Optional replacement of existing major moveable equipment with the same equipment which exceeds the dollar threshold ***or which is the subject of a health planning regulation*** requires a certificate of need and shall follow the full review process in the appropriate batch.

(e) Mandatory replacement of major moveable equipment, as defined at N.J.A.C. 8:33-1.1, which exceeds $1,000,000 ***or which is the subject of a health planning regulation*** requires a certificate of need and shall follow the expedited review process.

8:33-3.8 Minor moveable equipment

Regardless of capital cost, a certificate of need shall not be required for the acquisition, replacement, expansion or transfer by any person, including a physician, of minor moveable equipment. The Department will not support any appeal to the Hospital Rate Setting Commission for additional reimbursement in the schedule of rates as a result of the acquisition of minor moveable equipment by general acute care hospitals.

8:33-3.9 Changes in cost/scope/financing

(a) Any proposed change in the cost of an approved project shall require a change of cost review and shall follow the expedited review process outlined in N.J.A.C. 8:33-5, except as follows:

1. A certificate of need for change in cost for an original certificate of need approval issued after *[the effective date of these rules]* ***September 8, 1992*** may not exceed 10 percent of the approved capital cost *[including]* ***plus*** any construction cost factor calculated by the Department for the life of the certificate of need. Any certificate of need application for change in cost which exceeds 10 percent will not be accepted for processing. Any cost in excess of the approved certificate of need will not be eligible for reimbursement.

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2. A certificate of need for change in cost for an original certificate of need approval issued prior to the effective date of these rules may be filed regardless of the amount of the increase in cost.

3. A change of cost application must be filed with the Department prior to expenditure of funds and/or commitment to expend funds which would result in total project costs which exceed the approved certificate of need costs. The Department shall not process any applications for changes in scope and/or cost when the changes in scope have occurred and/or costs have already been incurred and construction has been initiated or the project implemented by the time the application is submitted for processing unless the Commissioner determines that the changes arose from extraordinary unforseeable circumstances outside the applicant's control.

(b) The following criteria apply to a proposed change in the location of an approved, but unimplemented, certificate of need project:

1. Relocation of the proposed project within the same municipality does not require a certificate of need review. The applicant shall submit written notification to the Certificate of Need Program with appropriate documentation of site control.

2. Relocation of the proposed project within the same county requires a certificate of need and shall follow the expedited review process.

3. Relocation of the proposed project outside the approved county will not be accepted for processing. Failure of the applicant to implement the project within the same county will result in nullification of the approved certificate of need.

(c) The following criteria shall apply to changes in square footage:

1. Any increase in the total approved square footage to be renovated and/or constructed does not require a certificate of need, unless it also results in an increase in total project costs and would be subject to the criteria identified at (a) above.

2. Any decrease of less than 10 percent of the total approved square footage to be renovated and/or constructed does not require a certificate of need.

3. Any decrease of 10 percent or greater of the total approved square footage to be renovated and/or constructed with a commensurate reduction in cost requires a certificate of need and shall folllow the expedited review process. An application for a decrease in square footage of 10 percent or greater without a commensurate reduction in cost will not be accepted for processing.

(d) The following criteria shall apply to changes in beds, complement of major moveable equipment and array of services:

1. A certificate of need for change in scope for an original certificate of need approval issued prior to *[the effective date of these rules]* ***September 8, 1992*** may be filed providing that the scope change results in a reduction of beds, elimination of approved major moveable equipment or elimination of services and shall follow the expedited review process. All applications for change in scope must be filed with the Department no later than December 31, 1993. Applications filed after that date will not be accepted for processing.

2. The Department will not accept for processing the following changes in scope for an original certificate of need approval issued prior to *[the effective date of these rules]* ***September 8, 1992*** . Failure to implement the scope of the project as approved will result in nullification of the approved certificate of need and require the filing of a new certificate of need application in the next appropriate cycle.

i. Any increase in the number or category of approved beds;

ii. Addition of approved major moveable equipment; or

iii. Addition/expansion of services approved within the application or any standard categories of health care services.

(e) The following criteria apply to changes in service area, access or availability to the approved project, population served:

1. The Department will not accept for processing the following changes in the scope of any approved certificate of need. Failure to implement the scope of the project as approved will result in nullification of the approved certificate of need and require the filing of a new certificate of need application in the next appropriate cycle.

i. Relocation of the proposed project outside the county for which it was originally approved; or

ii. Change in the population served including percentage of Medicaid and medically indigent required to be served as a condition of certificate of need approval.

(f) The Department will not accept for processing any change in scope for an original certificate of need approval issued after *[the effective date of these rules]* ***September 8, 1992*** unless the change is for the exclusive purpose of reducing the scope of the project with a commensurate reduction in cost. Failure to implement the scope of the project as approved will result in nullification of the approved certificate of need and require the filing of a new certificate of need application in the next appropriate cycle.

(g) Any change in financing or change in the method of financing, which will result in an increase in capital-related operating costs of 10 percent or more shall be considered a change in the financing of the project and shall follow the expedited review process. ***Wherever the refinancing will not result in an increase in capital-related operating costs of 10 percent or more and, in the case of general acute care hospitals, will not cause a hospital to exceed its maximum capital cost per admission allowance under the State's hospital reimbursement system, no certificate of need for a change in financing shall be required. The Department will, however, require written notification from the approved applicant of the change that was effectuated through an approved refinancing within 30 calendar days of securing the refinancing.***

(h) Any modifications to the project as approved shall be reported to the Department's Certificate of Need Program in writing for review and approval prior to implementation.

8:33-3.10 Duration of certificate of need

(a) The following criteria apply to the duration of a certificate of need:

1. For a certificate of need approved after the effective date of this rule, the certificate of need shall be valid for a period of five years from the date of approval, unless the State Health Plan specifies a different period of time for which a certificate of need for that service shall be valid or the Commissioner grants additional time in the initial certificate of need approval for complex projects submitted by hospitals which can only be completed in phases. For complex hospital projects, the applicant will be required to petition for the extended period of time in its application, providing a detailed schedule for project implementation and identifying a specific time frame for project completion.

i. If the project has not been approved and/or licensed by the Department's Division of Health Facilities Evaluation and Licensing within the timeframe identified within this subchapter, the certificate of need shall automatically be deemed to be terminated, unless the Commissioner determines that the failure of the applicant to complete the project within this timeframe was the result of extraordinary unforseeable circumstances beyond the control of the applicant (for example, zoning litigation through the first court decision, sewer moratorium). In making this determination, the Commissioner may request the advice and comment of the State Health Planning Board and/or the local advisory board within whose boundaries the project is located.

2. For a certificate of need approved prior to the effective date of this rule, the certificate of need approval shall remain valid until the expiration date noted in the most recent extension of time. The applicant will be required to file for a extension of time 60 days prior to the current expiration and to propose a detailed time frame identifying the remaining time needed to complete the approved subject. Where the Commissioner determines that the approval should be extended for an additional period of time beyond its current expiration date, he or she will assign a final expiration date.

8:33-3.11 Demonstration ***and research*** projects

(a) *[Applications subject to certificate of need requirements seeking approval as a demonstration/research project shall follow the following process:

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1. The applicant shall submit a request to the local advisory board to recommend the incorporation of the proposed demonstration/research project into the State Health Plan.

2. The State Health Planning Board (SHPB) shall consider the recommendations of the local advisory board. Where the SHPB determines that the State Health Plan should allow for a specific type of demonstration or research project, the SHPB shall revise the plan subject to the approval of the Health Care Administration Board.

3. If the revised plan is adopted identifying the need for a demonstration/research project, the Commissioner may invite certificate of need applications in response to the need specified in the State Health Plan in accordance with the review process identified at N.J.A.C. 8:33-4.1.]* ***(Reserved)***

***(b) Projects which satisfy the definition of a research project, as specified at N.J.A.C. 8:33-1.3, shall be exempt from certificate of need requirements as long as they are conducted exclusively for the purposes of investigational studies and scientific research.**

(c) At the conclusion of the research project, the health care services and equipment provided in the course of the research will no longer have certificate of need exemption status. At that time, if the services and equipment used are to be continued such that they will be provided to the general population or where billings for such services or equipment shall occur or reimbursement received, a certificate of need must be obtained in accordance with the provisions of this chapter and all other applicable health planning rules.*

SUBCHAPTER 4. THE REVIEW PROCESS

8:33-4.1 Request for certificate of need applications

(a) ***The full review process involves the review of a certificate of need application by the local advisory board(s) and the State Health Planning Board, as well as the Department of Health.*** The full review process for certificate of need applications will be activated upon notice by the Commissioner inviting certificate of need applications *[in response to]* ***in consideration of the*** specific needs identified in the State Health Plan. The notice shall become effective upon the date of publication in major newspapers of general circulation in the State. The notice will also be distributed to health care associations on file with the Department, filed with the Office of Administrative Law and published in the New Jersey Register. ***Beginning in calendar year 1993 the Commissioner shall publish in the New Jersey Register in February of each year an anticipated schedule for receipt of certificate of need applications subject to full review procedures during the current calendar year. The Commissioner may announce additional or special calls for certificate of need applications beyond those identified in the yearly notice or may delete announced calls from the yearly notice. Wherever practical, the Commissioner shall provide notice in accordance with this section to allow for a minimum of 90 days between the date of publication of the Commissioner's notice inviting certificate of need applications and the date for submission of applications in response to the notice(s).*** The notice will identify the needed service(s), proposed geographic area(s) to be served, the date the application is due, the date the application is deemed complete for processing, the date the local advisory board must submit its recommendation to the Commissioner and the date that the State Health Planning Board must submit its recommendation to the Commissioner. The local advisory *[Board(s)]* ***board(s)*** shall forward recommendations to the State Health Planning Board and Commissioner within 45 days after the application is deemed complete for processing and the State Health Planning Board shall forward recommendations to the Commissioner within 90 days after the application is deemed complete for processing unless a fair hearing is requested by an applicant in accordance with the procedures identified at N.J.A.C. 8:33-4.14. A decision should generally be rendered by the Commissioner approximately three months after the application is deemed complete for processing.

(b) ***The expedited review process involves review of a certificate of need application by the Department of Health. It does not include a review by the local advisory board(s) or State Health Planning Board.*** The expedited review process will include 12 review cycles. The beginning of each cycle shall be the fifteenth day of each month and a decision should generally be rendered by the Commissioner approximately two months after the application is deemed complete for processing. Deadlines for initial submission of applications for expedited review shall be no later than the first day of the month preceding the beginning of a review cycle.

8:33-4.2 Development of applications

(a) Application for a certificate of need shall be made to the Department, in accordance with the requirements of this chapter, and shall be in such form and contain such information as the Department may prescribe.

(b) Before filing an application, applicants are encouraged to contact the local advisory/board(s) in the proposed service area(s) and the Department to examine the relationship of the proposed project to the applicable plans, guidelines, and criteria. Applicants should refer to Exhibit 1 of the chapter Appendix, incorporated herein by reference, for information and assistance in determining how the proposed service area relates to the appropriate local advisory board. If the proposed service area overlaps more than one local advisory board planning region, the applicant shall contact all affected local advisory boards and the Commissioner will invite comment from the appropriate boards.

(c) An applicant or any principal thereof, whose certificate of need application is in any appeal or hearing status, may not file a certificate of need application for the same health care service in the same service area which is similar to, dependent upon, or related to the application being appealed as determined by the Commissioner, while such appeal or hearing is pending.

8:33-4.3 Submission of applications

(a) *[Three]* ***Fifteen*** copies of the application shall be submitted to the appropriate local advisory board(s) simultaneously with 15 copies to:

Certificate of Need Program
New Jersey State Department of Health
CN 360, Room 604
John Fitch Plaza
Trenton, New Jersey 08625-0360
(609) 292-6552

(b) Below is the schedule of fees, based on total project costs, required when submitting any application for a certificate of need for the expedited review or full review process. Fees shall be paid in full at the time applications are filed with the Certificate of Need Program. Failure to pay the appropriate application filing fee in full shall form a sufficient basis to deem the application to be incomplete. Certified checks, cashiers' checks or money orders must be made payable to Treasurer, State of New Jersey. No cash or personal checks will be accepted. The certificate of need application fee shall be non-returnable, except that, if an application is submitted in the incorrect batch, is unresponsive to the notice issued by the Commissioner or inappropriately requests expedited review, it may be declared not accepted for processing by the Department, in which case the filing fee will be returned.

Total Project Cost (TPC)	Fee Required
[$1,000.00] ***$1,000,000*** or less	$ 5,000
Greater than $1,000,000 but less than $10,000,000	$ 5,000 + 0.05% of TPC
$10,000,000 or greater	$100,000
Transfer of ownership	$ 5,000
Change in Cost/Scope	$ 5,000

8:33-4.4 Certificate of need filing requirements

(a) An applicant shall document in the application that he or she owns the site where the facility, service, or equipment will be located, or has an ownership or lease option for such site, which option is valid at least through the certificate of need processing period. A duly executed copy of the deed, option or lease agreement for the site must be submitted with the certificate of need application and include identification of site, terms of agreement, date of execution

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and signature of all parties to the transaction. If the site is optioned or leased by the applicant, a copy of the deed held by the current owner is required at the time of filing.

(b) One hundred percent of the ownership and operation of the proposed facility, service or equipment shall be accounted for in the certificate of need application. Each and every principal involved in the proposal shall be identified by name, home address and percentage of interest, except that if the ownership and operation is a publicly held corporation, each and every principal who has a 10 percent or greater interest in the corporation shall be identified by name, home address and percentage of interest. Where a listed principal has an ownership or operating interest in another health care facility, in this or any other state, identification of the principal(s), the health care facilities in which they have an ownership or operating interest, and the nature and amount of each interest shall be specified.

(c) If the applicant is a registered corporation, the name and address of the registered agent shall be identified in the application.

(d) If a management company will be hired, the name and address of all principals in the management company shall be identified and, if the certificate of need is approved, prior to licensure, a copy of the management agreement shall be submitted to the Certificate of Need Program and the Division of Health Facilities Evaluation and Licensing. Any change in management subsequent to certificate of need approval shall be reported to the Division of Health Facilities Evaluation and Licensing.

(e) The operator of the proposed facility, service, or equipment shall file and sign the application. In the case of transfer of ownership the proposed owner/operator is considered to be the applicant. However, both the current owner/operator and proposed owner/operator shall file and sign the application.

(f) If the applicant does not comply with all of the above provisions, the Department will determine the application to be incomplete.

8:33-4.5 Review for completeness

(a) The Department alone shall make the determination of the completeness status of applications. If a local advisory board chooses to comment on the completeness status of applications, it must provide the Department with written comments 20 days after the application filing deadline. ***The Department will make a decision on the completeness status of an application after the applicant has been given the opportunity to supplement the application within a specified timeframe in response to specific questions by the Department and/or LAB.*** The Department will make a decision on the completeness by the beginning of each review cycle and will notify both the applicant and the affected local advisory board(s) of its determination. Only complete applications will be processed. If an application has been determined to be incomplete, the Department shall notify the applicant and the appropriate local advisory board(s) in writing citing the specific deficiencies in the application. The applicant may file a new application with the appropriate information, which will be processed in the next appropriate cycle.

(b) An application which is submitted in the incorrect batch, is unresponsive to the notice issued by the Commissioner, or inappropriately requests expedited review may be declared not accepted for processing by the Department. The Department will notify the applicant of this decision and the filing fee will be returned.

(c) Once an application has been submitted to the Department of Health, no subsequent submission of information will be accepted, unless specifically requested in writing by the Department, the State Health Planning Board or the local advisory board(s). Any questions and subsequent responses must be forwarded by the State Health Planning Board or the local advisory board(s) to the Department on a timely basis.

(d) An applicant or principal(s) must submit a single application for beds or services subject to batching requirements and shall not submit more than one application for a given site in a given batch. Violations of this rule will result in a determination that all applications submitted by the applicant and/or principal in the given batch will be deemed not accepted for processing.

8:33-4.6 Modification of applications

(a) Under no circumstances shall an application be modified or altered to change the number or category of inpatient beds, proposed services, equipment subject to a planning regulation, or change in site after the application submission deadline date. An applicant desiring to make such a modification or alteration shall be required to withdraw the application from the current cycle and submit a new application for the next cycle.

(b) Modifications not specified in (a) above, such as changes in square footage and change in cost, will be permitted if such changes are in response to completeness questions from the Department and made prior to submission of the application to the review process.

8:33-4.7 Deferral of applications

(a) An applicant may request in writing a deferral for up to a total of six months or, for batched applications, deferral into the next applicable batch for that service. If the applicant fails to notify the Department in writing to reactivate the application within this time frame, a new application will be required.

(b) The local advisory board, the State Health Planning Board, or the Department may defer a***n individual*** certificate of need application *[for up to a total of six months or may defer an entire batch of applications into the next applicable batch for that service.]* ***where the application is not competitive or comparatively reviewed with other applications. Where projects are competitive or comparatively reviewed, the local advisory board, the State Health Planning Board, or the Department may defer the entire batch. In the case of an application or batch of applications proposed for more than one local advisory board planning region, one local advisory board may not defer without concurrence of all other local advisory boards reviewing the application or batch of applications.*** In the instance of projects which are the subject of a capital cap, ***only the Commissioner may defer any or all applications in the batch.*** *[the]* ***The*** State Health Planning Board may recommend deferral of the entire ***capital*** batch *[subject to approval by]* ***to*** the Commissioner. *[All such applications must be deferred and the deferral may not exceed six months.]* ***The basis for any deferral must be specified in writing to the applicant. The period of deferral of an individual certificate of need application or a batch of certificate of need applications may not exceed six months.***

(c) An applicant may revise the deferred project costs to account for inflation and may be requested by the Department to submit additional updated information prior to reactivation of the application.

1. Reactivated applications with no changes or with only a change in cost may continue in the review process from the point of deferral unless the applicant is required to submit new information in response to a change in the applicable requirements.

2. Reactivated applications with any change in project scope will be treated as a new application and shall follow the review process beginning with submission of the application to the Department, except that if the application is modified in a non-substantive way, that is, if the modification were proposed separately, it would either not require certificate of need review or would require only an expedited review, the application may continue from the point of deferral.

(d) When a deferral is requested by the local advisory board, it shall confirm that request in writing to the Department and such requests will be reflected in the official record of the application(s).

(e) The Department will not accept any requests for a deferral from the applicant once the State Health Planning Board or any standing committee of the State Health Planning Board authorized to make recommendations to the Board on the disposition of certificate of need applications has made its recommendation.

8:33-4.8 Withdrawal of applications

[(a)] An applicant may submit a written request for withdrawal of its application prior to final action by the Commissioner. The certificate of need filing fee shall not be returned in the event of a withdrawn application. Once an action has been taken by the Commissioner, the application shall not be withdrawn.

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8:33-4.9 General criteria for review

(a) The State Health Planning Board shall prepare and revise annually, a State Health Plan. The State Health Plan shall identify the unmet health care needs in an area by service and location and it shall serve as *[the basis upon which all full review certificate of need applications shall be approved. The plan shall be effective beginning January 1, 1992.]* ***an advisory document which may be considered when certificate of need applications are reviewed for approval.*** The State Health Planning Board shall consider the recommendations of the local advisory boards in preparing and revising the plan to incorporate specific regional and geographic considerations of access to, and delivery of, health care services at a reasonable cost. The State Health Planning Board shall incorporate the recommendations of the local advisory boards into the plan unless the recommendations are in conflict with the best interests of Statewide health planning. ***If any recommendations of the local advisory boards are not incorporated into the plan, the State Health Planning Board shall identify those recommendations, which shall be listed separately for each local health planning region, in an addendum to the plan and shall state the specific reason that each recommendation is in conflict with the best interests of Statewide health planning.***

(b) No certificate of need shall be issued unless the action proposed in the application for such certificate is consistent with the health care needs identified in the State Health Plan and the action is necessary to provide required health care in the area to be served, can be economically accomplished and maintained, will not have an adverse economic or financial impact on the delivery of health care services in the region or Statewide, and will contribute to the orderly development of adequate and effective health care services. In making such determinations there shall be taken into consideration:

1. The availability of facilities or services which may serve as alternatives or substitutes;

2. The need for special equipment and services in the area;

3. The possible economies and improvement in services to be anticipated from the operation of joint central services;

4. The adequacy of financial resources and sources of present and future revenues;

5. The availability of sufficient manpower in the several professional disciplines; and

6. Other applicable requirements which are specified in any health planning rule adopted by the Department of Health.

(c) It shall be the responsibility of the applicant to adequately and appropriately demonstrate that the proposed project meets the health care needs identified in the State Health Plan, other State plans and policies, and State Health planning rules, the need that the population served or to be served has for the services proposed and the relationship of the services proposed to be provided to the existing health care system of the area in which the services are proposed to be provided. It is not incumbent upon the review process to demonstrate lack of need.

(d) No certificate of need shall be granted to any facility that currently fails to provide or fails to contractually commit to provide services to medically underserved populations residing or working in its service area as adjusted for indications of need. In addition, no certificate of need shall be granted to any facility that fails to comply with State and Federal laws regarding its obligation not to discriminate against low income persons, minorities, and disabled individuals.

(e) For the three-year period beginning January 1, 1992 through December 31, 1994, the Commissioner shall limit approval of certificates of need for hospitals for capital construction projects that would be financed by the New Jersey Health Care Facilities Financing Authority to a Statewide total of $225,000,000 per year for all projects, exclusive of the refinancing of approved projects.

1. "Capital construction project" shall include the purchase of major moveable equipment, as well as any modernization, construction or renovation project.

2. The annual cap shall include the total project cost of each approved certificate of need for acute care hospitals including the following:

i. All amounts approved for all applicable projects submitted prior to the current certificate of need moratorium but not acted on before January 1, 1992;

ii. All capital construction projects, including all those that are or would be financed by the Health Care Facilities Financing Authority. These may include projects that are financed partially through hospital equity or a source other than the Health Care Facilities Financing Authority, if the project is deemed eligible for such financing by the Authority;

iii. The cap shall not apply to a certificate of need application for a change in cost to a project originally approved prior to January 1, 1992; and

iv. The cap shall not apply to a certificate of need application which is funded totally by cash equity and will not result in any future increase in capital reimbursement under Chapter 83.

3. Approvals of certificate of need applications within the annual $225,000,000 shall permit approval of projects in the following two categories:

i. Construction/renovation/modernization: Approvals in this category may total up to $205,000,000;

ii. Major Moveable Equipment: Approvals in this category may total up to $20,000,000;

iii. In any year where the full allocation within the above amounts is not awarded through certificate of need actions by the Commissioner, projects of the remaining category may be approved.

4. The annual cap shall apply to the year in which the certificate of need applications are received.

8:33-4.10 Specific critera for review

(a) Each applicant for a certificate of need must show how the proposed project will promote access to low income persons, racial and ethnic minorities, women, disabled persons, the elderly, and persons with HIV infections and other persons who are unable to obtain care. In determining the extent to which the proposed service promotes access and availability to the aforementioned populations, the applicant, where appropriate, shall address in writing the following:

1. The contribution of the proposed service in meeting the health related needs of members of medically underserved groups as may be identified in the applicable local health plan and State Health planning rules as deserving of priority;

2. The extent to which medically underserved populations currently use the applicant's service or similar services in comparison to the percentage of the population in the applicant's service area which is medically underserved, and the extent to which medically underserved populations are expected to use the proposed services if approved;

3. The performance of the applicant in meeting its obligation, if any, under any applicable State and Federal regulations requiring provision of uncompensated care, community services, or access by minorities and handicapped persons to programs receiving Federal financial assistance (including the existence of any civil rights access complaints against the applicant);

4. How and to what extent the applicant will provide services to the medically indigent, Medicare recipients, Medicaid recipients and members of medically underserved groups;

5. The extent to which the applicant offers a range of means by which a person will have access and availability to its service (for example, outpatient services, admission by house staff, admission by personal physician);

6. The amount of charity care, both free and below cost service, that will be provided by the applicant. In determining eligibility for this care, the applicant shall use the eligibility categories A and B of the Hill-Burton Act regulations 42 CFR 124,501 et seq.;

7. Access to public or private transportation to the proposed project;

8. As applicable, effective communication between the staff of the proposed project and non-English speaking people and those with speech, hearing, or visual handicaps must be documented; and

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9. Where applicable, the extent to which the project will eliminate architectural barriers to care for handicapped individuals.

(b) Each applicant for certificate of need must demonstrate that the proposed project can be economically accomplished and maintained; that it will address otherwise unmet needs in a particular municipality, county, and/or regional health planning area; that it will not have an adverse economic or financial impact on the delivery of health care services; and that projected volume is reasonable. Evaluation of the applications will include a review of:

1. Demographics of the area, particularly as related to the populations affected by the proposed project;

2. Economic status of the service area, particularly as related to special health service needs of the population; and future facility cash flow;

3. Physician and professional staffing issues;

4. Availability of similar services at other institutions in or near the service area;

5. Provider's historical and projected market shares;

6. The immediate and long term financial impact on the institution this review will assess:

i. Whether the method of financing identified is accurately calculated and economically feasible, and is the least cost method available;

ii. Impact of the proposed project on capital cost, operating cost, projected revenues, and charges for the year prior to the application and the two years following project completion;

iii. Impact of the proposed project on the provider's financial condition, as measured by financial statements, including balance sheets, income statements and cash-flow statements;

iv. Whether the applicant has demonstrated the ability to obtain the necessary capital funds;

v. Whether the applicant has demonstrated that the project will result in an excess of revenue within two years after completion of the project;

vi. Whether the minimum equity requirement of at least 15 percent has been met;

(1) Equity (non-debt) is defined as a non-operating liquid asset contribution that would result in a reduction of debt. Equity may include cash, donations, net projected cash from fundraising.

(2) Land may be considered as equity if the land is included in the project cost, and the owner of the land has clear title to the land, not subject to liens or encumbrances.

(3) The appraised value of land may be considered as equity if an independent appraisal is included as part of the certificate of need application and the above criteria are met.

(4) The Commissioner may reduce the equity requirement for applicants who can demonstrate that the proposed project will primarily serve a medically underserved population;

vii. The feasibility of refinancing both new and existing debt. When it is economically feasible, the applicant must agree to refinance;

viii. For acute care hospitals, compliance with the reimbursement rules in N.J.A.C. 8:31B, and substantiation that capital reimbursement will be sufficient to meet capital costs under the Department's policy guidelines for capital; and

ix. The ability of acute care hospitals to meet the operating costs associated with the project, based on payment as defined in N.J.A.C. 8:31B; and

7. Each applicant for certificate of need must demonstrate how the proposed project will comply with applicable rules and regulations governing the construction, modernization or renovation of the project. The applicant shall address the following:

i. A cost estimate of the project stated in those dollars which would be needed to complete the project over the anticipated period of construction, assuming that construction was to begin at the time of the certificate of need submission;

ii. A detailed description of the project including square footage, construction type, current and proposed use of areas proposed for renovations, anticipated construction related circumstances, impact of asbestos abatement, accounting of all displaced department services areas, relocations and vacated areas; and

iii. The probable impact of the construction project on the costs and charges of providing health care services.

(c) For projects exceeding $15,000,000 in cost, institutions shall submit to the Department independently verified historical and projected financial and utilization information as identified in (b) 1 through 6 above.

(d) The Commissioner may request any additional information deemed necessary to establish that the proposed project will be economically maintained and will not adversely affect the State's health care system.

(e) Each applicant for certificate of need shall demonstrate character and competence, quality of care, and an acceptable track record of past and current compliance with State licensure requirements, applicable Federal requirements, and State certificate of need requirements, including, but not limited to, the following:

1. The performance of the applicant in meeting its obligation under any previously approved certificate of need including full compliance with the cost and scope as approved, as well as all conditions of approval;

2. Any person with a history of noncompliance with statutory or regulatory requirements which, as determined by the Department, threaten the life, safety or quality of care of patients shall be ineligible to file a certificate of need application until a period of at least one year has elapsed, during which time the person must have demonstrated a record of continuous compliance with licensing or regulatory standards. The one-year period shall be measured from the time of the last licensure or certification action indicating full compliance with regulatory standards; and

3. No certificate of need application will be approved for any applicant with existing non-waiverable violations of licensure standards at the time of filing, or before final disposition of the application or for an applicant with a history of noncompliance with licensing, statutory or regulatory standards which, as determined by the Department, threaten the life, safety or quality of care of patients. Furthermore, no certificate of need application will be accepted for processing if it is possible for the Department to determine the unacceptability of the applicant's track record. An exception will be in the case of applications submitted for the purpose of correcting recognized major licensure deficiencies. An exception to this provision may also be granted for applications submitted for the closure or substantial reduction of underutilized beds, services, or equipment.

8:33-4.11 Notification of review cycles

The Department shall submit written notification to the local advisory board for the health planning region in which the proposed project is to be offered or developed and local advisory boards serving contiguous health planning regions, of the certificate of need applications received in a review cycle, applications deemed complete for processing and the proposed schedule for the review. The local advisory board shall be exclusively responsible for providing notification of certificate of need applications to members of the public through newspapers of general circulation and other means deemed acceptable by the local advisory board.

8:33-4.12 Functions of local advisory boards

(a) Each local advisory board shall conduct local health planning for its designated region and make recommendations at least annually to the State Health Planning Board for incorporation into the State Health Plan.

(b) The local advisory board shall review certificate of need applications for proposed projects in its region and make recommendations to the Commissioner consistent with the State Health Plan and all appropriate health planning rules.

(c) The local advisory board shall furnish written decisions to the Commissioner which provide the explicit basis for any recommendations made by the local advisory board on certificate of need applications. Such written decisions shall be forwarded to the Commissioner within 45 days after the application is deemed complete for processing unless the application has been deferred pursuant to N.J.A.C. 8:33-4.7 or because of the conduct of an administrative

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hearing regarding one of the batched applications. These written decisions may take the form of minutes of the local advisory board.

(d) The local advisory board shall be responsible for the following activities:

1. To the extent possible, assistance to the applicant in the completion of appropriate certificate of need application forms;

2. Written notification to its service area public of the beginning of a review, which shall include notification of the proposed schedule for the review, the public comment period for persons directly affected by the review, and the manner in which notification will be provided of the time and place for public comment;

3. Provision for public comment in the course of agency review if requested by one or more persons directly affected by the proposed project; and

4. Evaluation of the public need for each proposal in accordance with the State Health Plan, the criteria for review identified in N.J.A.C. 8:33-4.9 and 4.10 and the requirements of applicable State health planning rules.

(e) The following activities shall not be the responsibility of the local advisory boards:

1. Involvement in architectural plans review of approved projects;

2. Monitoring of the construction of approved projects;

3. Determining compliance with Departmental licensure requirements; or

4. Evaluating the character and competence of the applicant, based upon State licensure, survey records, or other information of State regulatory agencies.

8:33-4.13 Role of the State Health Planning Board

(a) The State Health Planning Board shall review applications for certificates of need and make recommendations to the Commissioner in accordance with the State Health Plan and all applicable health planning rules.

(b) The State Health Planning Board shall furnish written decisions to the Commissioner which provide the explicit basis for any recommendations made by the Board on certificate of need applications. Such written decisions shall be forwarded to the Commissioner within 90 days after the application is deemed complete for processing unless the application has been deferred pursuant to N.J.A.C. 8:33-4.7 or because of the conduct of an administrative hearing regarding one of the batched applications. These written decisions may take the form of minutes of the State Health Planning Board.

(c) A member of the State Health Planning Board shall not vote on any matter before the Board concerning an individual or entity with which the member has, or within the last 12 months has had, any substantial ownership, employment, medical staff, fiduciary, contractual, creditor or consultative relationship. A member who has had such a relationship with an individual or entity involved in any matter before the Board shall make a written disclosure of the relationship before any action is taken by the Board with respect to the matter and shall make the relationship public in any meeting in which action on the matter is to be taken.

8:33-4.14 Procedures for review by local advisory boards and the State Health Planning Board

(a) If at least 25 percent of the quorum of voting members at a meeting of a local advisory board votes affirmatively to approve a certificate of need application, regardless of whether the local advisory board's recommendation is to approve or deny the application, the application shall be forwarded to the State Health Planning Board for its review of the application. If the application does not receive the required minimum number of affirmative votes, the application shall not be submitted to the State Health Planning Board or the Commissioner for their reviews, respectively.

(b) If at least 25 percent of the quorum of voting members at a meeting of the State Health Planning Board votes affirmatively to approve a certificate of need application, regardless of whether the State Health Planning Board's recommendation is to approve or deny the application, the application shall be forwarded to the Commissioner for his or her review of the application. If the application does not receive the required minimum number of affirmative votes, the application shall not be submitted to the Commissioner of Health for his or review.

(c) If an application which is consistent with the State Health Plan does not receive the required minimum number of affirmative votes by either a local advisory board or the State Health Planning Board, respectively, the applicant may request a fair hearing to permit the application to move to the next level for review. The request for a fair hearing shall be made to the Commissioner of Health within 30 days of the vote by the local advisory board or State Health Planning Board, as applicable. The fair hearing shall be held within 60 days of the request. If the *[hearing examiner]* ***Administrative Law Judge*** determines that the application should be reviewed by the next level for review, the applicant shall be so notified and the State Health Planning Board or the Commissioner, as applicable, shall review the application.

1. If a request for fair hearing is received within 30 days, it will be forwarded to the Office of Administrative Law where it will be processed expeditiously.

2. The Administrative Law Judge will review the reasonableness of the local advisory board's or State Health Planning Board's reasons for denial, as stated in its written decision, based on the documenting evidence that was *[considered by]* ***presented to*** the LAB or SHPB. No other documentation may be introduced during the course of the hearing.

3. The decision of the Administrative Law Judge on whether the certificate of need application should proceed to the next step in the review process will be the final decision.

4. All certificate of need applications competing for the same service in the same area will be deferred by the Department until a final decision is rendered.

5. The process will be reactivated at the next appropriate step (to the State Health Planning Board or to the Commissioner) upon notice of the final decision of the Administrative Law Judge.

8:33-4.15 Procedures for Commissioner of Health review

(a) The Commissioner may approve or deny an application for a certfificate of need ***upon consideration of the State Health Plan and*** if the approval or denial is consistent with *[the State Health Plan and]* all applicable health planning rules. The Commissioner shall issue a written decision on his or her determination of a certificate of need application which shall specify the reasons for approval or disapproval. The decision will be sent to the applicant, to the appropriate local advisory board and to the State Health Planning Board, and shall be available to others upon request.

(b) Pursuant to N.J.S.A. 26:2H-9, if the Commissioner recommends denial of a certificate of need application, the applicant shall be granted an opportunity for fair hearing to contest the Commissioner's action. Further, no decision shall be made by the Commissioner contrary to the recommendations of the State Health Planning Board or the Local Advisory Board on the disposition of a certificate of need application unless the State Health Planning Board and the applicant shall be granted an opportunity for a hearing.

(c) A request for a fair hearing shall be made to the Department within 30 days of receipt of notification of the Commissioner's decision. The fair hearing shall be conducted according to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1***, and the record shall be limited to the documentary evidence presented to the reviewing agencies below***. The Health Care Administration Board, within 30 days of receiving all appropriate hearing records, or, in the absence of a request for a hearing within 30 days of receiving the denial recommendations of the Commissioner, shall make its determination.

(d) After the commencement of a fair hearing pursuant to (c) above, and before a decision is made, there shall be no ex parte contacts between any person acting on behalf of the applicant or holder of a certificate of need, or any person opposed to the issuance of a certificate of need, and any person in the Department who exercises any responsibility for reviewing the application. Ex parte communication is defined as an oral or written communication not

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on the public record with respect to which reasonable prior notice to all parties is not given. It shall not include requests for status reports on any matter or proceeding. Any communications made after commencement of the fair hearing that are placed in the record of the proceedings are made available to all parties are not ex parte and are not prohibited.

(e) The determination of the Health Care Administration Board is the final decision of the Department where the Commissioner has recommended denial of a project application or where his or her decision to approve is contrary to the recommendation of the State Health Planning Board or the Local Advisory Board and a fair hearing is requested and held.

[(f) If the Commissioner intends to approve or deny an application for a certificate of need contrary to the State Health Plan, the Commissioner shall submit to the Health Care Administration Board the entire record of the application, including the recommendations of the local advisory board and the State Health Planning Board and the Commissioner's specific reasons for his or her intention to act contrary to the State Health Plan. If the Health Care Administration Board agrees with the Commissioner, it shall request the Commissioner to hold the affected application and direct the State Health Planning Board to amend the State Health Plan to reflect its determination. Upon the effective date of the amendment to the State Health Plan, the Commissioner shall reconsider the application. However, where the State Health Plan is silent on an issue(s) related to a service or facility proposed in a certificate of need application, the Commissioner shall rely on appropriate Departmental policies and planning rules, as well as any appropriate recommendations of the State Health Planning Board and local advisory board, in making a determination on the application.]

*[(g)]***(f)*** The Department shall notify, upon their request, providers of health services and other persons subject to certificate of need requirements of the status of the review of certificate of need applications, findings made in the course of such review, and other information respecting such review after the certificate of need is deemed complete for processing.

*[(h)]***(g)*** If the Department determines that the holder of an approved certificate is not making a good faith effort to implement the project, the Commissioner may null and void the certificate. Prior to such a determination, the Department must notify the holder of the certificate of its intent to initiate the nullification process. The holder of the Certificate shall have 30 days from the date of such notice to submit written documentation of the substantial progress which has been made, and which will continue, in implementing the Certificate. If, after the review of the documentation submitted, a notice of nullification is nevertheless issued, the holder may request a hearing pursuant to (c) above.

8:33-4.16 Conditions on approval/monitoring

(a) Conditions may be placed on certificate of need approval by the Commissioner if they relate to material presented in the application itself, are prescribed in State rules, relate to the criteria specified in N.J.A.C. 8:33-4.9 and 4.10 or promote the intent of the Health Care Facilities Planning Act, N.J.S.A. 26:2H-1 et seq., as amended. The State Health Planning Board and local advisory board shall not recommend the inclusion of conditions in a certificate of need approval which are not consistent with the provisions of this subchapter.

(b) Any conditions placed on a certificate of need approval shall become part of the licensure requirements of the approved facility. Failure to comply with approved certificate of need conditions may result in licensure or rate action by the Department and may constitute an adequate basis for denying certificate of need applications by an applicant who is out of compliance with conditions on previous approvals. The applicant must contest any condition, if at all, within 30 days of receipt of notice. The applicant will vacate his right to oppose said condition(s) if he fails to submit written notice that he contests any condition to the Department within this time. If the applicant contests a condition, the Commissioner will suspend his or her approval of the certificate of need in order to consider the objection. Furthermore, the Commissioner has the right to nullify the approval of the certificate of need. The Commissioner may, at his or her discretion, consult with the State Health Planning Board to obtain its recommendation on the contested condition(s). *[The Commissioner reserves the right to modify a condition subject to the agreement of the applicant at any time after the 30 days and prior to licensing in order to respond to changes in the health care system while the project is being implemented.]*

(c) When conditions are included in the Commissioner's approval letter, the applicant shall file a progress report on meeting such conditions with the Certificate of Need Program at least 12 months from the date of approval and annually for the first two years after project implementation and at any other time requested by the Department in writing. Failure to file such reports may result in the nullification of the approved certificate of need, fines and penalties imposed through licensure or rate action and/or taken into consideration in the review of subsequent certificate of need applications.

(d) Where an applicant has failed to meet conditions of approval of previously approved certificates of need, it may form an adequate basis for the Department to bar the applicant from filing any subsequent certificate of need until the conditions in question are satisfied.

SUBCHAPTER 5. EXPEDITED REVIEW PROCESS

8:33-5.1 Statement of purpose

(a) The expedited review process shall be used for the following specific applications:

1. Community-based primary care centers;
2. Outpatient drug/alcohol counseling;
3. Basic life support ambulance and invalid coach;
4. Mental health services which are exclusively out-patient and, therefore, non-bed related;
5. Establishment of or changes to residential health care bed capacity;

[6. Decrease in licensed beds with a total project cost less than the threshold;]

*[7.]***6.*** Mandatory renovations;

*[8.]***7.*** Mandatory replacement of fixed or major moveable equipment in excess of the threshold;

*[9.]***8.*** Transfer of ownership of all health care facilities and components thereof except general acute hospitals;

*[10.]***9.*** Change in site of an approved but unimplemented certificate of need project within the same county. A change in site within the same municipality will not require a certificate of need. However, notification of the change must be submitted to the Certificate of Need Program;

*[11.]***10.*** Relocation ***or replacement*** of *[a]* ***an existing*** health care facility within *[the same municipality or within]* the same county ***providing the relocation or replacement complies with N.J.A.C. 8:33-3.5***;

11. Replacement at the same site of an existing health care facility which exceeds the dollar threshold set forth at N.J.A.C. 8:33-3.6 providing the replacement complies with N.J.A.C. 8:33-3.5;

12. Establishment of a ***new*** continuing care retirement community (CCRC) with a health care facility component or ***the*** change in bed capacity of a health care facility component *[of]* ***serving*** a CCRC facility;
13. Establishment of a restricted admissions facility or change in bed capacity of a restricted admissions facility as articulated in the Long-Term Care chapter of the State Health Plan and specific health planning rules related to long-term care;
14. Change in cost to an original certificate of need issued after the effective date of these rules which is 10 percent or less of the approved capital cost including an inflation factor;
15. Change in cost to an original certificate of need issued prior to the effective date of these rules;
16. Establishment of or changes in the capacity of a pediatric day health care facility; or
17. Decrease in the capacity of an adult day health care facility.

(b) The expedited review process may also be used in lieu of the full review process, as noted in these rules, or in the following limited situations:

1. Emergency situations which demand rapid action; or

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2. When the project has minimal impact on the health care system as a whole.

8:33-5.2 Process

(a) The expedited review process will include 12 review cycles. The beginning of each cycle shall be the 15th day of each month and a decision should be rendered by the Commissioner approximately two months after the application is deemed complete for processing. Deadlines for initial submission of applications for expedited review shall be no later than the first day of the month preceding the beginning of a review cycle.

(b) Applications will be reviewed to determine the completeness of the required information. The Department shall make a determination by the beginning of the cycle as to whether the application is complete for processing.

(c) The determination of whether or not a project is eligible for processing under the expedited review process shall be made by the Department.

(d) Interested parties, including the State Health Planning Board, the Health Care Administration Board, local advisory boards, shall be notified by the Department of the expedited review applications deemed complete for processing.

(e) Certificate of need application forms for expedited review (except transfer of ownership) may be obtained from, and 10 copies shall be filed with:

Certificate of Need Program
New Jersey State Department of Health
John Fitch Plaza
CN 360, Room 604
Trenton, New Jersey 08625
(609) 292-6552

(f) Certificate of need application forms for expedited review for transfers of ownership may be obtained from, and 10 copies shall be filed with:

Health Facilities Evaluation
New Jersey State Department of Health
CN 367
Trenton, New Jersey 08625
(609) 588-7791

(g) Applications shall be reviewed by appropriate Department staff for the purpose of providing information to assist the Commissioner in making the final decision.

8:33-5.3 General requirements

(a) Minimum information required for all expedited review projects shall consist of:

1. Project description, including capital cost, operating costs and revenues, square footage, services affected, equipment involved, source of funds, utilization statistics, both inpatient and outpatient, how the project will foster economies within patient charge structure and justification for the proposed project;

2. The extent to which all residents of the area will have access to services, particularly the medically underserved; and

3. Assurances by the applicant, that all appropriate access criteria identified at N.J.A.C. 8:33-4.9 and 4.10 will be met.

8:33-5.4 Specific requirememts

(a) In addition to the requirements of N.J.A.C. 8:33, the following information shall be provided, as appropriate, for all expedited review projects:

1. For mandatory replacement or renovation, or explanation of the mandatory nature, including written opinion regarding hazards and safety effects upon patient care by experienced professionals, or from Federal, State, county or municipal governmental agencies;

2. For a change in cost, scope or financing, a description of new project costs by category, new square footage and new financing alignment;

3. For a change in beds, the number of beds to be added or deleted, a description of service area, required changes in staffing patterns, assurances that the impact on existing and approved facilities will foster optimum utilization and factors affecting travel time in area and availability of health personnel supply for staffing, and explanation of beds by service, the services affected, and the total number of beds available at the completion of the project; or

4. For a transfer of ownership, identification of all major licensure deficiencies and date of violation for any health care facility for any applicant (including any principals thereof) who owns (in whole or in part), manages or operates or has owned (in whole or in part) managed, or operated any health care facility, especially:

i. Curtailment of admissions; and

ii. A record of non-compliance with State licensure standards (N.J.A.C. 8:39) or comparable Federal, Medicare and Medicaid certification requirements.

8:33-5.5 Required commitments for the medically underserved

(a) The applicant shall make at least a minimum commitment to provide care to the medically underserved population as follows:

1. Community-based primary care centers: The applicant must provide a minimum of 10 percent of total visits to the medically underserved.

2. Outpatient drug/alcohol counseling: The applicant must provide a minimum of 10 percent of total visits to the medically underserved.

3. Ambulance/invalid coach: The applicant must agree to become a Medicaid provider.

APPENDIX

EXHIBIT 1

LOCAL ADVISORY BOARDS IN NEW JERSEY

Region	Name of Agency	Counties Served
I	Region One/Health Planning Consortium	Morris Passaic Sussex Warren
II	Fairleigh Dickinson University	Bergen Hudson
III	Region III Local Advisory Board	Essex Union
IV	Midstate Health Advisory Corp.	Hunterdon Mercer Middlesex Somerset
V	HealthVisions, Inc.	Burlington Camden Cumberland Gloucester Salem
VI	Jersey Coast Health Planning Council, Inc.	Atlantic Cape May Monmouth Ocean

EXHIBIT 2

STANDARD CATEGORIES OF HEALTH CARE SERVICES

Note: The installation or implementation of any of the specified health care services as shown below, which have not been previously provided by the health care facility, will require a certificate of need.

A. Bed-related
1. Medical/Surgical
2. Obstetrics, gynecology
3. Pediatric
4. Adult and pediatric intensive care (ICU)
5. Cardiac care (CCU)
6. *[Rehabilitation]* ***Comprehensive rehabilitation***
7. Long-term care
8. Residential health care
9. Adult acute psychiatric
10. Adult intermediate and special psychiatric
11. Child and adolescent acute psychiatric
12. Child and adolescent intermediate psychiatric

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13. Alcohol detoxification
14. Alcohol residential treatment
15. Drug free residential (therapeutic community)

B. Non-bed-related
1. Outpatient and clinic services
2. Home health agency
3. Drug rehabilitation-outpatient drug free
4. Alcohol rehabilitation
5. Outpatient mental health care
6. Partial hospitalization
7. Mental health emergency/screening
8. Drug rehabilitation-detoxification/maintenance
9. Comprehensive outpatient rehabilitation facility
10. Adult day health care
11. Pediatric day health care

C. Special Services
1. Renal dialysis
2. Invasive cardiac diagnostic services
3. Burn center, unit or program
4. Cardiac surgical services
5. Organ transplant/organ procurement
6. Megavoltage radiation oncology
7. Organ bank
8. Perinatal services including neonatal intensive or intermediate services
9. Hospice program
10. Mobile intensive care or advanced life support services
11. Medical day care
12. Positron emission tomography services
13. Magnetic resonance imaging services
14. Extracorporeal shock wave lithotripsey services

*[14.]****15.*** Any service for which regionalization criteria or health planning regulations have been developed.

*[15.]****16.*** Other new health/medical care technologies including any medical equipment which has received FDA pre-marketing approvals

***EXHIBIT 2a**

HEALTH CARE SERVICES WITHIN THE STANDARD CATEGORIES

Note: Within some of the STANDARD CATEGORIES OF HEALTH CARE SERVICES are those component services which are considered to be sub-elements of such CATEGORIES. The component services are listed below and shown within the appropriate STANDARD CATEGORY. If any health facility or organization is currently providing one or more component services within a STANDARD CATEGORY the implementation of additional component services within that STANDARD CATEGORY shall not be regarded as the institution of a new health care service. Thus, the addition of a component service within a previously existent STANDARD CATEGORY shall not require a Certificate of Need application provided that the institution of the service does not exceed the monetary limits as stated in N.J.A.C. 8:33.

A. Bed-related
1. Medical/Surgical
2. Obstetrics, gynecology
3. Pediatric
4. Adult and pediatric intensive care (ICU)
5. Cardiac care (CCU)
6. Comprehensive rehabilitation
7. Long-term care
8. Residential health care
9. Adult acute psychiatric
10. Adult intermediate and special psychiatric
11. Child and adolescent acute psychiatric
12. Child and adolescent intermediate psychiatric
13. Alcohol detoxification
14. Alcohol residential treatment
15. Drug free residential (therapeutic community)

B. Non-bed-related
1. Outpatient and clinic services

Component Services

Allergy	**Inoculation**
Arthritis	**Medical**
Cardio-vascular	**Muscular Dystrophy**
Cerebral Palsy	**Neurology**
Cystic Fibrosis	**Obstetrics**
Dermatology	**Parasitology**
Diabetes	**Pediatrics**
Diagnostic and Preventive Medicine	**Podiatry**
	Proctology
Employee Health	**Psychiatric**
Endocrinology	**Sickle Cell Anemia**
Eye, Ear, Nose, Throat	**Speech**
Family Planning	**Stress testing**
Genito-Urinary	**Surgical**
Glaucoma	**Thoracic**
Gynecology	**Toxemia**
Hearing	**Tuberculosis**
Hypertension	**Tumor Cancer**
	Venereal disease

2. Home health agency
3. Drug rehabilitation-outpatient drug free
4. Alcohol rehabilitation
5. Outpatient mental health care
6. Partial hospitalization
7. Mental health emergency/screening
8. Drug rehabilitation-detoxification/maintenance
9. Comprehensive outpatient rehabilitation facility
10. Adult day health care
11. Pediatric day health care

C. Special Services
1. Renal dialysis
2. Invasive cardiac diagnostic services
3. Burn center, unit or program
4. Cardiac surgical services
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6. Megavoltage radiation oncology
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8. Perinatal services including neonatal intensive or intermediate services
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10. Mobile intensive care or advanced life support services
11. Medical day care
12. Positron emission tomography services
13. Magnetic resonance imaging services
14. Extracorporeal shock wave lithotripsey services
15. Any service for which regionalization criteria or health planning regulations have been developed.
16. Other new health/medical care technologies including any medical equipment which has received FDA pre-marketing approvals*

EXHIBIT 3

EXAMPLES OF MAJOR MOVEABLE EQUIPMENT

Cardiac catheterization laboratory equipment

Extracorporeal shock wave lithotripter (kidney and/or biliary)

Linear accelerator (including Cobalt 60 unit)

Nuclear magnetic resonance (NMR) and magnetic resonance imaging (MRI) equipment

Positron emission tomography (PET)

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(a)

DIVISION OF HEALTH PLANNING AND RESOURCES DEVELOPMENT

Certificate of Need: Regionalized Perinatal Services

Adopted New Rules: N.J.A.C. 8:33C

Proposed:June 1, 1992 at 24 N.J.R. 2005(a).

Adopted: August 14, 1992 by Frances J. Dunston, M.D., M.P.H., Commissioner, Department of Health (with approval of the Health Care Administration Board).

Filed: August 17, 1992 as R.1992 d.343, **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 26:2H-5.

Effective Date: September 8, 1992.

Operative Date: November 1, 1992.

Expiration Date: September 8, 1997.

Summary of Public Comments and Agency Responses:

List of Commenters

Ainora, Catherine A., Vice President, Planning and Marketing, Elizabeth General Medical Center; Bornstein, Lester M., President, Newark Beth Israel Medical Center; Budde, Ann M., Vice President, Administration, South Jersey Hospital System; Cohen, Morris, M.D., Acting Chairperson, Gateway Maternal and Child Health Consortium, Inc.; Donlen, Judy, D.N.Sc., Executive Director, Southern New Jersey Perinatal Cooperative; Farley, Jean Buerle, R.N.C., M.S.N., Project Director, Central New Jersey Perinatal Consortium; Fox, Howard A., M.D., Chairman, Department of Pediatrics, Monmouth Medical Center; Frances, Sister Jane, President, St. Joseph's Hospital and Medical Center; Frisoli, Garry, M.D., Director of Perinatology, Overlook Hospital; Hogarty, Marie, R.N.C., M.S.N., Project Director, Northwest New Jersey Regional Perinatal Network; Kerney, Jane D., Vice President, Communications/Planning, The Medical Center at Princeton; Knuppel, Robert A., M.D., M.P.H., Professor and Chairman, Department of Obstetrics and Gynecology, Robert Wood Johnson Medical School; Leggiero, Michael A., North Hudson Community Action Corporation; Lloyd, John K., President, Jersey Shore Medical Center; McDonald, Denise, M.S.N., R.N.C., Assistant Vice President, Maternal and Child Health, Memorial Hospital of Burlington County; McLaughlin, William R., Somerset Medical Center; Melini, Carlo B., M.D., President, New Jersey Chapter/American Academy of Pediatrics; Middleton, John R., M.D., F.A.C.P., Medical Director, Raritan Bay Medical Center; Mirmanesh, Jay, M.D.; Murray, Richard E., President, Kennedy Memorial Hospitals; Musci, Michael N., Jr., D.O., Neonatologist, Rancocas Hospital; Oths, Richard P., President, Morristown Memorial Hospital; Patashnick, Melvyn, Representing the Northern Perinatal Consortium; Persichilli, Judith M., Executive Vice President, St. Peter's Medical Center; Rhodes, Carole Stapleton, Trustee, Families and Children Together of Northern New Jersey, Inc.; Rhodes, Carole Stapleton, Chief Planning Officer, University Hospital; Sherman, Harold S., Senior Vice President, St. Francis Medical Center; Skolnick, Lawrence, M.D., M.P.H., Director of Neonatology, Morristown Memorial Hospital; Sun, Shyan C., M.D., Professor and Director, Division of Neonatology, Children's Hospital of New Jersey; Terrill, Thomas E., Ph.D., Executive Vice President, University Health System of New Jersey; Wagner, David A., Senior Vice President, St. Barnabas Medical Center.

General Comments

COMMENTS: Eighteen commenters support the concepts described in the rules and particularly note the networking with community facilities as well as the preventive approach in perinatal health care. One commenter also supports the concept of regionalization of both perinatal and pediatric services. The Department is commended for its vision in attempting to reorganize the system of perinatal care in New Jersey.

RESPONSE: The Department appreciates the comments supporting the concepts described in the certificate of need rules for perinatal services.

COMMENTS: The American Academy of Pediatrics/New Jersey Chapter is of the opinion that the State's perinatal and neonatal statistics are more directly impacted by social issues such as drugs, poverty, lack of jobs, and education. This commenter describes the rules as imposing another layer of bureaucracy.

RESPONSE: The Department recognizes its limitations in influencing social problems rooted in poverty. Health is frequently perceived as a low priority by many populations. Real impact on all of these issues will not be made without concurrent strategies in education and job training. The proposed consortia model begins by addressing health issues on a local level. Real impact on the issues affecting maternal and child health care can only be made with comprehensive local input and holistic planning efforts.

COMMENTS: Elizabeth Medical Center commented that the current consortia were developed as a result of funding from the Robert Wood Johnson Foundation and are being adopted ignoring the existence of other consortia. The same commenter stated that a model is being built around the Southern New Jersey Perinatal Cooperative which has yet to demonstrate effectiveness when compared to the current existing consortia. This commenter was also concerned that the rules do not recognize the ability of more than the original seven Robert Wood Johnson Foundation funded perinatal consortia could exist.

Saint Barnabas Medical Center opposes the rules.

St. Joseph's Hospital and Medical Center requested that the Department "grandfather" the existing Robert Wood Johnson Foundation consortia. Many commenters expressed strong support for the concept of the consortia as described in N.J.A.C. 8:33C.

Five commenters were concerned regarding the description of the consortia as having "no more than three staff members."

One commenter opposes the plan for regionalization as defined in the rules and questions the effects on infant mortality.

RESPONSE: The references to the Robert Wood Johnson Foundation funded consortia and the size of the consortia are in the nonregulatory part of these rules as part of the historical summary and the regulatory flexibility analysis. The rules establish criteria for the development of a consortium and do not preclude the development of additional consortia, or the addition of staff to existing consortia. The Department cannot adopt in regulation an initiative supported and developed by private funding. Southern New Jersey Perinatal Cooperative is used as a model for funding. It is expected that each consortium will be unique in structure and should reflect the community it represents.

The opposition expressed by St. Barnabas is noted, but as no basis was stated, no appropriate response can be made.

As for the comment regarding the effects of regionalization on infant mortality, there is both national and Statewide documentation which supports the concept of regionalized services which improve birth outcomes. Since regionalization was first introduced in New Jersey in 1981, the infant mortality rate decreased from 12.0 to 9.4. The Southern New Jersey Perinatal Cooperative has also been extremely successful at increasing the number of maternal transports to regional facilities from 40 percent to 93 percent and neonatal transports from 40 percent to 71 percent.

COMMENTS: Rancocas Hospital commented that the Department does not recognize the utilization of recently licensed neonatal nurse practitioners.

RESPONSE: Although legislation recently amended the Nurse Practice Act, (see P.L. 1991, c.377) the Board of Nursing is in the process of developing licensure rules for nurse practitioners, as they are not currently licensed.

COMMENTS: Commenters objected to the requirements by designated facility in the Summary which discussed facility, staffing and task capability on a matrix, as follows: Nine commenters stated that a Community Perinatal Center (CPC)-Intermediate should not be allowed to maintain infants on ventilators as long as five days. Other comments offered specific language concerning the education and experience of pediatricians, citing that the current rule specifies one year of neonatal medicine which does not accurately reflect the training requirements for either a pediatric residency or neonatal fellowship. Comment was also received regarding the requirements for obstetric certifications. Rancocas Hospital commented that a CPC-Intermediate should be allowed to provide Total Parenteral Nutrition (TPN) but that these facilities should have in-house physicians if ventilating infants. Children's Hospital of New Jersey stated that the rules need clarifying regarding in-house physician coverage whenever an infant is on a ventilator. Two commenters request that any hospital that wishes to provide major specialized perinatal services such as ventilatory support, transport, etc. should be required to provide appropriate levels of manpower including neonatologists,

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perinatologists, and other professional staff. They also recommend volume requirements be specified. One commenter strongly opposed that the CPC-Intensive be allowed to establish a neonatal transport team. The same commenter recommends the use of second and third year residents for in-house coverage of neonatal intensive care units in academic institutions with pediatric residency programs.

RESPONSE: In order to respond to the clinical issues raised by many commenters, and at the request of the Health Care Administration Board, the Department requested the opinion of national experts, and has delineated these opinions in Table 1, following:

TABLE I

NATIONAL COMMENT	CPC—INTERMEDIATE ISSUES		CPC—INTENSIVE AND RPC ISSUES
	Ventilatory Support	TPN	Neonatology Coverage In-House
Guidelines for Perinatal Care, Third Edition, published by AAP and ACOG	Not beyond the emergency period without adequate personnel with expertise, and equipment	Not specified for a particular level; instead describes the skills needed to manage infants	Neonatologist available 24 hrs. per day for consultation; Personnel qualified to handle neonatal emergencies must be in-house
John Discroll, M.D. Acting Director of Pediatric Services Baby's Hospital New York City, N.Y. (Ref. by AAP Nat'l)	No more than 48 hrs.	Only intensive care	Attending pediatrician or neonatal fellow; no residents
Nigel Paneth, M.D. Director, College of Human Medicine, Michigan State University	No more than 48 hrs.	Only intensive care	Neonatologist or 1st year fellow; no residents
George Little, M.D. Director of Maternal and Child Health Dartmouth-Hitchcock Medical Center	No more than 48 hrs.	Only intensive care	Standard team—resident and attending; at a minimum, someone in-house who can reintubate
David E. Gagnon Executive Director, National Perinatal Information Center	Opposes regulations		
John Hartline, M.D. Director of Neonatology, Brown Methodist Kalamazoo, Michigan	Not beyond stabilization	Only intensive care	Neonatologist; no residents
Jeffrey Pomerance, M.D., Director of Neonatology, Cedars Sinai, Los Angeles, Ca.	Not beyond stabilization	Not addressed	Neonatologist; neonatal fellow or pediatrician with post-graduate training when infant is unstable
David Wells, M.D. Co-Director Neonatal Care Program, Greenville Hospital System Greenville, S.C.	Not beyond stabilization; separate CPAP; CPAP ok at intermediate	Yes, at intermediate	Residents and/or neonatal nurse practitioner with neonatalogist readily available
State of California Department of Health Services	No more than 4 hours	Not addressed	Neonatologist; neonatal fellow or pediatrician with post-graduate training when infant is unstable

Table 1 supports the position of limiting ventilatory support in an intermediate facility to a period of time which is less than 48 hours, excluding intermediate facilities from providing total parenteral nutrition (TPN), and also requiring appropriate physician coverage whenever infants are on ventilators. The Accreditation Council for Graduate Medical Education was contacted to clarify the experience requirements for pediatricians. In addition to these rules, N.J.A.C. 8:43G-19, Hospital Licensing Standards for Inpatient Obstetric Services, does specify minimum requirements for staffing at intensive facilities. Volume has not been utilized exclusively within the rules because the goal of the Department is to reduce low birthweight outcomes. N.J.A.C. 8:33C-7.2(b) (and 8:43G-19.19(f) and 19.20(b)2 adopted elsewhere in this issue of the New Jersey Register) will be amended to reflect the consensus of national and State opinions. As for the issue of the neonatal transport team, the Perinatal Technical Advisory Committee (PTAC) recommended that more flexibility be built into the perinatal system because

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of increases in medical technology. The response to this issue is more fully addressed in that portion of this Summary concerning N.J.A.C. 8:33C-10.2.

COMMENTS: The Medical Center at Princeton states that the consortia seem to be funded for activities which a tertiary care center could provide. They endorse the proposal from St. Peter's Medical Center that the consortia become committees of the Local Advisory Boards in order to avoid the development of an entirely new planning and health delivery bureaucracy due to overlapping roles.

St. Peter's Medical Center requested that the Department enumerate the benefits of free-standing 501(c)(3) Consortia vis-a-vis organizing them under the Local Advisory Board. St. Peter's submitted a document representing a total revision of the published rule endorsing the integration of the Consortia into the Local Advisory Boards. They request that the entire document be published as public comment and not just summarized.

RESPONSE: The focus of the consortia should be on prevention activities clearly outlined in the requirements of the regional plan as specified in the rules. The requirements for outreach, professional education and Total Quality Improvement are not intended to be focused on facility care only. The Consortia and the Local Advisory Boards (LABs) must work together on many planning issues but clearly the role of the consortia is not limited to planning. The boundaries of the LABs and the Consortia are not consistent. Except for the central region, the LAB configurations do not recognize maternal and child health provider patterns and market forces. Linking the consortia to the LABs would dismantle the successful system established by the Robert Wood Johnson Foundation and force providers into patterns not currently in existence. Although the Department cannot, by regulation, formally "grandfather" the Robert Wood Johnson Foundation, the Department does recognize the benefits of this system. The definition of a maternal and child health region utilizes provider relationships as a basis for the consortia. The definitions for the LABs included parameters other than Maternal and Child Health. The LABs do not obtain enough funding to support all of the activities of the consortia. When the Department looked to implementing the recommendations of the PTAC, it was determined that, in order for the consortia to be funded through the hospital reimbursement system, the consortia must be designated and licensed. It was additionally determined that the certificate of need applications for individual hospital designations could only be submitted for the region as a whole by an entity which does not have any fiduciary interest in a particular institution due to restraint-of-trade issues. For LABs to take on this responsibility would represent a conflict of interest due to their role of approving certificates of need on a local level. Except for amendments made concerning the clinical issues of ventilatory support and neonatology coverage, there will be no changes to the rule as a result of these comments.

SUBCHAPTER 1. GENERAL PROVISIONS

N.J.A.C. 8:33C-1.2 Definitions

COMMENTS: Elizabeth General Medical Center states that the definition of the central service facility is a licensed ambulatory care center is contrary to the recommendations of the PTAC. The Central New Jersey Perinatal Consortium would like clarification of a central service facility regarding its definition of "some direct provision of health care services."

RESPONSE: Elizabeth General Medical Center is directed to N.J.S.A. 26:2H-2, Definitions, where there is the category "central service facility" which loosely describes the responsibilities of the proposed consortia and could be licensed by the Department in order for the consortia to be funded. The Department elected not to be narrow in its definition of the central service facility, but rather to allow for provision of additional services to be developed in response to community need, such as perinatal transport systems.

COMMENTS: Several commenters would like clarification of both nursing management positions as defined in the rule which are currently listed as "clinical nurse coordinator or supervisor" and "unit nurse manager." Suggested language changes included amending "clinical nurse coordinator or supervisor" to "administrative nursing director" and to describe "unit nurse manager" as responsible for clinical services. The definition of "perinatal clinical nurse specialist" is inconsistent with N.J.A.C. 8:43G-19. The definition of "hospital provider" seems to imply that individual physicians are considered part of this group. Specific language was offered to amend this section including the deletion of the phrase "does not provide care at" from the definition of a non-hospital provider.

RESPONSE: The Department agrees that the proposed definition of "hospital provider" concurs with the recommended change to the definition of non-hospital provider and that the definition of hospital provider is confusing. The intent was that only physicians directly employed by hospitals will be considered hospital providers. N.J.A.C. 8:33C-1.2 will be amended. Although defined in this rule, the nursing positions are not referenced anywhere else in these rules. N.J.A.C. 8:43G-19 more clearly describes the requirements of these positions. Therefore, the Department will delete the references to these positions in N.J.A.C. 8:33C-1.2 and amend N.J.A.C. 8:43G-19 as offered by the commenters (see notice of adoption elsewhere in this issue of the Register).

N.J.A.C. 8:33C-1.4 Maternal and Child Health Service Regions

COMMENTS: Specific references to dates, that is, 1988-1990, should be deleted and changed to generic references.

RESPONSE: The comments on referenced data are duly noted and N.J.A.C. 8:33C-1.4(b), 2.7(b), 2.10(a)1, and 9.2(a) will be amended accordingly to comply with the State Health Plan, as adopted (see 24 N.J.R. 2561(a)).

COMMENTS: St. Barnabas Medical Center states that the concept of "rational and cohesive networks of service" is being subjected to a good "stretching." This commenter further states that, in a state as urbanized and as compact as New Jersey, the severe problems of access caused by "geographic isolation" are not an issue.

RESPONSE: The definition of a maternal and child health service region is directly from the recommendations in the PTAC report. The Department does not agree that geographic isolation is not an issue. As stated in the proposal of these rules, geographic isolation is a significant problem. There will be no change to the rule as a result of this comment.

SUBCHAPTER 2. REGIONAL MATERNAL AND CHILD HEALTH CONSORTIA

N.J.A.C. 8:33C-2.2 Governance of the region

COMMENTS: Two commenters expressed concern over the composition of the Board of Directors. They expressed opposition to the specificity of the rule and the ratio of hospital vs. non-hospital participation. One commenter requested that the Board be one-half hospitals to make up for the preponderance of non-hospital providers in the general membership. Two other commenters requested more flexibility in the ratio of hospital to non-hospital to consumer ratios. Four commenters would like the size of the Board to be amended to allow for each hospital member to be represented.

RESPONSE: The rule sets the minimum requirement for the size of the Board of Directors. This rule does not preclude the Board from being larger in order for each hospital in the region to have a seat, as long as the composition remains one third consumers, one-third non-hospital providers and one-third hospital providers. The Department concurs with the comment on the size of the Board and will amend N.J.A.C. 8:33-2.2 accordingly to be consistent with the State Health Plan.

COMMENTS: Comment was also made regarding the certification in maternal and child health for the registered nurse selected to serve on the consortia boards. A case was made for a certification in community health being of equal value from a prevention perspective.

RESPONSE: The Department agrees that certified community health nurses can bring the appropriate prevention perspective to the consortia. N.J.A.C. 8:33C-2.2(c) will be amended to include community health nursing as an appropriate certification for registered nurses on the consortia boards of directors.

N.J.A.C. 8:33C-2.4 Data reporting

COMMENTS: Concern was expressed for the confidentiality of records of the member organizations.

RESPONSE: In N.J.A.C. 8:33C-2.4(c), the consortia are required to comply with N.J.A.C. 8:43G-4.1(a)21, Hospital Licensing Standards, for confidentiality of patient records, which addresses their concern regarding the release of data and quality assurance, which utilize patient records.

COMMENTS: Two commenters requested that the Department not require any new forms.

RESPONSE: The Department does not intend to require any new reporting forms and is currently evaluating existing forms for the purpose

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of streamlining existing reporting mechanisms. There will be no change to the rule as a result of these comments.

N.J.A.C. 8:33C-2.6 Functions of the Regional Maternal and Child Health Consortia

COMMENTS: Elizabeth General Medical Center indicated that the relationship between the Local Advisory Board (LABs) and the Maternal and Child Health Consortia is unclear.

RESPONSE: Consortia will work closely with LABs and may have to work with more than one at a time. The first task for both the Consortia and the LABs are the certificate of need applications for designation. Following this process, the Consortia and LABs are expected to work together on all regional planning issues involving maternal and child health activities.

COMMENTS: Newark Beth Israel and Gateway Maternal and Child Health Consortium, Inc. support the concept of maternal transports but express concern over implementation due to lack of funding. Specific estimates on cost were submitted.

RESPONSE: The Department appreciates the support for the proposed transport system. The rule does not specify staffing. Since these are adult transports, it is not necessary for the vehicles and equipment to be specialized as with high risk neonates. If maternal-fetal transports are appropriately made, then the number of neonatal transports should proportionately decrease, thus diverting the costs.

N.J.A.C. 8:33C-2.7 Regional Perinatal Plan

COMMENTS: Eighteen commenters expressed concern about the formula to be used to determine the need for intensive care and intermediate care bassinets within a region, stating that the distinction between intermediate and intensive care days is often "unclear and therefore arbitrary." There was question regarding utilization, occupancy standards and the minimum number of intermediate bassinets as a requirement for a unit. It was stated that the data needed to calculate the formula is unavailable. There was also criticism regarding the use of historical utilization data for determining bed need. Specific language was offered to combine both intermediate and intensive as a method of resolution.

Two commenters requested that each region be allowed to determine bed need, utilizing a formula developed at the consortia level.

RESPONSE: The Department agrees that it does not have an accurate record of intermediate or intensive bassinets. Many hospitals upgraded their neonatal service to intensive but continued to report intermediate neonates because of their original designation. Likewise, many hospitals were providing intermediate care, but do not have currently-approved intermediate bassinets and were, therefore, not accurately reporting care delivered. The Department will revise 8:33C-2.7(a)4i according to a formula which accurately reflects the need for intensive care bassinets. The minimum size of an intermediate unit was also amended to four intermediate bassinets to reflect the needs defined in the revised formula. This was done at N.J.A.C. 8:33C-2.7(b)5. Historical data will not be used but rather the most current UB82, D.R.G. data available, which is a more accurate representation of actual intensive care bassinets needed. The occupancy rate of 85 percent is used in the bassinet need methodology to assure that the number of units approved are appropriately utilized. An expectation of lower occupancy levels will cause a proliferation of unnecessary beds at considerable cost to the system. The new formula does allow for an appropriate increase in the number of licensed intensive care bassinets, and deletes intermediate bassinets from the formula. The regions will determine their intermediate bed need.

COMMENTS: Monmouth Medical Center proposes that the Department of Health form a standing committee of perinatal providers to review quarterly statistics, neonatal matched birth and death certificates and other outcome measures so that this group can provide consultative assistance to the consortia Statewide.

RESPONSE: The Department supports the concept that the total quality improvement program be primarily a peer review process. However, the Department may choose to organize a Statewide standing committee through the Office of Regionalized Maternal and Child Health Services, once implemented.

COMMENTS: Letters of agreement should be updated annually, in order to allow for the resolution of conflicts. Another commenter disagreed with the need for letters of agreement.

RESPONSE: Facilities and regions are required to form four year agreements for continuity of health planning and delivery. There is a conflict resolution process should this issue arise. The letter of agreement represents the commitment between hospitals to insure the coordinated delivery of services to all patients in the region and has always been part of the regionalized system of perinatal care in New Jersey. The consortium does not replace the necessity for these agreements.

COMMENTS: Two commenters expressed reservation about the ability for each of the consortia to have a fully completed regional perinatal plan for the certificate of need application due this fall. The commenters offered that the Department should consider the initial designations be contingent on full completion of the regional perinatal plan within a 12-month period.

RESPONSE: The Department will review the rule for the minimum criteria necessary for certificate of need applications. The Department will consider that the initial designations be based on minimum criteria in the certificate of need application and the final designation will be contingent upon submission of a fully completed regional perinatal plan within a specified time frame. There will be no change to the rule as a result of these comments.

N.J.A.C. 8:33C-2.10 Plan for a perinatal transport system

COMMENTS: St. Joseph's Hospital and Medical Center would like all regional perinatal centers to be required to accept transports from adjacent regional centers when needed, if a bed is available.

RESPONSE: The Department agrees that regional centers should cooperate on issues of capacity relative to transports. Language will be added to N.J.A.C. 8:33C-2.10 to indicate this.

COMMENTS: Two commenters endorsed the concept of maternal transports but expressed reservation regarding the cost of implementation.

RESPONSE: The Department strongly supports the implementation of a maternal-fetal transport system as part of the delivery of tertiary perinatal care. The Department appreciates the support for this concept. The Department refers the commenter to N.J.A.C. 8:33C-2.6 where issue of funding maternal transports is more fully discussed.

SUBCHAPTER 3. COMMUNITY-BASED SERVICES

N.J.A.C. 8:33C-3.2 Functions of community based service members

COMMENTS: Elizabeth General Medical Center states that the section on community-based services is confusing and duplicative to N.J.A.C. 8:33C-2.6 which is the section describing the functions of the consortia. St. Barnabas Medical Center states that the issue of "determining needs" should be the responsibility of the entire consortia, "not just a subset of the consortia."

RESPONSE: The Department does not agree that this is duplicative. The intent of this section is to highlight the importance of community agency involvement in the consortia and describe community-based care. Traditionally, the development of a regionalized system of perinatal care has been hospital focused. It was recommended by the PTAC that a stronger emphasis be placed on prevention with active participation from the community. There will be no change to the rule as a result of this comment.

SUBCHAPTER 4. GENERAL REQUIREMENTS FOR FACILITIES WITH OBSTETRIC AND/OR NEWBORN SERVICES

N.J.A.C. 8:33C-4.2 Compliance

COMMENTS: Elizabeth General Medical Center stated that delivery privileges cannot be dictated by the consortium.

RESPONSE: The Perinatal Technical Advisory Committee suggested that the system of perinatal regionalization be more flexible to encourage physicians to appropriately refer and co-manage patients with the perinatologists from the regional perinatal center. The PTAC recommended that physicians be allowed staff privileges at the regional perinatal center to enhance this relationship. The rule does not intend to require that the consortia enforce this activity. The Department believes that delivery privileges should, at all times, benefit the patient. This requirement refers directly to the hospital's certificate of need application. N.J.A.C. 8:33C-4.2(b) and 9.3(c) will be amended to reflect this.

COMMENTS: Overlook Hospital expressed that each consortium should have the latitude and flexibility to modify designation criteria. Perinatal centers should be allowed to provide levels of care even though all criteria for the higher level designation may not be met.

RESPONSE: The rule does allow for facilities to change designations as regional needs fluctuate. In addition, the rule does allow a degree

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of flexibility in the functioning of facilities based on regional need. These rules specify minimum criteria for personnel and skills which should be met for designation. There will be no change to the rule as a result of this comment.

N.J.A.C. 8:33C-4.3 Comprehensive perinatal record

COMMENTS: The American Academy of Pediatrics/New Jersey Chapter opposes the requirement that a comprehensive record be used by the providers. Memorial Hospital of Burlington County questions the ability of hospitals to enforce this requirement.

RESPONSE: In order to improve birth outcomes, impact must be made during the prenatal period. This includes issues of access to health care and the quality of that care in addition to social factors. Robert Wood Johnson Foundation funding was successful in implementing comprehensive prenatal care records for all hospital based services and other publicly funded clinics. Success has not been as great with private physicians. The rule does not specify a record; it generically describes minimum criteria as recommended by the PTAC. The Department submits that the administrative burden overall on physicians to perform a thorough history is benign compared to the dollar cost of poor infant outcomes as well as quality of life issues. Hospitals routinely have requirements for providers. There will be no change to the rule as a result of this comment.

SUBCHAPTER 6. COMMUNITY PERINATAL CENTER—BASIC

N.J.A.C. 8:33C-6.1 Definition; care to be provided

COMMENTS: Morristown Memorial Hospital feels that the criteria used to describe the CPC-Basic is too conservative and offers suggested language of "neonates weighing more than 2000 grams and greater than 34 weeks."

RESPONSE: A CPC-Basic is defined as providing only normal newborn care. However, the Department recognizes that some normal neonates may weigh less than 2500 grams which a CPC-Basic may adequately care for. There is this flexibility allowed in the language of the rule via the letters of agreement to be developed with Regional Perinatal Centers (RPC).

COMMENTS: South Jersey Hospital System expressed that the Department should be flexible regarding the parameters of birthweight and gestational age and linking these criteria to reimbursement, especially in emergency management of deliveries.

RESPONSE: The rule does allow flexibility for unanticipated deliveries. The language clearly states that each facility "shall provide care to mothers **expected** to deliver neonates ..." in a certain weight and gestational age category. Linkage to reimbursement is not part of these rules, but would be equally flexible. There will be no change to the rule as a result of these comments.

8:33C-6.2 High risk mothers and neonates

COMMENT: Morristown Memorial Hospital commented that the transport requirement for the CPC-Basic is too stringent. A capable CPC-Basic should be able to provide a brief period of intravenous fluid therapy or supplemental oxygen and not have to transport after stabilization.

RESPONSE: This position is contrary to all of the basic tenets of regionalized perinatal services. **Guidelines for Perinatal Care,** American College of Obstetricians and Gynecologists and American Academy of Pediatrics, specifically states that a Level I or basic facility may only stabilize unexpectedly small or sick neonates before transfer. There will be no change to the rule as a result of this comment.

SUBCHAPTER 7. COMMUNITY PERINATAL CENTER—INTERMEDIATE

N.J.A.C. 8:33C-7.1 Definition; care to be provided

COMMENTS: The birthweight and gestational age requirement at the intermediate level is 1,499 grams and 32 weeks. Memorial Hospital of Burlington County comments that it should be greater than 1,000 grams and 28 weeks because of the decrease in respiratory distress syndrome with the onset of surfactant therapy. Somerset Medical Center requested that references to gestational age be deleted since birthweight is more indicative of the care to be delivered.

RESPONSE: While the Department recognizes that the advances in medical technology have enabled hospitals, other than tertiary centers, to manage low birthweight infants, it is still necessary to concentrate resources for the care of very low birthweight infants at a few centers of excellence to insure that there are sufficient numbers to maintain the skills of the staff. The number of very low birthweight births have continued to increase in New Jersey and have significantly impacted on infant mortality. Studies have shown that the birthweight specific mortality of very low birthweight infants significantly increased at intermediate level hospitals both nationally and in New Jersey. Birthweight is linked to gestational age because the language of the rule emphasizes maternal-fetal management and clearly states "patients expected to deliver neonates greater than ..." There will be no change to the rule as a result of this comment.

N.J.A.C. 8:33-7.2 High risk mothers and neonates

COMMENTS: Eight commenters addressed the definition of short-term ventilation at the intermediate level hospital. Only two commenters wanted the language changed to longer than five days; six commenters wanted shorter than five days in addition to the nine commenters who expressed this opinion on the facility matrix in the proposal Summary.

RESPONSE: As discussed in the "General" section above, attached, on Table 1, is documentation which supports the position that short-term ventilatory support should be defined as less than 48 hours. N.J.A.C. 8:33C-7.2(b) will be amended accordingly.

COMMENTS: The American Academy of Pediatrics/New Jersey Chapter states that care to infants requiring either ventilatory support and/or TPN should be allowed to be administered by all neonatologists or pediatricians. "It seems unwise to limit these physicians to a particular morbidity or technological intervention, simply because they practice in other than a Level III facility." The Chapter feels that the consortia should monitor quality of care locally without State regulations which are so specific.

RESPONSE: In response to the Academy's position that these rules micro-manage, there are many such regulations which the Department has promulgated in trauma, licensing, etc. The PTAC specified task capability rather than volume as a criterion for designation. Based on current practice and the findings of the Perinatal Technical Advisory Committee, it is the Department's position that these issues could not be enforced by local quality assurance in the absence of regulation. This especially becomes an issue when conflicts arise. There will be no change to the rule as a result of this comment.

SUBCHAPTER 8. COMMUNITY PERINATAL CENTER—INTENSIVE

N.J.A.C. 8:33C-8.1 Definition; care to be provided

COMMENTS: Two commenters stated that the differentiation with regard to staffing and task capability between a CPC-Intensive and Regional Perinatal Center is virtually identical. These commenters stated that it is, therefore, arbitrary to prohibit a CPC-Intensive from taking care of neonates less than 999 grams and 28 weeks gestation.

RESPONSE: The rules do not prohibit a CPC-Intensive from caring for an infant less than 999 grams and 28 weeks if this meets regional needs. However, the CPC-Intensive is responsible for making maternal-fetal transports to an RPC whenever the expected low birthweight delivery is preventable. The new emphasis in this rule is the role of the RPC in the realm of maternal-fetal management and the availability of the resource of a perinatologist. There will be no change to the rule as a result of these comments.

SUBCHAPTER 9. REGIONAL PERINATAL CENTER

N.J.A.C. 8:33C-9.2 Designation criteria

COMMENTS: Kennedy Memorial Hospital would like the designation of regional perinatal center to be based on the facility's capability to provide the level of service and the demonstrated need in the community and not include the historical utilization and services.

RESPONSE: The Department does not feel that it would be appropriate to evaluate the need for a regional perinatal center in the absence of appropriate data. The criteria of community need is included in the designation and should be determined on a local level.

COMMENTS: St. Joseph's Hospital and Medical Center indicated that the term "referrals" should be eliminated and that only the number of maternal-fetal transports should be used as criterion for the designation of regional perinatal centers.

RESPONSE: The PTAC specifically recommended that 80 referrals or transports be used as criterion for the designation of regional perinatal centers. Referrals reflect the co-management of patients with physicians

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from community perinatal centers to prevent the need for an emergency transport and are the specific responsibility of the regional perinatal center. There will be no change to the rule as a result of these comments.

N.J.A.C. 8:33C-9.3 Personnel

COMMENTS: St. Joseph's Hospital and Medical Center requested that obstetricians from community perinatal centers be required to have a perinatal consult for all high risk maternal patients that they are involved in treating at the regional facility.

St. Peter's Medical Center would like the language regarding privileges to state that "consideration be given to granting privileges to obstetricians from community centers, if all hospital specific criteria are met."

RESPONSE: The Department agrees with both of these comments and will amend N.J.A.C. 8:33C-9.3 accordingly.

N.J.A.C. 8:33C-9.4 Services

COMMENTS: St. Jospeh's Hospital and Medical Center would like the community perinatal center-intensives to be required to have clinic services for high risk maternal patients to ensure that these facilities also serve the medically indigent patients in their catchment areas.

RESPONSE: The intent of requiring a high risk obstetric clinic in regional facilities is due to the emphasis on maternal-fetal management. Requiring a CPC intensive facility to have such a clinic would require these facilities to have perinatologists on staff. The intent of this rule is to increase the number of maternal referrals and transports to regional centers; this should decrease the need for neonatal transports by having these infants delivered at the most appropriate site—the regional center. N.J.A.C. 8:33C-4.2 requires all facilities to provide ambulatory services including indigent care. In addition, N.J.A.C. 8:33C-4.3 requires that regions demonstrate that all providers assess for high risk within a region and document this assessment on a comprehensive perinatal record. There will be no change to the rule as a result of this comment.

COMMENT: University Hospital supports the requirement that regional perinatal centers have distinct prenatal clinic services devoted to women identified as high risk but encourages the Department to use this service to further develop the one stop shopping concept.

RESPONSE: The Department appreciates the support for this section of the rule and does support the one stop shopping concept.

N.J.A.C. 8:33C-9.5 Consultation, referral, transport and follow-up

COMMENTS: St. Joseph's Hospital and Medical Center would like community perinatal centers to be required to document that the majority of their transports were sent to the designated Regional Perinatal Center. This puts the control for transport patterns in the hands of the facilities where transports originate. St. Barnabas Medical Center indicates that the use of singular language in N.J.A.C. 8:33C-9.5(c) refers only to one regional perinatal center per region and does not reflect that there may be more than one per region.

RESPONSE: The intent of this documentation is for the region to demonstrate that the transport pattern is appropriate. The Department's position is that it is easier for the Regional Perinatal Center to provide this documentation. The Department will amend N.J.A.C. 8:33C-9.5(c) upon adoption to include langauge which recognizes regions which have more than one regional perinatal center.

SUBCHAPTER 10. SPECIALTY ACUTE CARE CHILDREN'S HOSPITALS

N.J.A.C. 8:33C-10.1 Services required

COMMENT: Morristown Memorial Hospital feels that in-house coverage of a neonatologist at a children's hospital is unwarranted and costly.

RESPONSE: This requirement is based on guidelines developed by the National Association of Children's Hospitals and Regional Institutions (NACHRI) and reflects the coverage in existence in the currently designated Children's Hospitals of New Jersey. There will be no change to the rule as a result of this comment.

N.J.A.C. 8:33C-10.2 Referrals and transports

COMMENTS: St. Joseph's Hospital and Medical Center opposes allowing transports at the community perinatal center level. The commenter suggested that allowing transports to the community perinatal center would encourage attrition of private patients to the community perinatal center, thus leaving the regional perinatal center primarily responsible for the inner city poor and medically indigent. Also, that physicians at the referring facility should be required to evaluate their patients for stability before a transport is requested.

RESPONSE: The PTAC recommended that more emphasis be placed on prevention and meeting specific community needs. As stated in the rule, the CPC-Intensive can only accept transports if specified in the letter of agreement with the RPC and there is a documented need for the service in the regional perinatal plan. The Department asserts that every transport should be made following the stabilization of a patient and is implicit as part of sound medical practice. The rule refers repeatedly to transports being made "as soon as possible." There will be no change to the rule as a result of this comment; however, for organizational clarity, N.J.A.C. 8:33C-10.2 is being recodified as N.J.A.C. 8:33C-11.1, as a subchapter entitled, "Letters of Agreement," with the subsequent subchapter appropriately recodified.

SUBCHAPTER 11. REVIEW CRITERIA

COMMENTS: Elizabeth General Medical Center expresses concern about the funding of the consortia in order to hire appropriate staff to accomplish the task described in N.J.A.C. 8:33C-2.6, Functions of the Regional Maternal and Child Health Consortia.

RESPONSE: The Department believes that $4.4 million in funds Statewide will be adequate to meet all the requirements specified in N.J.A.C. 8:33C.

SUBCHAPTER 12. ENFORCEMENT AND SANCTIONS

COMMENT: Concern was expressed by Memorial Hospital of Burlington County over the enforcement of compliance through the reimbursement system.

RESPONSE: Reimbursement will only be excluded for obstetric admissions if a facility fails to participate in a consortia.

COMMENTS: The Central New Jersey Perinatal Consortia and St. Peter's Medical Center would like an explicit contingency plan for funding to be developed by the Department.

RESPONSE: The Department will work to develop specific contingency plans for funding by the end of calendar year 1992. N.J.A.C. 8:33C-2.3 and 12.4 will be broadened in the discussion of funding mechanisms.

COMMENT: St. Barnabas Medical Center feels that licensed ambulatory facilities should be required to participate.

RESPONSE: The State Health Plan does require some licensed ambulatory facilities and community based agencies to participate in the consortia. The Department will certainly consider funding as another mechanism for encouraging this participation among providers other than hospitals.

Other Issues Not Addressed by these Rules

COMMENTS: The Department is encouraged to provide funding to support programs for the education of post-doctoral fellows in Maternal-Fetal Medicine.

There is much concern over the ability of the Department to implement this system in light of the instability of the current reimbursement system and the controversy surrounding the State Health Plan.

Certificate of Need filing fees appear to be excessive for and inappropriate for individual hospitals. It would appear that each region should only have to pay one fee ($5,000) inclusive of the consortia and their member hospitals.

Care for pediatric patients is not specified.

The designation of regional pediatric centers should be consistent with those hospitals designated as regional perinatal centers.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*).

CHAPTER 33C
CERTIFICATE OF NEED: REGIONALIZED PERINATAL SERVICES

SUBCHAPTER 1. GENERAL PROVISIONS

8:33C-1.1 Scope and Purpose

The New Jersey Department of Health currently licenses and regulates inpatient and outpatient providers of obstetric and pediatric services in licensed general acute hospitals and freestanding ambulatory care centers throughout the State. The effort to lower infant and maternal mortality and improve child health requires that these services be linked into organized regional service delivery networks. The purpose of this chapter is to establish criteria and

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standards for review of certificate of need applications from Regional Maternal and Child Health Consortia, to designate Perinatal Centers within each region, to specify the requirements for regional perinatal needs assessment and planning, to specify criteria for regional prevention activities, and to specify the minimum utilization required to assure quality perinatal services.

8:33C-1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings***, unless the context clearly indicates otherwise***:

"Central service facility" means a health care facility, regulated by the Department of Health, providing essential administrative and clerical support services to two or more direct providers of health care services in a region which may also include some direct provision of health care services.

"Certified nurse midwife" means a registered professional nurse, licensed as such by the New Jersey State Board of Nursing, who is also a graduate of an accredited school certified by the American College of Nurse Midwives, and licensed as such by the New Jersey Board of Medical Examiners.

"Clinical nurse coordinator or supervisor" means a registered professional nurse, currently licensed by the New Jersey State Board of Nursing, who has administrative responsibility over the areas of labor, delivery, recovery, the nurseries, postpartum and antepartum units.

"Commissioner" means the New Jersey State Commissioner of Health.

"Community perinatal center" means any licensed facility providing preconceptional, prenatal, intrapartum, including delivery of the patient, and postpartum care to women.

"Consumer" means an individual who may receive specific health care services in a specific consortium region and who is not a health care provider and has no fiduciary interest in a health care service.

"High risk" means any patient identified with a medical/obstetrical condition requiring more than routine medical or surgical intervention.

"High risk infant follow-up" means a system of screening and tracking infants with potentially serious health problems or at risk for developmental delays following discharge from the hospital.

"Hospital provider" means an individual who is a direct provider of a health care service or has administrative responsibility for a health care facility which is a licensed acute care hospital ***or who is employed by a hospital***.

"Infant" means a child from the period from birth to one year of age.

"In-hospital coverage" means a system whereby an individual is physically present in the hospital.

"Intensive care" means a hospital unit in which are concentrated special equipment and skilled personnel for the care of seriously ill patients requiring immediate and continuous attention.

"Intermediate care" means a hospital unit in which special equipment and personnel are available to care for stable, though ill, patients.

"Intermediate birth weight" means any neonate weighing between 1500 and 2500 grams at birth.

"Intrapartum" means the period occurring during childbirth or delivery.

"Letter of agreement" means the document signed by both the Regional Perinatal Center and the Community Perinatal Center which defines the relationship between the two centers and specifies all tasks to be provided. If there is more than one hospital within the region able to meet the qualifications of a Regional Perinatal Center, then the Regional Perinatal Centers first develop cooperative letters of agreement with each other; then with the Community Perinatal Centers within the region, facilitated by the Regional Maternal and Child Health Consortia. The letters of agreement are then submitted by the Regional Maternal and Child Health Consortia as part of the certificate of need application.

"Low birth weight" means any neonate weighing less than 2500 grams at birth.

"Maternal and child health service region" means the perinatal and pediatric service delivery area. Contained within each region is at least one Regional Perinatal Center, one Regional Pediatric Center and the balance, Community Perinatal Centers ***and Community Pediatric Centers***.

"Maternal-fetal transport" means the transport of the high risk patient for maternal management.

"Mid-level practitioner" means a certified nurse midwife or a nurse practitioner.

"Neonatal (newborn)" means the period up to 28 days after birth.

"Neonatologist" means a physician who is board certified in pediatrics with a certification in neonatology from the American Board of Pediatrics, Sub-Board of Neonatal/Perinatal Medicine or the American Osteopathic Board of Pediatrics, Sub-Board of Neonatology.

"Non-hospital provider" means an individual who is a health care provider or has administrative responsibility for health care facility but is not employed by*[, and does not provide care at,]* a hospital.

"Nurse practitioner" means a registered professional nurse with a current New Jersey license who has completed an accredited nurse practitioner certification program and is certified by a national professional organization.

"Obstetrician" means a physician who is certified, or eligible for certification, by the American Board of Obstetrics and Gynecology, Inc. or the American Osteopathic Board of Obstetrics and Gynecology.

"On-call coverage" means a system whereby an individual is readily available to be at the facility within 30 minutes of initial contact.

"One-stop shopping" means the integration of all services for the purpose of primary care access at a single site.

"Pediatrician" means a physician who is certified or eligible for certification by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics.

"Perinatal" means the period before and after birth; defined in New Jersey and generally accepted as week 20 of gestation through the neonatal period.

["Perinatal clinical nurse specialist" means a registered professional nurse, licensed as such by the New Jersey State Board of Nursing, who provides in-hospital and regional professional education as well as perinatal clinical expertise in consultation with bedside providers.]

"Perinatologist" means a physician who is board certified in obstetrics/gynecology with additional certification in maternal-fetal medicine from the American Board of Obstetrics and Gynecology, Inc., Division of Maternal-Fetal Medicine or the American Osteopathic Board of Obstetrics, Sub-Board of Maternal-Fetal Medicine.

"Physician" means a person who is licensed or authorized as such by the New Jersey State Board of Medical Examiners.

"Postpartum" means the period up to six weeks following birth.

"Preconceptional care" means assessing an individual for risk factors and counseling the individual prior to pregnancy.

"Prenatal (antepartal)" means the period occurring prior to birth, with reference to the fetus.

"Provider" means an individual who is a provider of health care either directly through the provision or administration of health services or indirectly by having a fiduciary interest in such services.

"Public health nursing home visits" means visits made or supervised by a licensed registered professional nurse who is employed by a local health department or home health agency. This includes those visits made by the nurse or by a community outreach worker or volunteer under the direction of the nurse.

"Referral" means the process whereby the attending physician at the Community Perinatal Center transfers the responsibility of the patient's care to a physician specializing in either neonatal or maternal-fetal medicine at the Regional Perinatal Center. This can consist of consultation only with transfer back to the care of the attending physician or continued follow-up by the Regional Perinatal Center through delivery.

"Regional perinatal activities" means the activities of the Regional Maternal and Child Health Consortia which include the development

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of the regional perinatal plan, the development of a region wide system for total quality improvement, the development of a plan for perinatal transport, the provision of regional professional education and the development of a system to resolve conflicts.

"Regional Perinatal Center" means a licensed perinatal care facility able to provide a full range of perinatal services to its own patient population and support to its own regional affiliates.

"Regional Maternal and Child Health Consortium" means a voluntarily formed non-profit organization, incorporated under Section 501(c)(3) of the Internal Revenue Code, consisting of all inpatient, ambulatory perinatal and pediatric care providers and related community organizations in a maternal and child health service region, licensed as a central service facility by the Department of Health.

"Regional perinatal plan" means the plan developed by the Regional Maternal and Child Consortia which describes how prenatal, intrapartum, newborn and infant follow-up services are delivered in the region. The plan is submitted to the Department of Health as part of the certificate of need application.

"Regionalization" means the planning and delivery of services within a specific geographic zone for the best use of financial and medical resources such as staffing, equipment, facilities, education, and expertise to coordinate appropriate quality health care to a specific population.

"Total quality improvement program" means the process designed to review quality of care and perinatal outcomes. Total quality improvement is an activity of the individual facilities and the Regional Maternal and Child Health Consortia.

"Transport" means the process whereby the attending physician at the Community Perinatal Center assesses that the status of the patient has become acutely high risk and arranges for the transfer of the care of the patient to the specialist at the Regional Perinatal Center via moving the patient with an emergency vehicle.

["Unit nurse manager" means a registered professional nurse currently licensed by the New Jersey State Board of Nursing who has administrative responsibility over an individual hospital care unit.]

"Ventilatory support" means the application of positive pressure ventilation and oxygen through mechanical devices to include continuous positive airway pressure (CPAP).

"Very low birth weight" means any neonate weighing less than 1500 grams at birth.

8:33C-1.3 Submission of Certificate of Need applications

(a) Applications for the establishment of Regional Maternal and Child Health Consortia to service specific maternal and child health regions shall be batched and reviewed in accordance with N.J.A.C. 8:33.

(b) Individual requests for designation of Regional Perinatal Centers and Community Perinatal Centers shall only be accepted as part of the certificate of need application of a Regional Material and Child Health Consortium.

(c) Certificate of Need applications for Regional Perinatal Centers and Community Perinatal Centers shall be submitted to the Local Advisory Boards and the Department of Health and shall be completed in accordance with the prescribed certificate of need rules at N.J.A.C. 8:33.

8:33C-1.4 Maternal and child health service regions

(a) A maternal and child health service region is a service area containing the full spectrum of care for the purpose of providing accessible and effective comprehensive, risk-appropriate care to all pregnant women and their infants, children, including children with special health care needs, and adolescents. The maternal and child health service region shall consist of perinatal and pediatric service regions.

(b) To be designated as a maternal and child health service region for the purposes of this chapter, the certificate of need application shall specify that (using data provided by New Jersey Department of Health for *[1990 or for a three-year average of 1988, 1989 and 1990]* ***the last three consecutive years of data available or the most recent year which is consistently applied in all applications within a region**) in the proposed region there are sufficient hospital members, with a three-year documented history of transfer relationships, to deliver a minimum of 10,000 women a year or provide risk appropriate care to 100 very low birth weight neonates a year. (As the number of low birth weight infants changes, the Department shall revise the minimum of 100 accordingly, in accordance with the requirements of the Administrative Procedure Act (N.J.S.A. 52:14B-1 et seq.) and N.J.A.C. 1:30.) The certificate of need application shall further specify that service regions shall have a geographic distribution which enables the development of a rational and cohesive network of services, recognizing existing transportation and patient referral patterns.

(c) The Commissioner may, at his or her discretion, grant a waiver to the delivery requirement of 10,000 women a year, if the applicant has been able to provide quantifiable evidence of severe problems of access to needed perinatal services due to geographic isolation. In no case may the number of deliveries be below 8,000 women per year.

(d) At least one facility which is currently willing and able to meet the qualifications for a Regional Perinatal Center shall be listed as such in the Certificate of Need application. If there is more than one facility which is willing and able to meet the qualifications for a Regional Perinatal Center, then those facilities shall develop cooperative letters of agreement with each other. The Regional Perinatal Centers shall then develop letters of agreement with the Community Perinatal Centers, facilitated by the Regional Maternal and Child Health Consortium.

8:33C-1.5 Service evaluation

All applicants for Regional Maternal and Child Health Consortia, Regional Perinatal Centers and Community Perinatal Centers shall agree to make their staff and records available for evaluation of the effectiveness of their perinatal services by staff of the New Jersey Department of Health or its designee. This evaluation and its outcome shall be a requirement of continued reimbursement through the rates. Such an evaluation shall measure effectiveness and shall be in addition to the inspection of basic compliance with licensing requirements.

SUBCHAPTER 2. REGIONAL MATERNAL AND CHILD HEALTH CONSORTIA

8:33C-2.1 Membership

(a) The perinatal and pediatric facilities within the proposed service region shall form a Regional Maternal and Child Health Consortium. Applicants for the Regional Maternal and Child Health Consortium shall be an association which shall include all agencies in the region involved in the delivery of perinatal and pediatric health services. Specifically, the Regional Maternal and Child Health Consortium shall include, but not be limited to, as general members:

1. All licensed acute care hospitals with obstetric and/or pediatric services and birthing centers;

2. All licensed ambulatory care facilities which provide prenatal care and care to infants and families with children up to age 18;

3. Professional organizations, non-profit organizations, and local or county governmental agencies concerned with the needs of families with infants, children and adolescents, including those with special health care needs, for example, community health centers, local health departments, Women, Infants and Children (WIC) and family planning agencies, local advisory boards, and Human Services Advisory Councils; and

4. Voluntary and consumer organizations, such as Healthy Mothers, Healthy Babies Coalitions.

8:33C-2.2 Governance of the region

(a) All members of the maternal and child health service region which agree to associate and apply to become the Regional Maternal and Child Health Consortium shall formally establish a non-profit corporation consistent with the Internal Revenue Code Under Title 26 of the United States Code Section 501(c)(3).

(b) The non-profit organization established in accordance with (a) above shall develop by-laws, voted upon by the general membership, which will establish participatory governance by all member organiza-

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tions and will define the specific composition of a Board of Directors. Each member agency shall have one membership vote in the organization.

(c) The Board of Directors shall be nominated from and voted upon by the general membership. The Board shall consist ***of a minimum*** of 18 to 21 members, one-third hospital providers, one-third non-hospital providers and one-third consumers. The composition shall be such as to assure appropriate representation of agencies concerned with women's reproductive health and the needs of pregnant women, infants, young children, adolescents and children with special needs. At least two members shall be physicians, holding a current New Jersey license, one who is board eligible or certified in obstetrics, and one who is board eligible or certified in pediatrics. At least one member shall be a registered professional nurse, holding a current New Jersey license with a certification in ***either*** maternal and child health nursing ***or in community health nursing***. At least one member shall be a health officer.

8:33C-2.3 Budget

The Regional Maternal and Child Health Consortium shall develop a budget plan which links all projected salary and non-salary costs, as described under N.J.A.C. 8:33C-2.5, to the regional perinatal plan. Subsequent to certificate of need approval, in order to receive funding under Chapter 83 reimbursement ***or other funding mechanism***, the Regional Maternal and Child Health Consortium shall provide a budget assessment demonstrating that the benefits achieved justify the costs incurred. A projected budget and budget assessment shall be provided to the Department annually.

8:33C-2.4 Data reporting

(a) All Regional and Community Perinatal Center Applicants shall indicate their willingness to comply with the following data reporting:

1. B2 Quarterly Inpatient Utilization Report; and

2. New Jersey Department of Health Maternity and Newborn Services Reporting System.

(b) All Regional and Community Perinatal Center applicants shall provide, as requested by the Regional Maternal and Child Health Consortium and the Department of Health, individual patient data, compiled from the comprehensive patient record, for the purpose of regional and State total quality improvement program monitoring.

(c) The Regional Maternal and Child Health Consortia shall be required to comply with patient confidentiality requirements as specified in Hospital Licensing Standards N.J.A.C. 8:43G-4.1(a)21.

8:33C-2.5 Staffing requirements of the Regional Maternal and Child Health Consortia

The Consortia shall have staffing requirements in accordance with N.J.A.C. 8:35, Maternal and Child Health Consortium Licensing Standards.

8:33C-2.6 Functions of the Regional Maternal and Child Health Consortia

(a) Regional Maternal and Child Health Consortia applications shall describe their functions, which shall consist primarily of:

1. The development of a regional perinatal and pediatric plan;

2. The development of a region-wide system for total quality improvements;

3. The provision of regional professional education;

4. The development of a plan for a perinatal transport system;

5. The development of a plan for the provision of infant follow-up services; and

6. The development of a system to resolve conflicts within the region.

(b) The application shall also describe the responsibility of the regional board of directors in determining the manner in which each function will be accomplished.

8:33C-2.7 Regional perinatal plan

(a) The Regional Maternal and Child Health Consortia shall develop and submit a plan, to be called the regional perinatal plan, which describes how prenatal (specifically, community-based), intrapartum, newborn and infant follow-up services are to be delivered in the region. In addition, planned outreach and education activities shall be included. The regional perinatal plan shall be submitted to the Department of Health for approval as the basis for the certificate of need application which will designate individual hospitals as Regional Perinatal Centers or Community Perinatal Centers. *[Once the plan is approved, certificate]* ***Certificate*** of need applications for new, expanded, or replacement perinatal services will require compliance with this chapter***and*** *[,]* the regional perinatal plan*[, and the State Health Plan]*. The certificate of need may be denied if compliance is not demonstrated.

(b) The specific components of the regional perinatal plan shall include:

1. A needs assessment which describes the current status of the region with respect to the occurrence of infant mortality, low birth weight births, availability of preconceptional and prenatal care, and intrapartum, newborn, intermediate and intensive care services, proportion of women receiving risk appropriate prenatal care, fertility rates and social, cultural, economic and demographic factors influencing the perinatal needs of the communities served by the region;

2. A description of perinatal services in the region, in existence *[as of January 1, 1992]* ***at the time of application***. This description shall include a list, by county, of all of the following:

i. Currently practicing obstetric, prenatal care and family planning providers, specifying those providers who accept Medicaid and who are HealthStart certified;

ii. Currently practicing perinatal specialists, both nursing and medical;

iii. Currently practicing pediatric care providers, both primary and specialists, serving children under the age of two, specifying those providers who accept Medicaid and who are HealthStart certified;

iv. A list of sites, both licensed ambulatory and private practice, where family planning, genetic counseling, prenatal care, and pediatric primary care is provided;

v. A description, by hospital, of the existing inpatient maternity and newborn services to include:

(1) The number and occupancy rate of labor, delivery, recovery and postpartum beds;

(2) Normal newborn bassinet capacity and utilization;

(3) Intermediate care bassinet capacity and utilization;

(4) Intensive care bassinet capacity and utilization; and

(5) Documentation of coverage commitments by professional staff in each facility for ambulatory, emergency department and inpatient services;

vi. Existing maternal and newborn transport capabilities (include actual number of transports, sent or received in *[1991]* ***the most recent year available at the time of application***); and

vii. The current number of at risk infant follow-up programs and the number of infants in follow-up for *[1991]* ***the most recent year available at the time of application.***

3. An assessment of gaps in services developed by comparing the identified needs described in (b)1 above with the current resources described in (b)2 above. The Regional Maternal and Child Health Consortium shall develop a specific formula for estimating the annual needs in the region utilizing data from the preceeding two years and projecting the needs for the upcoming four years. This formula shall cover the maternal and child health service region's needs in the following areas:

i. Prenatal care services;

ii. Antepartum beds;

iii. Capacity to transport laboring mothers and sick neonates;

iv. Labor, delivery and postpartum beds;

v. Intermediate care bassinets; and

vi. Intensive care bassinets;

4. A demonstration of the overall need for *[intermediate and]* intensive care bassinets, utilizing the methodology contained in (b)4i *[and ii]* below***, and for intermediate bassinets***. The overall need shall be based on data from the preceeding two years and a projection of the needs for the next four years. The number of births, the number of intermediate weight births, and the number of very low birth weight births shall be the same as those reported to the

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Department for the most recently available year. The Statewide average length of stay per birth weight category shall be determined by the Department every two years.

i. The total number of intensive care bassinets approved for all Regional and Community Perinatal Centers in each region shall be determined by the following formula:

$$\text{*[Intensive bassinets needed} = \frac{\text{(number of live births in the region)} \times \text{(the Statewide average intensive days per birth)} \times \text{(the ratio of the region's low birth weight to the State's low birth weight rate)}}{365 \times \text{the utilization factor of 85 percent occupancy or 1.18.}}$$

ii. The total number of intermediate bassinets approved for all Regional and Community Perinatal Centers in each region shall be determined by the following formula:

$$\text{Intermediate bassinets needed} = \frac{\text{(number of live births in the region)} \times \text{(the Statewide average intermediate days per birth)} \times \text{(the ratio of the region's low birth weight rate to the State's low birth weight rate)}}{365 \times \text{the utilization factor of 85 percent occupancy or 1.18.]*}}$$

$$\text{*}\frac{(axb) + (cxd) + (exf) + (gxh) + (ixj) + (kxl) + (mxn) + (oxp)}{365} \times 1.18$$

where

a = Regional number of live births < 1000 grams discharged alive plus the regional number of live births < 1500 grams with a significant operating room procedure discharged alive

b = Statewide average length of stay for type of patients defined in a above

c = Regional number of live births < 1500 grams not included in a above

d = Statewide average length of stay for type of patients described in c above

e = Regional number of live births > or equal to 1500 grams but < 2500 grams with a significant operating room procedure with major multiple problems

f = Statewide average length of stay for type of patients described in e above

g = Regional number of live births equal to or > 1500 grams but < 2000 grams either with a significant operating room procedure without multiple major problems or with multiple major problems without a significant operating room procedure

h = Statewide average length of stay for patients described in g above

i = Regional number of live births equal to or > 2000 grams but < 2500 grams either with a significant operating room procedure without multiple major problems or with multiple major problems without a significant operating room procedure

j = Statewide average length of stay for patients described in i above

k = Regional number of live births equal to or > 1500 grams but < 2500 grams with a major problem but without a significant operating room procedure

l = Statewide average length of stay for type of patients described in g above

m = Regional number of live births equal to or > 2500 grams with a significant operating room procedure without multiple major problems, or multiple major problems without a significant operating room procedure

n = Statewide average length of stay for patients described in m above

o = Regional number of live births equal to or > 2500 grams with a significant operating room procedure and multiple major problems.

p = Statewide average length of stay for patients described in o above

*[iii.]***ii.** Regional Perinatal Centers shall be the preferred provider for rendering neonatal intensive care. In no case shall intermediate or intensive bassinets be approved at both Regional and Community Perinatal Centers which will duplicate the same need delineated by (b)4i above. The final allocation of such bassinets shall be made by the Commissioner, ***taking into account the existing interim and approved intermediate and intensive care bassinets in each region and*** following the approval of the Regional Maternal and Child Health Consortium;

5. The minimum size of any *[intermediate or]* intensive neonatal care unit shall be six bassinets. ***The minimum size of any intermediate neonatal care unit shall be four bassinets. Waiver to the minimum size of an intermediate unit only may be considered by the Commissioner in cases where geographic inaccessibility can be demonstrated and where no additional costs will be incurred***;

6. A definition of specific objectives, based on the assessment of gaps, using measurable outcome criteria, to address the gaps in existing hospital and community services within the region. For example, an objective could be lowering the very low birth weight rate by a specified percentage through several stated intervention approaches. Provider and patient behaviors which can result in poor utilization of services, non-participation in care, lack of coordinated services, and other perinatal service delivery problems shall also be addressed;

7. A plan to encourage the use of mid-level practitioners, such as obstetric and pediatric nurse practitioners, family planning nurse practitioners and certified nurse midwives, especially in areas of assessed provider shortages;

8. A prevention plan which describes both clinical (inpatient and ambulatory) and non-clinical services to be provided to mothers and families in the region (both at risk and general) to help reduce the incidence of identified, behaviorally based perinatal problems. This section shall include the need for improved coordination of services with emphasis on the "one-stop shopping" service integration concept. In addition, the prevention plan shall address outreach and education regarding nutrition, smoking, drug and alcohol consumption during pregnancy, availability and utilization of genetic services, family planning and preconception counseling. The plan shall also document involvement and participation of community based organizations already serving the at risk population and communities; and

9. The activities planned, by specific organization members, to achieve the described objectives. This plan should include specific patient care services and areas of planned expansion. The list of activities shall also include:

i. Specific letters of agreement, valid for at least four years, between each Community Perinatal Center and the Regional Perinatal Centers in the region as to the scope of services to be provided by each facility. If there is more than one hospital able to meet the qualifications of a Regional Perinatal Center, then the Regional Perinatal Centers shall first develop cooperative letters of agreement with each other, then with the Community Perinatal Centers in the region, facilitated by the Consortia.

8:33C-2.8 Regional professional education

(a) The Regional Maternal and Child Health Consortium application shall describe the organization's planned actions for providing or coordinating an ongoing area-wide program of professional education to all perinatal service providers in its region. These programs shall include joint input from neonatal/perinatal physicians and neonatal/perinatal clinical nurse specialists. Regularly scheduled regional conferences shall, at a minimum, cover the following areas:

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1. Review and management of the major perinatal maternal illnesses occurring in the region;
2. Review and update for the identification and management of major neonatal conditions occurring in the region;
3. Development of appropriate hospital and community based linkages to insure maternal and newborn followup; and
4. Techniques and methods of risk assessment and providing culturally sensitive, risk appropriate prenatal care for antepartal women.

8:33C-2.9 Total quality improvement program

(a) The Regional Maternal and Child Health Consortium shall describe how it will meet its responsibility for establishing a total quality improvement process which covers all aspects of perinatal service. This process shall be managed by a specific subcommittee which shall meet at least quarterly and shall include all the components specified in N.J.A.C. 8:35.

(b) The Regional Maternal and Child Health Consortium application shall assure that each member hospital has a perinatal total quality improvement system, in accordance with N.J.A.C. 8:35-3.1(f). The regional total quality improvement plan developed by the subcommittee shall be reviewed by the Department and shall receive Department approval prior to its implementation.

8:33C-2.10 Plan for a perinatal transport system

(a) The Regional Maternal and Child Health Consortia application shall assure the responsibility of the Regional Maternal and Child Health Consortia to develop or enhance a regional maternal and neonatal transport system in order to insure timely access by the patient to risk-appropriate care. The Regional Maternal and Child Health Consortium shall develop and submit a plan which describes the transport system for at-risk intrapartum women and neonates. The transport system plan shall include:

1. Documentation of current transport capabilities with appropriate data, based on *[1991]* ***the most recent year available at the time of application*** actual transports;
2. Planned system, and needed enhancements to the system, to insure appropriate maternal and newborn transport for advanced levels of care;
3. Planned system, and needed enhancements for back (return) transports, of mothers or infants;
4. A written policy and procedure protocol for maternal and neonatal transports shall be developed by the Regional Maternal and Child Health Consortium. It shall be made clear in this protocol that the most at-risk infants and mothers shall be triaged and transported to the most advanced appropriate level of care within the region, in accordance with the letters of agreement.
5. Under circumstances where the proposed region does not have a bed or bassinet available to accommodate a transport, in accordance with the region's transport plan, the Regional Perinatal Center is responsible for making arrangements for transport to an adjacent Regional Perinatal Center. ***Regional Perinatal Centers are encouraged, in the State of New Jersey, whenever possible, to cooperate across consortia boundaries in accepting patients when capacity is reached in any region.***

8:33C-2.11 Infant follow-up

The Regional Maternal and Child Health Consortia shall assure that a system for appropriate discharge planning and infant follow-up exists, in accordance with N.J.A.C. 8:35.

8:33C-2.12 Conflict resolution

Each Regional Maternal and Child Health Consortium shall assure the development of a conflict resolution mechanism in accordance with N.J.A.C. 8:35.

SUBCHAPTER 3. COMMUNITY-BASED SERVICES

8:33C-3.1 Services; agencies

(a) As part of the certificate of need application, the Regional Maternal and Child Health Consortia shall document the involvement of community based services in the development of the regional perinatal plan. The eligible agencies shall include, but not be limited to, the following:

1. Local and/or county health departments;
2. Women, Infants and Children (WIC) agencies;
3. County Boards of Social Services;
4. March of Dimes;
5. Healthy Mothers, Healthy Babies Coalitions;
6. Family planning agencies;
7. Church or local community groups (such as urban leagues);
8. Home health agencies;
9. Alcohol and drug treatment agencies;
10. Community health centers;
11. Local advisory boards; and
12. Special Child Health Services County Case Management Units (when not administered by local health departments).

8:33C-3.2 Functions of community based service members

(a) The community based service members of the Regional Maternal and Child Health Consortium shall be primarily responsible for determining the medical/social maternal and child health needs of the community and for providing input into the prevention plan as part of the Regional Maternal and Child Health Consortium application. The prevention plan shall be incorporated in the regional perinatal plan as described in N.J.A.C. 8:33C-2.7(b)8. The component issues shall be addressed as follows:

1. Capacity of Services—The members should determine if there is an adequate number of providers/services to meet the maternal and child health needs of the community. They should also describe if the services accept Medicaid, are HealthStart certified, and the waiting time for first appointments.
2. Accessibility of Services—The members should describe the days and hours of operation, the location, transportation, child care availability, and service integration design.
3. Cultural Sensitivity—The members should assess the existing services to determine if they are sensitive to the cultural diversity of the community.
4. Outreach—Additional emphasis needs to be placed on outreach activities. As part of the regional perinatal plan, the members shall develop a plan to encourage women to seek early preconceptional and prenatal care, remain in prenatal care and return for preventive postpartum, family planning and pediatric services.

SUBCHAPTER 4. GENERAL REQUIREMENTS FOR FACILITIES WITH OBSTETRIC AND/OR NEWBORN SERVICES

8:33C-4.1 Application requirements

Individual Community Perinatal Center or Regional Perinatal Center applications shall be submitted as part of the Regional Maternal and Child Health Consortium's certificate of need application, by any licensed facility that provides or plans to provide prenatal, intrapartum, and postpartum care to women and their newborns. The requirements specified in N.J.A.C. 8:33C-4 through 6 shall be the basis for planning services.

8:33C-4.2 Compliance

(a) All Regional Perinatal Centers and Community Perinatal Centers shall demonstrate the ability to be in compliance with current hospital licensure standards, N.J.A.C. 8:43G-19.

(b) All Regional Perinatal Centers and Community Perinatal Centers shall document in the certificate of need application that ambulatory prenatal, postpartum, and normal newborn care is provided, and that these services are in accordance with the HealthStart Standards, N.J.A.C. 10:49-3, and the Standards for Obstetric-Gynecologic Services published by the American College of Obstetricians and Gynecologists. In the interest of continuity of care, *[all certified nurse midwives providing prenatal care shall be allowed delivery privileges. All physicians providing prenatal care shall be provided with the opportunity to deliver their patients, whenever possible.]* ***consideration should be given to granting privileges to all private practitioners (including obstetricians, family practitioners and certified nurse midwives) providing obstetric care, if all hospital-specific criteria are met.***

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8:33C-4.3 Comprehensive perinatal record

(a) As part of routine prenatal care, all providers within the region shall agree to use a comprehensive standardized perinatal record. This record shall include, at a minimum, a separate, identifiable section to assess for all risk factors. All antepartal patients shall be assessed for risk during the first prenatal visit and updated during subsequent visits. Additional sections of this comprehensive record shall include:

1. A complete reproductive and gynecologic history, history of medical illnesses and surgery, history of substance use (tobacco, alcohol and drugs), family illnesses, behavioral and environmental assessment, nutritional and social assessment, psychological history and risk status;
2. A complete physical exam;
3. A section for laboratory results and procedures; and
4. A plan of care.

8:33C-4.4 Consultation services

(a) Consultation services shall routinely be available from:

1. Registered dieticians or nutritionists;
2. Geneticists and genetic counselors;
3. Social workers;
4. Public health nurses;
5. Other physician specialties (medical, surgical, radiology, and pathology);
6. Pediatric subspecialists (infectious disease specialists, general surgeons, etc); and
7. Lactation consultants.

8:33C-4.5 Description of services provided

(a) Each Regional Perinatal Center and Community Perinatal Center application shall describe how it will provide services based on its capabilities and the needs described in the regional perinatal plan, and shall demonstrate in the certificate of need application that the following services, and personnel, are in existence at the time of application for the certificate of need:

1. Community Perinatal Center-Birthing Center;
2. Community Perinatal Center-Basic;
3. Community Perinatal Center-Intermediate;
4. Community Perinatal Center-Intensive;
5. Regional Perinatal Center; and
6. Designated Specialty Acute Care Children's Hospitals.

8:33C-4.6 Basis for provision of services

The services which any Community Perinatal Center is authorized to perform shall be based on the expressed interest of the facility, the needs of its community, as described in the regional perinatal plan, the capabilities of its staff and the facility's physical resources. The approved tasks may range from those performed by a birthing center, which provides non-surgical maternity care for low risk women and normal newborns, to the tasks of a facility which provides a specified range of neonatal special care services, but does not have the broad range of high risk maternal care and regional service responsibilities of a Regional Perinatal Center.

8:33C-4.7 Management of at-risk patients

All Community Perinatal Centers shall describe, in writing, the method of management for patients assessed to be at risk during the prenatal period, which should include referral to a provider with advanced capabilities in maternal-fetal medicine for initial consultation. After the initial consultation, management of the patient should be provided in accordance with N.J.A.C. 8:33C-9.4(a). Letters of agreement between all facilities within a region shall be specific regarding the coordination of services, transports, and referrals.

SUBCHAPTER 5. BIRTHING CENTERS

8:33C-5.1 Definition; affiliation required; care to be provided

A Community Perinatal Center-Birthing Center applicant shall consist of any licensed facility which provides routine intrapartum care to less than 500 uncomplicated maternity patients per year. Routine, uncomplicated intrapartum care is defined as care not requiring surgical intervention. At a minimum, birthing centers shall demonstrate an affiliation with a Community Perinatal Center-Intermediate facility or higher capability for obstetric and pediatric support. Prenatal, postpartum and newborn care shall be provided in accordance with N.J.A.C. 8:33C-4.

8:33C-5.2 Personnel

(a) The Community Perinatal Center-Birthing Center shall demonstrate that it has professional staff able to provide routine services to patients delivering at the center. This professional staff shall include, at a minimum, 24 hour a day, seven day a week on-call coverage of the center's services by:

1. A certified nurse midwife, in accordance with standards of the Board of Medical Examiners, as set forth in N.J.A.C. 13:35-2.6 through 2.12, or a physician with obstetrical training and experience;
2. A board eligible or certified obstetrician for consultation who has admitting privileges at a Community Perinatal Center-Intermediate maternity service hospital;
3. A board eligible or certified pediatrician; and
4. A registered nurse.

8:33C-5.3 Services

(a) Proposed routine intrapartum services shall be limited to:

1. Use of local anesthetics;
2. Performance of an episiotomy and repair;
3. Repair of lower third vaginal lacerations only; and
4. Systemic analgesia.

(b) The Community Perinatal Center-Birthing Center shall be prohibited from:

1. General and conduction anesthesia;
2. Inhibiting, stimulating or augmenting labor with chemical agents; and
3. The use of obstetric forceps or other surgical intervention.

8:33C-5.4 High risk mothers and neonates

Criteria for transfer of mothers and infants shall be in accordance with the standards of the Board of Medical Examiners governing solo management by certified nurse midwives as set forth in N.J.A.C. 13:35-2.6 through 2.12.

SUBCHAPTER 6. COMMUNITY PERINATAL CENTER-BASIC

8:33C-6.1 Definition; care to be provided

The Community Perinatal Center-Basic facility applicants shall consist of licensed hospitals which provide services primarily for uncomplicated maternity and normal newborn patients. They are characterized by physically separated facilities for labor and delivery with Cesarean section capability within the perinatal suite. They must also provide supportive care for infants returned from Regional or Community Perinatal Center-Intensive care facilities. These facilities shall provide care to patients expected to deliver neonates greater than 2499 grams and 36 weeks gestation. Any facility with less than 800 deliveries per year can not apply for a level greater than Community Perinatal Center-Basic. Prenatal, postpartum and newborn care is to be provided in accordance with N.J.A.C. 8:33C-4 and N.J.A.C. 8:43G-19.

8:33C-6.2 High risk mothers and neonates

(a) Community Perinatal Center-Basic applicants shall assure that maternal-fetal transports be made as soon as possible to the facility with advanced capabilities in accordance with the regional perinatal plan and letters of agreement between facilities.

(b) Community Perinatal Center-Basic applicants shall assure that any high risk neonate delivered at the Community Perinatal Center-Basic shall be immediately transported, following stabilization, to the facility with advanced capabilities as specified in the terms of the regional perinatal plan and letters of agreement.

SUBCHAPTER 7. COMMUNITY PERINATAL CENTER-INTERMEDIATE

8:33C-7.1 Definition; care to be provided

The Community Perinatal Center-Intermediate facility applicants shall meet all the requirements of routine prenatal care, postpartum, newborn, and Community Perinatal Center-Basic, as specified in

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N.J.A.C. 8:33C-4 and 6 and N.J.A.C. 8:43G-19. In addition, it shall also provide assurance for care for some complicated maternity patients and neonates. These facilities shall provide care to patients expected to deliver neonates greater than 1499 grams and 32 weeks gestation.

8:33C-7.2 High risk mothers and neonates

(a) Community Perinatal Center-Intermediate applicants shall assure that maternal-fetal transports shall be made as soon as possible to the facility with advanced capabilities in accordance with the regional perinatal plan.

(b) Community Perinatal Center-Intermediate applicants shall assure that any high risk infant anticipated as requiring ventilatory support longer than *[five (5) days]* ***48 hours*** cumulatively or otherwise with needs exceeding the facility's capabilities as described in the letter of agreement shall be transported as soon as possible after delivery to the facility with advanced capabilities as specified in the terms of the regional perinatal plan and letters of agreement ***and in accordance with N.J.A.C. 8:43G-19.20(b)2***.

SUBCHAPTER 8. COMMUNITY PERINATAL CENTER-INTENSIVE

8:33C-8.1 Definition; care to be provided

The Community Perinatal Center-Intensive facility applicants shall meet all of the requirements as specified in N.J.A.C. 8:33C-4, 6 and 7 and N.J.A.C. 8:43G-19. Additionally, it shall also provide assurance for care for complicated maternity patients and neonates in accordance with the scope of functions described in the regional perinatal plan. These facilities shall provide care to patients expected to deliver neonates greater than 999 grams and 28 weeks gestation.

8:33C-8.2 High risk mothers and neonates

(a) Community Perinatal Center-Intensive applicants shall assure that maternal-fetal transports, for patients exceeding its capability, will be made, as soon as possible, to the facility with advanced capabilities for care in accordance with the regional perinatal plan.

(b) Community Perinatal Center-Intensive applicants shall assure that any high risk infant delivered at the Community Perinatal Center-Intensive in need of specialized services or exceeding its capability must be transported to the facility with advanced capabilities as specified in the terms of the regional perinatal plan and letters of agreement.

(c) Community Perinatal Center-Intensive applicants shall assure that any high risk infant managed at the Community Perinatal Center-Intensive is followed in accordance with Department of Health, Special Child Health Services' standards for High Risk Infant Screening and Tracking or is referred to a Regional Perinatal Center for high risk infant screening and tracking services as specified in the letters of agreement.

SUBCHAPTER 9. REGIONAL PERINATAL CENTER

8:33C-9.1 Documentation of services

Regional Perinatal Center applicants shall document their ability to provide the full range of perinatal services defined for the Community Perinatal Center N.J.A.C. 8:33C-4, 6, 7 and 8 and N.J.A.C. 8:43G-19 as well as the tertiary services defined in N.J.A.C. 8:33C-9.2.

8:33C-9.2 Designation criteria

(a) The Regional Perinatal Center shall document that the following criteria were met *[in 1990 or for a three year average (1988, 1989, 1990)]* ***for the most recent year or the average of the last three consecutive years of data available and which is consistently applied in all applications within a region*** in order to be designated a Regional Perinatal Center:

1. Annual acceptance of over 80 maternal referrals or transports; and

2. Provision of full neonatal management to over 40 very low birth weight infants annually.

8:33C-9.3 Personnel

(a) The Regional Perinatal Center shall demonstrate that it has a full complement of professional staff who are able to provide advanced clinical services to patients treated at the Regional Perinatal Center, and who also have sufficient time and interest to provide regional consultation and training to insure regional access to risk appropriate perinatal expertise and staff development. Staffing qualifications and availability shall comply with N.J.A.C. 8:43G-19.

(b) The Regional Perinatal Center shall document that it has routinely available consultation services from other professionals, including, but not limited to:

1. A geneticist and genetic counselor;

2. A registered dietician;

3. Public health nursing; and

4. Pediatric subspecialists (that is, infectious disease specialists) and pediatric general surgeons and surgical subspecialists.

(c) In the interest of continuity of care, Regional Perinatal Centers *[shall allow staff privileges to obstetricians from the Community Perinatal Centers in their region.]* ***should give consideration to granting privileges to all practitioners providing obstetric care from community perinatal centers, if all hospital-specific criteria are met. These providers are encouraged to obtain a perinatal consult for their high risk patients managed at the Regional Perinatal Center.***

(d) The Regional Perinatal Center shall document that all registered nurses have completed a continuing education course in maternal-fetal or neonatal nursing within one year of the application for the certificate of need.

8:33C-9.4 Services

(a) The Regional Perinatal Center shall document its ability to provide, on a continuous basis, care for high risk mothers who have a broad spectrum of conditions including preexisting maternal disorders such as significant heart, renal or metabolic diseases, chronic infectious diseases, substance abuse, as well as major complications of pregnancy. It must also document the ability to care for high risk newborns who may be very low birth weight in need of complex neonatal respiratory and metabolic support, or other infants in need of major or surgical intervention in accordance with N.J.A.C. 8:43G-19.

(b) The Regional Perinatal Center shall document its ability to provide the full range of prenatal, to include antenatal testing, postpartum and infant health services to families in the region. It shall have a distinct prenatal clinic service devoted to women identified as high risk. The perinatologist shall be responsible for the direction of care for the women in this service and available to provide consultation to the attending physicians.

(c) The Regional Perinatal Center shall agree to maintain, on a continuous basis, neonatal intensive care services, in order to assure the maintenance of appropriate skill levels and expertise of the staff.

8:33C-9.5 Consultation, referral, transport and follow-up

(a) The Regional Perinatal Center application shall document that the perinatologists at the Regional Perinatal Center shall be available on a 24 hour basis to provide consultation to the attending physicians at the Community Perinatal Centers. Consultation by the perinatologist may be provided by:

1. Provision of telephone consultation to the attending physician at the community based setting or Community Perinatal Center;

2. Co-management with the attending physician of the stabilized at risk patient at the community based setting or Community Perinatal Center. Ongoing consultation by the perinatologist shall be provided as needed for the duration of the patient's pregnancy; or

3. Total management of the high risk patient referred by the attending physician at the Community Perinatal Center to the perinatologist at the Regional Perinatal Center.

(b) The Regional Perinatal Center shall specify the conditions requiring maternal/fetal or neonatal transport.

(c) The Regional Perinatal Center***s*** shall also document that *[it]* ***they*** receive the majority of transports for the region.

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(d) The Regional Perinatal Center shall provide documentation that high risk infant follow-up services are provided in accordance with the guidelines established by the Department of Health, Special Child Health Services.

SUBCHAPTER 10. SPECIALTY ACUTE CARE CHILDREN'S HOSPITALS

8:33C-10.1 Services required

(a) The designated Specialty Acute Care Children's Hospitals, as specified in N.J.S.A. 26:2H-18a, shall be recognized for the provision of highly specialized regional neonatal care. They must meet all of the criteria for the neonatal services of the Regional Perinatal Center in N.J.A.C. 8:33C-9 but are not required to provide obstetric services. This shall include 24 hour a day, seven day a week in-hospital coverage by a neonatologist.

(b) These services shall include the capability of performing subspecialty surgical procedures. They shall document leadership in providing the latest technology in neonatal medicine and statewide consultation.

SUBCHAPTER 11. LETTERS OF AGREEMENT

8:33C-*[10.2]****11.1*** Referrals and transports

(a) The letters of agreement between facilities shall specify that any patient requiring specialized perinatal care shall be referred to a provider with privileges at a Community Perinatal Center-Intensive or Regional Perinatal Center as specified in the letter of agreement and regional perinatal plan in accordance with N.J.A.C. 8:43G-19.

(b) Maternal-fetal and neonatal transports shall be provided by the Community Perinatal Center only if these services are approved activities delineated in the letter of agreement with the Regional Perinatal Center in accordance with N.J.A.C. 8:43G-19.

SUBCHAPTER *[11]****12***. REVIEW CRITERIA

8:33C-*[11.1]****12.1*** Application review; general

Perinatal designations and certificate of need will be granted to Regional Maternal and Child Health Consortia for all facilities within their maternal and child health service region. Applications from the Regional Maternal and Child Health Consortia must contain all the individual facility applications for perinatal services with their letters of agreement and be submitted as one package with the regional perinatal plan. Applications shall be reviewed by Local Advisory Boards and the Department of Health for compliance with the State Health Plan and in accordance with the certificate of need process.

8:33C-*[11.2]****12.2*** Maternal and Child Health Consortia application review criteria

(a) Applications for Regional Maternal and Child Health Consortia shall be reviewed on the basis of the following criteria:

1. Full compliance with all standards and guidelines in this chapter;

2. The appropriate plan for region wide access to preconceptional, prenatal, intrapartum, postpartum, family planning and pediatric services by all women and infants in the region including the medically indigent and those covered by Medicaid;

3. Development of the most cost effective linkages with existing providers of prenatal care; and

4. Content of plans to overcome existing gaps in and barriers to care.

8:33C-*[11.3]****12.3*** Regional and Community Perinatal Centers application review criteria

(a) Applications for Regional and Community Perinatal Centers will be reviewed for the following:

1. Community need for the services being proposed as stated in the regional plan;

2. Documentation that all facilities are in compliance with these rules;

3. The demonstration of effective linkages with other components in the proposed regional system of care; and

4. Documentation of the need for advanced maternal and newborn care in the region.

8:33C-*[11.4]****12.4*** Change in designation

Applications for a change in designation shall be considered a significant change in scope and shall follow the full certificate of need review process through the Regional Maternal and Child Health Consortia.

8:33C-*[11.5]****12.5*** Change in number of bassinets; renovation; construction

Applications submitted for a change in the number of bassinets, or renovation, or construction must be submitted separately, adhere to the certificate of need rules for such projects and initially be endorsed by the Regional Maternal and Child Health Consortia for comment and approval.

SUBCHAPTER *[12.]****13.*** ENFORCEMENT AND SANCTIONS

8:33C-*[12.1]****13.1*** Participation

Facilities providing obstetric inpatient hospital services shall participate in a Regional Maternal and Child Health Consortia. Failure to participate shall be deemed as not providing an appropriate array of services and continuity of care. Such failure to participate may be cause for having obstetrical services excluded from the hospital reimbursement rates.

8:33C-*[12.2]****13.2*** Shift or change of participation

The shift of a facility participating in one Regional Maternal and Child Health Consortium to another shall occur without break in time and only on the express approval of the Department of Health once the facility had gone through the conflict resolution process as specified in N.J.A.C. 8:33C-2.12.

8:33C-*[12.3]****13.3*** Monitoring

The Department shall monitor compliance with the terms and conditions of approved applications for Regional Maternal and Child Health Consortia, Regional Perinatal Centers and Community Perinatal Centers. The Department will determine if operations of the Regional Maternal and Child Health Consortium or any of its component agencies materially complies with the presentations made in the Regional Maternal and Child Health Consortium's application for its certificate of need and all conditions assigned to its certificate of need approval.

8:33C-*[12.4]****13.4*** Reimbursement

Only those Regional Material and Child Health Consortia that have been approved through the certificate of need process shall have the Regional Maternal and Child Health Consortia's and their constituent hospitals' expenditures included ***either*** in the hospital reimbursement rates ***or an alternate funding mechanism***.

8:33C-*[12.5]****13.5*** Penalties

Failure to document compliance with the certificate of need application and all conditions assigned them shall result in licensing sanctions and the disallowance of reimbursement for non-conforming practices.

(a)

DIVISION OF HEALTH PLANNING AND RESOURCES DEVELOPMENT

Certificate of Need Policy Manual for Long-Term Care Services

Adopted Repeal and New Rules: N.J.A.C. 8:33H

Proposed: June 1, 1992 at 24 N.J.R. 2014(a).

Adopted: August 14, 1992 by Frances J. Dunston, M.D., Commissioner, Department of Health (with approval of the Health Care Administration Board).

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Filed: August 17, 1992 as R.1992 d.344, **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 26:2H-5 and 26:2H-8.

Effective Date: September 8, 1992.

Expiration Date: September 8, 1997, except for N.J.A.C. 8:33H-1.15, which expires March 8, 1994.

Summary of Public Comments and Agency Response:

The Health Care Administration Board (HCAB) voted on August 13, 1992, to adopt N.J.A.C. 8:33H, with the provision that N.J.A.C. 8:33H-1.15 will sunset 18 months from its effective date. Within this 18 month period, the HCAB is requesting that the Department of Health compile data and analyze the issue of access to nursing home care for Medicaid-eligible patients. At the conclusion of 18 months, the Department of Health anticipates proposing revisions to N.J.A.C. 8:33H-1.15, based upon the analysis.

Comments were received from the following: The New Jersey Association of Health Care Facilities (NJAHCF); Mr. Dan Moles, Administrator of Ashbrook Nursing Home; the Long-Term Care Overview Panel; the State Department of Human Services, Division of Medical Assistance and Health Services; Mr. Edward Tetelman, Director of Legal and Regulatory Affairs, State Department of Human Services; and the New Jersey Association of Non-Profit Homes for the Aging (NJANPHA). Comments were also received after the submission deadline from Rachelle Bernstecker, Regional Director of Health Planning, Marriott; these comments were not processed.

COMMENT: Mr. Dan Moles, Administrator of Ashbrook Nursing Home, recommends that N.J.A.C. 8:33H-1.1(d), 1.14, and 1.15 be amended to indicate that the criteria for nursing home Certificates of Need should be equally applied to all other long term care alternatives, such as alternate family care, assisted living, and comprehensive personal care. Applicants for these kind of projects should be required to meet the requirement that 55 percent of all new admissions be Medicaid and that the facility maintain a patient mix that is at least 45 percent Medicaid.

RESPONSE: It is the Department's intent to develop operating guidelines, licensing standards, and planning rules as they are applicable and relevant to the new long-term care alternatives, including alternate family care, assisted living, and comprehensive personal care homes. Because these services are still in the formulation stage, it is not possible to state what the Certificate of Need criteria will be at this time, as indicated in N.J.A.C. 8:33H-1.1(d). Therefore, the commenter's recommendation cannot be accepted.

COMMENT: NJAHCF recommends changes in the definitions of "assisted living residence" and "nursing home" at N.J.A.C. 8:33H-1.2, in order to better delineate the differences between these categories. For "assisted living" they recommend the Department follow the definition used by the State of Oregon. Mr. Moles also requests that the definition of "assisted living" be amended to allow two adults the right to choose to live in one room together if they wish to do so for personal, social or financial reasons. He furthermore states that the reference to "nursing care and supervision as needed" in the definition is not an appropriate concept in the assisted living setting because it is too general. Mr. Moles also states that "assisted living," "comprehensive personal care homes," and "residential health care facilities" should be combined. Attempting to distinguish these concepts would confuse the public and require a costly educational effort for all participants in the industry.

RESPONSE: The Department accepts NJAHCF's recommendation to amend the definition of "nursing home." The licensing definition of a "facility" as it is set forth in N.J.A.C. 8:39, Licensing Standards for Long-Term Care Facilities, has been added to the definition of "nursing home" in N.J.A.C. 8:33H-1.2. For "assisted living residence" and "comprehensive personal care homes," it is the Department's intent to develop licensing standards and planning rules pertaining to these services within the next year. At that time, the definition for each will be amended to convey the appropriate meaning, taking into consideration the commenter's recommendations. The Department is not prepared at this time to provide a detailed response, but will address the commenter's concerns at the time the licensing and planning rules are developed for such services.

COMMENT: N.J.A.C. With regard to N.J.A.C. 8:33H-1.2, Mr. Moles proposes that: (1) the definition of "deficiency" should be amended so that it applies only to those facilities with deficiencies remaining after appeal procedures have concluded, assuming a facility initiates an appeal; (2) "direct admission Medicaid patient" should be changed to "direct admission Medicaid resident"; (3) the definition of "long term care bed" should specify which facility and community based programs would be included in the definition; (4) "Long Term Care Committee" should encompass an expanded role to enable them to approve long term care projects which they review; and (5) "nursing home eligibility" be given a clear, concise definition.

RESPONSE: The Department does not accept Mr. Moles' proposed amendment to the definition of "deficiency." Rather, the definition has been amended to indicate when a deficiency is valid. Every deficiency is appealable, meaning that for Certificate of Need review purposes, a deficiency is only a deficiency after all appeals are exhausted; this will render the examination of a facility's track record virtually useless in CN review. Appeals take several months or longer to appeal. The Department accepts the commenter's recommendation regarding "resident" and has modified the term "direct admission Medicaid patient" to indicate that "patient" and "resident" may be used interchangeably. There is no reference to "long-term care bed" in N.J.A.C. 8:33H-1.2; however, "long-term care placement" is defined; the types of long-term care programs and services covered by the general definition are specified in N.J.A.C. 8:33H-1.4(b). The definition of "Long-Term Care Committee" used in this chapter delineates the required responsibilities of these committees; should the Local Advisory Board which appoints the Committee determine that it would like this group to be involved in reviewing long-term care projects, there is nothing in this definition or chapter to preclude that. However, County Long-Term Care Committees are primarily intended to serve a planning function; they are not expected to take over the Local Advisory Board's responsibility for reviewing Certificate of Need applications. The term "nursing home eligible" is used only once, at N.J.A.C. 8:33H-1.5(d)2iii, to indicate individuals who are likely to need nursing home placement. The Department concludes that this minimal usage does not wárrant definition in N.J.A.C. 8:33H-1.2.

COMMENT: The New Jersey Association of Health Care Facilities (NJAHCF) recommends that N.J.A.C. 8:33H-1.3 be amended to include the title of N.J.A.C. 8:43, Manual of Standards for Licensure of Residential Health Care Facilities, since it was apparently inadvertently omitted from this section.

RESPONSE: The Department accepts NJAHCF's recommendation to add the title of N.J.A.C. 8:43, Manual of Standards for Licensure of Residential Health Care Facilities to N.J.A.C. 8:33H-1.3.

COMMENT: NJAHCF states that residential health care facilities should be added to the list of long-term care options in N.J.A.C. 8:33H-1.4(b), because they are included in the Certificate of Need program. In N.J.A.C. 8:33H-1.4(d)3, both NJAHCF and Mr. Moles recommend that nursing facilities should be added to the list of options at subparagraphs (d)3i through v to make it consistent with the list in subsection (b). Mr. Moles also indicates that the "default" proposal should be the responsibility of the Local Advisory Board, not the State Health Planning Board.

RESPONSE: The non-nursing home options listed in N.J.A.C. 8:33H-1.4(b) may all substitute for nursing home placement, to some extent. Residential health care specifically excludes individuals with nursing facility-level needs, and it would, therefore, not be appropriate to include it in N.J.A.C. 8:33H-1.4(b). In N.J.A.C. 8:33H-1.4(d)3, nursing facilities have intentionally been omitted from the list of options available to counties that have fallen into "default" by not proposing an acceptable placement mix. The omission of nursing homes may act as an inducement to counties to complete an acceptable placement mix proposal while they have the full range of options available to them. Similarly, responsibility for the default proposal is placed in the hands of the State Health Planning Board, so that the Local Advisory Board will be motivated to work with each county to facilitate the process of developing an acceptable placement mix. Otherwise, if many counties were allowed to fall into default, Local Advisory Boards might essentially take over the task of formulating the placement mix proposals without involving the counties.

COMMENT: The Long-Term Care Overview Panel expresses concern about County Long-Term Care Committees' compliance with the placement mix proposal requirements in N.J.A.C. 8:33H-1.4 and 1.5. They request a clarification be made in N.J.A.C. 8:33H-1.4(d), stating that the Department of Health will review each Local Advisory Board's set of county long-term care placement mix proposals for compliance with the

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rules. If the proposal is not in compliance, it will be returned to the Local Advisory Board (LAB) for corrective action. This change should eliminate any confusion regarding the role of the LAB and the Department of Health in ensuring compliance with the placement mix methodology.

RESPONSE: The Department concurs that problems could arise if the six Local Advisory Boards interpret and apply the rules in N.J.A.C. 8:33H-1.4 and 1.5 differently in determining the acceptability of their regions' county long-term care placement mix proposals. Consequently, changes have been made in N.J.A.C. 8:33H-1.4(d)1, to stipulate that the proposal will be returned to the Local Advisory Board for corrective action should the Department of Health, in consultation with the State Health Planning Board, identify that a county placement mix proposal is not in compliance with the rules, as the rules have been applied uniformly in the review of all county placement mix proposals.

COMMENT: Mr. Moles states that the methodology in N.J.A.C. 8:33H-1.4(i) which is used to determine need for new nursing home beds should take into consideration area occupancy rates, and a 95 percent overall occupancy rate should be used as a benchmark indicating need for additional nursing home beds. The current formula ignores the fact that many sponsors of residents may bring elderly relatives in from other counties and states for nursing home placement. Formulas tied to the elderly population of a specific area do not take these dynamics into consideration. With regard to N.J.A.C. 8:33H-1.4(m), Mr. Moles recommends that county Long-Term Care Committee within each LAB region should coordinate planning efforts for the AIDS/HIV-positive population so that an excess of beds is not created as a by-product of ensuring access to care.

RESPONSE: The formula set forth in N.J.A.C. 8:33H-1.4(i) is based upon a Statewide average rate of nursing home utilization; therefore, the effect of migration within the State (that is, patients moving from one county to another to receive care) may be discounted. The amount of immigration from other states is negligible, when viewed on a Statewide basis. The Department prefers not to use occupancy rates as a basis for significant nursing home bed expansion, due to the fact that occupancy rates may vary from one year to the next. It can take five or more years for a new nursing home to be built. Consequently, use of an occupancy factor as the trigger for new bed construction is viewed by the Department as an unsatisfactory measure. The commenter's suggestion regarding a coordinating role for LABs in planning long-term care services for persons with AIDS/HIV infection is noted; the Department agrees that this activity by LABs would be very beneficial. With respect to N.J.A.C. 8:33H-1.4(m), however, the ultimate responsibility for addressing access problems for patients with AIDS/HIV infection is left with the Department of Health. The Department would look not only at available resources within a particular LAB region, but also at the availability and accessibility of resources across LAB regions. "Regional" needs, in the case of the AIDS/HIV infected population, may extend beyond any one LAB's borders, particularly in the northern part of the State. Therefore, no change has been made in this subsection.

COMMENT: NJAHCF requests that N.J.A.C. 8:33H-1.5 include a need methodology for residential health care facilities.

RESPONSE: N.J.A.C. 8:33H-1.12 contains the Certificate of Need criteria for residential health care facilities and calls for an expedited review. The expedited review does not entail an examination of need for the project. The Department would have no purpose in moderating the development of this service, and use of a need formula might tend to limit the supply of residential health care. There has been relatively little Certificate of Need activity for this level of care in the recent past, which suggests that an uncontrolled, haphazard proliferation of additional, possibly underutilized, facilities is unlikely in the future.

COMMENT: The State Department of Human Services, Division of Medical Assistance and Health Services, states that the ratio of four adult day health care slots for every one nursing facility slot is too low. Since there are only a small number of persons attending adult day health care who meet nursing facility admission criteria, a more generous ratio, such as five or six to one should be used in N.J.A.C. 8:33H-1.5(d)2iii.

RESPONSE: The four-to-one ratio was reviewed and considered by the Long-Term Care Overview Panel of experts that provided input to the Department of Health as N.J.A.C. 8:33H was developed. The ratio was accepted as reasonable by that group, in the absence of data to the contrary. The Department will attempt to gather data in the future to document the precise number and ratio of persons using adult day health care who would be nursing home-eligible. The Department would prefer to have a sound empirical basis before making a change in this ratio.

COMMENT: The New Jersey Association of Non-Profit Homes for the Aging (NJANPHA) proposes that the Department of Health should have Medicaid to pay the costs associated with the specialized behavior management unit as proposed N.J.A.C. 8:33H-1.7. If Medicaid will not pay those costs, then the requirements should be pared down.

RESPONSE: Staff members from the Division of Medical Assistance and Health Services (Medicaid) in the Department of Human Services have indicated a recognition of the need for model units for patients with severe behavior management problems. They were actively involved in developing the requirements in N.J.A.C. 8:33H-1.7. However, the Department of Health is not in a position to mandate what other agencies of State government, such as Medicaid, must do. Applicants who are interested in establishing specialized model units should consult Medicaid directly regarding reimbursement rates for this service.

COMMENT: Mr. Moles suggests that the categories of specialized long-term care covered in N.J.A.C. 8:33H-1.7 should include other conditions, such as coma, brain injury, and rehabilitation. He also suggests that the criteria for units for patients with severe behavior management problems stated in N.J.A.C. 8:33H-1.7(e) should be used as guidelines rather than requirements. This would allow the DOH the benefit of learning about alternative ways of providing care which may produce higher quality and greater cost-effectiveness.

RESPONSE: The repealed N.J.A.C. 8:33H included only one type of specialized care: ventilator care. In the new chapter, the category has been expanded to include model units for patients with severe behavior management problems. Commonalities between the two types of patients included in the specialized care category are that both experience critical problems accessing long-term care services and both require care that is not typically available in nursing homes. The requirements in N.J.A.C. 8:33H-1.7 are aimed at addressing the access difficulties of such patients, while assuring high quality treatment. As the commenter has pointed out, a number of other conditions could be included in the specialized care section; however, general long-term care facilities typically are, or should be, treating patients with problems such as coma and brain injury. Some facilities may choose to create separate units for patients with such conditions. Provided that an increase in the bed complement is not required, general long-term care facilities may do so without obtaining a Certificate of Need. To provide specialized long-term care as it is defined in this chapter, however, one must receive a Certificate of Need. The Department chooses not to accept the commenter's recommendation to amend N.J.A.C. 8:33H-1.7 to add other conditions/categories to the types of specialized long-term care. The Department notes that the rules do not preclude the development of services to address other conditions.

COMMENT: NJAHCF requests that N.J.A.C. 8:33H-1.7(h) be amended so that respiratory therapy coverage for ventilator care units would be required in-house, rather than on-call. The commenter suggests that this is current practice.

RESPONSE: The requirement for on-call respiratory therapy coverage is a minimum expectation. There is nothing to preclude facilities from increasing that coverage so that a respiratory therapist is present on the unit 24 hours a day, if they find that this is necessary to assure good quality care. Providing 24 hour-a-day staffing with respiratory therapists is costly; if the facility is able to assure good patient outcomes without this measure, they should not be mandated to provide 24 hour-a-day staffing. The "on-call" requirement is, therefore, maintained in the rule.

COMMENT: Mr. Moles proposes that the Medicaid utilization requirement for adult day health care programs as cited in N.J.A.C. 8:33H-1.8(e) should be increased from 20 percent to 45 or 55 percent. These requirements should be the same as those applied to nursing homes, so that the market will be balanced with respect to financial resources.

RESPONSE: Unlike nursing homes, adult day health care programs are reimbursed by an array of payers, including United Way, Peer Group funding, Community Care Program for the Elderly and Disabled, Department of Health, private patients, and Medicaid. The differential between private and Medicaid payment rates is generally small, so that day care programs have little incentive to favor out-of-pocket payers over Medicaid clients, as may be the case in nursing homes. Adult day health care programs typically serve large numbers of Medicaid clients. Consequently, the Department maintains that there is not a basis for raising the Medicaid utilization requirement in N.J.A.C. 8:33H-1.8(e).

COMMENT: The New Jersey Association of Health Care Facilities recommends that N.J.A.C. 8:33H-1.9(a), regarding the desired occupancy rate for nursing homes that propose to expand, be deleted. If not, it

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should be reduced from 95 percent to 85 percent. Current Statewide occupancy is 93 percent and does not denote inefficiency. Utilizing the 95 percent rate would preclude the expansion of many quality care providers.

RESPONSE: The requirement for 95 percent annual occupancy in a nursing home that proposes to expand is intended to prevent underutilized facilities from receiving Certificate of Need approval to add beds. While an occupancy level as low as 85 percent would tend to indicate that the facility is having operational difficulties, it is acceptable to the Department to lower the requirement to 90 percent. This rate should effectively serve the desired purpose. Accordingly, N.J.A.C. 8:33H-1.9(a) has been amended.

COMMENT: NJANPHA supports the Department in doing away with mandatory nursing unit and nursing home minimum sizes; however, it should not leave in their place shadow requirements in the form of "recommended" minimum sizes, because these recommendations will prejudice the review, or discourage providers from experimenting with different configurations. Therefore, N.J.A.C. 8:33H-1.9(d) and (f) should be deleted. Mr. Moles recommends that size requirements be used only as guidelines.

RESPONSE: The Department does not wish the recommended sizes in N.J.A.C. 8:33H-1.9(d) and (f) to be regarded as requirements. In view of the protective stipulations contained in subsection (e), requiring facilities to be sized so that they will be adequately staffed and financially feasible, the Department agrees to delete 1.9(d) and (f).

COMMENT: NJANPHA objects to the 240 bed maximum size limit contained in N.J.A.C. 8:33H-1.9(g) and (h). Facilities should be judged by the quality of their care, not by their size. There are excellent facilities in New Jersey with more than 240 beds. To categorically prohibit them from ever increasing their bed size because of a hypothetical harm that might come to residents does a disservice to people who want to live there. A better approach would be to provide that proposed expansion beyond 240 beds will result in greater scrutiny of the facility's track record. Furthermore, Statewide restricted admission facilities should be exempted from this size limitation because they serve special populations who probably could not find a substitute for the particular religious or fraternal environment they seek. Finally, this size limit should never be a bar to the renovation of existing facilities. Otherwise there will be a disincentive for such facilities to modernize, and this could lead to mounting licensure deficiencies that could make a facility unsafe. Therefore, N.J.A.C. 8:33H-1.9(g) and (h) should be deleted, or alternatively, facilities proposing to exceed 240 beds should be held to a higher level of scrutiny.

RESPONSE: Currently there are fewer than 15 nursing homes in New Jersey that exceed 300 beds. The Department maintains that very large nursing homes are generally undesirable for several reasons. Should a severe quality of care problem arise to the extent that patients must be relocated, the task of closing a very large facility and finding alternative placements would be far more onerous than with a smaller facility Furthermore, smaller facilities can be more easily and closely managed, and systemic problems can typically be more readily remedied. They may foster a more homelike, intimate environment where residents and their families, staff, and management all have the opportunity to know one another. Another problem with large facilities is that they represent a "clumping" of nursing home beds in one location, which is not necessarily the most geographically accessible site for many county residents. The establishment of several smaller facilities in different parts of a county offers the advantage of convenience for visiting friends and family members and the opportunity for facility residents to maintain ties with their nearby community. Notwithstanding the aforementioned considerations, the Department has amended N.J.A.C. 8:33H-1.9(g) to allow Statewide restricted admissions facilities to propose additions which will exceed the 240 bed limit, provided that these facilities can demonstrate acceptable licensing track records. Because they specifically and identifiably offer residents other benefits in terms of fraternal or religious association opportunities, and because residents have typically chosen to relocate a considerable distance from their home communities to live in these facilities, the problems presented by other large facilities are attenuated. The Department has also amended N.J.A.C. 8:33H-1.9(h) to allow any facility which exceeds the size requirement to undertake a renovation or replacement project which will not necessarily reduce the institution's bed capacity.

COMMENT: Mr. Moles requests that the terms, "home-like environment" and "efficient facility," should be more clearly spelled out in N.J.A.C. 8:33H-1.9(b).

RESPONSE: The commenter's suggestion regarding the term, "homelike environment," is accepted. The rule has been amended to include the following: "(as opposed to a hospital-like environment)." There may be any number of ways to achieve a homelike environment; however, the traditional modeling of nursing homes to look and feel like hospitals is not desirable when the inhabitants will generally reside in this setting for months or years. With regard to the term, "efficient facility," the commenter is referred to N.J.A.C. 8:33H-1.16 for precise requirements.

COMMENT: NJANPHA states that the reference to staffing requirements is inappropriate in N.J.A.C. 8:33H-1.9(e); they should be dealt with under licensing standards. Staffing requirements change from time to time, but if a facility is approved with a particular staffing condition it will be imbedded in the facility's license forever. Therefore, N.J.A.C. 8:33H-1.9(e) should be deleted. Alternatively, Mr. Moles states that N.J.A.C. 8:33H-1.9(e) should specifically reference that Medicaid will fully reimburse the staffing pattern described in this paragraph.

RESPONSE: The Department of Health is not in a position to obligate another agency of State government, such as Medicaid, to reimburse services. In N.J.A.C. 8:33H-1.9, the Certificate of Need applicant is given great flexibility in determining the size of nursing units proposed for construction. However, it behooves the applicant to take reimbursement policies into consideration when designing the facility and projecting how it will be staffed. The staffing requirements referenced in N.J.A.C. 8:33H-1.9(e) are intended to protect patients on small units from inadequate staff coverage, which could jeopardize their health and safety. The requirements are not expected to be onerous for units that are adequately sized. Therefore, the requested changes have not been made.

COMMENT: The New Jersey Association of Health Care Facilities suggests that N.J.A.C. 8:33H-1.10(b) be amended so that continuing care retirement communities (CCRCs) would be required to have a minimum of four independent living units for every one nursing home bed, or other long-term care option, such as an assisted living unit or comprehensive personal care bed. This would make the provision consistent with N.J.A.C. 8:100-18.15. Also, the Association requests that N.J.A.C. 8:33H-1.10(g) be amended so that CCRCs would have to fill 100 percent of their nursing home beds with members of the CCRC within five years after opening. Since CCRCs are exempt from the need methodology, it would be unfair to allow them to occupy beds with patients from the general community. NJANPHA, on the other hand, expresses support for the proposed seven year fill-up period, with 90 percent occupancy by CCRC residents in the nursing home component thereafter.

RESPONSE: It is the Department's intent to develop licensing standards and planning rules for assisted living and comprehensive personal care homes within the next year. At that time, N.J.A.C. 8:33H-1.10(b) will be amended, if the Department determines that these services should be regarded as interchangeable with nursing home beds for the purposes of a CCRC. In view of the typical health profile of new CCRC residents and their actual experience with utilizing nursing home beds, it would be unrealistic to expect that 100 percent of a CCRC's beds would be occupied by members of the CCRC within five years from opening. The requirement at subsection (g) as proposed will give CCRCs a more reasonable period of seven years to reach a 90 percent occupancy level for patients drawn from within the CCRC. Since most CCRCs have only 60 nursing home beds, the number of beds that could be occupied by non-CCRC patients at 90 percent is a maximum of six beds. This small number should have an insignificant effect on the occupancy rates of other "competing" nursing homes in the area.

COMMENT: NJANPHA expresses support for a possible requirement in N.J.A.C. 8:33H-1.10 to require that at least 45 percent of the nursing home patients who are non-CCRC residents be Medicaid-eligible persons, during the seven year fill-up period. However, when a CCRC nursing home fills up with its own residents to the point where only a tiny number of beds is available to outsiders, the cost and trouble of filing Medicaid cost reports outweighs the value of the benefit. The commenter proposes a *de minimis* exception to the Medicaid requirement when no more than four beds are available to patients from outside the CCRC (which would translate into two Medicaid beds).

RESPONSE: The Department concurs with NJANPHA that a Medicaid occupancy requirement should be explicitly stated in the rule to clarify that, of CCRC beds occupied by non-CCRC members, 45 percent will be utilized by Medicaid-eligible patients during the seven year fill-up period. This requirement has been added at N.J.A.C.

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8:33H-1.10(g)1. The Department also accepts the commenter's request for a *de minimus* exception; this has been incorporated at N.J.A.C. 8:33H-1.10(h)1.

COMMENT: NJANPHA requests that N.J.A.C. 8:33H-1.11(a)1, regarding Statewide restricted admissions facilities, be changed from a requirement of 100 percent occupancy to 90 percent occupancy by members of the specified religious or fraternal organization and their immediate family members. People who require nursing home care and who want the special atmosphere of a religious or fraternal home may not be able to get this if growth of the general nursing home bed supply is constrained. The Department of Health could increase modestly the number of facilities available to meet these needs by modifying the requirements for a facility to be considered a Statewide restricted admissions facility.

RESPONSE: N.J.A.C. 8:33H-1.11(b) is intended to convey that Statewide restricted admissions facilities are exempt from compliance with the need methodology in N.J.A.C. 8:33H-1.5 and from the county-based planning requirements in N.J.A.C. 8:33H-1.4, through the reference to the expedited review process, which does not include such requirements. These facilities can expand as desired to accommodate the demand of members of their religious sect or fraternal organization. To clarify this, N.J.A.C. 8:33H-1.11(b) has been amended. The fundamental reason for exempting these facilities from the need methodology is because they are serving a specific membership. The Department cannot accept the commenter's proposed relaxation of the 100 percent membership requirement and still maintain that these facilities should be exempted from other planning requirements; therefore, that change has not been made.

COMMENT: NJAHFC requests that N.J.A.C. 8:33H-1.13(i) be amended so that acute care hospitals proposing the conversion of beds to long-term care would be required to convert the entire hospital, or at least 100 beds. This is the language in the existing certificate of need rule, and it should remain in effect. Also, NJAHCF and Mr. Moles state that hospital conversion projects should be required to meet all applicable building and operational standards to assure the appropriate care of long-term care patients.

RESPONSE: The size requirement for conversion projects involving acute care hospital beds has been omitted from the rule, because these facilities must now meet a more stringent requirement pertaining to the documentation of need for the long-term care beds. In the repealed N.J.A.C. 8:33H, acute care conversions could be approved in areas where there was no bed need. The new requirements should be more equitable for all Certificate of Need applicants. With regard to the building standards and codes for conversion projects, N.J.A.C. 8:33H-1.13(a) addresses these requirements. The rule has been amended to include the following at N.J.A.C. 8:33H-1.13(i)5: "The Certificate of Need application complies with all other applicable requirements in this chapter."

COMMENT: NJAHCF recommends that N.J.A.C. 8:33H-1.14(c) and (d) be amended to indicate that when an ownership has two Level A deficiencies or one Level A deficiency repetitively, the Department would perform a five-year look-back to determine the true track record. A Certificate of Need should be awarded if the previous history is clear. Furthermore, multi-ownerships of three or more facilities should be allowed to file Certificate of Need applications for new projects if they only "stubbed their toe" in one facility and/or their application is for an addition to an existing facility that has not experienced licensing problems.

RESPONSE: The Department does not agree concerning the multi-ownership issue. It is the Department's view that applicants involved in multi-ownership must concentrate on improving the care in their facility with a questionable track record prior to undertaking new projects. With regard to subsections (c) and (d), amendments have been made which clarify how the track record will be interpreted with regard to noncompliance.

COMMENT: NJANPHA recommends deletion of the current proposed N.J.A.C. 8:33H-1.14(c) and replacement with a paragraph that gives the Department of Health discretion to deny an application from a provider who, during the 12 months preceding the Department's processing of the Certificate of Need application and extending until the time of the Commissioner's final decision: (1) had a deficiency that resulted in a curtailment or ban on admission; (2) had two or more Level A deficiencies; or (3) had a Level A deficiency in the same area as during the preceding survey. The Certificate of Need Application and Review Process Manual, N.J.A.C. 8:33, should have the identical provisions or should defer to this Manual in the area of compliance with regulatory standards (see proposed N.J.A.C. 8:33-4.10(e)). If the Department sticks with the proposed language, it will have to either turn down most applications from existing providers or it will begin making distinctions between various kinds of noncompliance without the benefit of any regulatory guidance whatsoever. The former outcome would be unnecessarily punitive. The latter would be arbitrary and would subject the Department to charges of capricious decision making.

RESPONSE: The Department has made amendments to N.J.A.C. 8:33H-1.14(c) and (d) to clarify how the track record will be interpreted with regard to noncompliance with State and Federal requirements, which will be evaluated by the Department for the 12 preceding months. The Department notes that the more rigorous standard would be applied, where a discrepancy occurs.

COMMENT: Mr. Edward Tetelman, Director of Legal and Regulatory Affairs, Department of Human Services, states that the Department is supportive of the proposed manual, N.J.A.C. 8:33H. However, he states that it is important that specific requirements in the various sections of the plan go beyond asking for information about the number of indigents, Medicaid eligibles, and low income Medicare and other persons, and establish requirements to assure that these individuals receive care.

RESPONSE: The Department of Health appreciates the Department of Human Services' support and acknowledges the commenter's point. The requirements of the entire Policy Manual are directed toward the provision of service.

COMMENT: NJAHCF and NJANPHA recommend that the utilization requirement for 36 percent "direct admission" Medicaid-eligible patients contained in N.J.A.C. 8:33H-1.15(a)1 and 2 be deleted or modified. The direct admission requirement for Medicaid-eligible patients, coupled with the number of private pay "spend-down" patients, would force all facilities to have in excess of their 45 percent Medicaid census, by which they legally can limit their Medicaid admissions. The commenters also recommend that N.J.A.C. 8:33H-1.15(a)3 and 4 be deleted or reworded per the statute regarding non-discrimination against Medicaid admissions to nursing homes (P.L. 1985, c.303; N.J.S.A. 10:5-12.2). The statute does not mandate 45 percent Medicaid occupancy, but rather requires first-come, first-serve admissions until a facility reaches 45 percent Medicaid occupancy.

RESPONSE: With regard to P.L. 1985, c.303, the 45 percent requirement is never stipulated as a ceiling on Medicaid occupancy, but rather a floor. It is the Department's position that the Medicaid utilization requirements in N.J.A.C. 8:33H-1.15 do not conflict with the statute. The requirement for 36 percent direct admission Medicaid patient occupancy has been in effect for over six years in the repealed version of N.J.A.C. 8:33H. As well, the Department has consistently applied a minimum 45 percent overall Medicaid utilization requirement as a condition of Certificate of Need approval for nursing homes. There have been virtually no complaints about the requirements, and they have withstood the test of time. The majority of Certificate of Need applicants for nursing homes have proposed to accept even higher percentages of 50 to 65 percent. High Medicaid occupancy in nursing homes appears to be the norm in New Jersey (and elsewhere in the nation), with Statewide occupancy averaging approximately 65 percent Medicaid patients. Nonetheless, Medicaid-eligible clients continue to have more difficulty than private pay patients in obtaining nursing home placement at the facility of their choice. Some operators of nursing homes argue that a high Medicaid census places a financial burden on them; this influences the amount and quality of care they provide. Consequently, they give preference to private pay patients, but these are becoming scarcer due to rising national trends in the practice of divesting personal assets prior to nursing home admission, in order to qualify for Medicaid reimbursement. The impact of problems such as asset divestiture needs to be addressed as part of a discussion of the larger issue, which is the public/private financing of long-term care. The Department believes such issues should be tackled, in the course of which Certificate of Need requirements for Medicaid-occupancy and other vehicles for assuring the poor access to nursing home care should be explored. The Department recognizes that there may be a need for change, but does not accept the commenters' recommendation to alter the standing Medicaid requirements at this time, since that would represent an inadequate and fragmentary approach to dealing with the larger issues.

COMMENT: The NJAHCF states that N.J.A.C. 8:33H-1.15(b) should be revised to specify that seven percent of the Medicaid beds should set aside for discharged psychiatric patients. The current requirement used in Certificate of Need over the past few years has been seven percent, with no backlog of patients awaiting placement in State

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hospitals. With regard to N.J.A.C. 8:33H-1.15(b), Mr. Moles recommended that the affected institutions or the County Long-Term Care Committees be consulted to offer input into the decision about the percentage.

RESPONSE: The Department accepts NJAHCF's recommendation, and the rule has been amended to indicate that seven percent of the approved long-term care beds should be reserved for occupancy by discharged psychiatric patients. It does not appear to be necessary at this time to involve the County Long-Term Care Committees or affected institutions, since, as the NJAHCF reports, the seven percent requirement has been in effect for several years, and the requirement has been successful in assuring an adequate number of placements for these patients.

COMMENT: NJAHCF requests that N.J.A.C. 8:33H-1.15(c)1 be modified with the word "eligible" inserted before "recipients" in reference to Supplemental Security Income (SSI) recipients. Some residents may be eligible for, but not paid by, the SSI program. In N.J.A.C. 8:33H-1.15(d), the text should be revised to state that 50 percent of the designated SSI beds should be reserved for discharged psychiatric patients. (Most of these patients are SSI recipients.) Also, in N.J.A.C. 8:33H-1.15(f), the utilization requirements in this section should only apply to transfers of ownership of existing facilities **with previous Certificate of Need conditions.** The transfer of a strictly private pay facility is legally permissible without Medicaid/SSI utilization conditions being applied.

RESPONSE: The Department accepts the commenter's suggestions and has inserted "eligible" after "SSI" in N.J.A.C. 8:33H-1.15(c)1. N.J.A.C. 8:33H-1.15(d) has been amended to state that 50 percent of the designated SSI beds should be reserved for discharged psychiatric patients. Because only 10 percent of a facility's beds are required to be occupied by Supplemental Security Income recipients, a seven percent set aside requirement for discharged psychiatric patients means that only three percent of the beds are available for other SSI recipients. A 50-50 requirement should be more equitable in promoting access for both discharged psychiatric patients and other SSI recipients. The amendment of N.J.A.C. 8:33H-1.15(f) is accepted for the reason stated by the commenter. This is consistent with the way transfers of ownership are currently handled.

COMMENT: Mr. Moles states that N.J.A.C. 8:33H-1.17(a) is too general in its reference to "architectural barriers" to care. The term should be more clearly defined.

RESPONSE: The term "architectural barriers" has purposefully been left general. Barriers may differ from one setting to another, depending on the type of care being provided and the level of impairment in the population to be served.

COMMENT: NJANPHA supports N.J.A.C. 8:33H-1.19(b)1, regarding Medicaid utilization, but believes that the 45 percent direct admission requirement will push a facility's overall Medicaid occupancy level well above 55 percent, and possibly to the point where it will have to choose between solvency and compromising patient care.

RESPONSE: The prioritization criteria in N.J.A.C. 8:33H-1.19(b) are not mandatory requirements. Rather, Certificate of Need applicants will select those criteria they choose to meet. There is a sufficiently large and diverse number of criteria so that no applicant can meet all of them. Proposing to meet one or more of them reflects a special commitment on the part of this criterion, especially because in N.J.A.C. 8:33H-1.13(b), the Department has already required an applicant to assure that RHCF residents will not be displaced, if the RHCF is converted to nursing beds. The commenter believes this should be a requirement and not a reward. Applicants who agree to this should get no bonus points; rather, they should be on a level playing field with other applicants.

RESPONSE: On reconsideration, the Department acknowledges that N.J.A.C. 8:33H-1.19(b)3 could be too easily misconstrued and may create the reverse incentive described by the commenter. Therefore, it has been deleted, since these criteria are intended as recommendations, providing incentive to providers.

COMMENT: NJANPHA proposes that N.J.A.C. 8:33H-1.19(b)4 be amended, with a 75 percent figure used as the benchmark to identify facilities that have relatively well-occupied residential health care facilities. As a measure of whether an RHCF is operating successfully, the 85 percent mark is too high. A recent study indicates that the Statewide average occupancy of RHCFs is between 75 percent and 80 percent.

RESPONSE: The Department would question whether a residential health care facility operating at 75 percent occupancy is financially viable and therefore indicative of successful operation, as N.J.A.C. 8:33H-1.19(b)4 states. Although this prioritization criterion is set at a high level and few may be able to meet it, those who do should receive a point for their accomplishment in the prioritization scale.

COMMENT: NJAHCF and NJANPHA request that N.J.A.C. 8:33H-1.19(b)6 be deleted or modified. Clinical nurse specialists are an added expense and difficult to applicant. Unlike the minimum Medicaid utilization requirements set forth in N.J.A.C. 8:33H-1.15, the text at N.J.A.C. 8:33H-1.19(b)1 reflects a special commitment to serve Medicaid-eligible patients. The Department can not accept the commenter's recommendation.

COMMENT: NJANPHA states that N.J.A.C. 8:33H-1.19(b)2 should be replaced with a requirement to maintain 125 percent of the Statewide average of acuity patients. The commenter believes it is a mistake to set an absolute percentage (20 percent) of heavy care cases, without regard to the Statewide average of acuity patients. The commenter believes the average is around 11 percent, so the Department is asking facilities to commit to nearly twice the State average.

RESPONSE: The prioritization criterion at N.J.A.C. 8:33H-1.19(b)2 is worth two points. The commitment to accept 20 percent heavy care cases should not be entered into lightly. The Department recognizes, however, that it may be unrealistic for an applicant to propose to meet this criterion, if there is not sufficient demand for heavy care among patients seeking nursing home placement. The paragraph has therefore been amended to require that applicants provide documentation from area hospital discharge planners or other appropriate sources to show that there is a need of the magnitude that would warrant 20 percent of the proposed beds being allocated for heavy care.

COMMENT: NJANPHA requests that N.J.A.C. 8:33H-1.19(b)3 be deleted. This criterion offers a perverse incentive to convert residential health care facilities (RHCFs) into nursing facilities. It also rewards a facility that does not have an RHC unit, as well as a facility that does have a unit but never got it operating successfully or at all. No public policy would be served by this criterion, especially because in N.J.A.C. 8:33H-1.13(b), the Department has already required an applicant to assure that RHCF residents will not be displaced, if the RHCF is converted to nursing beds. The commenter believes this should be a requirement and not a reward. Applicants who agree to this should get no bonus points; rather, they should be on a level playing field with other applicants.

RESPONSE: On reconsideration, the Department acknowledges that N.J.A.C. 8:33H-1.19(b)3 could be too easily misconstrued and may create the reverse incentive described by the commenter. Therefore, it has been deleted, since these criteria are intended as recommendations, providing incentive to providers.

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RESPONSE: The Department would question whether a residential health care facility operating at 75 percent occupancy is financially viable and therefore indicative of successful operation, as N.J.A.C. 8:33H-1.19(b)4 states. Although this prioritization criterion is set at a high level and few may be able to meet it, those who do should receive a point for their accomplishment in the prioritization scale.

COMMENT: NJAHCF and NJANPHA request that N.J.A.C. 8:33H-1.19(b)6 be deleted or modified. Clinical nurse specialists are an added expense and difficult to obtain. Staffing requirements should be dealt with under licensure standards, not here. NJANPHA suggests that if the Department insists on keeping this criterion, it should be expanded to include a facility that will be staffed with one or more full-time equivalent physicians. Such an arrangement is rare and facilities that have it should be recognized for their commitment to care.

RESPONSE: The Department accepts NJANPHA's recommendation to expand N.J.A.C. 8:33H-1.19(b)6 to include facilities staffed with a full-time physician, for the reasons stated. The benefits offered by clinical nurse specialists, in terms of their advanced knowledge, assessment skills, and ability to work with other staff to improve their patient care, are significant. Very few nursing homes currently employ clinical nurse specialists; this criterion should be an incentive to increase the number that do.

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COMMENT: NJAHCF requests that N.J.A.C. 8:33H-1.19(b)12 be deleted. In light of the Department's inability to survey for compliance with advisory licensing standards until recently, it would be unfair to use this as a priority barometer at this time. NJANPHA, on the other hand, states that a track record for high quality patient care should be the single most important factor when choosing among Certificate of Need applicants. The most significant indicator of quality is a facility's track record over a period of time. The commenter proposes an additional criterion: a three-year look-back period to determine track record. With respect to the advisory standards referenced in N.J.A.C. 8:33H-1.19(b)12, the commenter proposes that the Department confine this criterion to the most significant, identified advisory standards.

RESPONSE: The Department concurs that high quality care is the most important feature of a nursing home. The Department cannot accept that N.J.A.C. 8:33H-1.19(b)12 should be eliminated; however, the paragraph has been modified to identify the specific advisory standards that will be used to evaluate compliance with this criterion. Also, a new prioritization criterion has been inserted at N.J.A.C. 8:33H-1.19(b)3, regarding a three-year look-back at the licensing track record of a facility. Thus, quality of care will be measured by two points; N.J.A.C. 8:33H-1.19(b)3 and 12.

COMMENT: Mr. Moles recommends that there be mechanisms so that County Long-Term Care Committees can offer the Department input as to what the public thinks the priorities in N.J.A.C. 8:33H-1.19 should be.

RESPONSE: N.J.A.C. 8:33H is expected to undergo revision within the next year and as needed in the future. Individuals are always welcome to suggest changes and improvements to the rule, which can then be incorporated when the chapter is amended. The Long-Term Care Committees may communicate their recommendations directly to the Department, or they may work through their Local Advisory Boards. The Department believes that no special additional mechanisms are needed in the rules. Therefore, the requested change has not been made.

Summary of Agency-Initiated Changes:

In consideration of Assembly Bill No.1144 which has been enacted, the Department has deleted any reference to the State Health Plan as regulatory. The deleted reference is at N.J.A.C. 8:33H-1.3(a), where the reference to N.J.A.C. 8:100-16 and its title is changed to simply a reference to its adopted codification, N.J.A.C. 8:100-18.

At N.J.A.C. 8:33H-1.19(b)12, clarifying introductory text was added; the N.J.A.C. 8:39 advisory standards are specifically identified; and a substantial compliance is defined as "at least 65 percent of components of each of the five advisory standards." This last percentage was devised through consultation with the Nursing Home Advisory Group and through analysis of past voluntary inspections for compliance with advisory standards.

CHAPTER 33H
CERTIFICATE OF NEED POLICY MANUAL
LONG TERM CARE SERVICES

SUBCHAPTER 1. GENERAL PROVISIONS

8:33H-1.1 Purpose; scope

(a) The purpose of this chapter is to supplement N.J.A.C. 8:100-16, the Long-Term subchapter of the "State Health Plan," by setting forth Certificate of Need and related planning requirements which are necessary to effectuate N.J.A.C. 8:100-16.

(b) The Department of Health has a major responsibility for the promotion of high quality, efficiently and economically rendered health services which are available to all citizens of the State. To ensure significant progress toward the achievement of this goal, the Department should direct planning and Certificate of Need activities toward the following:

1. Health promotion and minimization of debilitation;
2. Enhancement of the quality of life of long-term care consumers/patients and their families and/or significant others;
3. Expansion of long-term care options to maximize consumer choice;
4. Increased geographic, economic, and architectural accessibility of long-term care services;
5. Expansion of long-term care services to the extent that they are needed, while minimizing excess, underutilized capacity;
6. Increased affordability of long-term care services, the cost of which must be born by consumers and the government;
7. Access to long-term care services without regard to race, ethnicity, or medical diagnoses, including HIV infection or a history of psychiatric illness;
8. Coordination of long-term care services; and
9. Community participation in decision-making about the development of expanded long-term care services.

(c) The rules contained in this chapter address the Certificate of Need requirements for the following categories and types of facilities, as they are defined in N.J.A.C. 8:33H-1.2:

1. Nursing homes;
2. Adult day health care programs;
3. Pediatric long-term care;
4. Specialized long-term care;
5. Continuing care retirement communities;
6. Statewide restricted admissions facilities; and
7. Residential health care facilities.

(d) N.J.A.C. 8:100-16 proposes the creation of new categories of care, referred to as alternate family care programs, assisted living residences, and comprehensive personal care homes. Until such time as licensing standards for such categories have been adopted, there shall be no Certificate of Need application process for these services.

(e) Home health care is recognized as an important component of the long-term care system; however, the Certificate of Need requirements for home health care agencies are not contained in this chapter. Applicants interested in offering home health services in New Jersey should refer to N.J.A.C. 8:33L.

(f) Some patients in nursing homes may, on occasion, require rehabilitative care. The rehabilitative services offered to patients in most nursing homes are distinguished from comprehensive rehabilitation, which may only be offered by a licensed rehabilitation hospital. Applicants interested in offering comprehensive rehabilitation should refer to N.J.A.C. 8:33M.

(g) The provisions contained in this chapter shall apply uniformly to Certificate of Need applications for private and public facilities, whether State, county, municipal, incorporated, not incorporated, proprietary, or nonprofit, unless it is otherwise stated.

(h) Where a Certificate of Need is granted for long-term care beds, the applicant shall agree to occupy those beds with patients who require general nursing home care or, if so designated in the letter of approval, specialized long-term care. Applicants approved for long-term care beds shall not admit patients who require a different licensing category of care, such as comprehensive rehabilitation, unless the Commissioner has determined that admission is warranted to respond to an emergency situation and has granted approval in writing.

1. Applicants shall not advertise their facilities' services in such a way that consumers might reasonably construe that the level of care provided is something other than general nursing home care or, if so designated in the letter of approval, specialized long-term care.

8:33H-1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings ***unless the context clearly indicates otherwise***:

"Adult day health care program" means a facility which is licensed by the Department of Health to provide preventive, diagnostic, therapeutic, and rehabilitative services under medical supervision to meet the needs of functionally impaired adult patients. Adult day health care facilities provide services to patients for a perod of time which does not exceed 12 hours during any calendar day.

"Alternate family care" means a contractual arrangement whereby no more than two individuals in need of long-term care receive room, board, and care in the private residence of a non-related family that has been trained to provide the necessary caregiving.

"Alternate family care program" means a program operated by a community-based agency such as a home health care agency which is responsible for recruiting, screening, training, and supervising

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alternate family caregivers, as well as matching patients with alternate family caregivers and monitoring their status within this arrangement.

"Applicant" means an individual, a partnership, a corporation (including associations, joint-stock companies, and insurance companies), or a political subdivision (including a county or municipal corporation) that submits a Certificate of Need application.

"Assisted living residence" means an establishment that offers apartment-style housing, congregate dining, assistance with activities of daily living, and nursing care and supervision as needed to four or more adult persons unrelated to the proprietor. Apartment units offer at least one unfurnished room per resident, a private bath, and a lockable door on the unit entrance.

"Commissioner" means the State Commissioner of Health.

"Community Care Program for the Elderly and Disabled" or "CCPED" means a Medicaid-funded, Federally waivered program offering case managed home and community-based care to persons who meet specific medical and financial nursing facility eligibility criteria.

"Comprehensive personal care home" means an establishment that provides food, shelter, assistance with activities of daily living, and nursing care and supervision as needed to four or more adult persons unrelated to the proprietor.

"Continuing care retirement community" means the provision of lodging and nursing, medical, or other related services at the same or another location to an individual pursuant to an agreement effective for the life of the individual or for a period greater than one year, including mutually terminable contracts, and in consideration of the payment of an entrance fee with or without other periodic charges. A fee which is less than the sum of the regular periodic charges for one year of residency is not considered an entrance fee.

"Deficiency" means a finding or findings by the Department of Health that a facility is not in compliance with applicable State licensure requirements and/or Federal requirements for a health care facility. ***A deficiency remains valid unless overruled in an Office of Administrative Law hearing or a judicial appeal process.***

"Department" means the New Jersey State Department of Health.

"Direct admission Medicaid patient" ***or "resident"*** means an individual who is admitted to a long-term care bed as a Medicaid eligible patient, or a private paying patient who will spend down to Medicaid eligibility within 180 days of placement in the long-term care bed.

"Financially feasible" means revenues exceed expenses during or before the third year subsequent to implementation of a certificate of need-approved project.

"General long-term care bed" means a long-term care bed for which there is no restriction imposed by certificate of need approval requirements or stipulations that would limit the type of nursing home patient who may occupy the bed or the type of nursing home care which may be provided to the occupant of the bed.

"Local Advisory Board" or "LAB" means a regional health planning agency designated by the Department of Health to make assessments and recommendations regarding the health needs within a specified geographical area. Local Advisory Board areas are as follows:

1. LAB region I: Morris, Sussex, Passaic, and Warren Counties;
2. LAB region II: Bergen and Hudson Counties;
3. LAB region III: Essex and Union Counties;
4. LAB region IV: Hunterdon, Mercer, Middlesex, and Somerset Counties;
5. LAB region V: Burlington, Camden, Cumberland, Gloucester, and Salem Counties; and
6. LAB region VI: Atlantic, Cape May, Monmouth, and Ocean Counties.

"Long-term care" means a wide range of personal care, psychosocial, nursing, and other supportive services for people with functional limitations due to chronic—and frequently degenerative—physical or cognitive disorders. Long-term care services range from in-home assistance provided by family members or a home care agency to nursing home care.

"Long-Term Care Committee" or "Committee" means a county-based group of volunteers which is designated by the Local Advisory Board for the purpose of identifying and addressing the county's service coordination issues, access problems, and public education needs pertaining to long-term care. In counties where there is a need for additional long-term care placements, the Committee has responsibility for formulating a placement mix proposal.

"Long-term care placement" means a unit of service provided to an individual requiring long-term care. The unit may be a bed, for example, a nursing home bed, or a slot, for example, an adult day health care slot.

"Medicaid-eligible patient" means, for the purpose of this chapter, a person who has received a determination of medical and financial eligibility for Medicaid coverage, or a person who qualifies medically and financially for Medicaid but who does not apply for Medicaid coverage, or a person whose care is paid for through General Assistance funds.

"Nursing home" or "nursing facility" means a facility that is licensed by the Department of Health *[for long-term care beds]* ***to provide health care under medical supervision and continuous nursing care for 24 or more consecutive hours to two or more patients who do not require the degree of care and treatment which a hospital provides and who, because of their physical or mental condition, require continuous nursing care and services above the level of room and board****.

"Pediatric long-term care" means a facility, distinct nursing unit, or program which is dedicated for occupancy by patients under age 20.

"Placement mix proposal" means a proposal formulated by a county Long-Term Care Committee specifying the number and types of long-term care placements which should be developed in order to meet the future needs of county residents.

"Project" means the construction, renovation, and/or related activities which are required in order to implement a certificate of need.

"Residential health care facility" means an inpatient facility licensed by the Department of Health to provide shelter, personal care assistance, and health maintenance and monitoring.

"Respite care" means a service that provides a brief period of relief from caregiving responsibilities for the family members and friends of individuals who require long-term care. It may be offered either on an outpatient basis, for example, in the form of adult day health care, or an inpatient basis, for example, in the form of residential health care.

"Specialized care" or "specialized long-term care" means a program of care provided in licensed long-term care beds for patients who require technically complex treatment with life supporting equipment, or who have serious problems accessing appropriate nursing home care due to their special treatment requirements as dictated by their medical diagnoses and level of functional limitation.

"Statewide restricted admissions facility" means a non-profit nursing home owned and operated by a religious or fraternal organization that serves only members of that organization and their immediate families.

8:33H-1.3 Relationship between licensure and Certificate of Need requirements

[(a)] The provisions of N.J.A.C. *[8:100-16, the Long-Term Care subchapter of the State Health Plan,]* ***8:100-18,*** N.J.A.C. 8:39, Licensing Standards for Long-Term Care Facilities, ***N.J.A.C. 8:43, Manual of Standards for Licensure of Residential Health Care Facilities,*** and N.J.A.C. 8:43F, Standards for Licensure of Adult Day Health Care Facilities are hereby incorporated by reference. Applicants receiving Certificate of Need approval under the provisions of this chapter shall comply with all applicable licensing requirements of N.J.A.C. 8:39, 8:43F, and 8:43.

8:33H-1.4 Role of counties, Local Advisory Boards, and the State in long-term care planning

(a) Local Advisory Boards shall appoint a Long-Term Care Committee in each county within their region.

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1. Each Long-Term Care Committee shall have at least 15 members, with equal representation from the following three sectors and no more than one person representing any agency or organization. The three sectors shall be:

i. Consumers, including users and potential users of long-term care services and their family members. To be recognized as a consumer, the person shall have no employment or ownership ties (either direct or familial) to an agency, facility, or program that provides long-term care or related health services in the county;

ii. Providers, including health and social service professionals, and the employees and owners of agencies, facilities, and programs providing long-term care or other health services; and

iii. Governmental, planning, and funding agencies, such as the county's Agency on Aging, Planning Board, Board of Social Services, Medicaid District Office, United Way, and Human Services Advisory Council.

2. All Long-Term Care Committee meetings shall be open to the public and shall provide opportunities for public comment.

3. All Long-Term Care Committee meetings shall be held in a handicap-accessible location within the county.

4. To the extent that data are available, the Local Advisory Board shall provide the most recent county-specific, LAB region-specific, and statewide long-term care and population data for consideration at the county Committee meetings.

(b) In each county where there is a projected need for new long-term care placements in accordance with the methodology specified in N.J.A.C. 8:33H-1.5, the Long-Term Care Committee shall formulate a proposal specifying the mix of options and the number of placements of each type that are to be developed in the county. Options shall be:

1. Alternate family care placements;

2. Home and community-based service waiver slots; that is, Community Care Program for the Elderly and Disabled (CCPED) and AIDS Community Care Assistance Program (ACCAP);

3. Adult day health care;

4. Upgraded residential health care facilities, otherwise to be known as comprehensive personal care homes;

5. Assisted living residences; and

6. Nursing facility beds.

(c) The county Long-Term Care Committee shall be responsible for formulating or updating its placement mix proposal as described in (b) above by August 1 of each year, except for 1992, in which year the deadline date shall be August 15, 1992.

1. The placement mix proposal shall be finalized by the county Committee by a majority vote, in which each Committee member shall have one independent vote.

2. At the time that the county Committee has voted on and finalized its placement mix proposal, including the desired number of placements for each option, the Local Advisory Board shall record the proposal in writing, including the Committee's stated rationale for selecting its mix of options.

(d) The Local Advisory Board shall make a determination as to whether each county's placement mix proposal and the process whereby it was developed by the county Long-Term Care Committee comply with all applicable requirements contained in this chapter and in N.J.A.C. 8:100-*[16]****18***.

1. When compliance with the requirements of this chapter has been determined, the Local Advisory Board shall accept the county's placement mix proposal and transmit it, along with the county Committee's rationale, to the State Department of Health so that implementation may be initiated. ***However, should the Department of Health, in consultation with the State Health Planning Board, identify that a county placement mix proposal is not in compliance with the rules the rules have been applied uniformly in the review of all county placement mix proposals, the proposal will be returned to the Local Advisory Board for corrective action prior to implementation.***

2. In the event that the Local Advisory Board determines non-compliance with the requirements of this chapter, the placement mix proposal shall be returned to the county Long-Term Care Committee, with a written statement identifying the reasons why it cannot be accepted. The county Long-Term Care Committee shall then revise or re-formulate the proposal for reconsideration by the LAB.

3. In the event that a county has not developed a placement mix proposal which is accepted by the Local Advisory Board within the time frame stipulated in (c) above, a "default" proposal shall be developed and implemented for the county by the State Health Planning Board. Options available in the default mix proposal shall be:

i. Alternate family care placements;

ii. Home and community-based service waiver slots; that is, Community Care Program for the Elderly and Disabled (CCPED) and AIDS Community Care Assistance Program (ACCAP);

iii. Adult day health care slots; and

iv. Comprehensive personal care homes; and

v. Assisted living residences.

(e) On an annual basis, the Department of Health, in collaboration with the Departments of Human Services and Community Affairs, shall conduct education/information sharing sessions for Local Advisory Board staff, county Long-Term Care Committee members, and other interested individuals, regarding the various long-term care options, interpretation of long-term care data, and the formulation of county long-term care placement mix proposals.

(f) In proposing the desired mix of new long-term care options, county Long-Term Care Committees shall take into consideration local conditions, to the extent that data are available, as follows:

1. Waiting lists, utilization data, and availability of existing long-term care services, both non-institutional and institutional;

2. Potential capacity of services which have received Certificate of Need approval but which are not yet licensed and operational;

3. Demographic data, such as age-specific population projections and estimates;

4. Data regarding consumer preferences for long-term care options;

5. Health personnel supply and staffing and resource availability;

6. Financial, cultural, and geographical access barriers to existing services;

7. Land use availability for new facility-based long-term care services, including assisted living residences; and

8. Medicaid Pre-Admission Screening data.

(g) The county Long-Term Care Committee's placement mix proposal shall reflect consideration for area residents' diverse needs and preferences and shall promote consumer choice from a variety of options. Therefore, each placement mix proposal shall include at least two of the options specified in (b)1 through 6 above.

1. An exception may be made to (g) above in the event that a county has a need for fewer than 60 additional long-term care placements.

(h) The sum total of long-term care placements of all types proposed by each county Long-Term Care Committee shall not exceed the county's projected need for new long-term care placements in accordance with the formula in N.J.A.C. 8:33H-1.5 below.

(i) In recognition of the uncertainty about when new and expanded alternatives to nursing home care will become available, the Department of Health shall assure the continued but controlled expansion of the nursing home bed supply in New Jersey. For the year 1992, county Long-Term Care Committees may request the approval of new nursing home beds as part of their placement mix proposals, provided that the number requested will not result in more than 9.2 beds per 100 population age 75 and over, based on population projections for 1997.

1. The Department of Health shall use two benchmarks to determine whether the number of new nursing home beds to be approved should be increased in 1993: a State legislature appropriation of Medicaid funds for initiation of the options identified in (a)1 through 5 above beginning in 1994; and submission by the Department of Human Services of a Federal Medicaid waiver request for new home and community-based long term care services; or, if a waiver is not required, an amendment to the Medicaid State Plan. In the event that the State Legislature has not appropriated funds and the Department of Human Services has not submitted a Medicaid waiver request to the U.S. Health Care Financing Adminis-

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tration (or, if a waiver is not required, the Medicaid State Plan has not been amended) by July 31, 1993, county Long-Term Care Committees may request the approval of new nursing home beds as part of their placement mix proposals, provided that the number requested will not result in more than 10.0 nursing home beds per 100 population age 75 and over in each county, based on population projections for 1998. In the event that the aforementioned benchmarks are achieved, county Long-Term Care Committees may request the approval of new nursing home beds as part of their placement mix proposals, provided that the number requested will not result in more than 9.2 nursing home beds per 100 population age 75 and over in each county, based on population projections for 1998.

(j) County Long-Term Care Committees shall have the option of choosing to treat assisted living residences and comprehensive personal care homes interchangeably in their placement mix proposals. In this manner, Certificate of Need applications for either of these two residential services may be approved to meet the county's placement need, depending on the applications' merits.

(k) In the case of long-term placement options for which licensing, reimbursement, and planning standards have not yet been adopted, or where reimbursement has not yet been authorized by Medicaid, county Committees proposing a placement mix which includes such options shall have the requested number of placements set aside and reserved for them, until such time as the necessary standards and authorizations become effective.

1. On an annual basis, counties with set-aside and reserved placements shall have the option of reconsidering and revising their placement mix proposals, thereby re-allocating the reserved placements.

2. In the case that a county placement mix proposal contains a request for Medicaid-waivered home and community-based service slots in excess of the number which Medicaid subsequently finds it has the resources to authorize, the county Long-Term Care Committee may reconsider and revise its placement mix proposal, thereby re-allocating the unauthorized placements.

(l) In the event that a State psychiatric hospital closes, the Department of Health, in collaboration with the Department of Human Services, shall determine the number of additional placements which are imminently needed to accommodate the influx of long-term care patients who are discharged from these hospitals. The number of placements needed shall be determined for each county, based upon the county of origin of the discharged psychiatric patients. In affected counties, the Long-Term Care Committee shall formulate a placement mix proposal dedicated specifically for these patients.

(m) In counties where there is a need for long-term care placements accordance with the placement methodology in N.J.A.C. 8:33H-1.5, the long-term care needs of persons who have AIDS or are HIV positive shall be met through the mix of options which are planned by the county Long-Term Committee. However, in counties where there is no long-term care placement need in accordance with the placement methodology in N.J.A.C. 8:33H-1.5, the Department of Health recognizes that there could be special access problems for the growing number of HIV-infected people who require long-term care. Consequently, in the event that the Department determines there is an unmet need for nursing home beds or other long-term care services for persons with AIDS or HIV-infection, consideration shall be given to the approval of the necessary type of long-term care placements, which shall be dedicated for exclusive use by this patient population.

1. In counties that do not have a projected long-term care placement need in accordance with the methodology in N.J.A.C. 8:33H-1.5, applications which exclusively propose long-term care services dedicated for patients with AIDS or HIV infection may be submitted in any month when Certificate of Need applications are accepted for processing.

8:33-1.5 Projection of need for long-term care placements

(a) New long-term care placements shall only be approved in counties with a net need for placements, in accordance with the formula contained in (d) below.

1. By June 30, 1993, the Department of Health, in collaboration with the Department of Human Services, shall devise a formula in accordance with the requirements of the Administrative Procedure Act and N.J.A.C. 1:30, to allow for the development of new long-term care options identified in N.J.A.C. 8:33H-1.4(b)1 through 5 in counties where the formula contained in (d) below projects an excess of long-term care placements.

(b) The projected need for long-term care placements shall be computed for each county, targeted five years into the future. The Department of Health shall release updated projections by April 1 of each year, or as soon thereafter as the necessary data are available.

(c) The source of population data to be used in projecting the need for long-term care placements shall be the most recent official population projections which are published by the New Jersey State Department of Labor.

1. For target years between those years for which the New Jersey State Department of Labor has issued official projections, the population numbers to be used in the need formula shall be derived using linear interpolations as follows for each age group, where "Year X" precedes "Year Y" and where "n" is the number of years that must be added to "Year X" in order to arrive at the "Target Year":

Step 1: $$\text{Projected Population for Year Y} - \text{Projected Population for Year X} = A$$

Step 2: $$\frac{A}{(\text{Year Y} - \text{Year X})} = B$$

Step 3: $$\text{Projected Population for Year X} + (B \times n) = \text{Projected Population for Target Year}$$

(d) The formula for computing the number of long-term care placements needed shall be as follows:

1. Sum 0.07 placements per 100 population age 20-64, plus 1.07 placements per 100 population age 65 to 74, plus 5.44 placements per 100 population age 75 to 84, plus 21.21 placements per 100 population age 85 and over;

2. From each county's total computed in (d)1 above, subtract the county's current inventory of long-term care placements, which shall include the following:

i. Licensed and Certificate of Need-approved general use long-term care beds, excluding pediatric long-term care beds and beds located in continuing care retirement communities and restricted admissions facilities;

ii. Home and community-based service waiver slots, including those currently available to the county and those which have been requested in the county's placement mix proposal (accepted in accordance with N.J.A.C. 8:33H-1.4(c)1);

iii. Twenty-five percent of licensed and Certificate of Need-approved adult day health care slots, which shall approximate the number of slots utilized by patients who are nursing home-eligible;

iv. Alternate family care placements, including those currently in use and those which have been requested in the county's placement mix proposal (accepted in accordance with N.J.A.C. 8:33H-1.4);

v. Assisted living residence units which have been requested in the county's placement mix proposal (accepted in accordance with N.J.A.C. 8:33H-1.4); and

vi. Comprehensive personal care beds which have been requested in the county's placement mix proposal (accepted in accordance with N.J.A.C. 8:33H-1.4);

3. Based on the computation in (d)2 above, the remainder equals the net, projected, new placement need for the county, if the number is a positive one. A negative number shall represent a projected excess of placements for the county.

(e) On an annual basis, the Department of Health shall review the need methodology contained in (d) above, along with other pertinent long-term care data, to determine whether there is a basis

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for amending the methodology in order to more accurately project future service requirements throughout the State.

8:33H-1.6 Pediatric long-term care

(a) Because of their unique growth and development needs, children who require nursing facility placement should be able to receive care in an environment that is dedicated to addressing these needs. For this reason, the Department shall give consideration to approving separate and distinct pediatric long-term care units in areas where they are needed.

(b) Because there are so few children who require nursing facility placement in New Jersey, pediatric long-term care units should be planned and developed to serve a regional need. For this purpose, the region shall be a Local Advisory Board region.

(c) The need for pediatric long-term care beds shall be determined in the following manner:

1. On a periodic basis (that is, at least once every two years), the Department of Health, in collaboration with the Department of Human Services, shall conduct a survey of acute care hospitals, special hospitals, and other health care facilities at a particular point in time to identify all children who are medically ready for discharge and who require transfer to a pediatric long-term care facility. In addition, the number of children who are known to have been placed in long-term care facilities outside of New Jersey shall be counted;

2. The number of pediatric patients computed in (c)1 above shall be grouped according to their county and LAB region of origin;

3. The projected rate of growth in the population under age 20 in each LAB region shall be calculated using the most recent New Jersey Department of Labor population projections, covering the five year period from the time a Certificate of Need application is accepted for processing up to the target year. The number of patients in each LAB region requring pediatric long-term care shall then be adjusted (that is, multiplied) by the aforementioned, region-specific population growth rate. The latter product shall then be added to the number of patients requiring pediatric long-term care in the LAB region;

4. The projected number of pediatric long-term care patients in each region requiring as derived in (c)3 above, shall then be adjusted (that is, divided by a factor of .85) to allow for a projected occupancy rate of at least 85 percent.

(d) Until such time as specific licensing standards and Certificate of Need requirements for pediatric day health care programs are adopted by the Department, applicants proposing these programs to serve chronically ill, medically fragile children, shall submit a Certificate of Need application for expedited review, in acordance with the applicable provisions of N.J.A.C. 8:33. Subsequent to Certificate of Need approval, the applicant shall apply to the Department for a waiver to the adult day health care licensing requirements contained in N.J.A.C. 8:43F which are not appropriate or applicable to the treatment of children, as follows:

1. The applicant shall identify the licensing requirements contained in N.J.A.C. 8:43F for which a waiver will be necessary; and

2. The applicant shall describe in detail the proposed program, target patient population, admission and discharge criteria, and the services to be provided.

8:33H-1.7 Specialized long-term care

(a) For the purposes of this chapter, specialized long-term care shall include the following categories:

1. Ventilator care for adult patients; and

2. Care of patients with severe behavior management problems, such as combative, aggresive, and disruptive behaviors.

(b) A Certificate of Need shall be required for the establishment of a new specialized care program, including the conversion of general long-term care beds for specialized care use, or for the expansion of an existing specialized care program. The Certificate of Need applicant shall identify the type of specialized care patients who will be admitted to the proposed nursing facility beds in accordance with the categories identified in (a) above. Specialized care beds shall be dedicated for exclusive use by the type or types of specialized care patients identified in the approval letter.

1. Certificate of Need approval shall be required in the event that an applicant intends to occupy specialized care beds with patients who do not require specialized care or patients who do not require the type of specialized care which was identified in the applicant's Certificate of Need. An application for the conversion of specialized care beds for some other use shall comply with the requirements in N.J.A.C. 8:33H-1.13(g).

(c) Specialized care beds shall be approved to meet a regional need. The applicant shall identify the Local Advisory Board region to be served as defined in N.J.A.C. 8:33H-1.2 and shall document how access to the unit's services shall be assured for residents throughout the region.

(d) The number of new beds needed in each LAB region for long-term ventilator care shall be determined in the following manner:

1. On a periodic basis (that is, at least once every two years), the Department of Health shall conduct a survey of acute care hospitals, special hospitals, and other health care facilities at a particular point in time to identify all patients who are medically ready for discharge and who are in need of transfer to a facility that provides long-term ventilator care;

2. Through the survey, the number of patients shall be counted for each LAB region;

3. The projected rate of growth in the population age 20 and over in each regional health systems area shall be calculated using the most recent New Jersey Department of Labor population projections, covering the four year period from the time a Certificate of Need application is accepted for processing up to the target year. The number of patients in each LAB region requiring ventilator care, as identified through the survey, shall then be adjusted (that is, multiplied) by the aforementioned, region-specific adult population growth rate. The latter product shall then be added to the number of patients in the regional service area requiring each type of specialized care:

Number of Patients Requiring Ventilator Care, Per Survey	×	Region-Specific Growth Rate, Population Age 20+	+	Number of Patients Requiring Ventilator Care, Per Survey;

4. The projected number of patients in each region requiring ventilator care as derived in (d)3 above, shall then be adjusted (that is, divided by a factor of .85) to allow for a projected occupancy rate of at least 85 percent, in accordance with (i) below.

(e) A formal methodology shall not be used to determine the number of beds needed for the specialized care of patients with severe behavior management problems. However, in the interest of promoting improved access to high quality care for these patients whose needs cannot safely and effectively be met in general long-term care facilities, the Commissioner shall give consideration to approving one model program in each LAB region. Model programs may be approved providing that the following requirements are met, in addition to all other applicable requirements of this chapter:

1. The applicant shall document to the satisfaction of the Department that the number of beds proposed is reasonable with respect to the need for specialized long-term care for patients with severe behavior management problems in the LAB region. However, no more than 32 beds in any one nursing home in each LAB region shall be approved for a model program. Protecting individuals' identities, the applicant shall provide patient-specific data to demonstrate that there is a sufficient number of individuals residing in the regional service area who could meet the model program's admission criteria at the time of application submission, in order to fill 85 percent of the proposed number of beds in the model program. Patient-specific data shall include each individual's age, sex, county of residence, diagnoses, functional impairments, current placement, and reasons why the current placement is inappropriate;

2. The facility shall develop and maintain a collaborative affiliation with at least one school of nursing which grants baccalaureate and/or master's degrees in nursing, one school of social work, and one medical school, for the purpose of providing ongoing clinical training and research on site in the specialized care unit;

3. The model program shall include a formal research and program evaluation component. The applicant shall describe in detail how patient care outcomes will be evaluated by an independent party

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or organization. A report of this evaluation shall be submitted to the Department within three years of licensure of the approved beds. In view of the fact that Medicaid does not reimburse for research-related expenses, the applicant shall identify funding sources and otherwise explain how the costs of research will be covered;

4. The application shall include admission and discharge criteria which assure that the most difficult-to-manage patients in the regional service area shall receive priority for placement in the model program;

5. The application shall include a detailed plan describing how continuity of care will be assured for patients who are admitted to and discharged from the model program. The facility in which the model program will be located shall have available at all times a reasonable number of beds in other nursing units within the facility in order to allow for the transfer of patients who are no longer in need of specialized care as it is offered in the model program. Furthermore, the applicant shall specify how other nursing homes throughout the region shall be involved in assuring continuity of care for patients who are admitted to and discharged from the model program;

6. The facility shall develop and maintain an ongoing program whereby designated staff members are available to offer other area health care facilities in the regional service area training, educational seminars, and technical assistance in the care of patients with severe behavior management problems;

7. The model program shall conduct multidisciplinary team meetings on a regular basis for the purpose of establishing and reviewing each patient's plan of care; the multidisciplinary team shall include staff members involved in direct patient care on the unit, such as physicians, nurses, social workers, psychologists, activities therapists, and so fourth. The certificate of need application shall document how the multidisciplinary team will promote innovative approaches to care for patients with severe behavior management problems; and

8. The special care unit shall have a medical director with demonstrated expertise in the care of adult patients with behavior management problems.

(f) The establishment, addition, or conversion of beds for either types of specialized care shall be approved only in those cases where the facility will have one or more distinct and separate nursing units which treat exclusively patients who require the type of specialized care for which the facility receives Certificate of Need approval.

(g) All applicants for specialized care beds shall provide the following, to the satisfaction of the Department of Health:

1. A detailed description of the services and program of care that will be provided;

2. Specific admission and discharge criteria for the proposed unit, which clearly identify the types of patients who will be treated in the specialized care beds;

3. A specific plan to provide inservice training for nursing staff and others who will work with specialized care patients, including an orientation program for new staff members, ongoing inservice education, and opportunities to pursue advanced education and certification in the appropriate clinical specialties;

4. A description of physical plant considerations and special architectural features of the proposed unit as well as an identification of any special equipment that will be installed in order to accommodate patients' needs;

5. A signed transfer agreement with at least one acute care hospital with a licensed capacity of at least 200 beds to which specialized care patients can be transferred within 30 minutes total travel time for the purpose of receiving emergency medical treatment, if the proposed specialized care unit will not be located within an acute care hospital. The applicant shall submit documentation of the reasons why a particular hospital was chosen for the transfer agreement, including a description of the hospital's resources and capability to address the needs of patients requiring the applicable type of specialized care; and

6. A specific plan to provide coordination and continuity of care for patients who may be discharged from the proposed specialized care beds when this is feasible and beneficial to the patient/family/significant other. Supporting documentation for the plan may include signed transfer agreements or referral arrangements with licensed home health agencies and other health care facilities in the nursing home's regional service area which maintain the resources and capability to offer follow-up specialized care.

(h) In the case of specialized care units proposing to treat ventilator dependent patients, the facility shall provide staffing for the nursing unit on which the ventilator beds are located that includes the 24 hour per day presence on the unit of at least one registered nurse and the 24 hour per day on-call availability of at least one respiratory therapist. In addition, the facility shall comply with licensure staffing requirements that are applicable to the care of ventilator-dependent patients.

(i) The minimum desired annual occupancy rate for specialized care units shall be 85 percent.

(j) In cases where there are two or more competing applications for specialized long-term care beds in the same health systems area, the prioritization criteria contained in N.J.A.C. 8:33H-1.19(e) shall be used in determining which applications should be approved or denied.

8:33H-1.8 Adult day health care programs

(a) Applications for new adult day health care programs and additions to existing programs shall only be approved in counties where there is a long-term care placement need in accordance with N.J.A.C. 8:33H-1.5 and where adult day health care slots are requested as part of the county's long-term care placement mix proposal, as described in N.J.A.C. 8:33H-1.4.

(b) An applicant proposing to eliminate or reduce the capacity of an existing adult day health care program shall submit a Certificate of Need application for expedited review, in accordance with the applicable provisions of N.J.A.C. 8:33, and shall comply with N.J.A.C. 8:33H-1.13(h).

(c) Priority shall be given to the approval of adult day health care programs that propose to serve a specified number of patients who are severely compromised in their ability to perform most or all activities of daily living. The applicant shall state the number of slots which, as a condition of Certificate of Need approval, will be dedicated for the care of patients who have these characteristics, identify potential referral sources, and describe how the program will be staffed to meet these patients' needs.

(d) Priority shall be given to the approval of programs to serve a specialized population, such as patients with Alzheimer's Disease and other behavior disorders or AIDS/HIV infection, provided that the applicant documents the need for the program among the identified patient population.

(e) As a condition of Certificate of Need approval, applicants shall have at least 20 percent of the approved slots utilized by Medicaid-eligible patients. This percentage, or a higher percentage if proposed by the applicant, shall be achieved within one year of licensure and maintained thereafter.

(f) Applicants proposing pediatric day health care programs shall comply with the requirements stated in N.J.A.C. 8:33H-1.6(d).

8:33H-1.9 Size and occupancy of nursing homes and nursing units

(a) The targeted annual occupancy rate for nursing homes should be *[95]* ***90*** percent.

1. Certificate of Need applicants proposing the addition of long-term care beds at nursing homes with an annual occupancy rate of less than *[95]* ***90*** percent of the licensed bed capacity for the most recent calendar year shall not be approved.

(b) Nursing homes shall be designed and sized to promote a homelike environment, ***as opposed to a hospital-like environment,*** efficient facility operation, and a high quality of life and care.

(c) The Certificate of Need application for a new or expanding nursing home or for a long-term care bed addition to an existing facility shall state the number of long-term care beds which is proposed for each nursing unit. The maximum nursing unit size for long-term care shall be 64 beds.

[(d) Although there shall be no minimum nursing unit size requirement for long-term care, it is generally recommended that new units be constructed with a minimum of 48 beds in order to promote operating efficiency.]

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*[(e)]***(d)** The applicant shall provide detailed documentation to show that each and every proposed nursing unit containing long-term care beds, regardless of its size, shall be staffed with at least one licensed nurse (that is, a registered nurse or licensed practical nurse) for each shift around the clock, and that there shall be at least two nursing personnel assigned to each nursing unit for each shift around the clock, and that the facility shall comply with or exceed all other applicable staffing requirements contained in N.J.A.C. 8:39, and that operation of the facility will be financially feasible thus staffed.

1. As a condition of Certificate of Need approval, the long-term care applicant shall agree to comply with the staffing requirements in (d) above, even if this necessitates exceeding the minimum staffing standards required for licensure, which are contained in N.J.A.C. 8:39.

[(f) Although there shall be no minimum size requirement for nursing homes, it is generally recommended that new facilities be constructed with a minimum of 96 long-term care beds in order to promote operational efficiency.]

*[(g)]***(e)** The maximum size of facilities receiving Certificate of Need approval for general or specialized long-term care beds shall be 240 beds.

*[i.]***1.** An exception to the maximum size requirement in *[(g)]* ***(e)*** above may be made in the case of existing facilities which are licensed for more than 240 long-term care beds, which propose to reduce their long-term care bed complement by at least 15 percent. Such facilities may be approved to maintain a licensed capacity which will exceed 240 long-term care beds at project completion, after a proposed number of long-term care beds has been eliminated, provided that all other applicable requirements of this chapter are met.

2. An exception to (e) above may be made in the case of Statewide restricted admissions facilities, which may be given consideration for an expansion which will result in a net capacity of more than 240 beds, provided that the facility meets the requirements of N.J.A.C. 8:33H-1.11 and all other applicable requirements of this chapter.

*[(h)]***(f)** A facility which is licensed for more than 240 general and/or specialized long-term care beds, which proposes *[either to maintain its existing long-term care bed complement through the construction of a replacement facility or]* to add long-term care beds, may receive Certificate of Need approval *[for a replacement, renovation, and/or expansion project,]* provided that the applicant designs the project to result in two or more separately licensed and staffed facilities, each in compliance with the maximum size requirement in *[(f)]* ***(e)*** above. ***However, a facility which is licensed for more than 240 general and/or specialized long-term beds which proposes a replacement or renovation project without adding beds may be considered for certificate of need approval, provided that it complies with all other applicable requirements of this chapter.***

*[(i)]***(g)** The maximum unit size for specialized long-term care beds shall be 32 beds.

8:33H-1.10 Continuing care retirement communities

(a) An applicant for a new or expanded continuing care retirement community shall submit an application for expedited review, in accordance with the applicable provisions of N.J.A.C. 8:33.

(b) Continuing care retirement communities shall contain a minimum of four independent living units for every one long-term care bed.

1. Residential health care beds may be counted as independent living units in meeting the four-to-one ratio requirement in (b) above.

(c) The Certificate of Need application for a continuing care retirement community shall include the results of a detailed marketing study, analyzing demographic and economic conditions in the proposed service area, specifying and quantifying the target income-age group to which the continuing care retirement community will be marketed, identifying competing alternatives to the continuing care retirement community which are available to consumers in the service area, and estimating the number of potential continuing care retirement community residents residing in the proposed service area.

1. The applicant shall identify those municipalities that will constitute the target service area to which the continuing care retirement community will be marketed.

(d) The Certificate of Need application for a continuing care retirement community shall include a copy of the proposed resident contract or agreement. This contract shall clearly disclose the health care and other services to be provided by the community; the term or duration of the contract; projected charges, including entrance fees and periodic or monthly payments; and residents' rights. The contract shall fully disclose the circumstances under which the contract may be terminated both by the resident and the community and shall include provisions for the appeal rights of residents.

1. As a condition of certificate of approval, the resident contract shall specify that residents will have continued access to and use of the continuing care retirement community's long-term care beds in the event that they become Medicaid eligible, provided that the resident complies with all other terms of the contract and provided that this arrangement does not threaten the financial viability of the continuing care community as a whole.

(e) The long-term care facility of a continuing care retirement community shall be constructed concurrently with or subsequent to that number of independent living units which is stated in the Certificate of Need application. Licensure of the long-term care beds shall not be granted until such time as the proposed number of independent living units has been completed.

(f) Prior to licensure of the long-term care beds, the applicant shall obtain a certificate of authority from the Department of Community Affairs for the operation of a continuing care retirement community.

(g) Within seven years of occupancy of the first independent living unit, at least 90 percent of the occupants of the long-term care facility shall be drawn exclusively from the membership of the continuing care retirement community.

1. During the first seven years of operation, the continuing care community may admit non-member patients from the outside community to the nursing home beds; however, in the beds occupied by non-members, the facility shall comply with the Medicaid utilization requirements specified in N.J.AC. 8:33H-1.15.

(h) After seven years of occupancy of the first independent living unit, no more than 10 percent of the occupants of the long-term care facility may be drawn from outside the continuing care retirement community, and of this group, at least 45 percent must be Medicaid-eligible persons.

1. An exception to the occupancy requirement paragraph in (h) above may be made for nursing homes in continuing care retirement communities where four or fewer beds are utilized by non-member patients on an annual basis. Such facilities may cease to meet the 45 percent Medicaid utilization requirement, provided that no Medicaid-eligible patient will be displaced from the facility as a result of this provision.

(i) An exception to the four-to-one ratio requirement stated in (b) above may be made in the case of continuing care retirement communities which have operated as such for at least five years and which propose to add nursing home beds exclusively to accommodate the needs of their continuing care retirement community members and their current patients. In this case, the applicant may be approved for a bed addition, provided that the applicant agrees to accept a condition of approval stipulating that the nursing home shall cease to admit any patients from outside the continuing care retirement community. From the time of Certificate of Need approval for the bed addition, the nursing home shall exclusively admit patients who are members of the continuing care retirement community.

8:33H-1.11 Statewide restricted admissions facilities

(a) An applicant proposing a new or expanded nursing home which meets the definition of a Statewide restricted admissions

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facility in N.J.A.C. 8:33H-1.2 shall state this fact in the Certificate of Need application and shall provide documentation that the following criteria are met:

1. The facility's bylaws explicitly state that only members of the specified religious or fraternal organization and their immediate family members will be admitted to 100 percent of the long-term care beds; and

2. At least 50 percent of the facility's patients are from outside the LAB region in which the facility is located.

(b) An applicant proposing a new or expanded Statewide restricted admissions facility shall ***be exempt from the need methodology in N.J.A.C. 8:33H-1.5 and the county-based planning process in N.J.A.C. 8:33H-1.4, and may*** submit a Certificate of Need application for expedited review, in accordance with the applicable provisions of N.J.A.C. 8:33.

(c) An applicant proposing a long-term care bed addition to an existing Statewide restricted admissions facility shall provide a detailed patient origin breakdown of the facility's current patient population. The applicant shall identify the county (or State, for out-of-State patients) of prior residence for each patient, as well as for any patients on the facility's admission waiting list.

(d) The applicant for a Statewide restricted admissions facility shall agree to meet the applicable utilization criteria for Medicaid, SSI, and discharged psychiatric patients, as stated in N.J.A.C. 8:33H-1.15. Facilities that do not participate in the State's Medicaid program shall document how they will subsidize the care of patients who are Medicaid-eligible.

8:33H-1.12 Residential health care facilities

(a) An applicant proposing a new or expanded residential health care facility shall submit a Certificate of Need application for expedited review, in accordance with the applicable provisions of N.J.A.C. 8:33. The applicant shall comply with the applicable utilization requirements for Supplemental Security Income recipients and former psychiatric patients, in accordance with N.J.A.C. 8:33H-1.15.

(b) An applicant proposing the elimination or reduction of residential health care beds or the closure of a residential health care facility shall submit a Certificate of Need application for expedited review, in accordance with the applicable provisions of N.J.A.C. 8:33. The applicant shall comply with all applicable requirements pertaining to the conversion or elimination of beds, in accordance with N.J.A.C. 8:33H-1.13.

8:33H-1.13 Conversion or elimination of licensed or Certificate of Need approved beds or services

(a) Applicants proposing to convert any licensed beds to long-term care beds shall submit schematic plans with a floor layout of the facility, illustrating how the proposed conversion will be accomplished. In order to assure that the bed conversion can be implemented in accordance with health facility construction standards, it is recommended that applicants consult with the Department's Office of Health Facilities Construction Services in the Division of Health Facilities Evaluation, prior to submitting a Certificate of Need application. Applications for bed conversions that are submitted without schematic plans shall be deemed incomplete.

(b) Applicants for the conversion of residential health care beds to long-term care beds or the elimination of residential health care beds shall document a commitment to enabling current residents to continue occupying their assigned beds until or unless a permanent relocation placement is requested by the resident.

1. The mixing of residential health care and long-term care beds within one or more units as a consequence of implementing a Certificate of Need to convert or eliminate beds may be permitted if necessary in order to avoid relocating or discharging residents who do not wish to move.

(c) An applicant whose project entails the discharge or permanent relocation of patients in order to effect the conversion or elimination of licensed beds shall provide compelling documentation, to the satisfaction of the Commissioner, that a greater public benefit is to be obtained from the proposed conversion or elimination of beds than would be obtained if the existing licensed bed complement were maintained. This documentation shall be submitted not only by applicants who propose to discharge or permanently relocate a specified number of patients upon receiving Certificate of Need approval, but also by any applicant who has discharged or relocated more than 25 percent of the residents of the beds in question during the 12 month period prior to submission of the Certificate of Need application for a bed conversion or elimination. Compelling documentation of public benefit may include, but shall not be limited to, the following:

1. Letters supporting the discharge or relocation of patients which are submitted by the patients themselves, their family members or significant others, and/or the patients' health care providers;

2. Evidence that patients' quality of life and/or care would either deteriorate if they were permitted to remain in the facility, or that it would improve as a result of their being discharged or relocated to other facilities;

3. Evidence that the quality of life and/or care of those patients who will remain as residents in the facility would either deteriorate unless the proposed beds are converted or eliminated, or substantially improve as a result of eliminating or converting the beds in question; and

4. Evidence that the relocation will afford patients' family members and significant others convenient access for visitation purposes; that is, the facility to which most patients are expected to be relocated shall be situated in an area that has readily available public transportation and/or easy access to major roadways.

(d) An exception to the documentation requirement in (c) above may be granted by the Commissioner in the case where an applicant proposes to completely and permanently close the facility in question and/or to cease operating as any type of health care facility. The applicant shall nonetheless comply with the requirements in (f) below, to the extent that they are applicable.

(e) Certificate of Need applications proposing the conversion of residential health care beds to long-term care beds may be approved provided that the county in which the applicant's facility is located has a documented nursing home bed need in accordance with N.J.A.C. 8:33H-1.4(g) and consistent with the county Long-Term Care Committee's placement mix proposal.

(f) Certificate of Need applications proposing the conversion of residential health care beds to long-term care beds or the elimination of one or more residential health care beds shall meet the following requirements:

1. If the project entails the relocation of patients from the facility, the applicant shall provide documentation of a transfer agreement with at least one other residential health care facility in the area that maintains admission policies, offers amenities, and charges fees which are similar to those of the applicant's residential health care facility. Furthermore, the applicant shall provide documentation that the residential health care facility which is the subject of the transfer agreement has the willingness and bed capacity to accommodate those patients who might be transferred from the applicant's facility, including Supplemental Security recipients and discharged psychiatric patients;

2. If the applicant's facility currently has patients occupying residential health care beds who may require or desire relocation, the applicant agrees to provide all necessary social service assistance to effect the relocation in a manner that maximizes consumer choice of placement alternatives. The applicant shall bear the cost of relocating patients as necessary and shall make arrangements for any residential health care resident at the facility who wishes to visit other residential health care facilities in the area, prior to making a relocation decision; and

3. The Certificate of Need application complies with all other applicable requirements in this chapter.

(g) The conversion of specialized care beds to general long-term care beds or to another specialized care use may be considered for approval, provided that the following conditions are met:

1. The applicant provides evidence, to the satisfaction of the Department of Health, that good faith efforts have been made to implement the existing specialized care unit as it was originally

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approved, for a period of at least 18 months prior to submission of the Certificate of Need application for conversion. Evidence shall include:

i. Records of efforts to establish appropriate referral sources and transfer agreements;

ii. Records of efforts to negotiate reimbursement rates with third party payors including Medicaid; and

iii. Without disclosing names or otherwise publicly divulging individuals' identities, a verifiable listing of all patients referred for admission over the 12 month period prior to application submission. The listing shall include each patient's age, medical diagnoses, county of residence, payment source, and clinical care needs. For each patient, the applicant shall indicate whether the patient was admitted to the special care unit, and if not, the reason why admission was denied and the name of the facility where the patient was finally placed; and

iv. A description of all efforts to recruit and train staff for the unit.

(h) Certificate of Need applications proposing the elimination or termination of an adult day health care program may be approved, provided that the following condition is met:

1. The applicant shall provide documentation of a transfer agreement with at least one other licensed adult day health care program in the county that maintains admission policies, offers services, and charges fees which are similar to those of the applicant's program. Furthermore, if the applicant currently has patients utilizing the adult health care program, the applicant shall provide documentation that the program which is to be the subject of the transfer agreement has the willingness and slot capacity to accommodate those patients who will be transferred from the applicant's program.

(i) A Certificate of Need application proposing the conversion of acute care hospital beds to general or specialized long-term care beds may be approved provided that the following conditions are met:

1. The county in which the hospital is located has a documented nursing home bed need in accordance with N.J.A.C. 8:33H-1.4(g) and consistent with the county Long-Term Care Committee's placement mix proposal.

2. The project entails a permanent conversion of beds located on one or more distinct nursing units (that is the creation of so-called "swing beds" shall not be approved);

3. The applicant documents plans for providing a suitable, home like living environment for long-stay patients or agrees to adopt admission policies limiting utilization of the proposed long-term care beds to patients whose stays can reasonably be expected to be less than 100 days; *[and]*

4. The capital cost of converting the acute care beds is less than that of new nursing facility construction**; and**

5. The Certificate of Need application complies with all other applicable requirements in this chapter*.

8:33H-1.14 Quality of care and licensure track record requirements for long-term care, residential health care, and adult day health care facilities

(a) The licensure "track record" of an applicant shall be evaluated by the Department to determine whether the applicant's proposed project may be approved. For this purpose, the following information shall be required:

1. Regarding the proposed ownership of the facility, the application shall identify each and every principal involved in the application, along with the percentage of each principal's interest. One hundred percent of the ownership of the proposed project shall be accounted for in the Certificate of Need application. If the applicant is a corporation, every investor with any amount of operational control over the proposed facility and every stockholder with 10 percent or more interest in the corporation shall be identified.

(b) Applicants shall demonstrate the capacity to provide a quality of care which meets or surpasses the requirements contained in the applicable licensing standards for the facility. Evidence of the capacity to provide high quality care shall include (b)1 below, and may also include (b)2 through 4 below:

1. A satisfactory record of compliance with licensure standards in existing health care facilities which are owned, operated, or managed, in whole or part, by the applicant. This may include reports issued by licensing agencies from other states, as well as from the Department;

2. Narrative descriptions or listings within the application of services, staffing patterns, policies and protocols addressing delivery of nursing, medical, pharmacy, dietary, and other services affecting residents' quality of care;

3. Documentation of compliance with the standards of accreditation of nationally-recognized professional bodies in fields pertaining to long-term care; and

4. A recommendation by the State Department of Human Services' Division of Medical Assistance and Health Services and Division of Mental Health and Hospitals regarding the quality of and access to services provided by the applicant to Medicaid patients and patients who have been discharged from State and county psychiatric hospitals.

*[(c) A recommendation to the Commissioner for denial of a Certificate of Need application may be made by the Department's Division of Health Facilities Evaluation and Licensing in consideration of any of the following criteria:

1. In the case of long-term care, a record of noncompliance with State licensure standards (N.J.A.C. 8:39) or comparable Federal Medicare and Medicaid certification requirements at any time during the 12 month period preceding the Department's processing of the Certificate of Need application and extending until the time of the Commissioner's final decision. Standards and requirements to be considered shall include but not be limited to the following areas:

i. Nursing;

ii. Patient Rights;

iii. Patient Assessment and Care Plan;

iv. Dietary Services;

v. Infection Control and Sanitation; and

vi. Pharmacy;

2. Evidence of noncompliance with applicable licensure requirements provided by an official state licensing agency in any state outside of New Jersey; and

3. Official records from any State agency indicating noncompliance with the agency's standards pertaining to life safety.]*

(c) The Department shall examine and evaluate the licensing track record of each applicant for the period beginning 12 months preceding submission of the Certificate of Need extending to the date the Commissioner issues a final decision, for the prupose of determining the capacity of an applicant to operate a health care facility in a safe and effective manner in accordance with State and Federal requirements. A Certificate of Need application may be denied or, in a competitive batching review, afforded no prioritization and provided by N.J.A.C. 8:33H-1.19, where an applicant has not demonstrated such capacity, by evidence of continuing or serious violations of State licensing standards or Federal certification standards. An applicant, for purposes of this rule, includes any person who was or is an owner or principal of a licensed health care facility, or who has managed, operated, or owned in whole or in part any health care facility.

[(d) Any applicant, including any principals thereof, who manages, operates, or owns in whole or in part any health care facility which has been cited for State licensing or Federal certification deficiencies which presented an immediate peril to the health, safety, or welfare of the facility's patients or residents at any time within the 12 month period prior to application submission and extending until the time of the Commissioner's final decision, shall not receive Certificate of Need approval.]

(d) A Certificate of Need submitted by an applicant who was cited for State licensing or Federal certification deficiencies during the period identified in (c) above, which presented a serious risk to the life, safety, or quality of care of the facility's patients or residents, shall be denied. A serious risk to life, safety, or quality of care of patients or residents includes, but is not limited to, deficiencies in State licensure or Federal certification requirements in the areas of nursing, patient rights, patient assessment of care plan, dietary services, infection control and sanitation, or pharmacy, resulting in:

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1. An action by a State or Federal agency to curtail or temporary suspend admissions to a facility; or

2. Issuance of two or more Federal Level A deficiencies in the areas identified above; or

3. Issuance of one or more Federal Level A deficiencies in the same area on two or more consecutive visits.

(e) In evaluating track record in (c) or (d) above, the Department may consider any evidence of noncompliance with applicable licensure requirements provided by an official state licensing agency in any state outside of New Jersey, or any official records from any agency of the State of New Jersey indicating the applicant's noncompliance with the agency's licensure or certification requirements in a facility the applicant owned, operated, or managed in whole or in part.*

*[(e)]****(f)*** No more than two Certificate of Need approvals shall be granted to an applicant for the construction of new nursing homes or residential health care facilities or for bed additions to existing or approved facilities, until such time as the applicant has established a licensing track record in New Jersey. For this purpose, the establishment of a licensing track record shall be accomplished by holding at least 10 percent ownership interest or through the actual operation or management of one or more licensed, operational inpatient health care facilities in the State of New Jersey for a period of at least 12 consecutive months.

*[(f)]****(g)*** In making a determination of Federal deficiencies in the case of long-term care, the Department shall use the requirements for long-term care Medicare/Medicaid participation found in 42 CFR Part 483 et al. in the areas of Resident Rights, Resident Behavior and Facility Practice, Quality of Life, and Quality of Care.

*[(g)]****(h)*** Applications for a Certificate of Need to modernize, renovate or initiate new construction shall, to the greatest extent possible and practical, be directed toward correcting life-safety code waivers in categories A and B, N.F.P.A. Life Safety Code 101, incorporated herein by reference.

1. Facilities with life-safety code waivers (whether waivered or not) should contact the Department of Health's Division of Health Facilities Evaluation and the Division of Health Planning and Resources Development to discuss the seriousness of the waivered conditions prior to submitting a Certificate of Need application.

*[(h)]****(i)*** Any applicant whose Certificate of Need has been denied for reasons related to a history of noncompliance with licensure requirements shall be ineligible for approval of another Certificate of Need until a period of at least one year has elapsed, during which time the applicant shall have demonstrated a record of compliance with licensing requirements. The one year period shall be measured from the time of that licensing inspection which is subsequent to the inspection in which noncompliance was determined and in which substantial compliance has thus been reestablished.

8:33H-1.15 Utilization requirements for Medicaid-eligible patients, Supplemental Security Income (SSI) recipients, and former psychiatric patients

(a) Applicants receiving Certificate of Need approval to add general or specialized long-term care beds to an existing facility or to construct a new nursing home or a replacement facility shall comply with the following utilization requirements:

1. Within one year from license issuance, a minimum of 36 percent of the total general long-term care bed complement shall be occupied by direct admission Medicaid-eligible patients, as defined in N.J.A.C. 8:33H-1.2. The facility shall continue to maintain at least 36 percent Medicaid-eligible direct admissions in its general long-term care beds annually thereafter.

2. Within one year from license issuance, a minimum of 36 percent of the total specialized long-term care bed complement shall be occupied by direct admission Medicaid-eligible patients, as defined in N.J.A.C. 8:33H-1.2. The facility shall continue to maintain at least 36 percent Medicaid-eligible direct admissions in its specialized long-term care beds annually thereafter.

3. A minimum of 45 percent of the total general long-term care bed complement shall be occupied by Medicaid-eligible patients who either have spent down to the level of Medicaid eligibility during their nursing home stay or who are directly admitted to the facility as Medicaid-eligible patients, as defined in N.J.A.C. 8:33H-1.2. The facility shall continue to maintain at least 45 percent overall occupancy by Medicaid-eligible patients in its general long-term care beds annually thereafter.

4. A minimum of 45 percent of the total specialized long-term care bed complement shall be occupied by Medicaid-eligible patients who either have spent down to the level of Medicaid eligibility during their nursing home stay or who are directly admitted to the facility as Medicaid-eligible patients, as defined in N.J.A.C. 8:33H-1.2. The facility shall continue to maintain at least 45 percent overall occupancy by Medicaid-eligible patients in its specialized long-term care beds annually thereafter.

(b) As a condition of Certificate of Need approval, *[a specified minimum percentage]* ***seven percent*** of the total number of long-term care beds shall be dedicated for occupancy by persons in need of nursing home care who are present or former patients of State/county psychiatric hospitals or community inpatient psychiatric units. *[The minimum acceptable percentage shall be determined on an annual basis by the Department of Health in consultation with the Department of Human Services. The Department of Health shall announce in the New Jersey Register the required percentage on January 1, or at least 30 days prior to the first filing date for that year for nursing home Certificate of Need applications.]*

1. Occupancy of beds by former psychiatric patients who are Medicaid-eligible may count toward the utilization requirements for Medicaid-eligible patients which are specified in (a) above, provided that the former psychiatric patient is Medicaid-eligible.

2. At the time of initial licensure of any long-term care beds approved in accordance with this chapter, the nursing home shall sign and subsequently maintain a written transfer agreement with either the Division of Mental Health and Hospitals (within the New Jersey Department of Human Services) or at least one county psychiatric hospital or facility with a community inpatient psychiatric unit, for the purpose of complying with the percentage requirement specified in paragraph (b) above.

(c) Applicants receiving Certificate of Need approval to add residential health care beds to an existing facility or to construct a new residential health care facility or a replacement facility shall comply with the following utilization requirements:

1. A minimum of 10 percent of the total residential health care bed complement shall be occupied by direct admission Supplemental Security Income ***eligible*** recipients. This percentage shall be achieved within one year of license issuance and maintained on an annual basis thereafter.

(d) As a condition of Certificate of Need approval, *[a specified minimum percentage of residential health care]* ***50 percent of the Supplemental Security Income eligible recipient*** beds shall be dedicated for occupancy by persons in need of residential health care who are State, county, or designated psychiatric short-term care facility patients. *[The minimum acceptable percentage shall be determined on an annual basis by the Department of Health in consultation with the Department of Human Services. The Department of Health shall announce in the New Jersey Register the required percentage on January 1, or at least 30 days prior to the first filing date for that year for nursing home Certificate of Need applications. For 1992, the percentage shall be seven percent. The specified minimum percentage shall apply to all applications reviewed and approved in batching cycles occurring during the calendar year.]*

1. Occupancy of beds by former psychiatric patients who are recipients of Supplemental Security Income may count toward the utilization requirements for Supplemental Security Income recipients which are specified in (c) above.

2. At the time of initial licensure of any residential health care beds approved in accordance with this chapter, the facility shall sign and subsequently maintain a written transfer agreement with either the Division of Mental Health and Hospitals (within the New Jersey Department of Human Services) or at least one county psychiatric

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hospital or designated psychiatric short-term care facility, for the purpose of complying with the percentage requirement specified in (d) above.

(e) A nursing home or residential health care facility that receives Certificate of Need approval for a change in cost, location, or scope shall comply with either the applicable utilization percentages for Supplemental Security Income recipients and Medicare-to-Medicaid and Medicaid-eligible patients which were stated in the Commissioner's original Certificate of Need approval letter, or the utilization percentages which are outlined in this chapter, whichever percentages are higher.

(f) A Certificate of Need applicant proposing a new or expanded facility, or a change in cost or scope to a previously approved project, or a transfer of ownership of an existing facility ***with previous Certificate of Need conditions***, who can produce documentation that the utilization percentage requirements in this section will cause a financial hardship may request a review of the financial feasibility of those percentages, which may result in a finding by the Department that a lower percentage is required for financial feasibility.

(g) This rule shall be operative from September 8, 1992 to March 8, 1994.

8:33H-1.16 Cost-efficiency and financial feasibility

(a) Applicants for a Certificate of Need shall demonstrate the financial feasibility of their projects. This analysis shall be based upon the projection of reasonable private pay and Medicaid charges, expenses of operation, and staffing patterns, relative to other facilities in the health systems area in which the proposed project will be located.

(b) Total project cost, construction cost per square foot, and cost per bed shall be taken into consideration in the review of Certificate of Need applications.

(c) Where projected construction and operating costs are considerably lower or higher than the average for the health systems area, as determined by the Department, the applicant shall provide an explanation at the request of the Department indicating factors contributing to said projections. This request for an explanation shall not be construed as an opportunity to change cost projections. Information regarding the most recent available facility costs in the health systems areas may be obtained from the Department's Division of Health Facilities Evaluation (Health Facilities Construction Services), CN 367, Trenton, N.J. 08625.

(d) Applicants shall describe their previous record of implementing Certificate of Need-approved long-term care projects, identifying each case in which a change in cost was requested in order to complete a project. All other things being equal, preference shall be given to approving applicants with a history of realistically projecting construction costs in their Certificate of Need applications, as reflected in the number and magnitude of previous requests for a change in cost.

(e) Applicants shall provide evidence in their financial projections that income generated by operation of the facility will be sufficient to provide care to the percentage of Medicaid-eligible or indigent patients specified in the application, or in accordance with N.J.A.C. 8:33H-1.15 whichever is greater.

(f) Applicants shall provide verification of the availability of at least 10 percent of the total project cost, including all financing and carrying costs, in the form of equity.

(g) As a condition of approval, applicants shall agree to make reasonable efforts to obtain the least cost financing available.

(h) Applicants proposing to add long-term care beds in an existing facility or to add long-term care beds in the course of replacing an existing facility shall provide documentation that the added beds will improve the efficient operation of the facility, reducing unit costs of care per patient.

8:33H-1.17 Environmental and physical plant considerations

(a) Health care facilities shall be designed and constructed in such a manner as to eliminate architectural barriers to care.

(b) Prior to submitting a Certificate of Need application, applicants proposing specialized long-term care beds shall consult with the Department's Division of Health Facilities Evaluation regarding the architectural design and construction of such projects. In addition to the standard construction requirements for nursing homes, (N.J.A.C. 8:39) the following shall be required.

1. Specialized care units approved for ventilator care shall have piped-in oxygen, suction equipment, emergency electrical outlets, and additional square footage for ventilator equipment and supplies;

2. Pediatric nursing home units shall include a play room or recreation room and suitable, adaptable space for educational uses such as tutoring; and

3. Specialized care units for patients with severe behavior management problems shall provide easy access to a protected outdoor area, such as a courtyard, patio, or garden.

8:33H-1.18 Location of facilities

(a) The applicant shall describe the proposed site of a project and the immediate surrounding community, identifying how the site is currently zoned and providing a time table for securing any and all necessary zoning and land use approvals. Long-term care facilities proposed to be located on sites which are currently zoned for heavy industrial use shall not be approved.

1. Applicants for long-term care, residential health care, and adult day health care facilities should not enter into costly land use or zoning approval procedures prior to receiving an approved Certificate of Need.

(b) The applicant shall identify the proposed facility's access to public transportation. Where possible, each facility shall be located where access is easily obtained via low-cost public transportation.

(c) The applicant for a long-term care or residential health care facility shall describe the availability to the proposed site of all necessary utilities. Where utilities are not already available at the proposed site, the applicant shall provide a timetable and detail the costs for obtaining these utilities.

(d) The applicant shall identify the proposed facility's proximity to any potential source of adverse environmental conditions. Long-term care and residential health care facilities shall be located so as to prevent exposure of patients to adverse environmental conditions which might hamper or interfere with their care, including excessive noise levels, offensive odors, or unsightly physical surroundings.

8:33H-1.19 Prioritization criteria and recommended features for the approval of nursing home projects

(a) In the case where two or more applications propose to meet a limited nursing home bed need in a particular county, these applications shall be reviewed in competition with each other using the prioritization criteria contained herein.

(b) Preference shall be given to the Certificate of Need approval of those projects that receive the greatest number of points using the criteria enumerated below. Each criterion shall count for one point, except that the criteria at (b)1 *[through 3]* ***and 2*** below shall count for two points each. In this manner, the maximum possible score shall be *[16]* ***15***. The criteria are as follows:

1. The applicant documents a commitment to occupy 55 percent or more of the facility's total long-term care bed complement with Medicaid-eligible patients within one year of licensure. This proportion shall include at least 45 percent occupancy of the total bed complement by direct-admission Medicaid-eligible patients and at least 10 percent occupancy by patients who convert from private pay status to Medicaid eligibility during their stay in the facility. Applicants may propose to accept higher percentages of Medicaid patients than those stated herein, however, no greater priority shall be given to applicants for such a commitment;

2. The applicant demonstrates a commitment to admit and maintain Medicaid-eligible "heavy care" or acuity patients in at least 20 percent of the proposed new beds (that is, patients who do not require specialized care, as it is defined in N.J.A.C. 8:33H-1.2, but who routinely require more than the 2.5 hours per day minimum amount of nursing care required in N.J.A.C. 8:39)***. In order to meet this criterion, the applicant is required to provide documentation from area hospital discharge planners or other appropriate re-***

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sources to show that there is a need of the magnitude that would warrant 20 percent of the proposed beds being dedicated for heavy care*;

3. *[The project does not require the discharge or permanent relocation of current residential health care residents to a different facility in order to convert the applicant's facility or any part thereof to long-term care beds, unless the relocation is to a replacement facility which is constructed or renovated by the applicant as part of the proposed project]* ***Above and beyond meeting the requirements in N.J.A.C. 8:33-1.14, the applicant has a track record for consistently high quality patient care in nursing facilities owned or operated by the applicant, as demonstrated by a satisfactory record of compliance with licensure standards during the three year period prior to application submission and submission of an affidavit to that effect***;

4. The applicant successfully operates at least one facility that is licensed for both residential health care and long-term care beds, and the facility has maintained an annual occupancy rate of at least 85 percent in its licensed residential health care beds during the most recent calendar year;

5. The facility will include a separate and distinct unit for young adult patients. The size of this unit should be proportionate to the county's need, taking into consideration the projected need for placements for individuals age 20 to 64 in accordance with the placement methodology in N.J.A.C. 8:33H-1.5, and the existence of other long-term care resources that are available for young adults in the area;

6. Within one year of licensure, the facility will be staffed with one or more full-time equivalent ***physician, or*** clinical nurse specialists who have received a master's degree in geriatric nursing or a related clinical field from a program accredited by the National League for Nursing;

7. The facility will provide tuition reimbursement and/or a career ladder program for facility personnel. The program and employee participation criteria shall be described in detail in the application. The facility will provide documentation to the Department of Health on an annual basis to show that one or more employees have received college or training school tuition reimbursement each year as part of this program;

8. The project will result in the elimination of life safety code waivers at an existing facility;

9. The project entails the conversion of excess acute care hospital bed capacity to long-term care, in accordance with the requirements in N.J.A.C. 8:33H-1.13(i);

10. The applicant has a track record of implementing long-term care projects in New Jersey in an especially timely manner (that is, long-term care construction projects owned, operated, or managed by the applicant have been licensed within four years of Certificate of Need issuance);

11. The applicant has no more than one other Certificate of Need approved but not yet licensed long-term care facility in New Jersey at the time that the current application is accepted for processing;

12. *[The]* ***Above and beyond meeting the requirements in N.J.A.C. 8:33H-1.14, the*** applicant has a track record for high quality patient care in nursing facilities owned or operated by the applicant in New Jersey, as demonstrated by compliance with five or more advisory standards contained in N.J.A.C. 8:39 at the time of the most recent annual licensing survey***. Advisory standards which will be taken into consideration are: access to care, patient assessment and care plans, pharmacy, infection control and sanitation, patient activities, dietary services, medical services, nurse staffing, physical environment, and quality assurance. Substantial compliance refers to compliance with at least 65 percent of the components of each of the five advisory standards***; and

13. The facility will promote not only a high quality of nursing and medical care but also a high quality of life for residents. Factors deemed to promote a high quality of life include, but are not limited to, the following:

i. Physical space inside the facility in excess of minimum construction requirements, designed for patients to meet privately with family and significant others;

ii. Year-round, easy access to protected, landscaped outdoor areas that are furnished with outdoor seating and tables; and

iii. Strategies to address the needs of patients with Alzheimer's Disease and related dementias, including, but not limited to, wandering tracks, behavior management programs, family support groups, and ongoing special activities.

(c) In the event that an applicant receives Certificate of Need approval for proposing to meet any or all of the prioritization criteria in (b) above, the specified criteria shall be included as conditions of Certificate of Need approval. Failure to comply with the conditions may result in licensure fines or other penalties.

(d) In the case where an applicant states a commitment to meet any or all of the prioritization criteria in (b) above, the applicant shall provide documentation that the costs of meeting the specified criteria have been factored into the applicant's financial feasibility analysis, in accordance with N.J.A.C. 8:33H-1.16.

(e) In Local Advisory Board regions where there is a need for specialized long-term care beds, priority shall be given to the approval of Certificate of Need applications for projects which are in compliance with all applicable requirements of this chapter and which meet the greatest number of the following criteria:

1. The facility will be centrally located in a geographically accessible location which is conveniently reached by public and private transportation by residents of all parts of the LAB region;

2. The facility has the physical space, bed capacity and architectural layout to accommodate an addition of specialized care beds in a timely manner in the future, should there be a need for more beds in accordance with N.J.A.C. 8:33H-1.7; and

3. The applicant documents a commitment to occupy 55 percent or more of the facility's specialized care bed complement with Medicaid-eligible patients within one year of licensure. This proportion shall include at least 45 percent occupancy by direct-admission Medicaid-eligible patients and at least 10 percent occupancy by patients who convert from private pay status to Medicaid eligibility during their stay in the facility. Applicants may propose to accept higher percentages of Medicaid patients than those stated herein, however, no greater priority shall be given to applicants for such a commitment.

(a)

DIVISION OF HEALTH FACILITIES EVALUATION

Examination Fee for Licensing Nursing Home Administrators

Adopted Amendment: N.J.A.C. 8:34-1.7

Proposed: July 6, 1992 at 24 N.J.R. 2414(a).

Adopted: August 12, 1992 by Frances J. Dunston, M.D., M.P.H., Commissioner, Department of Health (with approval of the Nursing Home Administrator Licensing Board).

Filed: August 17, 1992 as R.1992 d.345, **without change.**

Authority: N.J.S.A. 26:2H-1 et seq., specifically 26:2H-5, and P.L. 1991 c.78.

Effective Date: September 8, 1992.

Operative Date: October 1, 1992.

Expiration Date: November 15, 1993.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows.

8:34-1.7 Licensing requirements

(a)-(e) (No change.)

(f) Prior to taking the licensure examination, each applicant shall be required to submit an examination fee in the amount specified by the professional examination service utilized by the Department for the administration of the examination and approved by the Department and the Nursing Home Administrator's Board. The Department shall provide timely notice of the examination fee in the Public Notices section of the New Jersey Register.

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(a)

DIVISION OF HEALTH FACILITIES EVALUATION

Maternal and Child Health Consortia Licensing Standards

Adopted New Rules: N.J.A.C. 8:35A

Proposed: June 1, 1992 at 24 N.J.R. 2027(a).

Adopted: August 14, 1992 by Frances J. Dunston, M.D., M.P.H., Commissioner, Department of Health (with approval of the Health Care Administration Board)

Filed: August 7, 1992 as R.1992 d.346, **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 26:2H-5.

Effective Date: September 8, 1992.

Operative Date: November 1, 1992.

Expiration Date: September 8, 1997.

Summary of Public Comments and Agency Responses:

The Department received comments from the Southern New Jersey Perinatal Cooperative, the Northwest New Jersey Regional Perinatal Network, Dr. Garry Frisoli, Director of Perinatology at Overlook Hospital, and the following three hospitals: Elizabeth General Medical Center, Saint Barnabas Medical Center and the Memorial Hospital of Burlington County.

COMMENT: The Southern New Jersey Perinatal Cooperative and the Northwest New Jersey Regional Perinatal Network expressed concern about the statement in the Regulatory Flexibility Analysis which appeared to limit the Consortia's staff to no more than three staff members. Both commenters emphasized that the rules place even greater responsibilities on the Consortia than they have assumed in the past.

RESPONSE: As noted by the commenters, this statement appeared in the Regulatory Flexibility Analysis section. This section functions to provide general discussion of the anticipated impact of proposed rules but carries no regulatory authority. The Department places no restrictions on the number of staff employed by Consortia.

COMMENT: Elizabeth General Medical Center questioned why it was necessary to license Maternal and Child Health Consortia. The Commenter stated that licensure would create an additional level of bureaucracy and was contrary to the intent of the Consortium to function as a planning and advisory coordinating body. The commenter recommended, alternatively, that appropriate requirements be identified and incorporated into N.J.A.C. 8:33C and ultimately recommended that the Department delay implementation of any rule where the reimbursement mechanism has not been approved prior to implementation. Saint Barnabas Medical Center stated that Consortia should be licensed only if they provide direct services to patients. Dr. Garry Frisoli, Director of Perinatology at Overlook Hospital, wrote in support of the regionalized maternal and child health consortia and their functions as spelled out in N.J.A.C. 8:33C-2.6.

RESPONSE: The need for licensure of MCHCs is based on their integral role in the delivery of health care services in the regional perinatal system. The responsibility of MCHCs include case management services, quality assurance, and professional education. Furthermore, the opportunity for these entities to be formally recognized as a "licensed" health care facility facilitates their eligibility for third party reimbursement. The Department is investigating reimbursement mechanisms. The Department appreciates the comment in support of these rules.

N.J.A.C. 8:35A-3.1 Provision of services

COMMENT: Elizabeth General Medical Center objected to use of the term "implement" in this section and recommended that any reference to the Consortia implementing should be changed to "coordinate" and/or "recommend the implementation." The commenter stressed that Consortia have no direct authority or fiduciary responsibility.

RESPONSE: Maternal and Child Health Consortia (MCHC) are responsible for overseeing and monitoring the provision of perinatal services in the Maternal and Child Health Region and must implement a system of care not presently operable in many areas of New Jersey. The Department does not believe the commenter's suggested language appropriately reflects the level of responsibility assigned to MCHCs and, therefore, retains the rule as proposed.

COMMENT: Memorial Hospital of Burlington County requested clarification of the phrase "uniform regional system for automated data collection" as found in N.J.A.C. 8:35A-3.1(f), and expressed concern that it may require hospitals to purchase hardware and hire people to input data.

RESPONSE: The Department does not anticipate that the automated data collection system referred to in this rule will result in additional expense to hospitals. One of the primary purposes of such a system is to ensure the collection of the same type of information from every hospital. The type of system needed in the region will be determined by the MCHC, in collaboration with member facilities.

N.J.A.C. 8:35A-3.2 Compliance with laws and rules

COMMENT: Memorial Hospital asked whether Consortia would be subject to the ambulatory care standards. The commenter noted, with reference to N.J.A.C. 8:35A-3.2(b), that is also important to guarantee confidentiality in participating organizations.

RESPONSE: Maternal Child Health Consortia are subject to N.J.A.C. 8:43A, Manual of Standards for Licensure of Ambulatory Care Facilities, only if direct patient care services are provided on-site. For purposes of clarity, the Department has added additional language at N.J.A.C. 8:35A-3.2(a) to emphasize that MCHCs are subject to N.J.A.C. 8:43A only if they directly provide medical or nursing services to patients. The Department has also included a requirement for MCHCs to request prior approval from the Department before undertaking the provision of such services. The Department agrees with the commenter's position regarding the importance of protecting the confidentiality of participating organizations.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

CHAPTER 35A
MATERNAL AND CHILD HEALTH CONSORTIA
LICENSING STANDARDS

SUBCHAPTER 1. GENERAL PROVISIONS

8:35A-1.1 Scope

(a) The rules in this chapter pertain to all regional Maternal and Child Health Consortia (MCHC) which oversee and monitor regional maternal perinatal and child health service delivery networks.

(b) The purpose of this chapter is to provide maternal and child health services in a coordinated and cooperative prevention-oriented manner which is accessible, cost-effective and in accordance with N.J.A.C. 8:100-1.1 and 1.4.

8:35A-1.2 Definitions

The following words and terms, as used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Central service facility" means a health care facility, regulated by the Department of Health, providing essential administrative and clerical support services to two or more direct providers of health care services in a region and which may also include some direct provision of health care services.

"Community Perinatal Center" means any licensed facility providing, preconceptional, prenatal, intrapartum (including delivery of the patient), and postpartum care to women.

"Letter of agreement" means the document signed by both the Regional Perinatal Center and the Community Perinatal Center which defines the relationship between the two centers and specifies all tasks to be provided. If there is more than one hospital within the region able to meet the qualifications of a Regional Perinatal Center, then the Regional Perinatal Centers will first develop cooperative letters of agreement with each other; then with the Community Perinatal Centers within the region, facilitated by the Regional Maternal and Child Health Consortia. The letters of agreement are then submitted by the Regional Maternal and Child Health Consortia as part of the certificate of need application.

"Maternal and Child Health Consortium (MCHC)" means a voluntarily formed non-profit organization, incorporated under Section 501(c)(3) of the United States Internal Revenue Code, consisting

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of all inpatient, ambulatory perinatal and pediatric care providers and related community organizations in a maternal and child health service region, licensed as a central service facility by the Department of Health.

"Maternal and Child Health Service Region" means the perinatal and pediatric service delivery area defined by the concept of cooperative network formation. Contained within each region is at least one Regional Perinatal Center, one Regional Pediatric Center and the balance, Community Perinatal Centers.

"Maternal-fetal transport" means the transport of the high risk patient for maternal management.

"Perinatal" means the period before and after birth; defined in New Jersey and generally accepted as week 20 of gestation through the neonatal period.

"Regional Perinatal Center" means a licensed hospital which is the preferred provider of care to high risk mothers and high risk infants in the maternal and child health region. Such a facility is responsible for providing consultation, referral, transport and follow-up to the region.

"Regional Perinatal Plan" means the plan developed by the Regional Maternal and Child Consortia which describes how prenatal, intrapartum, newborn and infant follow-up services are delivered in the region. The plan is submitted to the Department of Health as part of the certificate of need application made pursuant to N.J.A.C. 8:33C.

"Transport" means the process whereby the attending physician at the Community Perinatal Center assesses that the status of the patient has become acutely high risk and arranges for the transfer of the care of the patient to the specialist at the Regional Perinatal Center via moving the patient with an emergency vehicle.

SUBCHAPTER 2. LICENSURE PROCEDURES

8:35A-2.1 Certificate of Need

(a) According to N.J.S.A. 26:2H-1 et seq., and amendments thereto, a regional Maternal and Child Health Consortia (MCHC) shall not be instituted, constructed, expanded, or licensed to operate except upon application for, and receipt of, a Certificate of Need issued by the Commissioner based upon criteria in N.J.A.C. 8:33C.

(b) Application forms for a Certificate of Need and instructions for completion, pursuant to N.J.A.C. 8:33 and N.J.A.C. 8:33C, may be obtained from:

Certificate of Need Program
Division of Health Planning and Resources Development
New Jersey State Department of Health
CN 360
Trenton, New Jersey 08625

(c) The MCHC shall implement all conditions imposed by the Commissioner as specified in the Certificate of Need approval letter. Failure to implement the conditions may result in the imposition of sanctions in accordance with N.J.S.A. 26:2H-1 et seq., and amendments thereto.

8:35A-2.2 Application for licensure

(a) Following receipt of a Certificate of Need, any person, organization, or corporation desiring to operate a MCHC shall make application to the Commissioner for a license on forms prescribed by the Department, in accordance with the requirements of this chapter. Such forms may be obtained from:

Director
Licensing and Certification
Division of Health Facilities Evaluation and Licensing
New Jersey State Department of Health
CN 367
Trenton, New Jersey 08625

(b) The applicant shall submit to the Department a nonrefundable fee of $500.00 for the filing of an application for licensure of a MCHC and for the annual renewal of the license.

(c) Each applicant for a license to operate a MCHC shall make an appointment for a preliminary conference at the Department with the Licensing and Certification Program.

8:35A-2.3 Surveys and temporary license

(a) When the written application for licensure is approved and the building is ready for occupancy, a survey of the MCHC by representatives of the Health Facilities Inspection Program of the Department may be conducted as follows to determine if the facility complies with the rules in this chapter:

1. The MCHC shall be notified in writing of the findings of the survey, including any deficiencies found; and

2. The MCHC shall notify the Health Facilities Inspection Program of the Department when the deficiencies, if any, have been corrected, and the Health Facilities Inspection Program will schedule one or more resurveys of the facility prior to occupancy.

(b) A temporary license may be issued to a MCHC when the following conditions are met:

1. At the discretion of the Department, a preliminary conference (see N.J.A.C. 8:43A-2.2(c)) for review of the conditions for licensure and operation may take place between the Licensing and Certification Program and representatives of the MCHC, who will be advised that the purpose of the temporary license is to allow the Department to determine the facility's compliance with N.J.S.A. 26:2H-1 et seq. and the rules pursuant thereto;

2. Written approvals are on file with the Department from the local zoning, fire, health, and building authorities; and

3. Survey(s) by representatives of the Department indicate that the MCHC complies with the rules in this chapter.

(c) A temporary license may be issued to a MCHC for a period of six months and may be renewed by the Department, if the applicant is determined by the Department to be in compliance with all applicable rules and regulations.

(d) The temporary license shall be conspicuously posted in the MCHC.

(e) The temporary license is not assignable or transferable, and it shall be immediately void if the MCHC ceases to operate or if its ownership changes.

(f) Survey visits may be made to a MCHC at any time by authorized staff of the Department. Such visits may include, but not be limited to, the review of all MCHC documents and patient records and conferences with patients.

8:35A-2.4 Full license

(a) A full license shall be issued on expiration of the temporary license, if surveys by the Department have determined that the MCHC is operated as required by N.J.S.A. 26:2H-1 et seq. and by the rules pursuant thereto.

(b) A license shall be granted for a period of one year.

(c) The license shall be conspicuously posted in the MCHC.

(d) The license is not assignable or transferable, and it shall be immediately void if the MCHC ceases to operate or if its ownership changes.

(e) The license, unless suspended or revoked, shall be renewed annually on the original licensure date, or within 30 days thereafter but dated as of the original licensure date. The MCHC will receive a request for renewal fee 30 days prior to the expiration of the license. A renewal license shall not be issued unless the licensure fee is received by the Department.

(f) The license may not be renewed if local rules, regulations, and/or requirements are not met.

8:35A-2.5 Surrender of license

The MCHC shall notify the Department of Health at least 30 days prior to the voluntary surrender of a license. As directed under an order of revocation, refusal to renew, or suspension of license, the license shall be returned to the Licensing and Certification Program of the Department within seven working days after the voluntary surrender, revocation, non-renewal, or suspension of license.

8:35A-2.6 Waiver

(a) The Commissioner or his or her designee may, in accordance with the general purposes and intent of this chapter, waive sections of these rules if, in his or her opinion, such waiver would not endanger the life, safety, or health of patients or the public.

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(b) A MCHC seeking a waiver of these rules shall apply in writing to the Director of the Licensing and Certification Program of the Department.

(c) A written request for waiver shall include the following:

1. The specific rule(s) or part(s) of the rule(s) for which waiver is requested;

2. Reasons for requesting a waiver, including a statement of the type and degree of hardship that would result to the MCHC upon compliance;

3. An alternative proposal which would ensure patient safety; and

4. Documentation to support the request for waiver.

(d) The Department reserves the right to request additional information before processing a request for waiver.

8:35A-2.7 Action against a license

(a) If the Department determines that operational deficiencies exist, it may require that all services provided within the MCHC cease. This may be done simultaneously with, or in lieu of, action to revoke licensure and/or impose a fine. The Commissioner or his or her designee shall notify the MCHC in writing of such determination.

(c) The provisions of this section shall apply to MCHC's with a temporary license and to MCHC's with a full license.

8:35A-2.8 Hearings

(a) If the Department proposes to suspend, revoke, deny, or refuse to renew a license, the licensee or applicant may request a hearing which shall be conducted 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.

(b) Prior to transmittal of any hearing request to the Office of Administrative Law, the Department may schedule a conference to attempt to settle the matter.

SUBCHAPTER 3. GENERAL REQUIREMENTS

8:35A-3.1 Provision of services

(a) The MCHC shall develop and implement a regional perinatal and pediatric plan in accordance with N.J.A.C. 8:33C, Certificate of Need: Regionalized Perinatal Services.

(b) The MCHC shall develop and implement a preterm labor prevention program, which shall include, but not be limited to, the following:

1. A computer-adaptable perinatal record, approved by the regional board of directors;

2. A comprehensive risk assessment protocol; and

3. Patient education and support services.

(c) The MCHC shall develop and implement a system for discharge planning, infant follow-up and child health care coordination in the MCHC region. This system shall assure post-discharge continuity of care and shall be linked to needed resources, such as:

1. Primary care services for all children in need of a primary care provider;

2. Referral to follow-up services for high risk infants which includes referral to high risk infant screening and tracking programs as appropriate;

3. Case management provided in coordination with Special Child Health Services County Case Management Units, as appropriate;

4. Public health nursing for home follow-up; and

5. Counseling services to parents, especially those experiencing perinatal or infant loss including, when appropriate, referral to the Sudden Infant Death Syndrome Resource Center established under N.J.S.A. 52:17B-88.

(d) The MCHC in conjunction with the designated Regional Perinatal Center shall coordinate and monitor the regional maternal and neonatal transport system. This system shall include written policies and procedures for the triage of mothers and/or infants to the most appropriate level of care in accordance with formal letters of agreement.

(e) The MCHC shall provide or coordinate on-going area wide professional education for all perinatal and pediatric service providers in the region, including at least regularly scheduled regional conferences. There shall be a mechanism for the annual assessment of the effectiveness of the regional education program.

(f) The MCHC shall establish a region-wide program for quality assurance which assures total quality improvement and includes regularly collecting and analyzing data to help identify health-service problems and their extent, and recommending, implementing, and monitoring corrective actions on the basis of these data. This program shall include, but not be limited to:

1. A uniform regional system for automated data collection;

2. Management by a specific subcommittee which shall meet at least quarterly;

3. Policies and procedures for collecting, abstracting and reporting data to the subcommittee for use in quality assurance activities; and

4. Criteria for review of perinatal and pediatric statistics and pathology, including, but not limited to, the following:

i. Transports with death;

ii. Non-compliance with rules regarding birth weight and gestational age;

iii. Cases in which no prenatal care was received;

iv. All maternal deaths;

v. All fetal deaths over 2500 grams not diagnosed as having known lethal anomalies;

vi. Selected pediatric deaths and/or adverse outcomes;

vii. Immunization of children two years of age in accordance with the provisions of N.J.A.C. 8:57 (Chapter 14 of the State Sanitary Code); and

viii. Admissions for ambulatory care sensitive diagnoses in children.

(g) Each consortium shall establish a committee of its members to resolve conflicts arising among consortium members or between a member and the consortium. The consortium shall establish policies and procedures for conflict resolution, including committee meeting times and composition, what constitutes a conflict of interest, and provision that:

1. Any facility or group of facilities affiliated with the Consortium may bring an issue for resolution to the committee.

2. The recommendations of the committee, if accepted by the parties, constitute the decision of the consortium. At the request of a party, the recommendations may be forwarded to the full board for consideration, as described in the consortium's policies and procedures.

3. Conflicts that are not resolved by the consortium to the satisfaction of all parties to the conflict may be referred to the Commissioner of Health for a recommendation. If the parties agree prior to the Commissioner's review, the decision will be binding.

8:35A-3.2 Compliance with laws and rules

(a) If the *[central service]* MCHC ***directly*** provides medical *[services and/]*or nursing services ***to patients*** *[directly in the MCHC]*, the *[central service]* MCHC shall ***request prior approval from the Department. The MCHC shall*** meet the applicable sections of N.J.A.C. 8:43A, Manual of Standards for Licensure of Ambulatory Care Facilities.

(b) The MCHC shall comply with patient confidentiality requirements as specified in Hospital Licensing Standards, N.J.A.C. 8:43G-4.1(a)21. The MCHC shall assure that all patient care records it possesses will be kept confidential. Information in the patient's records shall not be released to anyone outside the MCHC without the patient's approval, unless another health care facility to which the patient was transferred requires the information, or unless the release of the information is required and permitted by law, a third-party payment contract, a medical peer review, or the New Jersey State Department of Health. The MCHC may release data about the patient for studies containing aggregated statistics when the patient's identity is masked.

(c) The MCHC shall comply with applicable Federal, State, and local laws, rules, and regulations.

8:35A-3.3 Ownership

(a) The ownership of the MCHC and the property on which it is located shall be disclosed to the Department. Proof of this ownership shall be available in the MCHC. Any proposed change

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in ownership shall be reported to the Director of the Licensing and Certification Program of the Department in writing at least 30 days prior to the change and in conformance with requirements for Certificate of Need applications.

(b) No MCHC shall be owned, managed, or operated by any person convicted of a crime relating adversely to the person's capability of owning, managing, or operating the MCHC.

8:35A-3.4 Submission of documents and data

(a) The MCHC shall, upon request, submit in writing any documents which are required by the rules in this chapter to the Director of the Licensing and Certification Program of the Department, including formal letters of agreement from the member facilities of the MCHC region.

(b) The MCHC shall maintain and submit to the Department statistical data as required by the Department pursuant to the Administrative Procedure Act and N.J.A.C. 1:30.

8:35A-3.5 Policy and procedure manual

(a) A policy and procedure manual(s) for the organization and operation of the MCHC shall be developed, implemented, and reviewed at intervals specified in the manual(s). Each review of the manual(s) shall be documented, and the manual(s) shall be available in the MCHC to representatives of the Department at all times. The manual(s) shall include at least the following:

1. A written statement describing the MCHC's objectives and the services provided by the MCHC;

2. An organizational chart delineating the lines of authority, responsibility, and accountability for the administration of the MCHC;

3. Definition and specification of business hours, hours of operation, and full working week;

4. A system for referral of patients to sources of secondary and tertiary health care; and

5. Policies and procedures for the maintenance of personnel records for each employee, including, at a minimum, the employee's name, previous employment, educational background, credentials, license number with effective date and date of expiration (if applicable), certification (if applicable), verification of credentials, records of physical examinations, job description, records of staff orientation and staff education, and evaluations of job performance.

(b) The policy and procedure manual(s) shall be available and accessible to all staff and the public.

8:35A-3.6 Reportable events

The MCHC shall report to the Department of Health the termination of employment of the administrator/executive director, and the name and qualifications of the administrator's replacement, within seven days of the termination.

8:35A-3.7 Notices

(a) The MCHC shall conspicuously post a notice that the following information is available in the facility during business hours to patients and the public:

1. All waivers granted by the Department;

2. The list of deficiencies from the last annual licensure inspection and certification survey report (if applicable), and the list of deficiencies from any valid complaint investigation during the past 12 months;

3. The names and addresses of the members of the governing authority; and

4. The hours of operation and the business hours of the MCHC.

SUBCHAPTER 4. GOVERNING AUTHORITY

8:35A-4.1 Responsibility of the governing authority

(a) The MCHC shall have a governing authority, appointed in accordance with N.J.A.C. 8:33C, which shall assume legal responsibility for the management, operation, and financial viability of the MCHC. The governing authority shall be responsible for, but not limited to, the following:

1. Adoption and documented review of written bylaws, or their equivalent, in accordance with a schedule established by the governing authority;

2. Development and documented review of all policies and procedures, in accordance with a schedule established by the governing authority;

3. Establishment and implementation of a system whereby patient and staff grievances and/or recommendations, including those relating to patient rights, can be identified. This system shall include a feedback mechanism through management to the governing authority, indicating what action was taken;

4. Determination of the frequency of meetings of the governing authority and its committees, or equivalent, conducting such meetings, and documenting them through minutes;

5. Delineation of the duties of the officers of any committees, or equivalent, of the governing authority. When the governing authority establishes committees, their purpose, structure, responsibilities, and authority, and the relationship of the committee to other entities within the MCHC, shall be documented; and

6. Establishment of the qualifications of members and officers of the governing authority, the procedures for electing and appointing officers, and the terms of service for members, officers, and committee chairpersons or equivalent.

SUBCHAPTER 5. ADMINISTRATION

8:35A-5.1 Appointment of administrator/executive director

The governing authority shall appoint an administrator or executive director who shall be accountable to the governing authority.

8:35A-5.2 Administrator/executive director's responsibilities

(a) The administrator shall be responsible for, but not limited to, the following:

1. Planning for, and administration of, the managerial, operational, fiscal, and reporting components of the MCHC as determined by the governing authority; and

2. Establishing and maintaining liaison relationships and communication with MCHC staff and services, with support services and community resources, and with patients.

8:35A-5.3 Staff qualifications

(a) Each MCHC shall have:

1. An administrator/executive director who has a master's degree and at least three years of administrative or supervisory experience in health care planning or administration or financing, at least one year of which shall have been in maternal and child health services; and

2. A registered professional nurse with a master's degree in nursing, public health or administration from an accredited college or university and certification by the National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties or the American Nurses Association, and two years of experience in clinical maternal and child nursing.

(a)

DIVISION OF HEALTH FACILITIES EVALUATION

Hospital Licensing Standards
Obstetric Licensing Standards
Adopted Amendments: N.J.A.C. 8:43G-19

Proposed: June 1, 1992 at 24 N.J.R. 2045(a).

Adopted: August 14, 1992 by Frances J. Dunston, M.D., M.P.H., Commissioner, Department of Health (with approval of the Health Care Administration Board).

Filed: August 17, 1992 as R.1992 d.347, **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 26:2H-5.

Effective Date: September 8, 1992.

Expiration Date: February 5, 1995.

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Summary of Public Comments and Agency Responses:

The Department received, in total, 33 letters of public comment. The identity of the commenters follows:

Seven letters were received from physicians: Dr. Gerson Weiss of the University of Medicine & Dentistry of New Jersey, Dr. Harold Perl of Hackensack Medical Center, Dr. Skolnick of Morristown Memorial Hospital, Dr. Frisoli of Overlook Hospital, Dr. Michael Graff of Jersey Shore Medical Center, Dr. Thomas Potter of St. Joseph Hospital and Medical Center and Dr. Michael Musci, Jr. at Rancocas Hospital.

Twenty-three letters were received from hospitals: Newark Beth Israel Medical Center, Columbus Hospital, Hackensack Medical Center, Hackettstown Community Hospital, Holy Name Hospital, Jersey City Medical Center, Jersey Shore Medical Center, The Medical Center at Princeton, Memorial Hospital of Burlington County, Morristown Memorial Hospital, Our Lady of Lourdes Medical Center, Overlook Hospital, Rancocas Hospital, Raritan Bay Medical Center, Robert Wood Johnson University Hospital, Saint Barnabas Medical Center, St. Elizabeth Hospital, St. Joseph's Hospital and Medical Center, Somerset Medical Center, South Jersey Hospital System, University Health System of New Jersey and Valley Hospital.

Three letters were received from the following organizations: Gateway Maternal and Child Health Consortium, Northwest New Jersey Regional Perinatal Network, and the Southern New Jersey Perinatal Cooperative.

COMMENT: South Jersey Hospital System noted that patient rights were not addressed in the rules and would like clarity as to the right of patients to select an intensive perinatal service provider located in a state other than New Jersey.

RESPONSE: The Department directs the commenter to N.J.A.C. 8:43G-4, Patient Rights in the Licensing Standards for Hospitals, which sets forth the rights of every New Jersey hospital patient. The Department recognizes the rights of patients to seek alternative treatment in a health care facility of their choice, but emphasizes its belief that the regionalized perinatal system in New Jersey is designed to deliver the highest quality of care. The rules do not abridge this fundamental right of patients to seek care wherever they wish, but are intended to foster a system of care that benefits all New Jersey residents.

COMMENT: Dr. Gerson Weiss of the University of Medicine & Dentistry of New Jersey (UMDNJ) criticized the rules for not addressing means to prevent low birth weight babies, such as the identification and treatment of high risk patients early in their pregnancy. Dr. Weiss strongly recommended that each Regional Perinatal Center be required to provide high risk specialty obstetrical clinics with appropriate social services and out-reach programs.

RESPONSE: The Department agrees that the perinatal system must be designed to accomplish the goals outlined, but reminds the commenter that the rules in N.J.A.C. 8:43G-19 apply only to inpatient obstetric services. As such, they are intended to assure the high quality of care delivered in hospital facilities throughout New Jersey. The amendments being adopted are one component of the Department's planned regionalized network of perinatal services.

The critical issues identified by Dr. Weiss are discussed in detail in N.J.A.C. 8:33C, Certificate of Need—Regionalized Perinatal Services (see 24 N.J.R. 2005(a) and notice of adoption published elsewhere in this issue of the New Jersey Register). These rules require the establishment of a prevention plan for each Maternal and Child Health Service Region. The prevention plan describes both clinical (inpatient and ambulatory) and non-clinical services targeted at the reduction of behaviorally based perinatal problems.

N.J.A.C. 8:43G-19.1 Definitions

COMMENT: Comments were received noting that a definition of "clinical nurse coordinator" was not found in this section. Commenters also advised the Department that the definition of "nurse manager" was identical to that used to define "clinical nurse coordinator" in N.J.A.C. 8:33C, Certificate of Need: Regionalized Perinatal Services. Newark Beth Israel Medical Center and the Gateway Maternal and Child Health Consortium recommended elaboration of the clinical nurse specialist's responsibilities for regional education.

RESPONSE: The Department apologizes for omission of the term "clinical nurse coordinator" from this section and makes the necessary addition. Additionally, the Department eliminates the term "nurse manager," as this term is not used in these rules, and adds registered nurse manager.

The Department chooses not to delineate the regional educational responsibilities of the clinical nurse specialist, as it believes these responsibilities should reflect the needs of the Maternal and Child Health Service Region and should therefore be determined by the Regional Perinatal Center and the Maternal Child Health Consortium.

N.J.A.C. 8:43G-19.3 Obstetric staff qualifications

COMMENT: Numerous hospitals expressed concern about the staff qualifications set forth in this section. There was particular concern regarding the requirement for experience in specific service areas. Several commenters believed the service areas should be presented as alternatives and also commented that pediatrics was not included among the areas identified in the rule. St. Elizabeth Hospital requested clarification of the term "combined experience." Elizabeth General Medical Center asked the identity of the national nursing education accrediting body identified in the rules. Morristown Memorial Hospital found the phrase "date of application" unclear and inquired whether the phrase "date of appointment" would be preferable language.

RESPONSE: The Department concurs that the proposed educational and experience requirements were unduly restrictive. Although the Department has made no change to the number of years of experience required, it has amended the rules to no longer identify specific service areas. In its place, the Department calls for experience in "Maternal and Child Health inpatient services," thereby providing the flexibility requested by the commenters. This change also ensures recognition of experience in pediatrics and eliminates use of the term "combined experience." The national nursing education accrediting body referred to in the rule is the National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties or the American Nurses Association. The Department accepts the commenter's suggestion for replacement of the phrase "date of application" with "date of appointment." In keeping with the Department's reconsideration of the proposed staffing qualifications, it further revises the rules to make the education preparation requirements more consistent with the designation of the Community Perinatal Center. The Department replaces the broad phrase "Educational preparation in maternal-fetal and neonatal services in accordance with hospital policy" as found at N.J.A.C. 8:43G-19.3(d)2 and (e)2 with a requirement for the completion of a continuing education course in maternal-fetal or neonatal nursing. This requirement was originally proposed for Community Perinatal Center(s)—Basic and received no comment during the public comment period. In reviewing this requirement, the Department recognized that it also represented a minimum requirement for hospitals designated as a Community Perinatal Center—Intermediate or Intensive and revises the rule accordingly.

COMMENT: The Southern New Jersey Perinatal Cooperative urged the Department to consider the option of in-house coverage by Neonatal Nurse Practitioners, as soon as the rules concerning nurse practitioners are promulgated by the Department of Law and Public Safety.

RESPONSE: The Department is willing to consider amendments to the rules, but is unable to do so until licensing rules for neonatal nurse practitioners are promulgated.

N.J.A.C. 8:43G-19.3(b)

COMMENT: Memorial Hospital of Burlington expressed concern that the language of this rule could be interpreted so as to apply to all obstetric nurses and recommended inclusion of the phrase "at least" for clarity.

RESPONSE: The Department does not agree that the language of the rule needs revision and encourages the commenter to note that the rule refers to "a" full-time nurse, with responsibility for all nursing care on the inpatient obstetric service.

N.J.A.C. 8:43G-19.3(d)

COMMENT: Several commenters objected to the requirement for unit nurse managers. Somerset Medical Center recommended replacing the term "unit nurse manager" with "Maternal Child Nurse Manager" or "Maternal Child Health Department Nurse Manager." The commenter felt the term "unit nurse manager" did not reflect the efforts made to empower staff nurses. In comparing staff qualifications for unit nurse managers and perinatal clinical nurse specialists, Columbus Hospital commented that it is more important for the clinical nurse specialist to be experienced in all areas of obstetrics than it is for the unit nurse manager. Dover General Hospital commented that nurses functioning in an administrative capacity should not be required to have three years experience or continuing education courses in a clinical nursing area.

RESPONSE: The Department has reconsidered its decision to prescribe specific qualifications for unit nurse managers assigned to the obstetric service. The requirement for a registered nurse manager for

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each patient unit has already been established by the Department at N.J.A.C. 8:43G-17.1(b). The Department continues to permit N.J.A.C. 8:43G-17.1(b) to prevail for all patient care units, and therefore eliminates reference to unit nurse managers in these rules.

The Department, nonetheless, maintains its belief that at least one individual, possessing the qualifications set forth in this rule, should be assigned to the service. For this reason, the Department retains the staff qualifications set forth but no longer requires that this individual be designated as a unit nurse manager. The Department identifies this individual as an administrative nurse coordinator, and provides flexiblity for this individual to also function as the registered nurse manager at 8:43G-17.1(b). The Department also clarifies that this rule applies to Community Perinatal Centers—Intensive and Regional Perinatal Centers and allows the individual filling this position at Community Perinatal Center (Intermediates) to be assigned clinical responsibility for nursing care. Lastly, the Department adds the term "administrative nurse coordinator" to N.J.A.C. 8:43G-19.1.

N.J.A.C. 8:43G-19.3(e)

COMMENT: Our Lady of Lourdes commented that the requirement for a "clinical nurse coordinator" is unwarranted in light of the responsibilities of unit nurse managers and only serves to add an unnecessary tier of nursing management. Several commenters objected to the requirement for one year of neonatal intensive care experience. The Southern New Jersey Perinatal Cooperative believed such a requirement could lead to these positions being preferentially filled by nurses with only neonatal intensive care experience.

RESPONSE: The Department does not agree that unit nurse managers eliminate the need for a clinical nurse coordinator at Community Perinatal Centers—Intensive and Regional Perinatal Center(s). However, in view of the additional requirement at subsection (f) for a perinatal clinical nurse specialist, the Department eliminates the potentially duplicative position of clinical nurse coordinator for Regional Perinatal Centers. The Department acknowledges the commenter's concern regarding the requirement for one year of clinical neonatal intensive care experience, but believes such a requirement is appropriate for hospitals choosing to be designated as a Community Perinatal Center—Intensive. The Department strongly believes the requirement for clinical neonatal intensive care experience is reflective of the level of nursing experience and expertise needed for providing adequate and appropriate care to the neonates who will need the services of such facilities.

N.J.A.C. 8:43G-19.3(f)

COMMENT: The Southern Jersey Perinatal Cooperative asked that the rule be made more flexible to allow Perinatal Clinical Nurse Specialists to obtain NCC or ANA certification within one year of appointment, since exams are given no more than twice a year. The commenter also noted that it is not necessary to delineate experience requirements, in light of the requirement for NCC or ANA certification. The Northwest New Jersey Regional Perinatal Network commented that the qualifications set forth may preclude unit nurse managers from being promoted into this position. Memorial Hospital of Burlington suggested inclusion of a grandfathering provision and recommended broadening the requirements to include a master's degree in business or health care administration as well as in nursing.

RESPONSE: The Department acknowledges the concern regarding certification and has revised the rule to delay the implementation of this particular requirement until October 1, 1993. The Department believes this revision provides perinatal clinical nurse specialists with sufficient notice of the need to secure certification. The Department has retained the experience requirements delineated in the rule, as they specify that two of the five years of experience must have been served in an educational capacity. While the Department has eliminated reference to unit nurse managers in these rules, it nonetheless asserts that perinatal clinical nurse specialists have more extensive responsibilities than unit nurse managers and the qualifications set forth are commensurate with that level of responsibility. The Department does not believe that a master's degree in business or administration is appropriate educational preparation for clinical positions, and, therefore, has not made the requested change.

N.J.A.C. 8:43G-19.4(d) Obstetrics staff time and availability

COMMENT: St. Joseph's Hospital and Medical Center stated that board eligible obstetricians should not be precluded from fulfilling this requirement and noted that the term "obstetrician" was defined as "Board certified or eligible" in the definition section of N.J.A.C. 8:33C. Morristown Memorial Hospital commented on the cost of requiring a board certified obstetrician to be present at all times in a Regional Perinatal Center and stated that it should be sufficient for this individual to be available by telephone and able to arrive at the hospital within a specified time period.

RESPONSE: The Department agrees that limiting this position to board certified obstetricians is too restrictive and amends the language to permit "board eligible or certified obstetricians." With respect to the comment regarding the availability of this individual, the Department maintains its position that Regional Perinatal Centers should have 24 hour in-house coverage and, therefore, does not accept the commenter's request to eliminate the requirement for this individual to be present in the hospital and to substitute a requirement that the individual be available by telephone and able to reach the Center within a specified period of time.

N.J.A.C. 8:43G-19.6 Maternal-fetal transport and neonatal transport

COMMENT: Somerset Medical Center requested clarification of the requirement to transfer infants requiring "major surgery and other highly specialized services" found at N.J.A.C. 8:43G-19.6(e), and stated that surgical procedures have been appropriately and successfully performed on neonates at the hospital. Elizabeth General Medical Center requested a definition of major surgery and other highly-specialized services. Dr. Thomas Potter, Chairman of the Department of Pediatrics at St. Joseph's Hospital and Medical Center, stated that any neonatal surgery performed at a CPC—Intensive should be done in consultation with the RPC.

RESPONSE: The Department cannot specify, in a licensing rule, which individual surgical procedures are deemed to constitute major surgery. General criteria for major surgery are established by the New Jersey Board of Medical Examiners at N.J.A.C. 13:35-4.1, and each hospital should establish its definition of services permitted to be provided by its medical staff in bylaws or policies and procedures, in consideration of the safety of newborns and the professional standard of care. In addition, the Maternal and Child Health Consortia will develop a regional plan identifying service capabilities and responsibilities and transfer agreements will be based upon the regional assessment of a hospital's role in performing major surgery and other highly-specialized services.

COMMENT: Two commenters asked for information regarding the reimbursement mechanism for maternal-fetal and neonatal transport systems, particularly related to the portion of the costs not reimbursable from other sources such as depreciation, insurance, maintenance of the vehicle and staff time from the Regional Perinatal Center.

RESPONSE: The Department acknowledges the commenter's concerns regarding reimbursement but advises the commenter that the issue of reimbursement is beyond the scope of hospital licensing rules.

N.J.A.C. 8:43G-19.6(d)

COMMENT: St. Joseph's objected to permitting Community Perinatal Centers—Intensive to accept transports and stated that this is a regional responsibility and should, therefore, be restricted to Regional Perinatal Centers. The commenter cautioned that enabling Community Perinatal Centers—Intensive to accept transfers may lead to a situation where suburban populations are only, or primarily, treated in suburban hospitals, thereby leaving the poor or medically indigent as the exclusive province of inner city facilities. Dr. Potter also agreed that Community Perinatal Centers—Intensive should be precluded from accepting transfers.

RESPONSE: The Department advises the commenter that while these rules acknowledge the capability of Community Perinatal Centers—Intensive to accept neonatal transports, they do not speak to the role of individual CPCs—Intensive in a regional neonatal transport system. As set forth in N.J.A.C. 8:33C, the neonatal transport system developed for maternal and child health regions must be based upon an assessment of the needs of the individual region. The role of Community Perinatal Centers—Intensive in this system would be determined after a regional assessment was conducted. If it was determined that a Community Perinatal Center—Intensive should accept neonatal transports, N.J.A.C. 8:33C requires that there be documentation in the regional perinatal plan and delineation of this responsibility in the hospital's letter of agreement with the Regional Perinatal Center. Additionally, the transfer agreement would have to be developed in cooperation with the Maternal and Child Health Consortium. In order to ensure that this process is understood by all facilities, the Department has revised this licensing rule by specifying that Consortiums participate in the development of transfer agreements.

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N.J.A.C. 8:43G-19.19(c) Newborn care staff time and availability

COMMENT: Elizabeth General Medical Center stated that the 1:8 ratio for the basic nursery would be cost-prohibitive. The commenter suggested replication of a national standard which requires "one RN in the nursery and one caregiver to every six babies." St. Elizabeth Hospital questioned whether the 1:8 ratio applied to mother-baby dyads.

RESPONSE: The Department acknowledges the need for recognition of caregivers in the basic nursery. The Department has amended the rule on adoption to specify that licensed practical nurses may be included as staff in the nurse:infant ratio, as long as there is one registered professional nurse in the nursery whenever an infant is present. The 1:8 ratio does not include mothers, since they are not staff but are patients.

N.J.A.C. 8:43G-19.19(e)

COMMENT: Several commenters objected to the 1:3 ratio specified for intermediate nurseries and commented that infant acuity levels for individual infants in the nurseries should be the determinant of staffing needs. Dover General Hospital commented that a 1:3 ratio is too high because the majority of infants in an intermediate nursery are full term, well babies and suggested adjusting the ratio so that it fell more evenly between the basic requirement of 1:8 and the intensive requirement of 1:2. Newark Beth Israel Medical Center and the Gateway Maternal and Child Health Consortium recommended changing the ratio to 1:4.

RESPONSE: The Department has reconsidered this requirement in light of the comments received and reduces the ratio from 1:3 to 1:4. The Department further asserts that it is more appropriate, as well as cost effective, for full term well babies to be cared for in basic nurseries than in intermediate nurseries.

N.J.A.C. 8:43G-19.19(f)

COMMENT: Numerous hospitals and individual neonatalogists objected to this requirement and commented that a board-eligible or certified neonatologist should be available around the clock, but his or her mandated presence in the hospital is unnecessary, if there are other well-trained individuals at hand. Commenters emphasized that neonatologists are highly trained sub-specialists who command an income which would preclude most hospitals from affording 24-hour a day coverage. Dr. Harold Perl of Hackensack Medical Center stated that the pool of pediatricians who would fulfill this criteria is limited, thus making it impossible for each neonatal intensive care unit in New Jersey to have 24-hour in-house coverage. Dr. Skolnick of Morristown Memorial Hospital questioned why the Department singled out the particular subspecialty of neonatology for 24-hour presence in a hospital, given that it did not require the same of subspecialists for patients recovering from cardiac surgery, neurosurgery, and multiple trauma. Commenters questioned why the Department included a provision for a pediatrician with one year of training in neonatology, given that the training program in neonatal medicine entails a three-year fellowship.

RESPONSE: Upon publication of the proposed rules, the Department acknowledged that there would be much public comment with respect to this requirement, as well as several other clinical issues addressed in the proposal. In anticipation of the comments, the Health Care Administration Board requested the Department to seek opinions from national experts. (See Table 1 of Comments and Responses.) The Department contracted prominent physicians from institutions such as Michigan State University, Dartmouth-Hitchcock Medical Center and Baby's Hospital in New York City. Based upon advice from these individuals and recommendations from *Guidelines to Perinatal Care,* the Department has made several changes. The qualifications in this rule are being made more flexible to allow a board eligible or certified pediatrician with training and experience in neonatal medicine to fulfill this position. The Department has eliminated the requirement for one year of training in neonatology. The Department has made a similar revision at N.J.A.C. 8:43G-19.19(d), with respect to the physician coverage of intermediate nurseries. The requirement for "certification and/or one year training in neonatology" is replaced by the phrase "certification and/or training and experience in neonatal medicine."

COMMENTS: Commenters objected to the requirements by designated facility in the Summary which discussed facility, staffing and task capability on a matrix, as follows: Nine commenters stated that a Community Perinatal Center (CPC)-Intermediate should not be allowed to maintain infants on ventilators as long as five days. Other comments offered specific language concerning the education and experience of pediatricians, citing that the current rule specifies one year of neonatal medicine, which does not accurately reflect the training requirements for either a pediatric residency or neonatal fellowship. Comment was also received regarding the requirements for obstetric certifications. Rancocas Hospital commented that a CPC-Intermediate should be allowed to provide Total Parenteral Nutrition (TPN) but that these facilities should have in-house physicians if ventilating infants. Children's Hospital of New Jersey stated that the rules need clarifying regarding in-house physician coverage whenever an infant is on a ventilator. Two commenters request that any hospital that wishes to provide major specialized perinatal services such as ventilatory support, transport, etc., should be required to provide appropriate levels of manpower including neonatologists, perinatologists, and other professional staff. They also recommend volume requirements be specified. One commenter strongly opposed that the CPC-Intensive be allowed to establish a neonatal transport team. The same commenter recommends the use of second and third year residents for in-house coverage of neonatal intensive care units in academic institutions with pediatric residency programs.

RESPONSE: In order to respond to the clinical issues raised by many commenters, and at the request of the Health Care Administration Board, the Department requested the opinion of national experts, and has delineated these opinions in Table 1, following:

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TABLE I

NATIONAL COMMENT	CPC—INTERMEDIATE ISSUES		CPC—INTENSIVE AND RPC ISSUES
	Ventilatory Support	TPN	Neonatology Coverage In-House
Guidelines for Perinatal Care, Third Edition, published by AAP and ACOG	Not beyond the emergency period without adequate personnel with expertise, and equipment	Not specified for a particular level; instead describes the skills needed to manage infants	Neonatologist available 24 hrs. per day for consultation; Personnel qualified to handle neonatal emergencies must be in-house
John Discroll, M.D. Acting Director of Pediatric Services Baby's Hospital New York City, N.Y. (Ref. by AAP Nat'l)	No more than 48 hrs.	Only intensive care	Attending pediatrician or neonatal fellow; no residents
Nigel Paneth, M.D. Director, College of Human Medicine, Michigan State University	No more than 48 hrs.	Only intensive care	Neonatologist or 1st year fellow; no residents
George Little, M.D. Director of Maternal and Child Health Dartmouth-Hitchcock Medical Center	No more than 48 hrs.	Only intensive care	Standard team—resident and attending; at a minimum, someone in-house who can reintubate
David E. Gagnon Executive Director, National Perinatal Information Center	Opposes regulations		
John Hartline, M.D. Director of Neonatology, Brown Methodist Kalamazoo, Michigan	Not beyond stabilization	Only intensive care	Neonatologist; no residents
Jeffrey Pomerance, M.D., Director of Neonatology, Cedars Sinai, Los Angeles, Ca.	Not beyond stabilization	Not addressed	Neonatologist; neonatal fellow or pediatrician with post-graduate training when infant is unstable
David Wells, M.D. Co-Director Neonatal Care Program, Greenville Hospital System Greenville, S.C.	Not beyond stabilization; separate CPAP; CPAP ok at intermediate	Yes, at intermediate	Residents and/or neonatal nurse practitioner with neonatalogist readily available
State of California Department of Health Services	No more than 4 hours	Not addressed	Neonatologist; neonatal fellow or pediatrician with post-graduate training when infant is unstable

Table 1 supports the position of limiting ventilatory support in an intermediate facility to a period of time which is less than 48 hours, excluding intermediate facilities from providing total parenteral nutrition (TPN), and also requiring appropriate physician coverage whenever infants are on ventilators. The Accreditation Council for Graduate Medical Education was contacted to clarify the experience requirements for pediatricians. In addition to N.J.A.C. 8:33C, N.J.A.C. 8:43G-19, Hospital Licensing Standards for Inpatient Obstetric Services, does specify minimum requirements for staffing at intensive facilities. Volume has not been utilized exclusively within the rules because the goal of the Department is to reduce low birthweight outcomes. N.J.A.C. 8:33C-7.2(b) (and 8:43G-19.19(f) and 19.20(b)2) will be amended to reflect the concensus of national and State opinions. As for the issue of the neonatal transport team, the Perinatal Technical Advisory Committee (PTAC) recommended that more flexibility be built into the perinatal system because of increases in medical technology. The response to this issue is more fully addressed in the adoption of N.J.A.C. 8:33C-10.2, published in this issue of the New Jersey Register.

8:43G-19.20 Newborn care patient services

COMMENT: Several commenters objected to the service restrictions set forth for Community Perinatal Centers (CPCs) and believed that gestational age and weight parameters should be delineated in the agreement with the Regional Perinatal Center, rather than prescribed by the Department. Many commenters believed that exclusive reliance on age and weight parameters was too restrictive and stated that the condition of the neonate should also be a consideration. These commenters explained that it is possible for neonates to be born below the specified parameters and, at the same time, to be developmentally mature. South Jersey Hospital System asked for some degree of flexibility with respect to the weight and gestational age parameters and expressed

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concern about the possibility of reimbursement being denied for deliveries which were not within the parameters.

RESPONSE: While the Department retains the gestational age and weight criteria and maintains its belief that they represent reasonable and medically appropriate guidelines, it also recognizes that not all infants born below these parameters are necessarily in need of services provided in higher level facilities. The Department believes the neonates who most commonly fall into this category are born at Community Perinatal Centers—Basic and, to a lesser degree, at Community Perinatal Centers—Intermediate. In an attempt to be responsive to this situation, the Department has amended the rules to permit Community Perinatal Centers designated as Basic or Intermediate to provide care to infants born in the facility who are below the specified parameters only if the following two conditions are met: one, the infant does not require a higher level of care than permitted to be provided by the facility, and two, the medical record includes documentation that the birth was expected to fall within the age and weight parameter's identified for the facility. The language at N.J.A.C. 8:43G-19.20(b) 1 and 2 has been revised accordingly.

COMMENT: Dr. Frisoli, Director of Perinatology at Overlook Hospital, commented that greater flexibility should be allowed for community perinatal centers to provide a level of care for which they have demonstrated capability even though all criteria for the higher level designation may not be met. Dr. Frisoli specifically requested that CPCs—Intensive be provided the option to accept maternal transports, provide care to neonates less than 1000 grams or 28 weeks gestation and provide neonatal surgery. St. Elizabeth Hospital asked whether CPCs—Intermediate could be permitted to include specific categories of sick neonates if agreed upon by the Regional Perinatal Center, for example, 30-week neonates who need ventilator support, but remain stable.

RESPONSE: The Department directs the commenters to N.J.A.C. 8:33C, Certificate of Need: Regionalized Perinatal Services, which requires the development of letters of agreement between each Community Perinatal Center and the Regional Perinatal Center as to the scope of services to be provided by each facility. The Department advises the commenters to direct their requests for flexibility to the Regional Perinatal Center, but emphasizes that in no instance shall a Community Perinatal Center—Intensive be permitted to provide a service that is prohibited in the rules, such as accepting maternal transports.

COMMENT: Dr. Michael Graff of Jersey Shore Medical Center and Dr. Thomas Potter questioned the ability of CPCs—Intermediate to provide ventilator care for a period longer than 24 hours and believed that infants requiring ventilator support beyond this timeframe, or who required artificial surfactant, should be transferred to a Regional Perinatal Center. Numerous commenters stated that CPCs—Intermediate should be required to have more highly trained staff, if permitted to provide ventilator support beyond stabilization. The commenters believed that, at a minimum, trained respiratory therapists and in-house physician coverage should be required. Southern New Jersey Perinatal Cooperative believed coverage should be provided by a board-eligible or certified neonatologist, rather than a pediatrician with one year of neonatal training. Somerset Medical Center asked about guidelines to authorize retention of neonates who demonstrate improved clinical condition but continue to require mechanical ventilator support beyond the five-day period. Southern New Jersey Perinatal Cooperative believed the language of the rule should be revised to permit CPCs—Intermediate to obtain authorization from the neonatologist at the CPC—Intensive, as well as Regional Perinatal Center, given that the CPCs—Intensive will have the option of receiving neonatal transports.

RESPONSE: The provision of "short-term" ventilator support by Community Perinatal Centers—Intermediate was one of the clinical issues presented to the national experts as indicated on Table 1 of the adoption of N.J.A.C. 8:33C, published in this issue of the New Jersey Register, for their advice and guidance. After considerable debate, it was determined that "short-term" support should be limited to a length of time not to exceed 48 hours. It was felt that, for neonates who continued to require ventilatory support in excess of 48 hours, the medical specialists and resources available in higher level facilities should be readily available. The Department has revised the rule by replacing the time-frame "five cumulative days" with 48 hours. The Department also has expanded the conditions to be met if a Community Perinatal Center—Intermediate seeks to retain an infant longer than 48 hours. The Department has added a requirement for the Center to have the ability to intubate and to hourly monitor the partial pressure of oxygen in the neonate's blood. Additionally, authorization from the neonatologist on-call at the Regional Perinatal Center must be obtained on a daily basis. The language of the rule has been revised to incorporate these requirements. With respect to the commenter's request to include reference to Community Perinatal Centers—Intensive, the Department defers to the Regional Perinatal Center and Maternal Child Health Consortium for each region with respect to the responsibilities of Community Perinatal Centers—Intensive in the regional neonate transport system.

COMMENT: Holy Name Hospital, Somerset Medical Center, Robert Wood Johnson University Hospital and Dr. Michael Musci, Jr., a neonatologist at Rancocas Hospital, commented that CPCs—Intermediate are capable of providing total parenteral nutrition (TPN) therapy. One commenter added that, in order to provide parenteral nutrition therapy, the intermediate nursery should establish policies and a neonatologist should be available to make daily rounds. Somerset Medical Center opposed mandatory transfer of neonates who require TPN and cautioned that such a requirement would overburden Regional Perinatal Centers, as well as place a hardship on parents, who would have to travel a greater distance. Dr. Musci commented that it is incongruous to permit CPCs—Intermediate to ventilate infants but not provide neonatal TPN. Dr. Potter stated that CPCs should not provide TPN for more than 72 hours and that TPN should be provided in consultation with the Regional Perinatal Center.

RESPONSE: Based on opinion from national experts the Department has made no change to the restrictions in place with respect to the provision of total parenteral nutrition.

Summary of Agency-Initiated Changes:

The Department has included reference to Maternal and Child Health Consortiums at N.J.A.C. 8:43G-19.6(d). A definition of this term has been added at N.J.A.C. 8:43G-19.1(b). The Department has made a correction to N.J.A.C. 8:43G-19.20(d), with respect to the gestational age parameter for Community Perinatal Centers—Intensive. The parameter was incorrectly identified as 36 weeks in the proposal and is changed to 28 weeks. This change has no impact on these rules, but serves to make this parameter consistent with that correctly delineated for Community Perinatal Center—Intensive in the definition section, N.J.A.C. 8:43G-19.1(b).

Full text of the adoption follows (additions to the proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

SUBCHAPTER 19. OBSTETRICS

8:43G-19.1 Scope of obstetric standards; definitions

(a) The standards in this subchapter shall apply only to hospitals that have a separate, designated unit or service for obstetrics.

(b) The following terms, when used in this subchapter, shall have the following meanings.

***"Administrative nurse coordinator" means a registered professional nurse currently licensed by the New Jersey State Board of Nursing, who has administrative responsibility over the areas of labor and delivery, recovery, newborn nurseries and postpartum and antepartum.**

"Clinical nurse coordinator" means a registered professional nurse currently licensed by the New Jersey State Board of Nursing, who has clinical responsibility over the areas of labor and delivery, recovery, newborn nurseries and postpartum and antepartum.*

"Community Perinatal Center" means a licensed hospital designated within a Maternal and Child Health Service Region as one of the following:

1. "Basic" provides *[services primarily for]* ***care to*** uncomplicated maternity and normal newborn patients in accordance with the scope of functions delineated in its formal letter of agreement with the Regional Perinatal Center. Such a facility shall provide care to patients expected to deliver neonates greater than 2499 grams and 36 weeks gestation.

2. "Intermediate" provides care to complicated maternity patients and neonates in accordance with the scope of functions delineated in its formal letter of agreement with the Regional Perinatal Center. Such a facility shall provide care to patients expected to deliver neonates greater than 1499 grams and 32 weeks gestation.

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3. "Intensive" *[means a licensed hospital which]* provides care to complicated maternity patients and neonates in accordance with the scope of functions delineated in its letter of agreement with the hospital and the Regional Perinatal Center. Such a facility shall provide care to patients expected to deliver neonates greater than 999 grams and 28 weeks gestation.

["Inpatient obstetrics"] ***"Maternal and child health inpatient services"*** means labor and delivery, postpartum *[and]***,* newborn care ***and pediatric*** services.

Maternal and Child Health Consortium (MCHC)" means a voluntarily formed non-profit organization, incorporated under Section 501(c)(3) of the United States Internal Revenue Code, consisting of all inpatient, ambulatory perinatal and pediatric care providers and related community organizations in a maternal and child health service region, licensed as a central service facility by the Department of Health.

"Maternal and Child Health Service Region" means the perinatal and pediatric service delivery area defined by the concept of cooperative network formation. Contained within each region is at least one Regional Perinatal Center, one Regional Pediatric Center and the balance, Community Perinatal and Pediatric Centers.

"Mechanical ventilatory support" means the application of positive pressure ventilation and oxygen through mechanical devices to include continuous positive airway pressure (CPAP).

["Nurse manager" means a registered professional nurse currently licensed by the New Jersey State Board of Nursing, who has administrative responsibility over the areas of labor and delivery, recovery, newborn nurseries and postpartum and antepartum.]

"Perinatal clinical nurse specialist" means a registered professional nurse currently licensed by the New Jersey State Board of Nursing with a master's degree in a maternal and child health nursing specialty from an accredited college or university. This individual is responsible for providing hospital and regional professional education and consultation.

"Regional Perinatal Center" means a licensed hospital which is the preferred provider of care to high risk mothers and high risk neonates in the maternal and child health region. Such a facility is responsible for providing consultation, referral, transport and follow-up to the region.

["Unit nurse 'manager" means a registered professional nurse currently licensed by the New Jersey State Board of Nursing who has administrative responsibility over an individual hospital care unit.]

8:43G-19.2 Obstetrics policies and procedures

(a)-(d) (No change.)

Recodify (f) as (e) (No change in text.)

8:43G-19.3 Obstetrics staff qualifications

(a) (No change.)

(b) The inpatient obstetric service ***in hospitals designated as a Community Perinatal Center-Basic*** shall have a full-time ***registered professional*** nurse, with clinical responsibility for all nursing care***.*** *[, who is a registered professional nurse and who has completed:]* ***This individual may function as the registered nurse manager required at N.J.A.C. 8:43G-17.1(b). The qualifications for this position include the following:***

1. A minimum of three years of experience in inpatient obstetric services within the five years immediately preceding the date of appointment; and

2. *[A continuing education course in maternal-fetal or neonatal nursing approved by a nationally recognized nurse education accrediting body.]* ***Educational preparation in maternal-fetal or neonatal nursing, in accordance with hospital policy.***

(c) (No change.)

(d) The obstetric service in a hospital designated as a Community Perinatal Center-Intermediate ***or Intensive and Regional Perinatal Centers*** shall have *[unit nurse managers who are registered professional nurses and who have:]* ***a registered professional nurse who functions as an administrative nurse coordinator with responsibility for all nursing care. This individual may also function as the registered nurse manager required at N.J.A.C. 8:43G-17.1(b). Additionally, this individual may be assigned clinical responsibility for all nursing care at Community Perinatal Centers-Intermediate. The qualifications for this position include:***

1. A minimum of three years of *[combined]* experience in *[labor and delivery, newborn nursery, postpartum and neonatal intermediate or intensive]* ***maternal and child health inpatient services"*** within the five years immediately preceding the date of *[application]* ***appointment***; and

2. *[Educational preparation in maternal-fetal and neonatal services in accordance with hospital policy.]* ***A continuing education course in maternal-fetal or neonatal nursing approved by a nationally recognized nurse education accrediting body.***

(e) The obstetric service in a hospital designated as a Community Perinatal Center-Intensive *[or a Regional Perinatal Center, in addition to the unit nurse managers identified in (d) above,]* shall have a clinical nurse coordinator who is a registered professional nurse and who has:

1. A minimum of five years experience in *[labor and delivery, postpartum, newborn nursery and neonatal intensive care]* ***maternal and child health inpatient services*** within the seven years immediately preceding the date of *[application]* ***appointment***. Of the five years minimum experience, at least one year shall have been in a supervisory capacity and one year shall have been in clinical neonatal intensive care; and

2. *[Educational preparation in maternal-fetal and neonatal services in accordance with hospital policy.]* ***A continuing education course in maternal-fetal or neonatal nursing approved by a nationally recognized nurse education accrediting body.***

(f) The obstetric service in hospitals designated as a Regional Perinatal Center shall have a perinatal clinical nurse specialist who is responsible for intramural and regional staff training and consultation in perinatal care. This individual shall be a registered professional nurse with a master's degree in a maternal and child health nursing specialty from an accredited college or university and who has:

1. A minimum of five years experience in *[labor and delivery, newborn nursery or neonatal intensive care]* ***maternal and child health inpatient services*** within the seven years immediately preceding the date of appointment. Of the five years minimum experience, two years shall have been in an educational capacity; and

2. ***Effective October 1, 1993,*** *[Certification]* ***certification*** by the National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing Specialties or American Nurses' Association.

8:43G-19.4 Obstetrics staff time and availability

(a) The obstetric service in hospitals designated as a Community Perinatal Center-Basic shall be covered at all times by a board eligible or certified obstetrician or a board eligible or certified family practice physician with obstetric privileges, who is present in the hospital or available by telephone and able to arrive within 30 minutes of being summoned, under normal transportation conditions.

(b) The obstetric service in hospitals designated as a Community Perinatal Center-Intermediate shall be covered at all times by a board eligible or certified obsfetrician or an obstetric resident with at least three years of training, who is either present in the hospital or available by telephone and able to arrive within 30 minutes of being summoned, under normal transportation conditions.

(c) The obstetric service in hospitals designated as a Community Perinatal Center-Intensive shall be covered at all times by a board certified obstetrician, who is present in the hospital or available by telephone and able to arrive within 30 minutes of being summoned, under normal transportation conditions.

(d) The obstetric service in hospitals designated as a Regional Perinatal Center shall be covered at all times by:

1. A board ***eligible or*** certified obstetrician who is present in the hospital; and

2. A board certified obstetrician with certification in maternal-fetal medicine, who is either present in the hospital or available by telephone and able to arrive within 30 minutes of being summoned, under normal transportation conditions.

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(e) The physician in (d)2 above may also fulfill the requirement for physician coverage at (d)1 above during those times in which he or she is present in the hospital.

8:43G-19.6 Maternal-fetal transport and neonatal transport

(a) Maternal transports for maternal management shall only be accepted by a hospital designated as a Regional Perinatal Center. Maternal transports, when the expected birth weight or gestational age falls below the facility's certified capability for neonatal care, shall be made in accordance with the facility's letter of agreement.

(b) Each Community Perinatal Center shall establish and implement transfer agreements for patients who require a higher level of care for maternal management or delivery than the hospital is designated to provide. This shall be documented in its letter of agreement with the Regional Perinatal Center.

(c) The Regional Perinatal Center shall develop and implement policies and procedures that establish a maternal-fetal transport system which includes, at a minimum, a transport team staffed by health professionals with special training in maternal and fetal care in accordance with hospital policy.

(d) The hospital shall establish and implement transfer agreements for neonates who require a higher level of care than the hospital is designated to provide. Transfer agreements shall be developed ***in cooperation with the Maternal and Child Health Consortium,*** only with hospitals designated as Regional Perinatal Centers or Community Perinatal Centers-Intensive***, and*** in accordance with the Regional Perinatal Plan. The transport agreement shall also include provisions for return of the neonate to the sending hospital when the problems that required transport have been resolved.

(e) All infants, regardless of birth weights, who require major surgery or other highly specialized services shall be transported to a Regional Perinatal Center, children's hospital or specialized hospital capable of providing the care.

(f) All Regional Perinatal Centers and Community Perinatal Center—Intensives which have a letter of agreement to accept neonatal transports shall have, at a minimum:

1. A transport team staffed by health professionals with special training in neonatology;

2. Board eligible or certified anesthesiologists available with special training in the care of neonates;

3. Formal consultative relationship with physicians in the following pediatric subspecialties: anesthesiology, cardiology, hematology/oncology, infectious diseases, nephrology, neurology, pulmonary, radiology, and surgery; and

4. Written policies and procedures specific to the required arrival time for the physicians with pediatric subspecialties identified in (f)3 above.

8:43G-19.18 Newborn care staff qualifications

(a)-(e) (No change.)

(f) A hospital designated as a Regional Perinatal Center shall have a physician director of the neonatal intensive care nursery who is board certified in pediatrics with certification in neonatal medicine.

8:43G-19.19 Newborn care staff time and availability

(a) The basic newborn nursery shall be covered at all times by a pediatrician or family practice physician with pediatric privileges, who is either present in the hospital or available by telephone and able to arrive within 30 minutes of being summoned, under normal transportation conditions.

(b) The basic newborn nursery shall have a registered professional nurse present whenever an infant is in the newborn nursery. Additional staffing assignments shall be determined by acuity levels appropriate to infants.

(c) The basic newborn nursery shall have at least one registered professional nurse to every eight infants. ***However, so long as one registered nurse is on duty as required by (b) above, licensed practical nurses may be used to comply with the nurse:infant ratio requirement.***

(d) The intermediate nursery shall be covered at all times by a board eligible or certified pediatrician with certification and/or *[one year]* training ***and experience*** in *[neonatology]* ***neonatal medicine***, who is either present in the hospital or available by telephone and able to arrive within 30 minutes of being summoned, under normal transportation conditions. ***A physician who has training and experience in neonatal medicine shall be present in the hospital whenever an infant is on a ventilator.***

(e) The intermediate nursery shall have at least one registered professional nurse to every *[three]* ***four*** infants. Additional staffing assignments shall be determined by the acuity levels of the infants.

(f) The neonatal intensive nursery shall be covered at all times by a ***neonatal fellow or a*** board eligible or certified pediatrician with *[at least one year of]* training ***and experience*** in neonatal medicine, present in the hospital.

(g) The neonatal intensive nursery shall be covered at all times by a board certified pediatrician with certification in neonatal medicine, who is either present in the hospital or available by telephone and able to arrive within 30 minutes of being summoned, under normal transportation conditions. This physician may also serve as the physician director of the neonatal intensive care nursery.

(h) The neonatal intensive care nursery shall have at least one registered professional nurse to every two infants. Additional staffing assignments shall be determined by the acuity levels of the infants.

8:43G-19.20 Newborn care patient services

(a) (No change.)

[(b) Specialized services for newborns shall be provided as specified below:]

*[1.]**(b)* A Community Perinatal Center—Basic may provide care to neonates greater than 2499 grams and 36 weeks gestation. ***A Community Perinatal Center—Basic may provide care to infants born in the facility who are below the specified weight and age criteria only if the infant does not require a higher level of care than otherwise specified for Community Perinatal Centers—Basic and if it has been documented in the medical record that the birth was expected to meet the weight and age criteria. Service restrictions placed on Community Perinatal Centers—Basic include:**

1.* A Community Perinatal Center—Basic shall not provide mechanical ventilatory support, except for resuscitative measures *[, nor shall it provide total parenteral nutrition. Neonates needing such care shall be transferred in accordance with the hospital's letter of agreement.]**;

2. A Community Perinatal Center—Basic shall not provide total parenteral nutrition; and

3. A Community Perinatal Center—Basic shall transfer all neonates requiring a higher level of services than permitted to be provided by the facility in accordance with its letter of agreement.*

*[2.]**(c)* A Community Perinatal Center—Intermediate may provide care to neonates greater than 1499 grams and 32 weeks gestation. ***A Community Perinatal Center—Intermediate may provide care to infants born in the facility who are below the specified weight and age criteria only if the infant does not require a higher level of care than otherwise specified for Community Perinatal Center(s)—Intermediate and if it has been documented in the medical record that the birth was expected to meet the weight and age criteria. Service restrictions placed on Community Perinatal Centers—Intermediate include:**

1.* A Community Perinatal Center—Intermediate may provide short term mechanical ventilatory support. In no case shall mechanical ventilatory support exceed *[five cumulative days]* ***48 hours***, except in cases where authorization has been received from the neonatologist on-call at the Regional Perinatal Center and ***the Center has demonstrated ability to intubate and is able to hourly monitor the partial pressure of oxygen in the neonate's blood. Authorization from the neonatologist on-call at the Regional Perinatal Center shall be obtained on a daily basis and shall be*** documented in the medical record *[on a daily basis]*.

2. A Community Perinatal Center—Intermediate shall not provide total parenteral nutrition. *[Neonates needing such care shall be transferred in accordance with the hospital's letter of agreement.]*

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3. A Community Perinatal Center—Intermediate shall transfer all neonates requiring a higher level of services than permitted to be provided by the facility in accordance with its letter of agreement.

*[3.]**(d)* A Community Perinatal Center—Intensive may provide care to neonates greater than 999 grams and *[36]* ***28*** weeks gestation. A Community Perinatal Center—Intensive may provide long term ventilatory support and total parenteral nutrition.

*[4.]**(e)* A Regional Perinatal Center may provide long term ventilatory support and total parenteral nutrition.

Recodify existing (c)-(f) as ***(f)-(i)*** (No change in text.)

(a)

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: August 11, 1992 by the Drug Utilization Review Council, Robert Kowalski, Chairman.
Filed: August 17, 1992 as R.1992 d.348, **with portions of the proposal not adopted but still pending.**
Authority: N.J.S.A. 24:6E-6(b).
Effective Date: September 8, 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 Rugby Laboratories, Inc., requesting the deferral of Blue Ridge Laboratories' sucralfate 1 gm tablets and diltiazem 30 mg, 60 mg, 90 mg, and 120 mg tablets.

Rugby informed the Council that availability dates for both products are as yet uncertain and requested that they be deferred. Rugby also stated that the 483 Form and an explanation of the agreement between Blue Ridge, Marion and Rugby will be supplied before the Council takes action.

RESPONSE: It is the Council's opinion that adopting products that are not available in the market would inappropriately aid the marketing efforts of the manufacturer and cause confusion in the pharmacy industry. Therefore, the Council carried a motion to accept this product upon confirmation of the availability of Blue Ridge Laboratories' diltiazem product. The Council also agreed to continue to defer Blue Ridge Labs' sucralfate product pending the verification of availability to pharmacies.

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 a previous Register (see 24 N.J.R. 2557(b)). 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**:

Amiloride HCl/HCTZ tabs 5/50	Royce
Diltiazem tabs 30 mg, 60 mg, 90 mg, 120 mg	Blue Ridge Labs
Diltiazem tabs 30 mg, 60 mg, 90 mg, 120 mg	Mylan

The following products were **not adopted but are still pending**:

Amoxicillin caps 250, 500 mg	Atral
Berocca tabs substitute	Pioneer
Cephalexin caps 250, 500 mg	Atral
Diltiazem tabs 30 mg, 60 mg, 90 mg, 120 mg	Lederle
Ketoprofen caps 25 mg, 50 mg, 75 mg	Lederle
Lactulose soln 10g/15ml	Technilab
Metoclopramide HCl syrup 5mg/5ml	Lemmon
Metoprolol tartrate tabs 50 mg, 100 mg	Geneva
Piroxicam caps 10 mg, 20 mg	Royce
Sucralfate tabs 1 g	Blue Ridge Labs
Tetracycline caps 250, 500 mg	Atral
Vancomycin HCl oral soln powder 1 g, 2 g, 5 g	Lederle
Valproic acid caps, 250 mg	R.P. Scherer
Verapamil tabs 240 mg extended release	Baker Cummins

OFFICE OF ADMINISTRATIVE LAW NOTE: See related notice of adoption at 24 N.J.R. 2557(b).

(b)

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: August 11, 1992 by the Drug Utilization Review Council, Robert Kowalski, Chairman.
Filed: August 17, 1992 as R.1992 d.349, **with portions of the proposal not adopted but still pending.**
Authority: N.J.S.A. 24:6E-6(b).
Effective Date: September 8, 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 New Jersey 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," declined to adopt the products specified as "not adopted," and referred the products identified as "pending" for further study.

The following product and its manufacturer was **adopted**:

Atenolol/chlorthalidone tabs 50/25, 100/25	Danbury

The following drugs were **not adopted but are still pending**:

Amoxapine tabs 25mg, 50mg, 100mg, 150mg	Danbury
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
Nortryptylline HCl caps 10mg, 25mg, 50mg, 75mg	Danbury
Propoxyphene naps/APAP tabs 100/650	Danbury
Spironolactone tabs 25mg, 50mg, 100mg	Danbury
Spironolactone/HCTZ tabs 50/50	Danbury
Temezepam caps 15mg, 30mg	Danbury
Tolmetin sodium caps 400mg	Danbury
Tolmetin sodium tabs 200mg	Danbury
Trazodone HCl tabs 150mg	Danbury

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OFFICE OF ADMINISTRATIVE LAW NOTE: See related notices of adoption at 24 N.J.R. 947(b), 1897(a) and 2560(a).

(a)

DRUG UTILIZATION REVIEW COUNCIL
List of Interchangeable Drug Products
Adopted Amendments: N.J.A.C. 8:71

Proposed: March 2, 1992 at 24 N.J.R. 735(a).
Adopted: August 11, 1992 by the Drug Utilization Review Council, Robert Kowalski, Chairman.
Filed: August 17, 1992 as R.1992 d.350, **with portions of the proposal not adopted but still pending.**

Authority: N.J.S.A. 24:6E-6(b).

Effective Date: September 8, 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 March 23, 1992. Mark A. Strollo, R.Ph., M.S., served as the hearing officer. Four persons attended the hearing. Five comments were received as summarized in previous New Jersey Registers (see 24 N.J.R. 1896(a) and 2560(b)). The hearing officer recommended that the decisions be made based upon the available biodata, and that, in regard to Warner Chilcott's loperamide 2 mg capsules, further explanation of its bioequivalency data be supplied. 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 product and its manufacturer was **adopted**:

Tolmetin tabs 600 mg	Purepac

The following products were **not adopted but are still pending**:

Atenolol tabs 50 mg; 100 mg	Mutual
Atenolol/chlorthalidone tabs 50/25, 100/25	Mutual
Cefadroxil caps 500 mg	Zenith
Cefadroxil tabs 1000 mg	Zenith
Clemastine fumarate syrup 0.76mg/5 ml	Lemmon
Fluphenazine HCl oral soln 5 mg/ml	Copley
Leucovorin tabs 25 mg	W-C
Loperamide caps 2 mg	W-C
Metaproterenol syrup 10 mg/5 ml	Copley
Methocarbamol tabs 500 mg, 750 mg	Mutual
Minocycline tabs 50 mg, 100 mg	W-C
Minoxidil tabs 2.5 mg, 10 mg	Mutual
Nortriptyline caps 10 mg, 25 mg	Creighton
Nortriptyline caps 50 mg, 75 mg	Creighton
Pindolol tabs 5 mg, 10 mg	Purepac
Piroxicam caps 10 mg, 20 mg	Mutual
Piroxicam caps 10 mg, 20 mg	W-C
Propoxyphene naps/APAP tabs 50/325, 100/650	Mutual
Stuartnatal 1+1 tabs substitute	Vitarine
Timolol tabs 5 mg, 10 mg, 20 mg	W-C
Trazodone tabs 50 mg, 100 mg, 150 mg	Mutual

OFFICE OF ADMINISTRATIVE LAW NOTE: See related notices of adoption at 24 N.J.R. 1896(a) and 2560(b).

(b)

DRUG UTILIZATION REVIEW COUNCIL
List of Interchangeable Drug Products
Adopted Amendments: N.J.A.C. 8:71

Proposed: September 3, 1991 at 23 N.J.R. 2610(a).
Adopted: August 11, 1992 by the Drug Utilization Review Council, Robert Kowalski, Chairman.
Filed: August 17, 1992 as R.1992 d.351, **with portions of the proposal not adopted but still pending.**

Authority: N.J.S.A. 24:6E-6(b).

Effective Date: September 8, 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 September 24, 1991. Mark A. Strollo, R.Ph., M.S., served as the hearing officer. Two persons attended the hearing. Six comments were received as summarized in previous New Jersey Registers (see 23 N.J.R. 3334(a) and 24 N.J.R. 2558(a)). The hearing officer recommended that the decisions be made based upon the available biodata. The Council adopted the products specified as "adopted," declined to adopt the products specified "not adopted," and referred the products identified as "pending" for further study.

The following product and its manufacturer was **adopted**:

Cephalexin capsules 250 mg, 500 mg	Yoshitomi

The following drugs were **not adopted but are still pending**:

Albuterol tabs 2, 4 mg	Purepac
Atenolol tabs 50, 100 mg	W-C
Chlorthalidone tabs 25, 50, 100 mg	Zenith
Ibuprofen tabs 200, 400, 600, 800 mg	Invamed
Methocarbamol tabs 500, 750 mg	Mutual
Minoxidil tabs 2.5, 10 mg	Mutual
Piroxicam caps 10, 20 mg	Mutual
Propoxyphene naps/APAP 50/325, 100/650	Mutual
Sulindac tabs 150, 200 mg	Purepac
Trazodone tabs 50, 100, 150 mg	Mutual
Verapamil tabs 40 mg	Cord
Verapamil tabs 40 mg	Purepac

OFFICE OF ADMINISTRATIVE LAW NOTE: See related notices of adoption at 23 N.J.R. 3334(b), 24 N.J.R. 144(b), 24 N.J.R. 948(a) and 24 N.J.R. 2558(a).

(c)

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: August 11, 1992 by the Drug Utilization Review Council, Robert Kowalski, Chairman.
Filed: August 17, 1992 as R.1992 d.352, **with a portion of the proposal not adopted and portions of the proposal not adopted but still pending.**

Authority: N.J.S.A. 24:6E-6(b).

Effective Date: September 8, 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.

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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. Strollo, 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," 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**:

Atenolol tabs 25 mg	Lederle
Clemastine fumarate syrup 0.67mg/5ml	Copley
Golytely electrolyte gavage substitute	Copley
Iodinated glycerol elixir 60mg/5ml	Naska
Nucofed expectorant substitute	LuChem
Nucofed ped. expectorant substitute	LuChem
Piroxicam caps 10 mg, 20 mg	Searle
Rondec syrup substitute	LuChem
Tussi-Organidin DM liquid substitute	Naska
Tussi-Organidin liquid substitute	Naska

The following products were **not adopted**:

Hysocamine sulfate tabs 0.125 mg	Ferndale

The following products were **not adopted but are still pending**:

Acetazolamide tabs 250 mg	ALRA
Atenolol tabs 25 mg	Geneva
Atenolol tabs 50 mg, 100 mg	Novopharm
Atenolol/chlorthalidone tabs 50/25, 100/25 mg	IPR
Clemastine fumarate tabs 1.34 mg, 2.68 mg	Geneva
Clonidine HCl/chlorthalidone tabs 0.1/15 mg	Geneva
Clonidine HCl/chlorthalidone tabs 0.2/15 mg	Geneva
Clonidine HCl/chlorthalidone tabs 0.3/15 mg	Geneva
Clorazepate tabs 3.75 mg, 7.5 mg, 15 mg	ALRA
Darvon Compound-65 caps substitute	ALRA
Diltiazem HCl tabs 30 mg, 60 mg, 90 mg, 120 mg	Mutual
Fenoprofen caps 300 mg	W-C
Fenoprofen tabs 600 mg	W-C
Ibuprofen tabs 400 mg, 600 mg, 800 mg	ALRA
Imipramine tabs 10 mg, 25 mg, 50 mg	ALRA
Ketoprofen caps 25 mg, 50 mg, 75 mg	Biocraft
Lactulose syrup 10g/15ml	ALRA
Loperamide HCl caps 2 mg	Geneva
Loxapine caps 5 mg, 10 mg, 25 mg, 50 mg	Geneva
Meprobamate tabs 200 mg, 400 mg	ALRA
Metoclopramide tabs 5 mg	Biocraft
Naproxen sodium tabs 275 mg, 550 mg	Mutual
Naproxen tabs 250 mg, 375 mg	Mutual
Nucofed expectorant substitute	LuChem
Pediazole suspension substitute	ALRA
Potassium bicarbonate effervescent tabs 25 mEq	ALRA
Potassium chloride 20 mEq powder	ALRA
Potassium chloride ER tabs 10 mEq	ALRA
Potassium chloride ER tabs 8 mEq	Upsher-Smith
Propoxyphene HCl caps 65 mg	ALRA
Sucralfate tabs 1 gm	Biocraft
Sulfisoxazole tabs 500 mg	ALRA
Tolbutamide tabs 500 mg	ALRA
Tolectin sodium caps 400 mg	Geneva
Tolmetin sodium caps 400 mg	Lemmon
Tolmetin sodium tabs 200 mg	Geneva
Triamterene/HCTZ tabs 37.5/25 mg	Geneva
Verapamil tabs 40 mg	Geneva

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PUBLIC NOTICES

COMMUNITY AFFAIRS

(a)

DIVISION OF HOUSING AND DEVELOPMENT
FIRE SAFETY COMMISSION

Notice of Opportunity for Informal Public Input
Smoke Detector Requirements

Take notice that the Fire Safety Commission wishes to receive comments from interested persons concerning smoke detector requirements applicable to detached single family dwellings to which additions of less than 25 percent of the floor area are made.

Oral comments may be presented at **a meeting** of the Commission that will be held on September 16, 1992 at 10:00 A.M. at 3131 Princeton Pike, Lawrenceville, New Jersey in Building 6, Second Floor, Conference Room A.

Written comments may be submitted on or before that date to:

Jack P. Stockton, Secretary
New Jersey Fire Safety Commission
CN 809
Trenton, NJ 08625

(b)

DIVISION OF HOUSING AND DEVELOPMENT

Uniform Construction Code
Notice of Permit Extensions

Take notice that, pursuant to the "Permit Extension Act," P.L. 1992, c.82, and subject to the limitations therein set forth, any approvals granted by the Department of Community Affairs pursuant to the "State Uniform Construction Code Act," P.L. 1975, c.217, that expired on or after January 1, 1989, or that are scheduled to expire at any time prior to December 31, 1994, are hereby extended to December 31, 1994.

ENVIRONMENTAL PROTECTION AND ENERGY

(c)

ENVIRONMENTAL REGULATION
OFFICE OF REGULATORY POLICY

Notice of Annual Clean Water Council Public Hearing

Take notice that the Clean Water Council of the Department of Environmental Protection and Energy (DEPE) will hold a **public hearing** to seek comments on how the State, local government, business, non-profit organizations and individuals can help maximize the public investment in water quality improvement.

The Clean Water Council would like to hear comments on new approaches or case studies which have worked well in a particular area to encourage water pollution abatement. Of equal concern is the need to identify the stumbling blocks in existing programs and regulations which are costly and non-productive as far as directly improving water quality.

More money, more staffing and more programs will not occur in this economy. Therefore, how can the existing resources be better directed? What no-cost/cost sharing solutions to pollution prevention can you suggest?

Please use the following questions as a guide in preparing your remarks:

1. What can the DEPE do to improve water quality management?
(a) What programs are most successfully improving water quality?
(b) What programs do not work as well and how can they be modified?
2. What innovative approaches are being tried by local governmental entities, non-profit organizations, and private industry to improve water quality?
3. What can we as individual citizens do at home or at work to improve water quality?

The **public hearing** will be held on:

Tuesday, October 13, 1992 from 10:00 A.M. to 4:00 P.M.
at the Monmouth County Library
125 Symmes Drive
Manalapan, New Jersey

Parking will be made available in the lower parking lot.

Persons wishing to attend and/or make an oral presentation should call the Office of Regulatory Policy at 609-633-7021 to register.

Written comments will also be accepted at the hearing or may be sent to the DEPE's Office of Regulatory Policy at CN 029, 401 East State Street, Trenton, New Jersey 08625.

(d)

DIVISION OF PARKS AND FORESTRY

Notice of Public Hearing
Proposed Sale of Lands
Comprising Part of the Bakers Basin Properties

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 sale of the following State-owned lands to the New Jersey Department of Transportation to construct a roadway.

Parcel R101A—Consisting of 5.626 acres.
Parcel R101C—Consisting of 4.825 acres.
Parcel R101D—Consisting of 5.329 acres.
Parcel R101E—Consisting of 1.284 acres.
Parcel R101F—Consisting of 2.192 acres.

The above noted parcels have been valued at a total of $622,100.

The relevant sale documents will be available for review Monday through Friday between the hours of 8:00 A.M. to 4:00 P.M. at the State Forest Fire Warden's Office located on the 4th floor of 501 E. State Street, Station Plaza Building No. 5, Trenton, New Jersey.

The proposed lands and adjacent State-owned lands are no longer utilized for their former purpose as a Forest Fire Fighting Airport. This sale does not interfere with or affect the use of any other State-owned lands for this stated purpose.

The **public hearing** will be held on:

Thursday, October 8, 1992 at 10:00 A.M.
Lower Level Conference Room
Lawrence Township Municipal Building
Route 206
Lawrence Township, New Jersey

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 David Harrison, State Forest Fire Warden at (609) 292-1869.

Interested persons may submit written comments until October 15, 1992 to:

Gregory A. Marshall
Director
Division of Parks and Forestry
Department of Environmental Protection and Energy
CN 404
Trenton, NJ 08625

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(a)

OFFICE OF REGULATORY POLICY

Amendment to the Monmouth County Water Quality Management Plan

Public Notice

Take notice that on August 4, 1992, pursuant to the provisions of the New Jersey Water Quality Planning Act, N.J.S.A. 58:11A-1 et seq., and the Statewide Water Quality Management Planning rules (N.J.A.C. 7:15-3.4), an amendment to the Monmouth County Water Quality Management Plan was adopted by the Department. This amendment adopts a Wastewater Management Plan (WMP) for the Township of Middletown Sewerage Authority (TOMSA) planning area. The TOMSA WMP area is a portion of the WMP area for the Monmouth County Bayshore Outfall Authority (MCBOA) and the TOMSA WMP is submitted on behalf of MCBOA; MCBOA retains WMP responsibility for this area. The WMP addresses wastewater management planning for the Township of Middletown and the Boroughs of Atlantic Highlands and Highlands.

The WMP delineates all of the wastewater management planning area as the existing and future sewer service area. The WMP area and service area are changed at the Keansburg school site at Palmer and Euclid Avenues in Middletown Township; this area becomes, upon adoption of the WMP, part of the WMP area and service area of the Bayshore Regional Sewerage Authority. An expansion of the TOMSA facility is proposed to allow for the treatment of a wastewater flow increase, exclusive of infiltration and inflow, for the WMP area for the year 2010 of .55 million gallons per day (MGD), the existing permitted flow is 10.8 MGD.

(b)

OFFICE OF REGULATORY POLICY

Amendment to the Monmouth County Water Quality Management Plan

Public Notice

Take notice that on August 4, 1992, pursuant to the provisions of the New Jersey Water Quality Planning Act, N.J.S.A. 58:11A-1 et seq., and the Statewide Water Quality Management Planning rules (N.J.A.C. 7:15-3.4), an amendment to the Monmouth County Water Quality Management Plan was adopted by the Department. This amendment designates the site of Delicious Orchards, Block 46, Lot 15 in Colts Neck, as the service area for an onsite treatment facility with groundwater discharge (less than 20,000 GPD). It is proposed that the existing treatment facility be replaced and expanded. The projected wastewater flow is approximately 8,000 GPD.

(c)

OFFICE OF REGULATORY POLICY

Notice of Availability of Grants Water Quality Management Planning and Implementation Process Pass-Through Grant 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 grant program:

A. Name of program: Water Quality Management Planning and Implementation Process Pass-Through Grant Program.

B. Purpose: Sections 205(j)(3) and 604(b) of the Federal Clean Water Act as amended, require, with certain exceptions, that at least 40 percent of a State's funds awarded under Sections 205(j)(1) and 604(b) be allocated to other organizations for Water Quality Management Planning activities. It is the purpose of the Water Quality Management Planning and Implementation Process Pass-Through Grant Program to satisfy those requirements.

C. Amount of money in the program: A total of $696,225 will be available in the program in State Fiscal Year 1993.

D. Entities which may apply for funding under the program: Regional public comprehensive planning organizations and interstate organizations, including, but not limited to, the following:

1. Municipal governments;
2. County governments;
3. Soil conservation districts, if the district is chartered with appropriate powers as a unit of local government;
4. Interstate agencies of which New Jersey is a party; and
5. Water Quality Management Planning Agencies.

An application may only be submitted by the eligible agency/government body itself.

E. Qualifications needed by an applicant to be considered for the program: Applicants for funding must have staff and resource capability, expertise, and environmental experience to perform the proposed work.

F. Procedure for eligible entities to apply for grant funds: Applicants for a grant should specify in their cover letter the amount of funding requested for the proposed project. As a general guide, the grant amount requested should be no less than $50,000. The application should consist of a proposed scope of work and be written in the following format:

Introduction

There should be a brief description of the overall purpose and need for the project.

There should be a listing of the tasks of the project. Each task should be assigned a number which is keyed to the task number that is used in the Task Description and Project Budget sections.

Task Descriptions

Each task should be described in detail, with separate paragraphs discussing: objective, discussion (of the specifics of the task), and the product(s) to result from that task.

If any entity other than the applicant (for example, consulting firm or other agency) will be conducting a portion of the work, that must be so specified in the task descriptions. If laboratory analyses will be conducted as part of the project, the laboratory must be New Jersey State certified for those analyses, and that fact must be stated.

If samples are to be collected, the specific sites for the sampling must be shown on a United States Geological Survey quadrangle map (supplementary maps may also be included for clarity, if necessary). No sampling or analyses may be conducted until a Quality Assurance Project Plan is approved by the Department. All pages which comprise the scope of work must be of standard 8½ inch by 11 inch size.

Project Budget

There should be a brief introductory discussion regarding the total project cost, followed by a table providing the following information:

The cost for each task must be specified and there must be a breakdown of how that cost was derived. Staff time must be specified by title of each person to work on the task and their cost, based on the number of hours which they will work on the task multiplied by their hourly rate. All calculations must be shown. Other costs (for example, consultant, specific supplies, and travel) must also be included. Costs for equipment should not be included.

Project Schedule

A "time line" should be included. Month names should not be specified; but, instead, they should be listed by number (that is, from 1 to 12 since this is a 12 month project). The table should also contain the following statement: "Required written outputs will be submitted at the conclusion of each task, as indicated by the appropriate time lines."

G. Potential project subjects: Proposed projects should be of one year duration and pertain to one or more of the following subject areas:

1. Updating of Water Quality Management Plans to include revisions and specific amendments into one discrete document. In addition, the updating of the Water Quality Management Plans could include the development of model ordinances to protect environmentally sensitive areas, and the digitizing of water quality-related information for use in the Geographic Information System;
2. Toxics management for the protection of water quality;
3. Development and implementation of a management plan to address a water quality-related need specific to a major watershed. Possible subject areas include, but are not limited to, nonpoint source management, storm water management, and septic tank management.

For a lake-related proposal to be eligible for consideration for a grant, the project must involve a freshwater lake that offers public access through publicly-owned, contiguous land so that all persons have the

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same opportunity to enjoy the privileges and benefits of the lake. If user fees are charged, the fees must be used for maintaining public access and recreational facilities of the lake. Documentation attesting to the satisfaction of these requirements must be submitted with the lake-related grant application.

Grant monies may not be used for actual construction of facilities, or for dredging.

H. Address for submitting applications: Applications for funds should be submitted in triplicate to:

Barry Chalofsky, Assistant Administrator
Office of Regulatory Policy
CN 029
Trenton, New Jersey 08625

I. Deadline by which applications must be submitted: Complete proposals must be submitted by October 8, 1992.

J. Date by which applicants shall be notified of approval or disapproval: Applicants shall receive notice of preliminary approval or disapproval, pending further project review, of a Water Quality Management Planning and Implementation Process Pass-Through Grant by December 7, 1992.

(a)

DIVISION OF SOLID WASTE MANAGEMENT

Notice of Legislative Requirements
Dry Cell Battery Management Act
Public Law 1991, Chapter 521

Take notice that no later than October 20, 1992, pursuant to Section 8 of the Dry Cell Battery Management Act (P.L. 1991, c.521), (hereinafter "Act"), every manufacturer of mercuric oxide, nickel cadmium, and sealed lead-acid batteries offered for sale or promotional purposes in New Jersey must submit a **battery management plan** to the New Jersey Department of Environmental Protection and Energy, (hereinafter, "the Department") for each specified battery type manufactured. Prior to plan submission, all manufacturers of nickel cadmium and sealed lead-acid rechargeable batteries must consult with distributors and retailers that market their respective batteries. To be considered for approval by the Department, these **battery management plans** must include:

1. The designation of the battery collection system to be implemented in each county;
2. The designation of the manufacturer's funding source to defray costs of implementing said plan;
3. The strategy to be employed to inform consumers of disposal requirements at all store battery displays locations;
4. The plan for a Statewide consumer education program that assures the widespread dissemination of information concerning the environmental impact of the improper disposal of mercuric oxide, nickel cadmium and sealed lead-acid batteries and informs consumers that the manufacturers of same are liable for their environmentally sound disposal; and
5. The strategy to be employed for establishing and implementing, as the Department deems necessary, an industry-wide uniform coding system for the identification and labeling of said batteries.

The Department shall review the submitted plan for completeness within 30 days of receipt and shall notify the manufacturers if additional information is needed. If no such request is made, the plan shall be considered complete. If additional information is requested by the Department, the plan shall be considered complete only when the requested information is deemed adequate. The Department shall approve or deny a plan within 45 days of receipt of a complete plan. In the event that the Department fails to take action on a plan within the 45 days, the plan shall be considered approved. The Department must review any approved **battery management plan** at least once every 24 months after its initial approval. The Department may order a new plan submittal if the current plan is found to be no longer a convenient or economically feasible method for collection, transportation, recycling, or proper disposal.

Every manufacturer of mercuric oxide, nickel cadmium and sealed lead rechargeable batteries sold or offered for promotional purposes in New Jersey will be liable for the environmentally sound collection, transportation, recycling, or proper disposal of same at the manufacturer's own expense, and no manufacturer shall sell, offer for sale, or offer for promotional purposes in New Jersey any of the said batteries, unless the manufacturer thereof has a battery management plan approved by the Department pursuant to Section 8 of the Act.

No later than October 20, 1992, pursuant to Section 9 of the Act, every manufacturer of dry-cell batteries sold or offered for promotional purposes in New Jersey must submit to the Department a **dry-cell battery collection plan** to expand or increase the Statewide collection, recycling or proper disposal of all used dry-cell batteries. Each **dry-cell battery collection plan** submitted to the Department shall include, at a minimum: a strategy for expanding and increasing collection, recycling, and proper disposal of **all** dry-cell batteries in each county, including alkaline manganese, consumer mercuric oxide and zinc carbon batteries; and a strategy for establishing and implementing an industry-wide uniform coding system for the identification and labeling of all dry-cell batteries.

Pursuant to Section 7 of the Act, absent the Department's approval of respective **battery management plans,** battery manufacturers will be **prohibited** from sale and distribution in New Jersey of all mercuric oxide, nickel cadmium and sealed lead rechargeable batteries. Pursuant to Section 14 and except as otherwise provided in a **battery management plan** approved by the Department, every retailer that sells discrete nickel cadmium or sealed lead batteries will become a collection point for these same battery types and will be required to accept up to three nickel cadmium or sealed lead rechargeable batteries of the type and size sold, adhere to specific sign posting requirements, and maintain convenient, conspicuously placed collection receptacles. "Retailers," under this requirement, shall not include any retail establishment where food or food products are sold or offered for sale directly to the consumer for consumption off the premises of the retail establishment.

Pursuant to Section 4 of the Act, all alkaline manganese batteries, other than button or coin-shaped batteries, manufactured on or after January 1, 1992, and offered for sale or promotional purposes in New Jersey, must have a total mercury content equal or less than 0.025 percent (250 ppm) by weight. All alkaline manganese button or coin-shaped batteries manufactured on or after January 1, 1992, and offered for sale or promotional purposes in New Jersey, must have a total mercury content equal or less than 25 milligrams per battery. This section further requires that all zinc carbon batteries, manufactured on or after January 1, 1992, and offered for sale or promotional purposes in New Jersey, must have a total mercury content equal or less than 0.0001 percent (one ppm) by weight. Any alkaline manganese battery offered for sale or promotional purposes in New Jersey must have a total mercury content equal to or less than 0.0001 percent (one ppm) by weight on or after January 1, 1996.

Pursuant to Section 5 of the Act, all consumer mercuric oxide batteries manufactured on or after January 1, 1992, and offered for sale or promotional purposes in New Jersey must have a total mercury content equal or less than 0.025 percent (250 ppm) by weight. Consumer mercuric oxide batteries as sold by licensed hearing aid dispensers or other specialized hearing aid dispensers authorized by the Commissioner must have total mercury content equal or less than 0.025 percent (250 ppm) by weight on or after January 1, 1994.

Pursuant to Section 6 of the Act, all rechargeable consumer products manufactured on or after July 1, 1993, and offered for sale or promotional purposes in New Jersey, must contain a rechargeable nickel cadmium or sealed lead battery or battery pack that is readily removable. In addition, rechargeable consumer products, packaging, **or** the rechargeable cells must be labeled to alert consumers that the battery is prohibited from entering the solid waste stream and must be recycled. The rechargeable product's instruction manual must include information on proper disposal. Any person may apply for a temporary exemption from the Department from the redesign requirements. The Department may approve or deny a temporary exemption based on evidence furnished.

No later than April 20, 1993, and at least once every six months thereafter, every manufacturer of mercuric oxide, nickel cadmium or sealed lead batteries must submit a written report to the Department the return or recovery rates of the aforementioned batteries.

No later than April 20, 1993, and at least once every six months thereafter, every manufacturer of dry-cell batteries must submit a written report to the Department on used dry-cell battery return or recovery rates.

Pursuant to Sections 12 and 13 of the Act, no person shall knowingly dispose of used mercury oxide, nickel-cadmium or sealed lead acid batteries as solid waste. These battery types must be disposed of at a household hazardous waste collection site, within a recycling collection

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program, or as provided for in an approved battery management plan. No solid waste collector or facility shall knowingly collect or accept for disposal solid waste containing a visible quantity of used mercury oxide, nickel-cadmium or sealed lead acid batteries.

Pursuant to Section 17 of the Act, as a condition of any permit or approval, the Department may require the owner or operator of any resource recovery facility, in conjunction with the governing body of the county, to implement a countywide used dry cell battery source separation and collection program, as approved by the Department, to ensure that used dry cell batteries found to be of particular concern are removed from the solid waste stream prior to acceptance for disposal at the resource recovery facility.

Pursuant to Section 18 of the Act, the Commissioner, upon making a finding in writing that a specified used dry cell battery continually disposed of as solid waste presents a threat to the environment or public health and safety, may issue an order to every manufacturer of the specified battery describing the specific threat, and the specific measures which the battery manufacturers are directed to undertake to abate or eliminate any threat. The Department may require the following actions to be undertaken:

a. The preparation and submission of a battery management plan by the manufacturer for the specific used dry cell battery of concern;

b. The suspension of the sale or distribution of the specific dry cell battery without an approved battery management plan; or

c. The reduction of cadmium, lead or mercury concentrations in the dry cell to environmentally acceptable and technologically feasible levels as a condition for sale or distribution.

Pursuant to Section 20 of the Act any person convicted of a violation of this 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 the violation continues constitutes an additional, separate and distinct offense.

HEALTH

(a)

DIVISION OF HEALTH FACILITIES EVALUATION AND LICENSING

Notice of Examination Fee for Licensing Nursing Home Administrators

N.J.A.C. 8:34-1.7

Take notice that the examination fee charged to each applicant for nursing home administrator licensure will increase from $100.00 to $165.00 for the October 1992 examination and from $165.00 to $175.00 on April 1, 1993, for any subsequent examinations. This notice is being given in accordance with N.J.A.C. 8:34-1.7(f) which requires that the "Department shall provide timely notice of the examination fee in the Public Notices section of the New Jersey Register."

In order to be licensed as a nursing home administrator in New Jersey, a candidate must take the National Association of Boards of Examiners (NAB) examination. The Department administers the examination, which is purchased from NAB and the Professional Education Service (PES). The cost of the examination is determined by the NAB.

The New Jersey State Department of Health, due to current budgetary constraints, is not a member State Board of the NAB. Therefore, the Department has been notified by NAB that the examination fee charged to each candidate will be $165.00 for the October 1992 administration of the NAB examination and $175.00 for the April 1993 administration of the NAB examination.

(b)

CERTIFICATE OF NEED

Applications

Take notice, that, in accordance with the provisions of N.J.A.C. 8:33-5.1(c), Frances J. Dunston, M.D., M.P.H., Commissioner, New Jersey Department of Health, is inviting certificate of need applications for the following types of health care activities:

Long-term care beds and adult day health care slots in accordance with the provisions of N.J.A.C. 8:100-18, N.J.A.C. 8:33 and N.J.A.C. 8:33H, limited to the counties in which there is a need as identified herein.

Because health planning and licensing rules to guide review of the following services have not yet been adopted, certificate of need applications will not be accepted at this time for rehabilitation services or other types of long-term care services referenced in N.J.A.C. 8:33H, including assisted living and comprehensive personal care homes. A call for these services will be issued after the planning and licensing rules are adopted which is anticipated to be during 1993.

Geographic Area to be Served:	
General Long-term Care Beds:	**Need:**
LAB II	
Bergen County	Not available at this time*
Hudson County	Not available at this time*
LAB IV	
Hunterdon County	Not available at this time*
Middlesex County	585
LAB V	
Burlington County	132
Camden County	129
Cumberland County	30
LAB VI	
Ocean County	Not available at this time*
Adult Day Health Care Slots:	**Need:**
LAB I	
Warren County	44
LAB II	
Bergen County	Not available at this time*
Hudson County	Not available at this time*
LAB III	
Union County	96
Adult Day Health Care Slots:	**Need:**
LAB IV	
Hunterdon County	Not available at this time*
Mercer County	268
Middlesex County	388
LAB V	
Burlington County	120
Camden County	40
Cumberland County	32
Gloucester County	76
LAB VI	
Cape May County	108
Monmouth County	148
Ocean County	200

Specialized Long-term Care: There is a need for model units for patients with severe behavior management problems in all LABs except LAB V.

*Information regarding the need for long-term care beds and medical day care slots in these counties will be available September 3, 1992. For further information, please contact the appropriate LAB.

Date Application is Due: October 1, 1992

Date Completeness Review Decision Issued: November 16, 1992

Date Local Advisory Boards Will Review the Applications and Submit Recommendations to the Commissioner and the State Health Planning Board: On or Before December 31, 1992

Date State Health Planning Board Will Review the Applications and Submit Recommendations to the Commissioner: On or Before February 4, 1993

Applications May be Requested from and Must be Filed With:

New Jersey State Department of Health
Certificate of Need Program
CN 360
Trenton, NJ 08625-0360
609-292-6552

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Copies of the applicable rules are also available from the Certificate of Need Program. There is a fee for duplication and mailing.

Applications Must also be Filed With:

Local Advisory Board(s) serving the region of the proposed service.

Take further notice, that, in accordance with the provisions of N.J.A.C. 8:33-5.1(c), Frances J. Dunston, M.D., M.P.H., Commissioner, New Jersey Department of Health, is inviting certificate of need applications for the following types of health care activities:

Maternal and Child Health Consortia and Perinatal Designation for existing services in accordance with provisions of N.J.A.C. 8:100-4.1 et seq., N.J.A.C. 8:33 and N.J.A.C. 8:33C-1.19 et seq. as follows:

Community Perinatal Center-Birthing Center
Community Perinatal Center-Basic
Community Perinatal Center-Intermediate
Community Perinatal Center-Intensive
Regional Perinatal Center
Neonatal services provided in specialty acute care children's hospitals

The call is for designation only of existing perinatal services with no associated construction or capital costs. Pediatric services are not included at this time. A call for pediatric services will be issued after pediatric planning rules are adopted.

Geographic Area to be Served: Statewide

Date Application is Due: November 2, 1992

Date Completeness Review Decision Issued: December 14, 1992

Date Local Advisory Boards Will Review the Applications and Submit Recommendations to the Commissioner and the State Health Planning Board: On or Before January 29, 1993

Date State Health Planning Board Will Review the Applications and Submit Recommendations to the Commissioner: On or Before March 15, 1993

Applications May be Requested from and Must be Filed With:

Certificate of Need Program
New Jersey State Department of Health
CN 360
Trenton, NJ 08625-0360
609-292-6552

Copies of the applicable rules are also available from the Certificate of Need Program. There is a fee for duplication and mailing.

Applications Must also be Filed With:

Local Advisory Board(s) serving the region of the proposed service.

And, take further notice that, in accordance with the provisions of N.J.A.C. 8:33-5.1(c), Frances J. Dunston, M.D., M.P.H., Commissioner, New Jersey Department of Health, is inviting certificate of need applications for the following types of health care activities:

Capital expenditures for acute care general hospital services subject to the 1992 Statewide capital allowance of $225 million in accordance with the provisions of N.J.A.C. 8:100-14.1 et seq., N.J.A.C. 8:43I, N.J.A.C. 8:33, and P.L. 1991, c.187 including:

1. Construction, renovation, and modernization which address structural elements, medical/surgical units, ICU/CCU units, emergency departments, outpatient diagnostic and treatment services, and ancillary and administrative functions. Letters of intent have been filed in June of 1992 which identify projects acceptable within these guidelines with associated costs ranging from $400 to $600 million.

Because health planning rules to guide review of the following services have not yet been adopted, certificate of need applications will not be accepted at this time for construction, renovation and modernization affecting obstetric, neonatal, pediatric, psychiatric, cardiac, trauma, renal or surgical services. A call for these services will be issued after regulatory review and adoption of the appropriate planning rules which is anticipated in the first half of 1993.

As a point of reminder, in accordance with N.J.A.C. 8:100-14.8, no certificate of need applications for major renovation or construction projects in excess of $10 million will be accepted from hospitals (1) in a county in which the county's excess bed capacity for 1995 exceeds the number of beds in any hospital in the county or (2) in counties identified in N.J.A.C. 8:100-14.13 prior to the LAB's completion of a bed need study.

2. Changes in bed categories are limited to the addition of ICU/CCU beds, reduction of medical/surgical beds or reduction of pediatric beds.
3. Replacement of major moveable equipment.

Geographic Area to be Served: Statewide

Date Application is Due: December 1, 1992

Date Completeness Review Decision Issued: February 8, 1993

Date Local Advisory Boards Will Review the Applications and Submit Recommendations to the Commissioner and the State Health Planning Board: On or Before March 25, 1993

Date State Health Planning Board Will Review the Applications and Submit Recommendations to the Commissioner: On or Before May 9, 1993

Applications May be Requested from and Must be Filed With:

Certificate of Need Program
New Jersey State Department of Health
CN 360
Trenton, NJ 08625-0360
609-292-6552

Copies of the applicable rules are also available from the Certificate of Need Program. There is a fee for duplication and mailing.

Applications Must also be Filed With:

Local Advisory Board(s) serving the region of the proposed service.

HIGHER EDUCATION

(a)

NEW JERSEY HIGHER EDUCATION ASSISTANCE AUTHORITY

New Jersey College Loans to Assist State Students (NJCLASS)

Notice of Loan Interest Rates

N.J.A.C. 9:9-7

Take notice that the loan interest rate for student loans under the State loan program New Jersey College Loans to Assist State Students (NJCLASS) has now been established by the Authority pursuant to N.J.A.C. 9:9-7.7.

The loan interest rate is 7.90 percent, stepping up to 8.65 percent beginning with the borrower's fifth year of repaying loan principal. For those borrowers who choose the option of capitalizing loan interest during the in-school period, this program feature is offered at a loan interest rate of 8.20 percent, stepping up to 8.95 percent beginning with the borrower's fifth year of repaying loan principal.

This notice is published as a matter of public information.

HUMAN SERVICES

(b)

DIVISION OF THE DEAF AND HARD OF HEARING

Notice of Telecommunications Device for the Deaf Distribution Program

Take notice that the Division of the Deaf and Hard of Hearing announces the availability of free telecommunications devices for the deaf (TDDs) to eligible citizens.

A. **Name of program:** TDD Distribution Program.
B. **Purpose:** To create access to services provided by private and public agencies and businesses.
C. **Amount of available funding for the program:** A total of $50,000 for one year, the State Fiscal Year 1993.
D. **Organizations which may apply for a TDD:** None.
E. **Qualifications needed by an applicant to acquire a free TDD:** If single, annual income of $15,700 or, if married, $19,250 excluding real property; a degree of hearing loss or speech impairment which

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precludes the use of the standard voice telephone; New Jersey Resident, one per household.
There is a limited supply available and they will be distributed to qualified applicants in the order received.

F. **For additional information please contact:**
Division of the Deaf and Hard of Hearing
CN 074
Trenton, New Jersey 08625-0074
(609) 984-7281 V/TDD or (800) 792-8339 V/TDD

INSURANCE

(a)

THE COMMISSIONER

Notice of Cancellation and Nonrenewal of Fire and Casualty Coverage

Take notice that Samuel F. Fortunato, Commissioner of Insurance, pursuant to the provisions of N.J.S.A. 17:29C-3, has recertified to the Legislature the need for continuation of the notice of cancellation and nonrenewal requirement applicable to fire and casualty insurance policies, excluding accident and health policies for the fiscal year commencing July 1, 1992. The notice of cancellation and nonrenewal requirement is set forth at N.J.A.C. 11:1-5.2, which rule continues in full force and effect.

This notice is published as a matter of public information.

(b)

THE COMMISSIONER

Public Notice

List of Municipalities Requiring Payment of Liens by Companies Writing Fire Insurance

Take notice that Samuel F. Fortunato, Commissioner of Insurance, in accordance with the provisions of N.J.S.A. 17:36-9, announces the publication of New Jersey municipalities that have adopted ordinances pursuant to the aforementioned statute. Those municipalities, if any, which have adopted said ordinances since the previous date of publication shall be designated by asterisk.

LIST OF MUNICIPALITIES REQUIRING PAYMENT
OF LIENS BY COMPANIES WRITING FIRE INSURANCE

The following is a list of municipalities that have passed an ordinance requiring companies writing fire insurance on risks located in that municipality to pay unpaid liens out of any claimed payments in excess of $2,500.

	Date Filed with the Department of Insurance
Aberdeen, Township of 07747 (Monmouth County)	September 8, 1980
Absecon, City of 08201 (Atlantic County)	July 5, 1983
Alloway, Township of 08079 (Salem County)	December 20, 1984
Asbury Park, City of 07712 (Monmouth County)	May 25, 1979
Atlantic City, City of 08401 (Atlantic County)	March 19, 1979
Barrington, Borough of 08007 (Camden County)	September 17, 1982
Bayonne, City of 07002 (Hudson County)	March 12, 1979
Belmar, Borough of 07719 (Monmouth County)	March 5, 1982
Berkeley, Township of 08721 (Ocean County)	May 22, 1979
Berlin, Borough of 08009 (Camden County)	October 18, 1979
Berlin, Township of 08091 (Camden County)	March 20, 1980
Bloomfield, Town of 07003 (Essex County)	March 26, 1979
Brick, Township of 08723 (Ocean County)	May 2, 1980
Bridgeton, City of 08302 (Cumberland County)	April 30, 1979
Brigantine, City of 08203 (Atlantic County)	October 14, 1982
Buena, Borough of 08341 (Atlantic County)	November 1, 1982
Burlington, City of 08016 (Burlington County)	December 9, 1986
Butler, Borough of 07405 (Morris County)	November 14, 1980
Byram, Township of 07860 (Sussex County)	October 9, 1980
Camden, City of 08101 (Camden County)	May 4, 1979
Cape May, City of 08204 (Cape May County)	May 22, 1979
Carneys Point, Township of 08069 (Salem County)	July 2, 1979
Cedar Grove, Township of 07009 (Essex County)	August 10, 1979
Chatham, Township of 07928 (Morris County)	June 4, 1986
Cinnaminson, Township of 08077 (Burlington County)	August 30, 1979
Clinton, Township of 08801 (Hunterdon County)	December 10, 1981
Delran, Township of 08075 (Burlington County)	August 30, 1979
Dover, Town of 07801 (Morris County)	April 16, 1980
Dover, Township of 08753 (Ocean County)	September 26, 1979
East Orange, City of 07019 (Essex County)	February 20, 1979
East Windsor, Township of 08520 (Mercer County)	December 23, 1991
Eatontown, Borough of 07724 (Monmouth County)	March 23, 1979
Edgewater Park, Township of 08010 (Burlington County)	July 24, 1979
Elmer, Borough of 08318 (Salem County)	November 19, 1991
Egg Harbor, Township of 08221 (Atlantic County)	September 24, 1979
Egg Harbor, City of 08215 (Atlantic County)	May 21, 1981
Elizabeth, City of 07201 (Union County)	April 30, 1979
Ewing, Township of 08618 (Mercer County)	November 10, 1981
Fairfield, Township of 07006 (Essex County)	August 21, 1980
Fair View, Borough of 07022 (Bergen County)	September 5, 1979
Fanwood, Borough of 07023 (Union County)	June 29, 1979
Farmingdale, Borough of 07727 (Union County)	May 18, 1981
Florham Park, Borough of 07932 (Morris County)	April 25, 1979
Fort Lee, Borough of 07024 (Bergen County)	August 27, 1979
Franklin, Township of 07826 (Somerset County)	June 20, 1980
Gloucester, City of 08030 (Camden County)	January 24, 1989
Fredon, Township of 07860 (Sussex County)	October 28, 1980
Green, Township of 07821 (Sussex County)	July 20, 1982
Hackensack, City of 07602 (Bergen County)	April 22, 1980
Hamilton, Township of 08330 (Atlantic County)	November 18, 1982
Hammonton, Town of 08037 (Atlantic County)	August 3, 1979
Hanover, Township of 07981 (Morris County)	January 7, 1986
Hightstown, Borough of 08520 (Mercer County)	September 3, 1980
Hillside, Township of 07205 (Union County)	June 4, 1979
Hoboken, City of 07030 (Hudson County)	October 15, 1979
Holland, Township of 08848 (Hunterdon County)*	June 1, 1992
Holmdel, Township of 07733 (Monmouth County)	October 20, 1987
Hopewell, Township of 08302 (Cumberland County)	September 26, 1979
Howell, Township of 07731 (Monmouth County)	March 23, 1979
Irvington, Town of 07111 (Essex County)	March 20, 1979
Irvington, Township of 07111 (Essex County)	July 1, 1985
Jackson, Township of 08257 (Ocean County)	March 7, 1979
Jamesburg, Borough of 08831 (Middlesex County)	March 2, 1983
Jefferson, Township of 07981 (Morris County)	April 19, 1983
Jersey City, City of 07302 (Hudson County)	February 23, 1979
Keansburg, Township of 07734 (Monmouth County)	April 5, 1984
Kearny, Town of 07032 (Hudson County)	August 26, 1980
Keyport, Borough of 07735 (Monmouth County)	August 15, 1979
Kinnelon, Borough of 07405 (Morris County)	June 4, 1986
Lacey, Township of 08731 (Ocean County)	August 18, 1981
Lavallette, Borough of 08735 (Ocean County)	December 11, 1979
Lawrence, Township of 08648 (Mercer County)	April 24, 1979
Little Silver, Borough of 07739 (Monmouth County)	April 5, 1984
Logan, Township of 08096 (Gloucester County)	January 2, 1990
Long Branch, City of 07740 (Monmouth County)	December 4, 1987
Lopatcong, Township of 08865 (Warren County)	August 30, 1979
Lower, Township of 08024 (Cape May County)	June 5, 1979
Manchester, Township of 08733 (Ocean County)	September 21, 1982
Mannington, Township of 08079 (Salem County)	May 17, 1979
Maple Shade, Township of 08052 (Burlington County)	July 18, 1980
Maplewood, Township of 07040 (Essex County)	April 4, 1979
Matawan, Borough of 07747 (Monmouth County)	June 19, 1981
Maurice River, Township of 08332 (Cumberland County)	September 26, 1980
Medford Lakes, Borough of 08055 (Burlington County)*	February 3, 1992
Mendham, Township of 07949 (Morris County)	January 16, 1985
Millburn, Township of 07041 (Essex County)	May 19, 1981
Millville, City of 08332 (Cumberland County)	April 10, 1979

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Millstone, Township of 07726 (Monmouth County)	January 14, 1988
Montclair, Town of 07042 (Essex County)	April 5, 1979
Mount Holly, Township of 08060 (Burlington County)	January 29, 1980
Mount Laurel, Township of 08054 (Burlington County)	May 27, 1980
Neptune, Township of 07753 (Monmouth County)	January 4, 1982
Neptune City, Borough of 07712 (Monmouth County)	December 2, 1982
Newark, City of 07102 (Essex County)	March 16, 1979
New Brunswick, City of 08903 (Middlesex County)	January 30, 1986
North Plainfield, Borough of 07060 (Somerset County)	July 1, 1985
North Wildwood, City of 08260 (Cape May County)	August 24, 1979
Ocean, Township of 07755 (Monmouth County)	November 27, 1979
Ocean, Township of 08758 (Ocean County)	May 29, 1985
Orange, City of 07050 (Essex County)	July 2, 1979
Passaic, City of 07055 (Passaic County)	September 4, 1980
Paterson, City of 07050 (Passaic County)	February 16, 1979
Paulsboro, Borough of 08066 (Gloucester County)	May 7, 1981
Penns Grove, Borough of 08069 (Salem County)	July 9, 1979
Phillipsburg, Town of 08865 (Warren County)	July 13, 1979
Pine Hill, Borough of 08021 (Camden County)	March 2, 1982
Piscataway, Township of 08854 (Middlesex County)	March 20, 1981
Plainfield, City of 07061 (Union County)	April 5, 1979
Pleasantville, City of 08232 (Atlantic County)	December 27, 1979
Pohatcong, Township of 08865 (Warren County)	July 20, 1979
Princeton, Borough of 08540 (Mercer County)	July 16, 1980
Princeton, Township of 08540 (Mercer County)	September 25, 1980
Rahway, City of 07065 (Union County)	December 18, 1979
Randolph, Township of 07801 (Morris County)	May 10, 1979
Readington, Township of 08889 (Hunterdon County)	June 23, 1980
Red Bank, Borough of 07701 (Monmouth County)	September 9, 1980
Riverside, Township of 08075 (Burlington County)	May 10, 1979
Roosevelt, Borough of 08555 (Monmouth County)*	March 3, 1992
Roselle, Borough of 07203 (Union County)	August 8, 1979
Roselle Park, Borough of 07204 (Union County)	March 5, 1981
Runnemede, Borough of 08078 (Camden County)	May 6, 1982
Salem, City of 08079 (Salem County)	June 20, 1979
Sayreville, Borough of 08872 (Middlesex County)	September 19, 1979
Scotch Plains, Township of 07076 (Union County)	August 22, 1979
Sea Bright, Borough of 07760 (Monmouth County)	April 10, 1979
Sea Girt, Borough of 07762 (Monmouth County)	March 12, 1991
Seaside Heights, Borough of 08751 (Ocean County)	June 21, 1991
Seacaucus, Town of 07094 (Hudson County)	March 5, 1980
Somerdale, Borough of 08083 (Camden County)	July 28, 1982
Somerville, Borough of 08876 (Somerset County)	March 23, 1979
South Amboy, City of 08879 (Middlesex County)	July 12, 1984
South Harrison, Township of 08039 (Gloucester County)	December 29, 1988
South Orange Village, Township of 07079 (Essex County)	August 19, 1980
South Plainfield, Borough of 07080 (Middlesex County)	September 26, 1980
South River, Borough of 08882 (Middlesex County)	March 16, 1979
Spotswood, Borough of 08884 (Middlesex County)	June 19, 1981
Stafford, Township of 08050 (Ocean County)	May 2, 1985
Sussex, Borough of 07461 (Sussex County)	October 24, 1979
Tenafly, Borough of 07670 (Bergen County)	June 17, 1980
Tinton Falls, Township of 07724 (Monmouth County)	June 20, 1980
Trenton, City of 08608 (Mercer County)	June 12, 1980
Tuckerton, Borough of 08087 (Ocean County)	February 2, 1989
Union City, City of 07087 (Hudson County)	April 23, 1979
Upper Deerfield, Township of 08302 (Cumberland County)	May 19, 1989
Upper Pittsgrove, Township of 08318 (Salem County)	October 15, 1979
Ventnor City, City of 08401 (Atlantic County)	March 30, 1982
Verona, Borough of, Township of 07044 (Essex County)	February 23, 1984
Victory Gardens, Borough of 07801 (Morris County)	August 15, 1979
Vineland, City of 08360 (Cumberland County)	July 6, 1979
Washington, Borough of 07882 (Warren County)	June 24, 1986
Washington, Township of 08214 (Burlington County)	March 12, 1979
Washington, Township of 07853 (Morris County)	May 30, 1979
Waterford, Township of 08004 (Camden County)	July 9, 1984
Wayne, Township of 07470 (Passaic County)	October 6, 1986
Weehawken, Township of 07087 (Hudson County)	August 14, 1986
Wenonah, Borough of 08090 (Gloucester County)	July 1, 1985
West Deptford, Township of 08086 (Gloucester County)	November 14, 1988
Westfield, Town of 07090 (Union County)*	July 15, 1992
Westhampton, Township of 08060 (Burlington County)	June 4, 1979
West New York, Town of 07093 (Hudson County)	March 16, 1979
Westville, Borough of 08093 (Gloucester County)	March 18, 1988
West Orange, Town of 07052 (Essex County)	February 26, 1979
Westwood, Borough of 07675 (Bergen County)	November 28, 1991
Wildwood, City of 08260 (Cape May County)	December 5, 1984
Willingboro, Township of 08046 (Burlington County)	April 17, 1980
Winslow, Township of 08037 (Camden County)	November 13, 1980
Woodbury, City of 08086 (Gloucester County)	January 7, 1986
Woodlynne, Borough of 08107 (Camden County)	June 7, 1982
Woodridge, Borough of 07075 (Bergen County)	July 9, 1984
Woodstown, Borough of 08079 (Salem County)	September 8, 1983

LABOR

(a)

OFFICE OF THE CONTROLLER

Notice of Rates for Board and Room, Meals and Lodging Furnished by Employers in Addition to, or in Lieu of, Money Wages During Calendar Year 1993

Take notice that, in accordance with N.J.A.C. 12:16-4.8, the Department of Labor hereby publishes notice of the following rates for board and room, meals and lodging furnished by employers in addition to, or in lieu of, money wages during calendar year 1993:

Full board and room, weekly	$108.40
Lodging, per week	$ 46.40
Meals, per day	$ 12.40

If less than three meals per day, the individual meals shall be valued as follows:

Breakfast	$3.70
Lunch	$3.70
Dinner	$5.00

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LAW AND PUBLIC SAFETY

(a)

DIVISION OF HIGHWAY TRAFFIC SAFETY

Notice of Grant Availability to State and Local Governments for Projects Implementing Highway Traffic Safety Programs

Take notice that the State and Community Highway Safety Grant Project was established under the Federal Highway Safety Act of 1966, 23 U.S.C. 402. The Act requires each state to have a highway safety program approved by the Secretary of Transportation designed to reduce deaths, injuries and property damage resulting from traffic accidents.

The Governor is responsible for the administration of the State's Highway Safety Program through the New Jersey Division of Highway Traffic Safety in accordance with N.J.S.A. 52:17B. The Division of Highway Traffic Safety prepares a Highway Safety Plan, which identifies the State's traffic safety problems and describes the programs and projects to address those problems, and coordinates the funding for local and state projects. Activities under the 402 program area are centered predominantly on efforts to control the drinking driver, increase traffic law enforcement, improve the quality of emergency medical services through additional training of state and local personnel, and improve the collection and analysis of traffic accident data.

Approximately $3,500,000 will be available on a Statewide basis, during Federal Fiscal Year 1993, to units of government to address the Federal priority areas, which are: Alcohol and Other Drug Countermeasures, Police Traffic Services, Occupant Protection, Emergency Medical Services, Traffic Records, Motorcycle Safety, Pedestrian/Bicycle Safety and Roadway Safety.

Federal law requires that 40 percent of the funds be expended through grants to local governments. This notice solicits applications from government units that are interested in developing and implementing projects under this program.

A copy of the Highway Safety Plan and the Application for Highway Safety Project Grants are available by writing to: New Jersey Division of Highway Traffic Safety, CN-048, Trenton, New Jersey 08625 or telephone (609) 588-3750.

Grant applications will be accepted throughout the 1991-92 Federal Fiscal Year. The Division contemplates that application decisions will be rendered within 30 days of receipt.

TRANSPORTATION

(b)

OFFICE OF THE COMMISSIONER

Notice of Address for Petitions Involving the Sale, Lease or other Disposition of Railroad Property

Take notice that, effective immediately, petitions and filings to the New Jersey Department of Transportation relating to the sale, lease or other disposition of railroad property pursuant to N.J.S.A. 48:3-7 and N.J.A.C. 16:51-3.5 should be addressed to:

Director, Division of Right-of-Way
New Jersey Department of Transportation
1035 Parkway Avenue
CN-600
Trenton, N.J. 08625

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EXECUTIVE ORDER NO. 66(1978) EXPIRATION DATES

Pursuant to Executive Order No. 66(1978), an administrative rule is assigned an expiration date not to exceed five years from the date of promulgation by a State agency, unless the rule is exempt from the provisions of the order. In the Administrative Code, a single expiration date is affixed at the chapter level and applies to the entire chapter. See N.J.A.C. 1:30-4.4 for an explanation of expiration date assignment.

The following table is a complete listing of established New Jersey Administrative Code expiration dates and exemptions, by Title and Chapter. Current expiration dates may also be found in the loose-leaf volumes of the Administrative Code as a part of the Title Table of Contents for each executive department or agency, on the Subtitle Page for each group of chapters in a Title, and at the beginning of each Chapter.

This listing is published quarterly, in March, June, September and December, in the first issue of the month.

OFFICE OF ADMINISTRATIVE LAW—TITLE 1

N.J.A.C.	Expiration Date
1:1	4/21/97
1:5	9/13/96
1:6	4/21/97
1:6A	3/19/95
1:7	4/21/97
1:10	4/21/97
1:10B	9/13/96
1:11	4/21/97
1:13	4/21/97
1:13A	4/3/94
1:14	7/15/96
1:20	4/21/97
1:21	4/21/97
1:30	1/25/96
1:31	4/21/97

AGRICULTURE—TITLE 2

N.J.A.C.	Expiration Date
2:1	11/19/95
2:2	1/17/94
2:3	8/21/94
2:5	8/21/94
2:6	EXPIRED RULES
2:9	8/19/96
2:16	1/22/96
2:17	5/31/96
2:18	8/5/96
2:19	10/1/95
2:20	10/1/95
2:21	8/5/96
2:22	6/26/97
2:23	7/18/93
2:24	4/2/95
2:32	5/13/97
2:33	3/6/94
2:34	1/2/95
2:48	10/25/95
2:50	5/1/97
2:52	5/1/95
2:53	1/10/96
2:54	Exempt (7 U.S.C. 601 et seq. 7 C.F.R. 1004)
2:68	11/7/93
2:69	11/7/93
2:70	8/20/95
2:71	7/8/93
2:72	7/8/93
2:74	7/8/93
2:76	7/31/94
2:90	6/22/95

BANKING—TITLE 3

N.J.A.C.	Expiration Date
3:1	1/4/96
3:2	4/12/95
3:3	1/11/95
3:4	8/17/97
3:6	3/1/96
3:7	9/12/95
3:11	5/1/94
3:12	6/15/97
3:13	1/21/97
3:16	6/18/95
3:17	6/13/96
3:18	1/19/93
3:19	3/15/96
3:21	1/24/97
3:22	5/12/94
3:23	7/6/97
3:24	8/18/94
3:25	7/23/97
3:26	12/31/95
3:27	9/12/95
3:28	12/12/94
3:29	8/5/96
3:32	10/3/93
3:33	9/18/94
3:38	10/5/92
3:41	10/11/95
3:42	4/4/93

PERSONNEL—TITLE 4A

N.J.A.C.	Expiration Date
4A:1	10/5/92
4A:2	10/5/92
4A:3	9/6/93
4A:4	6/6/93
4A:5	10/5/92
4A:6	1/4/93
4A:7	10/5/92
4A:8	1/16/95
4A:9	10/5/92
4A:10	11/2/92

COMMUNITY AFFAIRS—TITLE 5

N.J.A.C.	Expiration Date
5:1	2/5/95
5:2	4/10/94
5:3	9/1/93
5:4	10/5/92
5:10	11/17/93
5:11	3/10/94
5:12	12/27/94
5:13	6/22/97
5:14	11/9/95
5:15	5/1/94
5:18	1/4/95
5:18A	1/4/95
5:18B	1/4/95
5:18C	2/5/95
5:19	2/1/93
5:20	9/3/96
5:22	2/5/95
5:23	3/1/93
5:24	7/10/95

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N.J.A.C.	Expiration Date
5:25	2/19/96
5:25A	4/20/97
5:26	2/7/96
5:27	5/2/95
5:28	12/13/95
5:29	2/19/96
5:30	6/29/93
5:31	12/1/94
5:33	8/6/95
5:34	12/3/95
5:37	1/7/96
5:50	10/27/93
5:51	9/1/93
5:52	1/2/95
5:70	4/22/97
5:71	6/4/95
5:80	4/20/95
5:91	2/7/96
5:92	2/7/96
5:100	6/18/95

DEPARTMENT OF MILITARY AND VETERANS' AFFAIRS—TITLE 5A

N.J.A.C.	Expiration Date
5A:1	3/12/95
5A:2	5/17/95
5A:3	2/3/97
5A:4	2/3/97

EDUCATION—TITLE 6

N.J.A.C.	Expiration Date
6:1	1/11/96
6:2	2/6/94
6:3	7/8/93
6:5	10/22/95
6:7	1/2/95
6:8	12/11/96
6:11	9/21/95
6:12	3/8/96
6:20	7/16/95
6:21	11/22/94
6:22	7/16/95
6:22A	12/19/93
6:24	1/11/96
6:26	8/3/97
6:28	4/10/94
6:29	2/8/95
6:30	7/5/93
6:31	11/16/94
6:39	8/14/94
6:43	8/10/95
6:46	4/10/94
6:51	8/5/96
6:53	4/10/97
6:64	1/11/93
6:68	2/26/95
6:70	10/17/94
6:78	11/7/93

ENVIRONMENTAL PROTECTION AND ENERGY—TITLE 7

N.J.A.C.	Expiration Date
7:1	8/15/95
7:1A	5/22/97
7:1C	6/15/95
7:1D	11/28/93
7:1E	9/3/96
7:1F	4/16/97
7:1G	9/29/94
7:1H	7/13/95
7:1I	7/18/93
7:2	10/7/96
7:3	3/21/93
7:4	8/17/97
7:4A	9/18/94
7:5	11/19/95
7:5A	6/24/93
7:5B	6/24/93
7:5C	1/16/95
7:6	6/9/94
7:7	5/12/94
7:7A	3/16/97
7:7E	7/24/95
7:7F	1/19/93
7:8	2/5/93
7:9	1/18/96
7:9A	8/21/94
7:10	9/1/94
7:11	5/13/93
7:12	4/11/93
7:13	7/14/94
7:14	4/27/94
7:14A	6/2/94
7:14B	12/21/92
7:15	10/2/94
7:18	7/3/96
7:19	2/26/95
7:19A	3/19/95
7:19B	3/19/95
7:20	5/2/95
7:20A	12/16/93
7:22	12/27/96
7:22A	2/5/95
7:23	6/9/94
7:24	4/22/96
7:25	2/15/96
7:25A	4/23/95
7:26	10/25/95
7:26A	11/18/96
7:26B	12/21/92
7:27	Exempt
7:27A	12/4/94
7:27B	Exempt
7:28	7/30/95
7:29	5/21/95
7:29B	2/1/93
7:30	12/4/92
7:31	6/20/93
7:36	11/21/93
7:38	9/18/95
7:45	2/6/94
7:50	Exempt
7:60	3/2/97

HEALTH—TITLE 8

N.J.A.C.	Expiration Date
8:7	9/14/95
8:8	4/12/94
8:9	2/14/96
8:13	9/8/92
8:18	11/6/94
8:19	5/11/95
8:20	3/2/95
8:21	10/23/95
8:21A	8/3/97
8:22	7/11/96
8:23	12/13/94
8:24	5/2/93
8:25	5/19/93
8:26	4/12/96

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N.J.A.C.	Expiration Date
8:31	1/16/95
8:31A	2/20/95
8:31B	8/17/95
8:31C	4/20/97
8:33	7/27/95
8:33A	EXPIRED RULES
8:33B	7/27/95
8:33C	9/8/97
8:33E	EXPIRED RULES
8:33F	11/16/94
8:33G	7/17/94
8:33H	9/8/97
8:33I	EXPIRED RULES
8:33J	4/24/94
8:33K	3/27/94
8:33L	11/16/92
8:33M	7/17/94
8:33N	5/15/94
8:33P	3/19/95
8:33Q	11/19/95
8:34	11/15/93
8:35A	9/8/97
8:38	4/3/94
8:39	6/20/93
8:40	12/6/96
8:41	2/13/93
8:41A	2/18/97
8:42	8/17/97
8:42A	6/19/94
8:42B	7/18/93
8:43	11/19/92
8:43A	7/27/95
8:43E	12/11/92
8:43F	2/20/95
8:43G	2/5/95
8:43H	8/21/94
8:43I	3/21/93
8:44	11/2/93
8:45	2/7/95
8:51	9/17/95
8:52	12/11/96
8:57	4/20/95
8:57A	4/20/95
8:59	9/29/94
8:60	5/3/95
8:61	10/4/96
8:65	6/17/96
8:66	3/5/95
8:66A	3/5/95
8:70	8/19/93
8:71	2/17/94
8:80	4/6/97
8:100	7/20/97

HIGHER EDUCATION—TITLE 9

N.J.A.C.	Expiration Date
9:1	2/21/94
9:2	5/4/95
9:3	9/27/93
9:4	9/26/96
9:5	4/1/96
9:6	4/30/95
9:6A	1/4/93
9:7	2/28/93
9:8	10/15/95
9:9	10/3/93
9:11	4/17/94
9:12	4/17/94
9:14	4/11/95
9:15	8/21/94

HUMAN SERVICES—TITLE 10

N.J.A.C.	Expiration Date
10:1	11/7/93
10:2	12/11/96
10:3	11/21/93
10:6	1/7/96
10:7	1/21/97
10:11	1/16/95
10:12	12/23/96
10:13	7/18/93
10:14	5/16/93
10:15	1/1/95
10:15A	1/1/95
10:15B	1/1/95
10:15C	1/1/95
10:31	6/5/94
10:36	12/31/92
10:37	11/2/95
10:38	4/29/96
10:39	5/7/95
10:40	5/11/94
10:41	3/20/94
10:42	8/19/96
10:43	8/21/94
10:44A	11/21/93
10:44B	7/16/95
10:45	2/20/95
10:46	9/17/95
10:47	11/2/95
10:48	12/19/95
10:49	8/17/97
10:50	2/27/96
10:51	10/9/95
10:52	2/8/95
10:53	4/27/95
10:54	2/15/96
10:55	3/8/95
10:56	8/21/96
10:57	2/13/96
10:58	2/22/96
10:59	2/15/96
10:60	2/19/96
10:61	2/15/96
10:62	12/19/93
10:63	11/28/94
10:64	2/22/96
10:65	2/19/96
10:66	12/15/93
10:67	2/19/96
10:68	6/28/96
10:69	6/6/93
10:69A	4/20/93
10:69B	11/21/93
10:70	6/7/96
10:71	12/24/95
10:72	8/24/97
10:73	7/15/96
10:80	5/19/94
10:81	8/24/94
10:82	8/24/94
10:83	1/19/94
10:85	12/20/94
10:87	1/27/94
10:89	5/24/95
10:90	10/14/92
10:91	9/4/95
10:95	Exempt
10:97	5/15/94
10:99	6/4/95
10:109	2/4/96
10:120	7/9/96
10:121	7/16/95
10:121A	12/7/92
10:122	5/15/94
10:122A	Exempt
10:123	7/13/95
10:123A	8/17/97

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N.J.A.C.	Expiration Date
10:124	12/7/92
10:125	6/4/95
10:126	11/7/93
10:126A	5/7/95
10:127	8/26/93
10:128	2/19/96
10:129	7/13/95
10:130	7/2/95
10:131	12/7/92
10:132	10/25/96
10:141	2/7/94

CORRECTIONS—TITLE 10A

N.J.A.C.	Expiration Date
10A:1	6/1/97
10A:2	2/5/95
10A:3	9/16/96
10A:4	5/7/96
10A:5	6/17/96
10A:6	11/2/92
10A:8	11/16/92
10A:9	2/18/97
10A:10	7/9/97
10A:16	7/6/97
10A:17	2/3/97
10A:18	5/27/97
10A:19	8/21/94
10A:20	2/18/97
10A:21	2/4/96
10A:22	7/5/93
10A:23	7/6/97
10A:31	3/5/95
10A:32	4/16/95
10A:33	5/2/94
10A:34	4/6/97
10A:35	4/15/96
10A:70	Exempt
10A:71	2/5/95

INSURANCE—TITLE 11

N.J.A.C.	Expiration Date
11:1	1/31/96
11:2	11/30/95
11:3	1/4/96
11:4	11/30/95
11:5	10/28/93
11:7	10/19/92
11:10	7/12/95
11:12	9/27/96
11:13	11/12/92
11:15	10/26/94
11:16	1/31/96
11:17	4/18/93
11:17A	1/2/95
11:17B	1/2/95
11:17C	1/2/95
11:17D	1/2/95
11:18	12/18/94

LABOR—TITLE 12

N.J.A.C.	Expiration Date
12:3	12/19/93
12:5	9/19/93
12:6	10/17/93
12:15	7/30/95
12:16	3/23/95
12:17	1/4/96
12:18	3/7/93
12:19	7/2/95
12:20	8/14/94
12:35	7/16/95
12:40	2/5/95
12:41	1/17/94
12:45	5/2/93
12:51	11/22/96
12:55	12/16/96
12:56	9/26/95
12:57	9/26/95
12:58	9/26/95
12:60	3/21/93
12:61	12/16/96
12:90	12/15/94
12:100	9/22/94
12:102	5/21/95
12:105	1/11/96
12:110	1/19/93
12:112	9/6/93
12:120	5/3/95
12:175	11/28/93
12:190	1/4/93
12:195	6/24/93
12:196	8/6/95
12:200	8/3/95
12:210	12/16/96
12:235	5/3/96

COMMERCE AND ECONOMIC DEVELOPMENT—TITLE 12A

N.J.A.C.	Expiration Date
12A:9	3/7/93
12A:10-1	10/13/94
12A:11	9/21/92
12A:12	9/21/92
12A:31	7/16/95
12A:50	8/15/93
12A:54	8/15/93
12A:60	11/21/93
12A:80	7/2/95
12A:100	7/17/96
12A:120	9/6/93
12A:121	12/5/93

LAW AND PUBLIC SAFETY—TITLE 13

N.J.A.C.	Expiration Date
13:1	7/5/93
13:2	7/24/95
13:3	4/25/93
13:4	1/17/96
13:10	3/27/94
13:13	7/16/95
13:14	9/16/96
13:18	3/30/95
13:19	8/18/94
13:20	12/13/95
13:21	12/13/95
13:23	5/26/94
13:24	9/27/94
13:25	3/16/95
13:26	9/26/93
13:27	2/20/95
13:28	5/16/93
13:29	5/23/95
13:30	3/12/95
13:31	11/20/96
13:32	10/23/92
13:33	3/12/95
13:34	10/26/93
13:35	9/21/94
13:36	9/27/94
13:37	1/23/95
13:38	8/27/95
13:39	6/19/94
13:39A	6/21/96
13:40	8/3/95

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N.J.A.C.	Expiration Date
13:40A	12/16/96
13:41	7/17/95
13:42	10/31/93
13:43	9/1/93
13:44	8/7/94
13:44B	11/2/92
13:44C	7/18/93
13:44D	8/7/94
13:44E	7/1/96
13:44F	6/15/97
13:45A	11/9/95
13:45B	4/17/94
13:46	9/4/95
13:47	1/27/97
13:47A	10/5/92
13:47B	2/21/94
13:47C	6/9/94
13:47K	9/17/95
13:48	1/17/96
13:49	12/16/93
13:51	9/16/96
13:54	11/18/96
13:59	7/30/95
13:60	1/16/97
13:61	3/5/95
13:62	3/19/95
13:63	8/19/96
13:70	1/25/95
13:71	1/25/95
13:75	6/5/94
13:76	6/27/93
13:77	2/1/93
13:78	3/20/94
13:80	9/17/95
13:81	8/6/95

PUBLIC UTILITIES—TITLE 14

N.J.A.C.	Expiration Date
14:1	6/1/97
14:3	5/6/96
14:5	12/2/96
14:6	9/3/96
14:9	4/1/96
14:10	9/6/96
14:11	EXPIRED RULES
14:12	11/4/96
14:17	4/24/94
14:18	7/26/95
14:25	3/5/95
14:29	3/4/96
14:30	2/19/96
14:32	1/22/96
14:38	4/1/96

ENERGY—TITLE 14A

N.J.A.C.	Expiration Date
14A:6	1/16/95
14A:8	1/16/95
14A:11	1/16/95
14A:13	EXPIRED RULES
14A:14	1/30/94

STATE—TITLE 15

N.J.A.C.	Expiration Date
15:2	5/2/93
15:3	8/19/96
15:5	7/6/97
15:10	4/15/96

PUBLIC ADVOCATE—TITLE 15A

N.J.A.C.	Expiration Date
15A:2	12/27/94

TRANSPORTATION—TITLE 16

N.J.A.C.	Expiration Date
16:1	10/1/95
16:1A	6/16/94
16:4	9/16/96
16:5	11/20/94
16:6	8/7/94
16:7	3/6/94
16:13	9/4/95
16:20A	2/20/95
16:20B	2/20/95
16:21	8/6/95
16:21A	11/20/94
16:21B	12/3/95
16:22	12/18/95
16:24	2/5/95
16:25	8/15/93
16:25A	7/18/93
16:26	9/5/94
16:27	4/8/96
16:28	6/1/93
16:28A	6/1/93
16:29	6/1/93
16:30	6/1/93
16:31	6/1/93
16:31A	6/1/93
16:32	2/8/95
16:38	10/15/95
16:41	9/8/97
16:41B	7/2/95
16:41C	5/4/97
16:43	5/10/95
16:44	5/25/93
16:45	9/18/94
16:46	11/6/94
16:47	4/20/97
16:49	2/8/95
16:51	2/14/97
16:53	7/17/94
16:53B	7/3/94
16:53C	6/16/93
16:53D	5/3/94
16:54	3/28/96
16:55	6/14/93
16:56	8/7/94
16:60	6/14/93
16:61	6/14/93
16:62	2/26/95
16:72	3/20/96
16:73	5/18/97
16:74	12/16/96
16:75	5/13/93
16:76	2/6/94
16:77	3/5/95
16:78	12/17/95
16:79	9/12/96
16:80	11/7/93
16:81	11/7/93
16:82	9/5/94

TREASURY-GENERAL—TITLE 17

N.J.A.C.	Expiration Date
17:1	5/6/93
17:2	11/8/94
17:3	8/15/93
17:4	6/8/95
17:5	11/30/95
17:6	11/22/93
17:7	12/19/93

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N.J.A.C.	Expiration Date
17:8	10/15/95
17:9	10/3/93
17:10	5/6/93
17:12	10/13/94
17:13	10/13/94
17:14	10/13/94
17:16	5/2/96
17:19	3/8/95
17:20	9/26/93
17:25	5/26/94
17:27	10/7/93
17:28	8/17/95
17:29	9/26/95
17:30	3/11/97
17:32	3/21/93
17:33	4/17/94
17:40	11/19/95
17:41	4/1/96
17:42	9/8/97

TREASURY-TAXATION—TITLE 18

N.J.A.C.	Expiration Date
18:1	7/21/94
18:2	9/6/93
18:3	3/14/94
18:5	3/14/94
18:6	3/14/94
18:7	3/14/94
18:8	2/24/94
18:9	6/7/93
18:12	7/29/93
18:12A	7/29/93
18:14	7/29/93
18:15	7/29/93
18:16	7/29/93
18:17	7/29/93
18:18	3/14/94
18:18A	2/3/97
18:19	3/14/94
18:21	2/19/96
18:22	2/24/94
18:23	2/24/94
18:23A	9/4/95
18:24	6/7/93
18:25	2/19/96
18:26	6/7/93
18:35	6/7/93
18:36	3/19/95
18:37	7/23/95
18:38	2/16/93
18:39	9/8/92

OTHER AGENCIES—TITLE 19

N.J.A.C.	Expiration Date
19:3	5/26/93
19:3A	11/4/96
19:3B	Exempt (N.J.S.A. 13:17-1)
19:4	5/26/93
19:4A	6/20/93
19:6	5/6/96
19:8	7/5/93
19:9	10/17/93
19:10	9/5/94
19:11	8/20/95
19:12	7/17/96
19:14	8/20/95
19:16	7/17/96
19:17	6/8/93
19:18	5/21/95
19:20	2/5/95
19:25	10/1/95
19:30	7/23/95
19:31	8/20/95
19:40	8/24/94
19:41	5/12/93
19:42	5/12/93
19:43	4/27/94
19:44	9/29/93
19:45	3/24/93
19:46	4/28/93
19:47	4/28/93
19:48	10/13/93
19:49	3/24/93
19:50	5/12/93
19:51	8/14/96
19:52	1/6/97
19:53	4/28/93
19:54	3/24/93
19:61	3/2/97
19:65	EXPIRED RULES
19:75	1/13/94

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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 July 6, 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 JUNE 15, 1992

NEXT UPDATE: SUPPLEMENT JULY 20, 1992

Note: If no changes have occurred in a Title during the previous month, no update will be issued for that Title.

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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. 2561 and 2806	September 3, 1991	24 N.J.R. 889 and 1138	March 16, 1992
23 N.J.R. 2807 and 2898	September 16, 1991	24 N.J.R. 1139 and 1416	April 6, 1992
23 N.J.R. 2899 and 3060	October 7, 1991	24 N.J.R. 1417 and 1658	April 20, 1992
23 N.J.R. 3061 and 3192	October 21, 1991	24 N.J.R. 1659 and 1840	May 4, 1992
23 N.J.R. 3193 and 3402	November 4, 1991	24 N.J.R. 1841 and 1932	May 18, 1992
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		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
ADMINISTRATIVE LAW—TITLE 1				
1:1-1.5, App. A	Conduct of administrative law judges	24 N.J.R. 2755(a)		
1:6A-9.2, 14.1, 14.4, 18.1, 18.3, 18.5	Special Education Program	24 N.J.R. 1936(a)	R.1992 d.331	24 N.J.R. 3091(a)
1:13A-1.2, 18.1, 18.2	Lemon Law hearings: exceptions to initial decision	24 N.J.R. 1843(a)		
1:31-3.1	Conduct of administrative law judges	24 N.J.R. 2755(a)		
Most recent update to Title 1: TRANSMITTAL 1992-3 (supplement May 18, 1992)				
AGRICULTURE—TITLE 2				
2:5-1	Equine entry restriction	Emergency (expires 9-18-92)	R.1992 d.321	24 N.J.R. 2737(a)
2:22	Insect control	24 N.J.R. 1662(a)	R.1992 d.294	24 N.J.R. 2556(a)
2:24-4	Volunteer Inspector Program: noncommercial apiaries and bees	24 N.J.R. 1141(a)	R.1992 d.278	24 N.J.R. 2421(a)
2:69-1.11	Commercial values of primary plant nutrients	24 N.J.R. 2318(a)		
2:71-2.2, 2.4, 2.5, 2.6	Jersey Fresh Quality Grading Program	24 N.J.R. 2318(b)		
2:71-2.28, 2.29	Inspection and grading charges for fruits and vegetables	24 N.J.R. 2321(a)		
2:76-3.12, 4.11	Farmland Preservation Program: pre-existing nonagricultural uses of enrolled lands	24 N.J.R. 893(b)	R.1992 d.325	24 N.J.R. 2831(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 nonagricultural uses on lands permanently deed restricted	24 N.J.R. 896(a)	R.1992 d.324	24 N.J.R. 2833(a)
2:76-6.15	Farmland Preservation Program: pre-existing uses on lands permanently deed restricted	24 N.J.R. 2833(a)		
Most recent update to Title 2: TRANSMITTAL 1992-2 (supplement June 15, 1992)				
BANKING—TITLE 3				
3:1-19	Consumer checking accounts	24 N.J.R. 1662(b)	R.1992 d.305	24 N.J.R. 2710(a)
3:4-1	Capital requirements for depository institutions	24 N.J.R. 1665(a)	R.1992 d.326	24 N.J.R. 2834(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)		
3:23	Department license fees	24 N.J.R. 1667(a)	R.1992 d.303	24 N.J.R. 2712(a)
3:25	Debt adjustment and credit counseling	24 N.J.R. 2106(a)	R.1992 d.323	24 N.J.R. 2836(a)
3:38	Mortgage bankers and brokers	24 N.J.R. 2653(a)		
3:38-1.9, 5.2, 5.3	Branch offices; mortgage services licensure exemption; solicitor registration	24 N.J.R. 1937(a)		
Most recent update to Title 3: TRANSMITTAL 1992-5 (supplement June 15, 1992)				
CIVIL SERVICE—TITLE 4				
Most recent update to Title 4: TRANSMITTAL 1990-3 (supplement July 16, 1990)				
PERSONNEL—TITLE 4A				
4A:1	General rules and Department organization	24 N.J.R. 2490(a)		
4A:2	Appeals, discipline, separations	24 N.J.R. 2491(a)		
4A:2-2.13	Expungement from personnel files of references to disciplinary action	23 N.J.R. 2906(a)		

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N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
4A:4-3.7, 7.10, 7.12	Reinstatement of permanent employee following disability retirement	24 N.J.R. 2107(a)	R.1992 d.338	24 N.J.R. 3091(b)
4A:4-7.11	Transfers and retention of employee rights in a consolidation	24 N.J.R. 2494(a)		
4A:5	Veterans and disabled veterans preference	24 N.J.R. 2495(a)		
4A:6-1, 2, 3, 4, 5	Leaves, hours of work, and employee development: preproposed readoption	24 N.J.R. 2496(b)		
4A:6-6	Awards program: preproposed readoption	24 N.J.R. 2496(a)		
4A:6-16	Sick leave injury (SLI) benefits: carpal tunnel syndrome and asbestosis	24 N.J.R. 2108(a)		
4A:7	Equal employment opportunity and affirmative action	24 N.J.R. 2496(c)		
4A:9-1	Political subdivision	24 N.J.R. 2498(a)		
4A:10	Violations and penalties	24 N.J.R. 2499(a)		

Most recent update to Title 4A: TRANSMITTAL 1992-1 (supplement January 21, 1992)

COMMUNITY AFFAIRS—TITLE 5

5:4-2	Debarment and suspension from Department contracting	24 N.J.R. 2322(a)		
5:10-25	Indirect apportionment of heating costs in multiple dwellings: methods, devices, and systems	24 N.J.R. 1844(a)		
5:12-2.1	Homelessness Prevention Program: eligibility	23 N.J.R. 3439(a)		
5:13	Limited dividend and nonprofit housing corporations and associations	24 N.J.R. 1668(a)	R.1992 d.290	24 N.J.R. 2556(b)
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)		
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)		
5:18-2.4A, 2.4B, 2.7	Uniform Fire Code: life hazard uses; permits	23 N.J.R. 2999(a)		
5:18A-2.9, 4.6	Fire Code enforcement: conflict of interest	24 N.J.R. 678(a)	R.1992 d.243	24 N.J.R. 2422(a)
5:19	Continuing care retirement communities	24 N.J.R. 1146(a)		
5:22-1, 2	Rehabilitation of one and two-unit residences and multiple dwellings: exemptions from taxation	24 N.J.R. 1669(a)	R.1992 d.291	24 N.J.R. 2556(c)
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)		
5:23-3.7, 3.8, 4.20	Indirect apportionment of heating costs in multiple dwellings: methods, devices, and systems	24 N.J.R. 1844(a)		
5:23-3.10, 5	UCC: enforcing agency classification; licensing of enforcement officials	24 N.J.R. 1446(a)	R.1992 d.272	24 N.J.R. 2424(a)
5:23-3.14	Uniform Construction Code: tent permits	24 N.J.R. 2656(a)		
5:23-3.21	UCC: one and two family dwelling subcode	23 N.J.R. 3444(b)		
5:23-4.5, 4.11, 4.14	UCC enforcement: conflict of interest	24 N.J.R. 678(a)	R.1992 d.243	24 N.J.R. 2422(a)
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)		
5:23-4.18, 4.20	UCC enforcing agencies: minimum fees	24 N.J.R. 169(b)		
5:23-4.18, 4.20	Uniform Construction Code: gas service entrances	24 N.J.R. 1846(a)	R.1992 d.313	24 N.J.R. 2712(b)
5:23-5.4	Uniform Construction Code: enforcement interns	24 N.J.R. 1669(b)	R.1992 d.292	24 N.J.R. 2557(a)
5:23-5.7	UCC: subcode official requirements	24 N.J.R. 2661(a)		
5:23-5.19	UCC: elevator inspector H.H.S. requirements	24 N.J.R. 2662(a)		
5:24-3	Protected housing tenancy in qualified counties and in planned real estate developments	24 N.J.R. 1453(a)	R.1992 d.287	24 N.J.R. 2429(a)
5:25-5.4	State new home warranty plan contributions	24 N.J.R. 2663(a)		
5:26-2.3, 2.4	Planned real estate development full disclosure: fees	24 N.J.R. 2657(a)		
5:26-9.1, 9.2	Protected housing tenancy in qualified counties and in planned real estate developments	24 N.J.R. 1453(a)	R.1992 d.287	24 N.J.R. 2429(a)
5:30-8.2	Unbudgeted school aid	24 N.J.R. 2766(a)		
5:33-1.2, 1.3, 1.5–1.8	Municipal tax collection procedures	24 NJ.R. 2766(a)		
5:33-4	Property tax and mortgage escrow account transactions	24 N.J.R. 2664(a)		
5:34-7	Cooperative purchasing by local contracting units	24 N.J.R. 2667(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)		
5:100-2.3, 2.4, 2.5	Ombudsman for Institutionalized Elderly: resident advance directives	24 N.J.R. 1455(a)	R.1992 d.284	24 N.J.R. 2431(a)
5:100-2.3, 2.4, 2.5	Ombudsman for Institutionalized Elderly: extension of comment period on resident advance directives	24 N.J.R. 1847(a)		

Most recent update to Title 5: TRANSMITTAL 1992-6 (supplement June 15, 1992)

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N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
MILITARY AND VETERANS' AFFAIRS—TITLE 5A				
5A:5	State veterans' facilities: admission criteria, care maintenance fee, transfer or discharge	24 N.J.R. 2499(b)		
	Most recent update to Title 5A: TRANSMITTAL 1992-1 (supplement February 18, 1992)			
EDUCATION—TITLE 6				
6:5-2.4, 2.5	Organization of Department: reporting responsibilities; public information requests	Exempt	R.1992 d.279	24 N.J.R. 2431(b)
6:8-9	Educational improvement plans in special needs districts	24 N.J.R. 2323(a)		
6:20-9.2	Policy and agreement for School Nutrition Programs: administrative correction	_____	_____	24 N.J.R. 2712(c)
6:21-5, 6, 6A, 6B, 6C, 8, 9	Pupil transportation: school bus and small vehicle standards	24 N.J.R. 2109(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)		
6:26	Establishment of pupil assistance committees	24 N.J.R. 1670(a)	R.1992 d.307	24 N.J.R. 2713(a)
6:28	Special education	24 N.J.R. 1150(a)	R.1992 d.280	24 N.J.R. 2434(a)
6:29-2.4	Attendance at school by pupils or adults infected by HIV	24 N.J.R. 2124(a)		
6:29-8	Nonpublic school nursing services	24 N.J.R. 2325(b)		
6:64	Public, school, and college libraries	24 N.J.R. 2126(a)		
	Most recent update to Title 6: TRANSMITTAL 1992-2 (supplement May 18, 1992)			
ENVIRONMENTAL PROTECTION AND ENERGY—TITLE 7				
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 requirements: preproposed new rules	24 N.J.R. 1968(a)		
7:4	New Jersey Register of Historic Places: procedures for listing of historic places	23 N.J.R. 2103(b)	R.1992 d.318	24 N.J.R. 2926(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)		
7:9-6	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)		
7:14-8.3	Water Pollution Control Act: administrative correction regarding affirmative defense by violator	_____	_____	24 N.J.R. 2448(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)		
7:15-1.5, 3.4, 3.6, 4.1, 5.22	Statewide water quality management planning	24 N.J.R. 344(b)		
7:19-6.8	Water supply interconnections: administrative correction	_____	_____	24 N.J.R. 2715(a)
7:25-5	1992-93 Game Code	24 N.J.R. 1847(b)	R.1992 d.315	24 N.J.R. 2715(b)
7:25-5.13	1992-93 Game Code: hunting prohibition in Monmouth County	24 N.J.R. 2773(a)		
7:25-6	1993-94 Fish Code	24 N.J.R. 2539(a)		
7:25-16.1	Defining freshwater fishing lines	24 N.J.R. 204(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)		

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N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
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)		
7:26-4.3	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)		
7:26-4.6	Solid waste program fees	23 N.J.R. 3690(a)	R.1992 d.311	24 N.J.R. 2726(a)
7:26-4.6	Solid waste program fees: extension of comment period	24 N.J.R. 1458(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)		
7:26-5.4, 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)		
7:26-8.16	Hazardous constituents in waste streams	23 N.J.R. 3093(b)		
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)		
7:27-25	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)		
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)		
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)		

Most recent update to Title 7: TRANSMITTAL 1992-6 (supplement June 15, 1992)

HEALTH—TITLE 8

8:13	Shellfish handling and shipping; hard and soft shell clam depuration	24 N.J.R. 2504(a)		
8:21-3.13	Repeal (see 8:21-3A)	24 N.J.R. 2410(b)	R.1992 d.354	24 N.J.R. 3100(a)
8:21-3A	Registration of wholesale drug distributors and device manufacturers and wholesale distributors	24 N.J.R. 2410(b)	R.1992 d.354	24 N.J.R. 3100(a)
8:21A	Good drug manufacturing practices; tamper-resistant packaging for over-the-counter products	24 N.J.R. 2003(c)	R.1992 d.316	24 N.J.R. 2729(a)
8:24-1.3, 2.5, 3.3, 13.2	Retail food establishments: "community residence"; eggs and egg dishes	24 N.J.R. 915(a)	R.1992 d.281	24 N.J.R. 2448(b)
8:31A-1.5, 7.4, 7.5, App. D	SHARE Manual: per diem add-on fee assessment	24 N.J.R. 2810(a)		
8:31A-App. A	SHARE Manual: administrative correction regarding Cost Center Record	———	———	24 N.J.R. 3103(a)
8:31B-4.40	Uncompensated care collection procedures	24 N.J.R. 1124(c)		
8:31C-1.5, 1.6	Residential alcoholism treatment facilities: target occupancy penalty	24 N.J.R. 1463(a)	R.1992 d.312	24 N.J.R. 2730(a)
8:33	Health care facilities and services: Certificate of Need application and review process	24 N.J.R. 2222(a)	R.1992 d.342	24 N.J.R. 3104(a)
8:33C	Regionalized perinatal services: Certificate of Need criteria and standards	24 N.J.R. 2005(a)	R.1992 d.343	24 N.J.R. 3131(a)

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N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
8:33H	Long-term care services: Certificate of Need policy manual	24 N.J.R. 2014(a)	R.1992 d.344	24 N.J.R. 3144(a)
8:34-1.7	Licensure examination fee for nursing home administrator	24 N.J.R. 2414(a)	R.1992 d.345	24 N.J.R. 3161(a)
8:34-1.7	Nursing home administrator licensure: examination fee	_____	_____	24 N.J.R. 3179(a)
8:35A	Maternal and child health consortia: licensing standards	24 N.J.R. 2027(a)	R.1992 d.346	24 N.J.R. 3162(a)
8:42	Home health agencies: standards for licensure	24 N.J.R. 2031(a)	R.1992 d.322	24 N.J.R. 2941(a)
8:43	Residential health care facilities: standards for licensure	24 N.J.R. 2506(a)		
8:43G-19	Hospital licensing standards: obstetrics	24 N.J.R. 2045(a)	R.1992 d.347	24 N.J.R. 3165(a)
8:45-1.3, 2.1	Blook bank licensure fees and Department laboratory services charges	24 N.J.R. 2508(a)		
8:65-2.5	Controlled dangerous substances: physical security controls	24 N.J.R. 174(a)		
8:65-10.1	Controlled dangerous substances: addition of methcathinone to Schedule I	_____	_____	24 N.J.R. 2451(a)
8:71	Interchangeable drug products (see 23 N.J.R. 3334(b); 24 N.J.R. 144(b), 948(a), 2558(a))	23 N.J.R. 2610(a)	R.1992 d.351	24 N.J.R. 3174(b)
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))	24 N.J.R. 61(a)	R.1992 d.349	24 N.J.R. 3173(b)
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 (24 N.J.R. 2557(b))	24 N.J.R. 1674(a)	R.1992 d.348	24 N.J.R. 3173(a)
8:71	Interchangeable drug products	24 N.J.R. 2414(b)	R.1992 d.352	24 N.J.R. 3174(c)
8:100	State Health Plan	24 N.J.R. 1164(a)	R.1992 d.299	24 N.J.R. 2561(a)
8:100-14.8, 14.13	State Health Plan: hospital inpatient services	24 N.J.R. 2704(a)		
8:100-16	State Health Plan: correction to Economic Impact statement regarding Long-Term Care Services	24 N.J.R. 1675(a)		

Most recent update to Title 8: TRANSMITTAL 1992-6 (supplement June 15, 1992)

HIGHER EDUCATION—TITLE 9

9:1-1.2, 3.1, 3.2, 3.4, 3.5	Teaching university	24 N.J.R. 1464(a)		
9:7	Student Assistance Programs	24 N.J.R. 2510(a)		
9:7-2.3, 2.11	Student Assistance Programs: administrative corrections	_____	_____	24 N.J.R. 2451(b)
9:9-7.2, 7.3, 7.8	NJCLASS program: family income limit, maximum loan amount, repayment	24 N.J.R. 1675(b)	R.1992 d.293	24 N.J.R. 2626(a)
9:9-7.6	NJCLASS Program: loan interest rate	24 N.J.R. 2687(b)		
9:9-7.6, 7.7	NJCLASS program: student loan interest rates	_____	_____	24 N.J.R. 3180(a)
9:11-1.5	Educational Opportunity Fund Program: financial eligibility for undergraduate grants	24 N.J.R. 1859(a)	R.1992 d.353	24 N.J.R. 3091(c)
9:16-1	Primary Care Physician and Dentist Loan Redemption Program	24 N.J.R. 1192(a)		

Most recent update to Title 9: TRANSMITTAL 1992-2 (supplement May 18, 1992)

HUMAN SERVICES—TITLE 10

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	23 N.J.R. 3417(a)		
10:35	County psychiatric facilities	24 N.J.R. 208(a)		
10:36	Patient supervision at State psychiatric hospitals	24 N.J.R. 1728(a)	R.1992 d.302	24 N.J.R. 2730(b)
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)		
10:49	New Jersey Medicaid Program: basic requirements for recipients and providers	24 N.J.R. 1728(b)	R.1992 d.317	24 N.J.R. 2837(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)		
10:52-1.6, 4	Medicaid reimbursement for outpatient laboratory services	24 N.J.R. 917(a)	R.1992 d.327	24 N.J.R. 2898(a)
10:53-1.5	Medicaid reimbursement for outpatient laboratory services	24 N.J.R. 917(a)	R.1992 d.327	24 N.J.R. 2898(a)
10:53A	Hospice Services Manual	24 N.J.R. 2778(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)		
10:71-5.6	Medicaid Only income eligibility standards for hospice care	24 N.J.R. 2778(a)		
10:72	New Jersey Care: Special Medicaid Programs Manual	24 N.J.R. 2145(a)		
10:72-1.1, 3.4, 4.1	New Jersey Care: Medicaid eligibility of children	24 N.J.R. 1860(a)		

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N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
10:81-1.6, 1.11, 1.12, 2.1, 2.2, 2.4, 2.7, 2.8, 3.8, 3.9, 3.18, 3.19, 4.2, 4.23, 5.2, 5.7, 5.8, 7.1, 7.4, 7.20, 8.22, 8.24, 9.1, 14.1, 14.18, 14.20, 14.21	Public Assistance Manual: Family Development Program and REACH/JOBS provisions	24 N.J.R. 2147(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)		
10:82-1.2–1.5, 1.11, 2.7–2.11, 4.4, 4.8	Assistance Standards Handbook: AFDC program requirements	24 N.J.R. 2155(a)		
10:82-2.8	Assistance Standards Handbook: administrative correction regarding earned income in AFDC segments	_____	_____	24 N.J.R. 2626(b)
10:82-4.9	Assistance Standards Handbook: DYFS monthly foster care rates	24 N.J.R. 2160(a)	R.1992 d.340	24 N.J.R. 3092(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)		
10:85-3.2, 10.1	General Assistance Manual: Family Development Program and work training requirements	24 N.J.R. 2160(b)		
10:86	Family Development Program Manual	24 N.J.R. 2161(a)		
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)		
10:122B	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)		
10:123A	Youth and Family Services: Personal Attendant Services Program	23 N.J.R. 2091(b)	R.1992 d.314	24 N.J.R. 2914(a)
10:131	DYFS: Adoption Assistance and Child Welfare Act of 1980 requirements	24 N.J.R. 2522(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)		

Most recent update to Title 10: TRANSMITTAL 1992-6 (supplement June 15, 1992)

CORRECTIONS—TITLE 10A

10A:1	Department administration, organization, and management	24 N.J.R. 1465(a)	R.1992 d.269	24 N.J.R. 2451(c)
10A:3-9.11	Office of Interstate Services: administrative correction	_____	_____	24 N.J.R. 3093(a)
10A:4-4.1	Prohibited inmate acts: administrative correction	_____	_____	24 N.J.R. 2731(a)
10A:5-1.3, 7	Temporary close custody	24 N.J.R. 1676(a)		
10A:6	Inmate access to courts	24 N.J.R. 2799(a)		
10A:8	Inmate orientation and handbook	24 N.J.R. 2330(a)		
10A:10	Interjurisdictional agreements and statutes	24 N.J.R. 1939(a)	R.1992 d.310	24 N.J.R. 2731(b)
10A:16	Medical and health services	24 N.J.R. 1677(a)	R.1992 d.283	24 N.J.R. 2452(a)
10A:18	Inmate mail, visits, and telephone use	24 N.J.R. 1204(b)	R.1992 d.262	24 N.J.R. 2627(a)
10A:23	Lethal injection	24 N.J.R. 1677(a)	R.1992 d.283	24 N.J.R. 2452(a)

Most recent update to Title 10A: TRANSMITTAL 1992-3 (supplement May 18, 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)

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N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
11:2-27	Determination of insurers in hazardous financial condition	23 N.J.R. 3197(a)	R.1992 d.282	24 N.J.R. 2456(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)		
11:3-2	Personal automobile insurance plan	24 N.J.R. 331(a)		
11:3-3	Automobile insurance: limited assignment distribution servicing carriers	24 N.J.R. 519(a)		
11:3-19.3, 34.3	Automobile insurance eligibility rating plans: incorporation of merit rating surcharge	24 N.J.R. 2332(a)		
11:3-33.2	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	24 N.J.R. 2812(a)		
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 inspection procedures: operative date	24 N.J.R. 2708(c)		
11:3-42	Producer Assignment Program	24 N.J.R. 2812(b)		
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)		
11:5-1.9, 1.38	Real Estate Commission: fee cap for mortgage services; transmittal of funds to lenders	24 N.J.R. 1957(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)		
11:7	Insurance of municipal bonds	24 N.J.R. 1958(a)		
11:13	Commercial lines insurance	24 N.J.R. 2830(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)		

Most recent update to Title 11: TRANSMITTAL 1992-6 (supplement June 15, 1992)

LABOR—TITLE 12

12:16-4.8	Board and room, meals and lodging in lieu of wages: 1993 rates	_____	_____	24 N.J.R. 3182(a)
12:56-8.10	Wage and Hour: housing credit for migrant seasonal farmworkers	Emergency (expires 9-6-92)	R.1992 d.306	24 N.J.R. 2638(a)
12:56-10	Wage and Hour: employment of learners; sub-minimum wage	24 N.J.R. 2129(b)	R.1992 d.328	24 N.J.R. 2924(a)
12:60-3.2, 4.2	Prevailing wages on public works contracts: telecommunications worker	24 N.J.R. 2689(a)		
12:100-4.2, 10, 17.1, 17.3	Safety standards for firefighters	24 N.J.R. 73(a)		
12:235-9.4	Workers' Compensation: appeal procedures regarding discrimination complaint decisions	24 N.J.R. 1684(a)		

Most recent update to Title 12: TRANSMITTAL 1992-1 (supplement February 18, 1992)

COMMERCE AND ECONOMIC DEVELOPMENT—TITLE 12A

12A:31-1, 2	Small businesses, minorities' and women's enterprises: direct loan and loan guarantee programs	24 N.J.R. 2131(a)	R.1992 d.330	24 N.J.R. 3093(b)

Most recent update to Title 12A: TRANSMITTAL 1992-1 (supplement February 18, 1992)

LAW AND PUBLIC SAFETY—TITLE 13

13:2-22	Alcoholic Beverage Control: licensee training and certification	24 N.J.R. 1958(b)		
13:28-5.1, 6.35	Schools of cosmetology and hairstyling: use of annex classrooms	24 N.J.R. 2333(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)		
13:34-1.1	Board of Marriage Counselor Examiners: annual license fees and charges	24 N.J.R. 2522(b)		
13:35-2.6–2.12, 2.14, 2A	Certified nurse midwife practice	23 N.J.R. 3632(a)	R.1992 d.332	24 N.J.R. 3094(a)
13:35-6.5	Medical practice: preparation of patient records	24 N.J.R. 50(a)		

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N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
13:35-6.17	Corporate medical practice: stay of operative date concerning "financial interest" and referrals to health care facilities	———	———	24 N.J.R. 2460(a)
13:35-6A	Medical practice: declaration of death upon basis of neurological criteria	23 N.J.R. 3635(a)	R.1992 d.309	24 N.J.R. 2731(c)
13:37	Certification of homemaker-home health aides: open public forum	24 N.J.R. 1861(a)		
13:38-2.4, 4, 5.1	Board of Optometrists: issuing prescriptions; certification by examination; fees	24 N.J.R. 2802(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)		
13:43-3.1, 4.1	Board of Shorthand Reporting: fee schedule	24 N.J.R. 1232(a)	R.1992 d.275	24 N.J.R. 2460(b)
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)		
13:45B	Employment and personnel services	23 N.J.R. 2470(a)		
13:45B	Employment and personnel services: extension of comment period	23 N.J.R. 2919(a)		
13:47A-1–8, 10, 11	Bureau of Securities rules	24 N.J.R. 2524(a)		
13:47K-5.2	Weights and measures: magnitude of allowable variations for packaged commodities	24 N.J.R. 1233(a)		
13:59-1.1, 1.2, 1.3, 1.4, 1.8	State Police: release of criminal history information	24 N.J.R. 1963(a)	R.1992 d.308	24 N.J.R. 2735(a)
13:70-13A.8	Thoroughbred racing: stay pending appeal of official's decision	24 N.J.R. 555(a)	R.1992 d.265	24 N.J.R. 2461(a)
13:71-3.3	Harness racing: stewards appeal hearings	24 N.J.R. 555(b)	R.1992 d.266	24 N.J.R. 2461(b)
13:71-3.8	Harness racing: stay pending appeal of official's decision	24 N.J.R. 556(a)	R.1992 d.267	24 N.J.R. 2461(c)
13:71-10.5	Harness racing: programmed trainer	24 N.J.R. 2340(a)		
13:71-20.6	Harness racing: passing lane in homestretch	24 N.J.R. 686(a)	R.1992 d.268	24 N.J.R. 2462(a)
13:75-1.7	Violent Crimes Compensation Board: denial of compensation	24 N.J.R. 1862(a)	R.1992 d.301	24 N.J.R. 2628(a)

Most recent update to Title 13: TRANSMITTAL 1992-6 (supplement June 15, 1992)

PUBLIC UTILITIES (BOARD OF REGULATORY COMMISSIONERS)—TITLE 14

14:0	Open Network Architecture (ONA): preproposal and public hearing regarding Board regulation of enhanced telecommunications services	23 N.J.R. 3239(a)		
14:3-3.2, 7.12	Discontinuance of fire protection service by water utility	24 N.J.R. 2341(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)		
14:3-11	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)		
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)		
14:12-1.2, 3.6, 4.1–4.3, 5.3	Demand side management	24 N.J.R. 2804(a)		
14:18-3.19	Cable television: interest on uncorrected billing errors	24 N.J.R. 1470(b)	R.1992 d.319	24 N.J.R. 2925(a)

Most recent update to Title 14: TRANSMITTAL 1992-2 (supplement June 15, 1992)

ENERGY—TITLE 14A

14A:11-2	Reporting of energy information by home heating oil suppliers	23 N.J.R. 2830(b)		

Most recent update to Title 14A: TRANSMITTAL 1992-1 (supplement May 18, 1992)

STATE—TITLE 15

15:2-4	Commercial recording: designation of agent to accept service of process	23 N.J.R. 2483(a)	Expired	
15:5	Division of the State Museum	24 N.J.R. 1239(a)	R.1992 d.286	24 N.J.R. 2462(b)
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 1992-1 (supplement May 18, 1992)

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N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
PUBLIC ADVOCATE—TITLE 15A				
Most recent update to Title 15A: TRANSMITTAL 1990-3 (supplement August 20, 1990)				
TRANSPORTATION—TITLE 16				
16:28-1.25	Speed limit zones along Route 23 in Wayne	24 N.J.R. 1688(b)	R.1992 d.276	24 N.J.R. 2462(c)
16:28-1.41	Speed limit zones along Route U.S. 9 in Atlantic County	24 N.J.R. 2806(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)		
16:28A-1.8	Bus stop zones along Route 10 in Parsippany-Troy Hills	24 N.J.R. 1967(a)	R.1992 d.304	24 N.J.R. 2736(a)
16:28A-1.15, 1.54	No stopping or standing zones along Route 23 in Hardyston Township and Route 181 in Jefferson Township	24 N.J.R. 1240(a)	R.1992 d.288	24 N.J.R. 2463(a)
16:28A-1.32	No stopping or standing zones along U.S. 46 in Clifton	24 N.J.R. 1689(a)	R.1992 d.277	24 N.J.R. 2463(b)
16:28A-1.57	Parking along U.S. 206 in Lawrence Township	24 N.J.R. 2342(a)	R.1992 d.336	24 N.J.R. 3097(a)
16:32-1	Designated routes for double-trailer trucks	24 N.J.R. 929(b)	R.1992 d.270	24 N.J.R. 2463(c)
16:41	Permits for work or activities involving State highway rights-of-way	24 N.J.R. 2237(a)	R.1992 d.341	24 N.J.R. 3097(b)
16:44-1.8	Renewal of contractor classification rating	24 N.J.R. 703(a)	R.1992 d.271	24 N.J.R. 2464(a)
16:53D-1.1	Zone of Rate Freedom for regular route autobus carriers: 1993 percentage maximums	24 N.J.R. 2343(a)	R.1992 d.355	24 N.J.R. 3097(c)
16:54	Licensing of aeronautical and aerospace facilities	24 N.J.R. 2542(a)		
Most recent update to Title 16: TRANSMITTAL 1992-6 (supplement June 15, 1992)				
TREASURY-GENERAL—TITLE 17				
17:3-4.1	Teachers' Pension and Annuity Fund: creditable salary	23 N.J.R. 3274(a)		
17:9-4.1, 4.5	State Health Benefits Program: "appointive officer"	23 N.J.R. 2612(b)		
17:9-4.2	State Health Benefits Program: part-time deputy attorneys general	24 N.J.R. 2345(a)		
17:16-20.1, 20.3	State Investment Council: international government and agency obligations	24 N.J.R. 1690(a)	R.1992 d.274	24 N.J.R. 2464(b)
17:20-2.1, 4.3, 4.4	Background checks and training of lottery agents and employees	24 N.J.R. 2238(a)		
17:20-4.8	Sale of lottery tickets at specific locations licensed	24 N.J.R. 2239(a)		
17:20-6.2	Redemption of winning lottery tickets	24 N.J.R. 2239(b)		
17:26	Repeal interim rules regarding Spill Compensation and Control Act (see 7:1J)	24 N.J.R. 1255(a)		
17:29-4.7	Charitable fund-raising among employees of local government units: administrative correction	———	———	24 N.J.R. 2925(b)
17:42-1	Lottery prize offset against overdue child support and public assistance overpayments	24 N.J.R. 2343(b)	R.1992 d.337	24 N.J.R. 3098(a)
Most recent update to Title 17: TRANSMITTAL 1992-4 (supplement June 15, 1992)				
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)		
18:7-4.5, 5.2	Corporation Business Tax: indebtedness and entire net worth	24 N.J.R. 175(a)	R.1992 d.289	24 N.J.R. 2628(b)
18:7-13.1	Corporation Business Tax: abatements of penalty and interest	23 N.J.R. 3275(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)		
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 1992-4 (supplement June 15, 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)		
19:9-1.1	Definition of "New Jersey Turnpike"	24 N.J.R. 2692(a)		
19:31-7	Local Development Financing Fund	24 N.J.R. 2534(a)		
Most recent update to Title 19: TRANSMITTAL 1992-5 (supplement June 15, 1992)				

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N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
TITLE 19 SUBTITLE K—CASINO CONTROL COMMISSION/CASINO REINVESTMENT DEVELOPMENT AUTHORITY				
19:40-2.5	Delegation of Commission authority	24 N.J.R. 2348(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)		
19:41-2.2	Surveillance of gaming operations	24 N.J.R. 1246(a)	R.1992 d.273	24 N.J.R. 2465(a)
19:41-14	Renewal of employee licenses	24 N.J.R. 2133(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)		
19:43-1.1–1.5, 1.8, 1.12, 1.13, 1.14	Junkets; casino service industries	24 N.J.R. 2695(b)		
19:44-8.3	Implementation of pai gow	24 N.J.R. 558(a)		
19:44-8.3	Implementation of pai gow poker	24 N.J.R. 569(a)		
19:44-9.4	Gaming school tables	24 N.J.R. 1471(a)	R.1992 d.333	24 N.J.R. 3099(a)
19:45-1.1, 1.2, 1.9, 1.9B, 1.9C, 1.46	Complimentary cash and noncash gifts	24 N.J.R. 2692(b)		
19:45-1.1, 1.2, 1.16, 1.18, 1.20, 1.33, 1.46	Exchange of coupons at gaming tables for gaming chips	24 N.J.R. 2536(a)		
19:45-1.1, 1.36A, 1.38, 1.41	Hopper storage areas in slot machines	24 N.J.R. 2137(a)		
19:45-1.8	Licensee records retention and destruction	24 N.J.R. 2348(b)		
19:45-1.10, 1.11, 1.46A	Location and surveillance of automated coupon redemption machines	24 N.J.R. 1472(a)		
19:45-1.11, 1.12	Implementation of pai gow	24 N.J.R. 558(a)		
19:45-1.11, 1.12	Implementation of pai gow poker	24 N.J.R. 569(a)		
19:45-1.12	Supervision of table games	24 N.J.R. 1249(b)	R.1992 d.335	24 N.J.R. 3099(c)
19:45-1.12	Baccarat staffing requirements	24 N.J.R. 2136(a)	R.1992 d.334	24 N.J.R. 3099(b)
19:45-1.14	Coin vault security	24 N.J.R. 2136(b)		
19:45-1.16, 1.17, 1.36	Internal design and operation of bill changers	24 N.J.R. 1472(b)		
19:45-1.19	Implementation of game of pokette	24 N.J.R. 2140(a)		
19:45-1.42	Slot drop and slot cash storage box procedures	24 N.J.R. 2695(a)		
19:46-1.1, 1.13D, 1.17, 1.18, 1.20	Implementation of game of pokette	24 N.J.R. 2140(a)		
19:46-1.7	Quadrant wager in roulette	24 N.J.R. 1871(a)		
19:46-1.10	Double exposure blackjack table layout	24 N.J.R. 2350(a)		
19:46-1.10, 1.17, 1.20	Use of card reader device in blackjack	24 N.J.R. 2351(a)		
19:46-1.13B, 1.15–1.19	Implementation of pai gow poker	24 N.J.R. 569(a)		
19:46-1.13C, 1.15, 1.16, 1.19A, 1.19B, 1.20	Implementation of pai gow	24 N.J.R. 558(a)		
19:46-1.25	Internal design and operation of bill changers	24 N.J.R. 1472(b)		
19:46-1.27	Slot machine density	24 N.J.R. 2138(a)		
19:47-2.1, 2.6, 2.9, 2.15	Use of card reader device in blackjack	24 N.J.R. 2351(a)		
19:47-2.11	Splitting pairs in blackjack	24 N.J.R. 1872(a)	R.1992 d.320	24 N.J.R. 2925(c)
19:47-5.2	Quadrant wager in roulette	24 N.J.R. 1871(a)		
19:47-8.2, 10	Game of pai gow	24 N.J.R. 558(a)		
19:47-8.2, 11	Pai gow poker	24 N.J.R. 569(a)		
19:47-8.2, 11	Pai gow poker: temporary adoption of new rules and amendments	———	———	24 N.J.R. 1517(a)
19:47-8.2, 12	Implementation of game of pokette	24 N.J.R. 2140(a)		
19:49	Junkets	24 N.J.R. 2695(b)		
19:65	Casino Reinvestment Development Authority: project criteria and conditions	24 N.J.R. 1692(b)		

Most recent update to Title 19K: TRANSMITTAL 1992-6 (supplement June 15, 1992)

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RULEMAKING IN THIS ISSUE—Continued

Battery management plan: content and submission by manufacturers ..... 3178(a)
HEALTH
Examination fee for licensure of nursing home administrator ..... 3179(a)
Certificate of Need applications for long-term care beds and adult day health care slots ..... 3179(b)
HIGHER EDUCATION
NJCLASS program: student loan interest rates ..... 3180(a)
HUMAN SERVICES
Telecommunications Device for the Deaf (TDD) Distribution Program ..... 3180(b)
INSURANCE
Notice of cancellation and nonrenewal of fire and casualty coverage: recertification of requirement to Legislature ..... 3181(a)
Municipalities requiring payment of liens by companies writing fire insurance ..... 3181(b)
LABOR
Board and room, meals and lodging in lieu of wages: 1993 rates ..... 3182(a)
LAW AND PUBLIC SAFETY
Highway Safety Project grant program ..... 3183(a)
TRANSPORTATION
Sale, lease or other disposition of railroad property: address for petitions and filings ..... 3183(b)

EXECUTIVE ORDER NO. 66(1978)
EXPIRATION DATES 3184

INDEX OF RULE PROPOSALS AND ADOPTIONS 3190

Filing Deadlines

October 19 issue:
Proposals ..... September 18
Adoptions ..... September 25
November 2 issue:
Proposals ..... October 2
Adoptions ..... October 9

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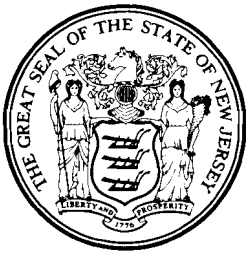

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