

NEW JERSEY REGISTER



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(Includes adopted rules filed through June 26, 1992)

MOST RECENT UPDATE TO NEW JERSEY ADMINISTRATIVE CODE: MAY 18, 1992

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INTERESTED PERSONS

Interested persons may submit comments, information or arguments concerning any of the rule proposals in this issue until **August 19, 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.

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NEW JERSEY REGISTER

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NEW JERSEY REGISTER, MONDAY, JULY 20, 1992

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

EXECUTIVE ORDER

(a)

OFFICE OF THE GOVERNOR

Governor Jim Florio

Executive Order No. 62(1992)

Creation of New Jersey Business—Higher Education Forum

Issued: June 19, 1992.

Effective: June 19, 1992.

Expiration: Indefinite.

WHEREAS, global interdependence has created unprecedented economic competition on an international scale; and

WHEREAS, success in the knowledge-driven economy of the 21st Century will be directly related to our investment in both human capital and research and development; and

WHEREAS, a strong and vital higher education system is a critical component of that investment, and a major factor affecting the competitiveness of the business sector; and

WHEREAS, the Board of Higher Education and the Chancellor of Higher Education have recognized this important relationship, and have instituted a strategic planning effort and other major initiatives to enhance the higher education system's contributions to the future of the State; and

WHEREAS, the quality of the higher education system, as well as the general welfare of New Jersey, will be strengthened by close collaboration between the leadership of our higher education and corporate communities; and

WHEREAS, no permanent Statewide organization exists to foster the regular exchange of ideas about issues of mutual concern or for joint policy and program development between these two communities; and

WHEREAS, the Governor, in consultation with the Chancellor, has proposed the establishment of a Business-Higher Education Forum to serve as a forum for such exchange and cooperative action.

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 a New Jersey Business—Higher Education Forum (hereinafter "the Forum") which shall be composed of individuals, appointed by the Governor, who are leaders of New Jersey's business and higher education communities. The Chair and Vice-Chair of the Forum shall be designated by the Governor from among the Forum's members.

2. The Forum is authorized to establish an Executive Committee and to organize itself in a manner to best carry out its responsibilities. The Forum is further authorized to establish such task forces or workgroups, as necessary, to address specific issues as they arise and to develop policy recommendations pertaining to those issues.

3. The Chancellor of Higher Education and the Commissioners of Commerce and Labor, together with the Chair of the State Board of Higher Education or a member of the State Board of Higher Education designated by the Chair, shall serve as ex-officio members of the Forum. The Chancellor of Higher Education shall also serve ex-officio on the Executive Committee of the Forum.

4. The Forum shall be in, but not of, the Department of Higher Education. The Department of Higher Education shall be responsible for providing staff, consultants and other resources.

5. The Forum shall advise the Governor, the Legislature, and the citizens of the State of New Jersey on:

a. Issues relating to human capital, academic research and development, and technology transfer;

b. Ways in which the higher education community can contribute to the economic growth, and to the quality of life, of the citizens of New Jersey.

6. The Forum shall also:

a. Provide specific advice and support to the Board and Chancellor of Higher Education on higher education's strategic planning, funding and accountability efforts;

b. Promote cooperative endeavors across the two sectors that benefit the economic and social welfare of the State;

c. Examine such other issues that may arise that are of mutual concern and of serious importance to New Jersey's future and its citizens.

7. The Forum shall coordinate its work with existing policy-making groups including, but not limited to, the following: the State Employment and Training Commission, the Commission on Science and Technology, and the New Jersey Council on Job Opportunities.

8. The Forum 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 Forum and furnish it with such assistance as is necessary to accomplish the purpose of this Order. The Attorney General shall act as legal counsel to the Forum.

9. This Order shall take effect immediately.

RULE PROPOSALS

PERSONNEL

(a)

MERIT SYSTEM BOARD

General Rules and Department Organization

Proposed Readoption with Amendments: N.J.A.C. 4A:1

Authorized By: The Merit System Board, Anthony J. Cimino, Commissioner, Department of Personnel.

Authority: N.J.S.A. 11A:1-2, 11A:2-1, 11A:2-3, 11A:2-6, 11A:2-7, 11A:2-11, 11A:2-12, 11A:3-1, 11A:3-6, 11A:4-13, 11A:10-1, 11A:10-3, 11A:10-4, 11A:11-2, 47:1A-2, 52:14B-3(l), 52:14B-3(3), 52:14b-4(f), Executive Order No. 11(1974).

Proposal Number: PRN 1992-306.

Public hearings concerning the proposed readoption with amendments will be held on:

Thursday, August 6, 1992 at 6:00 P.M.

Cherry Hill High School East

Kresson Road

Cherry Hill, New Jersey

Monday, August 10, 1992 at 6:00 P.M.

Paramus Catholic High School

425 Paramus Road

Paramus, New Jersey

Wednesday, August 12, 1992 at 5:30 P.M.

Department of Personnel Training Center

600 College Road East

Plainsboro, New Jersey

Please call the Regulations Unit at (609) 984-0118 if you wish to be included on the list of speakers.

Submit written comments by August 19, 1992 to:

Janet Share Zatz

Director of Appellate Practices

Department of Personnel

CN 312

Trenton, New Jersey 08625

The agency proposal follows:

Summary

Pursuant to Executive Order No. 66(1978), N.J.A.C. 4A:1 expires on October 5, 1992. The Merit System Board has reviewed the rules and, with the following exceptions, has determined them to be necessary, reasonable and proper for the purpose for which they were originally promulgated, as required by the Executive Order.

Subchapter 1 concerns the purpose and scope of the rules and definitions of commonly used merit system terms. Provisions include procedures for rule relaxation by the Board and petitions for rulemaking. The Board proposes an amendment to the definition of the term "demotion," based on Departmental review, due to numerous inquiries that have been received as to whether various situations fit within the definition since its adoption in 1987. The amendment would ensure that, in local service, a demotion would include a reduction in pay scale or a change from full time to part time and, in State service, a change from full time to part time. The definition already provides for a demotion to include, in local service, a reduction in title and, in State service, a reduction in class code.

Subchapter 2 covers public records and Department of Personnel access to appointing authority records. In response to a preproposal comment by Middlesex County (see 24 N.J.R. 1667(b)), the Board proposes an amendment to N.J.A.C. 4A:1-2.2(b) to clarify that individual personnel records, with certain exceptions, are not public records. A new subsection (c) would provide a cross reference to N.J.A.C. 4A:4-2.16, the rule on retention and inspection of examination records.

Subchapter 3 governs the organizational structure of the Department of Personnel and delineates the respective responsibilities of the Commissioner of Personnel and the Merit System Board. The Board proposes an amendment to N.J.A.C. 4A:1-3.3(a)2 to permit the Board to render

final administrative decisions on matters referred by the Commissioner, such as requests to extend or cancel eligible lists.

Subchapter 4 concerns delegation of certain merit system functions to appointing authorities, pilot programs, and a mechanism for consolidation of merit system functions in State service. In response to a suggestion submitted by the Communications Workers of America, the Board proposes an amendment to N.J.A.C. 4A:1-4.3 requiring that the Commissioner verify that proper notice to and consultations with affected negotiations representatives have taken place. It is noted that N.J.A.C. 4A:1-4.3(c) already requires an appointing authority requesting a pilot program to consult with affected negotiations representatives before submitting a proposal to the Commissioner.

Social Impact

As a part of the proposed readoption of N.J.A.C. 4A:1, some substantive additions have been made. The proposal will have an overall positive social impact on all users of merit system rules, in that the readoption with amendments will continue to be logically organized, understandable and reflective of current practice as well as current law.

Specifically, the proposed amendment to the definition of demotion would ensure that appropriate protections are provided in all situations in which a career service employee is demoted. The proposed amendment to the rule on public records should ensure that individual personnel records are not mistaken for other types of government records when an issue comes up concerning public access to such information. Finally, the proposed amendment to the rule on pilot programs would strengthen, but not modify, the existing requirement on consultations between an appointing authority and affected negotiations representatives before a pilot program proposal is submitted by an appointing authority to the Commissioner.

Economic Impact

The proposed readoption of N.J.A.C. 4A:1 with amendments will minimize the amount of inquiries and controversies requiring agency action. The proposal, therefore, will have a positive economic impact on State government, public employers and employees, and the taxpayers in general. In particular, the proposed amendment to the definition of demotion would help employees economically who are, in fact, demoted, by ensuring that they have layoff rights.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required since this proposed readoption with amendments will have no effect on small businesses as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The rules and amendments will regulate employment in the public sector.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 4A:1.

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

4A:1-1.3 Definitions

The following words and terms, when used in these rules, shall have the following meanings unless the context clearly indicates otherwise:

...

"Demotion" means, in local service, a reduction in title **or scale of compensation or a change from full time to part time**, and in State service, a reduction in class code **or change from full time to part time**.

...

4A:1-2.2 Public records

(a) The following Department of Personnel records shall be public:

1. An individual's name, title, salary, compensation, dates of government service and reason for separation;
2. Information on specific educational or medical qualifications required for employment;
3. Final orders of the Commissioner or Board; and
4. Other records which are required by law to be made, maintained or kept on file.

(b) [Personnel] **Individual personnel** records, except as specified in (a)1 through 3 above, are not public records and shall not be released other than to the subject employee, an authorized representative of the employee, or governmental representatives in connection with their official duties.

(c) See N.J.A.C. 4A:4-2.16 concerning examination records.

4A:1-3.3 Merit System Board

(a) The Merit System Board shall:

1. Hold a public meeting at least once each month, except August, at which three members shall constitute a quorum;
2. Render final administrative decisions on appeals **and on other matters referred by the Commissioner**, except for those matters listed in N.J.A.C. 4A:1-3.2(a)6 or delegated to the Commissioner;
3. Adopt rules for implementing Title 11A, New Jersey Statutes after public hearing, except that a public hearing shall not be required for the adoption of emergency rules. See N.J.A.C. 1:30-4.5 for Office of Administrative Law emergency rule adoption procedures;
4. Interpret the application of Title 11A, New Jersey Statutes, to any public body or entity; and
5. Perform such other duties as prescribed by law and these rules.

4A:1-4.3 Pilot programs

(a) The Commissioner may establish pilot programs, not to exceed one year, outside of the provisions of Title 11A, New Jersey Statutes, and these rules.

(b) Pilot programs may include, but are not limited to, the following:

1. Recruitment and selection;
2. Classification; and
3. Job sharing.

(c) Appointing authorities that request a pilot program shall consult with affected negotiations representatives prior to submission of a proposal.

(d) A proposal for a pilot program shall be submitted to the Commissioner and include:

1. A description of the program;
2. The individuals affected by the program;
3. The duration of the program;
4. The anticipated benefits of the program;
5. A summary of appointing authority consultations with negotiations representatives; and
6. Such other information as required by the Commissioner.

(e) **The Commissioner shall verify that proper notice to and consultations with affected negotiations representatives have taken place.**

[(e)](f) The Commissioner may accept, modify or reject the program and establish appropriate conditions.

(a)

MERIT SYSTEM BOARD

Appeals, Discipline and Separations

Proposed Readoption with Amendments: N.J.A.C. 4A:2

Authorized By: The Merit System Board, Anthony J. Cimino, Commissioner, Department of Personnel.

Authority: N.J.S.A. 2C:51-2, 11A:1-2(e), 11A:2-6, 11A:2-11(h), 11A:2-13 et seq., 11A:4-15(c), 11A:8-4 and 52:14B-10(c).

Proposal Number: PRN 1992-307.

Public hearings concerning the proposed readoption with amendments will be held on:

Thursday, August 6, 1992 at 6:00 P.M.
Cherry Hill High School East
Kresson Road
Cherry Hill, New Jersey

Monday, August 10, 1992 at 6:00 P.M.
Paramus Catholic High School
425 Paramus Road
Paramus, New Jersey

Wednesday, August 12, 1992 at 5:30 P.M.
Department of Personnel Training Center
600 College Road East
Plainsboro, New Jersey

Please call the Regulations Unit at (609) 984-0118 if you wish to be included on the list of speakers.

Submit written comments by August 19, 1992 to:

Janet Share Zatz
Director of Appellate Practices
Department of Personnel
CN 312
Trenton, New Jersey 08625

The agency proposal follows:

Summary

Pursuant to Executive Order No. 66(1978), N.J.A.C. 4A:2 expires on October 5, 1992. The Merit System Board has reviewed the rules and, with the following exceptions, has determined them to be necessary, reasonable and proper for the purpose for which they were originally promulgated, as required by the Executive Order.

Subchapter 1 provides a set of rules applicable to all appeals arising under Title 11A, New Jersey Statutes. In N.J.A.C. 4A:2-1.1, an amendment has been proposed, based on Departmental review, to ensure that in written record appeals, copies of all materials submitted are served on other parties and that each party has a right to review the file. This amendment would codify longstanding practice.

Subchapter 2 sets forth a comprehensive description of the major disciplinary appeal process. These rules apply to situations where permanent and probationary employees are removed, demoted for disciplinary reasons, or suspended or fined for more than five working days. In response to a pre-proposal comment by the Communications Workers of America (CWA) (see 24 N.J.R. 1667(b)), the Board proposes an amendment to N.J.A.C. 4A:2-2.5 to provide that the Preliminary Notice of Disciplinary Action contain a statement of facts supporting the charges. This amendment clarifies what material should be included in the current form (DPF-31A) under the heading "Specifications." The CWA also suggested that the rule on actions involving criminal matters provide for additional information to the employee concerning the forfeiture statute, N.J.S.A. 2C:51-2. In response, the Board proposes an amendment to N.J.A.C. 4A:2-2.7 providing that in situations where an employee is suspended pending criminal charges, the Preliminary Notice of Disciplinary Action should include information on the forfeiture law.

Amendments and recodification have been proposed to N.J.A.C. 4A:2-2.10, concerning back pay, in response to the recent decision *Del Rossi v. Department of Human Services*, Docket No. A-3556-90T2 (Appellate Division, May 15, 1992). In *Del Rossi*, the court held that the current rules were ineffective as authority to support an award of back pay to a State employee who was suspended pending criminal charges and later reinstated upon the employee's successful completion of the pretrial intervention program (PTI). Accordingly, the Board proposes an amendment providing for back pay in cases of suspension pending criminal charges where the employee is acquitted after trial, the charges are dismissed or the prosecution is terminated. Back pay would not be awarded where the charges are disposed of through pretrial intervention (PTI) or conditional discharge. Further, if disciplinary action is taken by the appointing authority after disposition of the criminal charges, back pay would not be awarded in cases of removal. In case of suspension, the suspension would consist of time already served and back pay would be reduced by up to six months, at the discretion of the appointing authority. Thus, if an employee receives a two month disciplinary suspension, the employee would receive back pay of at least the difference between the period of the suspension pending criminal charges, and six months. Additionally, unless the appointing authority determines that a six month denial of back pay is appropriate, the employee will receive back pay for the difference between six months and the two month suspension, or four months. Finally, the amendment provides that back pay for municipal police officers in these situations is determined in accordance with N.J.S.A. 40A:14-149.1 et seq.

Subchapter 3 provides a detailed set of rules concerning minor discipline and grievances in State service. This subchapter includes, in N.J.A.C. 4A:2-3.7, the standard for Commissioner or Merit System Board review of these matters.

Subchapter 4 sets forth the rules on termination at the end of the working test period. Upon the recommendation of an administrative law judge in an initial decision in a contested case rendered by the Board,

it was decided to revise the provision concerning notice of termination to the probationary employee. The current rule provides for such notice to be served not more than 10 working days prior to or five working days following the last day of the working test period. However, if notice is served 10 working days before the end of the working test period and additional days are involved preparing the notice, the probationary employee is effectively deprived of the opportunity to demonstrate improvement during the last month of the working test period. Therefore, the Board proposes to amend N.J.A.C. 4A:2-4.1(c) to allow a termination notice to be served no more than five days prior to the end of the working test period.

In a pre-proposal comment, Local 195, International Federation of Technical and Professional Engineers (IFPTE), called for a change in N.J.A.C. 4A:2-4.2(b) whereby improper notice of termination would result in permanent status. While the Board believes the notice provisions must be enforced, an absolute rule is not warranted. Therefore, the Board proposes to amend N.J.A.C. 4A:2-4.1(c) to provide that a termination notice served more than five working days after the end of the working test period will create a presumption that the employee has attained permanent status.

Subchapter 5 provides rules to implement two important employee protections included in the 1986 reform act: protection against reprisals for disclosure and protection against political coercion.

Subchapter 6 sets standards for employee resignations. N.J.A.C. 4A:2-6.1 covers resignations in good standing, while N.J.A.C. 4A:2-6.2 applies to resignations not in good standing, a form of disciplinary separation. Both IFPTE and CWA submitted preproposal comments on the latter rule. IFPTE proposed that resignation not in good standing be limited to situations where employees failed to provide sufficient advance notice of resignation. CWA suggested that a resignation not in good standing be imposed only when an employee evidenced an intent to abandon the job. The Board believes that experience over many years supports continuation of the "five day rule." However, in response to these comments, the Board has proposed amendments providing that requests for leaves of absence and extensions of leave shall not be unreasonably denied.

Social Impact

These rules continue to provide a fair and effective mechanism for the resolution of disputes through the appeal process. This process constitutes a principal means for implementing the statutory policies of the merit system law, in particular, retaining and separating employees on the basis of the adequacy of their performance. See N.J.S.A. 11A:1-2.

The proposed changes are intended to improve this process for the benefit of employees as well as appointing authorities. The amendments to N.J.A.C. 4A:2-1.1, on written record appeals, and N.J.A.C. 4A:2-2.5, on preliminary notices of disciplinary action, would ensure that the rules reflect current practice. The amendment to N.J.A.C. 4A:2-2.7, on actions involving criminal matters, would inform employees of an important law not contained in Title 11A, namely, the forfeiture law, N.J.S.A. 2C:51-2. The changes to N.J.A.C. 4A:2-2.10, concerning back pay, would fill a gap in the rules by providing a framework for these determinations where an employee is suspended pending criminal charges.

In the area of working test period appeals, the amendments proposed to N.J.A.C. 4A:2-4.1 would ensure that the provisions on termination notices are consistent with the statutory purpose and requirements of the working test period. See N.J.S.A. 11A:4-15.

Finally, the changes to the rules on resignation not in good standing will help to ensure that such actions are taken only against employees who have abandoned their jobs.

Economic Impact

These rules are primarily procedural. Therefore, the economic impact of this chapter is limited to the costs incurred by appointing authorities, employees, and employee representatives in complying with these procedures. The procedures set forth in these rules are relatively informal, consistent with due process requirements, to ensure that parties to appeals do not incur excessive costs due to burdensome procedural requirements.

The changes proposed by the Board mainly involve minor modifications to existing procedures. The changes to the rule on back pay generally reflect prior decisions rendered by the Board. Therefore, no substantial economic impact is anticipated based on the proposed amendments.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required since the rules proposed for readoption will have no effect on small businesses as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The rules would regulate employment in the public sector.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 4A:2.

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

4A:2-1.1 Filing of appeals

(a) All appeals to the Commissioner or Board shall be in writing, signed by the person appealing (appellant) or his or her representative and must include the reason for the appeal and the specific relief requested.

(b) Unless a different time period is stated, an appeal must be filed within 20 days after either the appellant has notice or should reasonably have known of the decision, situation or action being appealed.

(c) The appellant must provide any additional information that is requested, and failure to provide such information may result in dismissal of the appeal.

(d) Except where a hearing is required by law or these rules, or where the Commissioner or Board finds that a material and controlling dispute of fact exists that can only be resolved by a hearing, an appeal will be reviewed on a written record. **In written record appeals:**

1. **Each party must serve copies of all materials submitted on all other parties; and**

2. **A party may review the file at the Department of Personnel during business hours.**

(e) A party in an appeal may be represented by an attorney, authorized union representative or authorized appointing authority representative. See N.J.A.C. 1:1-5.4 for contested case representation at the Office of Administrative Law.

4A:2-2.5 Opportunity for hearing before the appointing authority

(a) An employee must be served with a Preliminary Notice of Disciplinary Action setting forth the charges **and statement of facts supporting the charges (specifications)**, and afforded the opportunity for a hearing prior to imposition of major discipline, except:

1. An employee may be suspended immediately and prior to a hearing where it is determined that the employee is unfit for duty or is a hazard to any person if permitted to remain on the job, or that an immediate suspension is necessary to maintain safety, health, order or effective direction of public services. However, a Preliminary Notice of Disciplinary Action with opportunity for a hearing must be served in person or by certified mail within five days following the immediate suspension.

2. An employee may be suspended immediately when the employee is formally charged with a crime of the first, second or third degree, or a crime of the fourth degree on the job or directly related to the job. See N.J.A.C. 4A:2-2.7.

(b) Where a suspension is immediate under (a)1 and (a)2 above, and is without pay, the employee must first be apprised either orally or in writing, of why an immediate suspension is sought, the charges and general evidence in support of the charges and provided with sufficient opportunity to review the charges and the evidence in order to respond to the charges before a representative of the appointing authority. The response may be oral or in writing, at the discretion of the appointing authority.

(c) The employee may request a departmental hearing within five days of receipt of the Preliminary Notice. If no request is made within this time or such additional time as agreed to by the appointing authority or as provided in a negotiated agreement, the departmental hearing may be considered to have been waived and the appointing authority may issue a Final Notice of Disciplinary Action.

(d) A departmental hearing, if requested, shall be held within 30 days of the Preliminary Notice of Disciplinary Action unless waived by the employee or a later date is agreed to by the parties.

(e) Appeals concerning violations of this section may be presented to the Commissioner through a petition for interim relief. See N.J.A.C. 4A:2-1.2.

4A:2-2.7 Actions involving criminal matters

(a) When an appointing authority suspends an employee based on a pending criminal complaint or indictment, the employee must be served with a Preliminary Notice of Disciplinary Action. **The notice should include the provisions of N.J.S.A. 2C:51-2 and a brief explanation of that statute.**

1. The employee may request a departmental hearing within five days of receipt of the Notice. If no request is made within this time, or such additional time as agreed to by the appointing authority or as provided in a negotiated agreement, the appointing authority may then issue a Final Notice of Disciplinary Action under (a)3 below. A hearing shall be limited to the issue of whether the public interest would best be served by suspending the employee until disposition of the criminal complaint or indictment. The standard for determining that issue shall be whether the employee is unfit for duty or is a hazard to any person if permitted to remain on the job, or that an immediate suspension is necessary to maintain safety, health, order or effective direction of public services.

2. The appointing authority may impose an indefinite suspension to extend beyond six months where an employee is subject to criminal charges as set forth in N.J.A.C. 4A:2-2.5(a)2, but not beyond the disposition of the criminal complaint or indictment.

3. Where the appointing authority determines that an indefinite suspension should be imposed, a Final Notice of Disciplinary Action shall be issued stating that the employee has been indefinitely suspended pending disposition of the criminal complaint or indictment.

(b) The appointing authority shall issue a second Preliminary Notice of Disciplinary Action specifying any remaining charges against the employee upon final disposition of the criminal complaint or indictment. The appointing authority shall then proceed under N.J.A.C. 4A:2-2.5 and 2.6.

(c) Where an employee has pled guilty or been convicted of a crime or offense which is cause for forfeiture of employment under N.J.S.A. 2C:51-2, the departmental hearing shall be limited to the issue of the applicability of N.J.S.A. 2C:51-2. If N.J.S.A. 2C:51-2 is found not applicable, related disciplinary charges, if any, may be addressed at the hearing.

4A:2-2.10 Back pay, benefits and seniority

(a) Where a disciplinary penalty has been reversed, the Board shall award back pay, benefits, seniority or restitution of a fine. Such items may be awarded when a disciplinary penalty is modified.

(b) **Where a municipal police officer has been suspended based on a pending criminal complaint or indictment, following disposition of the charges the officer shall receive back pay, benefits and seniority pursuant to N.J.S.A. 40A:14-149.1 et seq.**

(c) **Where an employee, other than a municipal police officer, has been suspended based on a pending criminal complaint or indictment, following disposition of the charges the employee shall receive back pay, benefits and seniority if the employee is found not guilty at trial, the complaint or indictment is dismissed, or the prosecution is terminated.**

1. **Such items shall not be awarded when the complaint or indictment is disposed of through Conditional Discharge, N.J.S.A. 2C:36A-1, or Pre-Trial Intervention (PTI), N.J.S.A. 2C:43-12 et seq.**

2. **Where disciplinary action has been taken following disposition of the complaint or indictment, such items shall not be awarded in case of removal. In case of suspension, where the employee has already been suspended for more than six months pending disposition of the complaint or indictment, the disciplinary suspension shall be applied against the period of indefinite suspension. The employee shall receive back pay for the period of suspension beyond six months, but the appointing authority may for good cause deny back pay for the period beyond the disciplinary suspension up to a maximum of six months.**

(d) Back pay shall include unpaid salary, including regular wages, overlap shift time, increments and across-the-board adjustments.

Benefits shall include vacation and sick leave credits and additional amounts expended by the employee to maintain his or her health insurance coverage during the period of improper suspension or removal.

1. Back pay shall not include items such as overtime pay and holiday premium pay.

2. The award of back pay shall be reduced by the amount of taxes, social security payments, dues, pension payments, and any other sums normally withheld.

3. The award of back pay shall be reduced by the amount of money which was actually earned or could have been earned during the separation. If an employee also held other employment at the time of the adverse action, the earnings from such other employment shall not be deducted from the back pay. However, if the employee increased his or her work hours at the other employment during the back pay period, earnings from such additional hours shall be subtracted from the back pay award.

4. Funds that must be repaid by the employee shall not be considered when calculating back pay.

[(b)](e) Unless otherwise ordered, an award of back pay, benefits and seniority shall be calculated from the effective date of the appointing authority's improper action to the date of the employee's actual reinstatement to the payroll.

[(c)](f) When the Board awards back pay and benefits, determination of the actual amounts shall be settled by the parties whenever possible.

[(d)](g) If settlement on an amount cannot be reached, either party may request, in writing, Board review of the outstanding issue. In a Board review:

1. The appointing authority shall submit information on the salary the employee was earning at the time of the adverse action, plus increments and across-the-board adjustments that the employee would have received during the separation period; and

2. The employee shall submit an affidavit setting forth all income received during the separation.

4A:2-4.1 Notice of termination

(a) An employee terminated from service or returned to his or her former permanent title at the conclusion of a working test period due to unsatisfactory performance shall be given written notice in person or by certified mail by the appointing authority.

(b) The notice shall inform the employee of the right to request a hearing before the Board within 20 days of receipt of the notice.

(c) The notice shall be served not more more than [10] **five** working days prior to or five working days following the last day of the working test period. **A notice served after this period shall create a presumption that the employee has attained permanent status.**

4A:2-6.2 Resignation not in good standing

(a) If an employee resigns without complying with the required notice in N.J.A.C. 4A:2-6.1, he or she shall be held as having resigned not in good standing.

(b) Any employee who is absent from duty for five or more consecutive business days without the approval of his or her superior shall be considered to have abandoned his or her position and shall be recorded as a resignation not in good standing. **Approval of the absence shall not be unreasonably denied.**

(c) An employee who has not returned to duty for five or more consecutive business days following an approved leave of absence shall be considered to have abandoned his or her position and shall be recorded as a resignation not in good standing. **A request for extension of leave shall not be unreasonably denied.**

(d) Where an employee is resigned not in good standing under (a), (b), or (c), the employee shall be provided with notice and an opportunity for a departmental hearing under N.J.A.C. 4A:2-2.5, and Final Notice and a right to appeal to the Board under N.J.A.C. 4A:2-2.8. An employee shall be in unpaid status pending the departmental decision. Should an employee seek to return to employment pending the departmental decision, a review under N.J.A.C. 4A:2-2.5(b) shall be conducted prior to continuation of the unpaid status.

(e) Where the resignation is reversed, the employee shall be entitled to remedies under N.J.A.C. 4A:2-2.10.

(f) The appointing authority or the Board may modify the resignation not in good standing to an appropriate penalty or to a resignation in good standing.

(a)

MERIT SYSTEM BOARD

Employee Transfers

Reproposed New Rule: N.J.A.C. 4A:4-7.11

Authorized By: The Merit System Board, Anthony J. Cimino,

Commissioner, Department of Personnel.

Authority: N.J.S.A. 11A:2-6(d) and 11A:4-16.

Proposal Number: PRN 1992-312.

Public hearings concerning the re-proposed new rule will be held on:

Thursday, August 6, 1992 at 6:00 P.M.

Cherry Hill High School East

Kresson Road

Cherry Hill, New Jersey

Monday, August 10, 1992 at 6:00 P.M.

Paramus Catholic High School

425 Paramus Road

Paramus, New Jersey

Wednesday, August 12, 1992 at 5:30 P.M.

Department of Personnel Training Center

600 College Road East

Plainsboro, New Jersey

Please call the Regulations Unit at (609) 984-0118 if you wish to be included on the list of speakers.

Submit written comments by August 19, 1992 to:

Janet Share Zatz

Director of Appellate Practices

Department of Personnel

CN 312

Trenton, New Jersey 08625

The agency proposal follows:

Summary

The Merit System Board previously published a proposed new rule N.J.A.C. 4A:4-7.11, concerning employee transfers when merit system political subdivisions are consolidated, on July 1, 1991 at 23 N.J.R. 1984(b), and conducted a public hearing on Thursday, July 18, 1991. Henry Maurer served as hearing officer. No comments were received at that time and no recommendations were made by the hearing officer. However, written comments on the proposed new rule were submitted by representatives of the Communications Workers of America (CWA) and the New Jersey Association of Counties. As a result of the Board's review of these comments, it was determined that the new rule should be repropose with changes and that an amendment also be proposed to existing rule N.J.A.C. 4A:9-1.2 (see proposal elsewhere in this issue of the New Jersey Register).

As noted in the Board's original proposal, when certain functions of a political subdivision operating under Title 11A have been consolidated or combined with another political subdivision also operating under Title 11A, a relaxation of the rules has had to be granted by the Merit System Board to allow for the transfer of employees to the receiving unit. N.J.S.A. 11:28-3 (now repealed) had specifically provided for this type of transfer. Title 11A does not contain an equivalent provision, but does provide for the general authority of the Board to regulate transfers. Under this general authority the Board initially proposed a new N.J.A.C. 4A:4-7.11 to provide for a transfer of employees to the receiving unit in a consolidation, and the retention by permanent and probationary employees of their status, as well as their seniority and leave entitlements.

The CWA proposed that language be added to N.J.A.C. 4A:4-7.11(a) to require that, when the receiving unit unilaterally abolishes the sending unit, the receiving unit would be obligated to transfer the affected employees to the receiving unit. The CWA expressed concern that employees who are not transferred would be laid off.

The Merit System Board notes that although employee transfers are mandated when the functions of one State agency are moved to another

State agency (see N.J.S.A. 52:14D-5), there is no equivalent statutory requirement for consolidation of functions between local government jurisdictions, or from local to State government. Thus, mandating employee transfers in these situations would exceed the authority of current statutory law. However, if employees are not transferred in these situations, they are entitled to the rights set forth in N.J.A.C. 4A:4-8, Layoffs. To clarify these rights, a new subsection (d) has been added to proposed new rule N.J.A.C. 4A:4-7.11.

The Association of Counties commented that N.J.A.C. 4A:4-7.11(a) should include language providing for the transfer of some or all of the employees, to address situations where the "receiving" unit needs only a portion of the "transferring" unit's work force. It also proposed that subsection (b) be changed to provide that employees so transferred would hold permanent status in the receiving unit only upon satisfactory completion of a working test period with the receiving unit. The Association argued that the receiving unit should be able to determine whether a transferred employee meets the receiving unit's own performance standards. Finally, the Association proposed that subsection (c) be changed to give the receiving unit flexibility in determining to what extent seniority and service for leave entitlements would be credited to affected employees. The Association stated that, without this flexibility, the receiving unit could be reluctant to accept the transfer of the employees due to salary requirements as well as fear that current employees of the receiving unit would be adversely affected.

In response to these comments by the Association of Counties, the Board observes that prior to the adoption of Title 11A in 1986, N.J.S.A. 11:28-3 (repealed) addressed consolidations of functions between or within merit system jurisdictions. This former statutory section clearly provided that when any such combination occurred, no employee in the career (formerly classified) service was to suffer any loss of seniority, pension rights, demotion rights or salary as the result of any such change. As noted above, current statutory law contains no such requirement. Therefore, the Association of Counties is correct in calling for recognition of the appointing authorities' discretion to transfer some or all employees, and the requested language has been added to the repropose subsection (a).

However, once the decision is made to transfer employees between units, the Board does not believe that such employees should be treated differently from other transferred employees. In all other transfers, employees are not subject to a new working test period, nor are they denied seniority or service credit for leave entitlements. Moreover, when a non-merit system jurisdiction is consolidated with a merit system jurisdiction, transferred employees with at least one year of service attain immediate permanent status with the new jurisdiction, with seniority from their original date of employment. Employees who are transferred between merit system jurisdictions should have no lesser rights. Therefore, the language in subsections (b) and (c) are not changed for this repropose. With regard to impact on compensation, it is noted that in local service, appointing authorities are only required under merit system law and rules to pay an employee a base salary within the established salary range for that title. See N.J.S.A. 11A:3-7 and N.J.A.C. 4A:3-4.1(a)2.

Social Impact

This proposed new rule, along with the proposed readoption of N.J.A.C. 4A:9 with amendments, would provide uniformity with respect to the rights of employees affected by the consolidation of functions, whether the consolidation takes place between merit system jurisdictions or involves a non-merit system jurisdiction. Repropose new rule N.J.A.C. 4A:4-7.11 would ensure that permanent or probationary employees being absorbed into the receiving unit retain all rights they had prior to the consolidation. Those not absorbed would retain their layoff rights.

Economic Impact

No substantial economic impact is expected from the repropose new rule. However, affected employees would enjoy more certainty in their status following a consolidation. In addition, Department of Personnel operations would function more efficiently without the need to request rule relaxation prior to a consolidation of functions of one merit system political subdivision with another.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required since this repropose new rule would have no effect on small businesses as defined under

the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The repropoed new rule would regulate employment in the public sector.

Full text of the proposed new rule follows:

4A:4-7.11 Transfer or combining of functions

(a) When any of the functions of a department, agency or unit of a political subdivision operating under Title 11A, New Jersey Statutes, are transferred, consolidated, unified, absorbed or combined with those of the State or of a separate political subdivision operating under Title 11A, New Jersey Statutes, the Department of Personnel upon request of both appointing authorities shall approve the transfer of some or all affected employees to the receiving unit.

(b) Any employee so transferred who holds permanent or probationary status in a title in the career service shall continue to hold such status in the receiving unit.

(c) Seniority calculations and leave entitlements for transferred permanent or probationary employees shall be calculated as if the entire period of service was in the receiving unit.

(d) If positions are abolished because they are made no longer necessary by the consolidation of functions, affected employees shall be accorded all layoff and special reemployment rights in N.J.A.C. 4A:8.

(a)

MERIT SYSTEM BOARD

Veterans and Disabled Veterans Preference

Proposed Readoption with Amendments: N.J.A.C. 4A:5

Authorized By: The Merit System Board, Anthony J. Cimino, Commissioner, Department of Personnel.

Authority: N.J.S.A. 11A:4-1(e), 11A:4-8, 11A:4-9, 11A:5-1 through 11A:5-8, 11A:5-15.

Proposal Number: PRN 1992-308.

Public hearings concerning the proposed readoption with amendments will be held on:

Thursday, August 6, 1992 at 6:00 P.M.
Cherry Hill High School East
Kresson Road
Cherry Hill, New Jersey

Monday, August 10, 1992 at 6:00 P.M.
Paramus Catholic High School
425 Paramus Road
Paramus, New Jersey

Wednesday, August 12, 1992 at 5:30 P.M.
Department of Personnel Training Center
600 College Road East
Plainsboro, New Jersey

Please call the Regulations Unit at (609) 984-0118 if you wish to be included on the list of speakers.

Submit written comments by August 19, 1992 to:

Janet Share Zatz
Director of Appellate Practices
Department of Personnel
CN 312
Trenton, New Jersey 08625

Summary

Pursuant to Executive Order No. 66(1978), N.J.A.C. 4A:5 expires on October 5, 1992. The Merit System Board has reviewed the rules and, with the following exceptions, has determined them to be necessary, reasonable and proper for the purpose for which they were originally promulgated, as required by the Executive Order.

Subchapter 1 concerns eligibility for veterans preference and how individuals may file for such a preference. The proposed amendments to eligibility provisions are necessary to comply with P.L.1991, c.390. That law, effective on January 16, 1992, provides for veterans preference for certain persons who served in the peacekeeping missions in Lebanon, Grenada and Panama and in Operation Desert Shield/Desert Storm. It also expands the period of eligibility for veterans preference for service

in World War Two, the Korean Conflict and the Vietnam Conflict to conform with the dates found in Federal law.

Subchapter 2 concerns the use of the veterans preference in open competitive and promotional examinations and for appointments to the noncompetitive division of the career service.

Social Impact

The proposed readoption with amendments continues to offer a concise series of rules which explain the nature and application of veterans and disabled veterans preference in plain language. The readoption with amendments will have an overall positive social impact upon users of the merit system rules, in that N.J.A.C. 4A:5 will still be logically organized, understandable and reflective of current law, including the recent enactment on dates for certain wars and veterans eligibility for service in some recent conflicts.

Economic Impact

The clarity and simplicity of N.J.A.C. 4A:5, with proposed amendments, will continue to minimize the amount of inquiries and controversies requiring agency action. Only a marginal economic impact is anticipated since the total number of individuals qualifying for the preference as recently broadened by legislation should not markedly increase the Department of Personnel workload.

Furthermore, the economic impact is based upon the statutes which establish veteran's preference, and the rules do not independently create an economic impact.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required since this proposed readoption with amendments will have no effect on small businesses as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The rules as amended will regulate employment in the public sector.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 4A:5.

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

4A:5-1.1 Veterans preference

(a) A person is entitled to veterans preference (abbreviated as "V") if he or she:

1. Served at least 90 days in the active United States military or naval service and had been discharged under conditions other than dishonorable, during:

- i. World War I, between April 6, 1917 and November 11, 1918;
- ii. World War II, on or after September 16, 1940 and on or before [September 2, 1945] **December 31, 1946**;
- iii. Korean Conflict, on or after June 23, 1950 and on or before [July 27, 1953] **January 31, 1955**; or
- iv. Vietnam Conflict, on or after December 31, 1960 and on or before [August 1, 1974] **May 7, 1975**;

v. The 90 day period must have begun on or before one of the ending dates above, and shall not include any period of education or training under the Army Specialized Training Program or the Navy College Training Program which was a continuation of a civilian course, nor any time spent as a cadet or midshipman at one of the service academies. During the period of the Vietnam conflict, the following are excluded: any service performed pursuant to the provisions of section 511(d) of Title 10, United States Code; or any service performed pursuant to enlistment in the National Guard or the Army Reserve, Naval Reserve, Air Force Reserve, Marine Corps Reserve or Coast Guard Reserve.

2. Served in the Lebanon peacekeeping mission or on board any ship actively engaged in patrolling the territorial waters of that nation for a period, continuous or in the aggregate, of at least 14 days. The 14 days must have commenced on or after September 26, 1982 and on or before February 26, 1984;

3. Served in the Grenada peacekeeping mission or on board any ship actively engaged in patrolling the territorial waters of that nation for a period, continuous or in the aggregate, of at least 14 days. The 14 days must have commenced on or after October 25, 1983 and on or before November 21, 1983;

4. Served in the Panama peacekeeping mission or on board any ship actively engaged in patrolling the territorial waters of that nation for a period, continuous or in the aggregate, of at least 14

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days. The 14 days must have commenced on or after December 20, 1989 and on or before January 31, 1990;

5. Served in the Arabian peninsula or on board any ship actively engaged in patrolling the Persian Gulf for the Operation Desert Shield/Desert Storm mission for a period, continuous or in the aggregate, of at least 14 days. The 14 days must have commenced on or after August 2, 1990;

[2.]6. Received a service-incurred injury or disability during a period in (a)1 above, regardless of the length of service;

[3.]7. Served in any army or navy of the United States allies in World War I between July 14, 1914 and November 11, 1918, or World War II between September 1, 1939 and September 2, 1945, provided he or she voluntarily enlisted in such service, was a United States citizen at the time of enlistment, did not renounce or lose United States citizenship, and was honorably discharged; or

[4.]8. Is the surviving spouse of a person entitled to veterans preference and has not remarried.

(a)

NEW JERSEY EMPLOYEE AWARDS COMMITTEE

Notice of Pre-Proposal

Awards Program

N.J.A.C. 4A:6-6

Authorized By: New Jersey Employee Awards Committee,

Anthony J. Cimino, Commissioner, Department of Personnel.

Authority: N.J.S.A. 11A:6-31.

Pre-Proposal Number: PPR 1992-7.

Take notice that the New Jersey Employee Awards Committee, pursuant to its authority to promulgate rules in accordance with the Civil Service Act, N.J.S.A. 11A, will receive preliminary comments on a possible readoption of N.J.A.C. 4A:6-6, due to expire on January 4, 1993.

N.J.A.C. 4A:6-6 permits local service to establish awards programs and establishes the awards programs for State service, including Recognition Awards, Suggestion Awards, Service Awards and departmental awards programs. These rules also establish the New Jersey Employee Awards Committee (Committee) and set forth its powers and duties; they further provide for departmental awards committees. The Committee hears appeals on awards matters.

Interested persons may submit written comments on the possible readoption of the aforementioned rules.

Submit comments by August 19, 1992 to:

Janet Share Zatz
Director
Division of Appellate Practices
CN 312
Trenton, New Jersey 08625

This is a notice of pre-proposal for a rule (see N.J.A.C. 1:30-3.2). Readoption of these rules must still comply with the rulemaking provisions of the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq., as implemented by the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30.

(b)

MERIT SYSTEM BOARD

Notice of Pre-Proposal

Leaves, Hours of Work and Employee Development

N.J.A.C. 4A:6-1, 2, 3, 4 and 5

Authorized By: Merit System Board, Anthony J. Cimino,

Commissioner, Department of Personnel.

Authority: N.J.S.A. 11A:2-6(d).

Pre-Proposal Number: PPR 1992-6.

Take notice that the Merit System Board, pursuant to its authority to promulgate rules in accordance with the Civil Service Act, N.J.S.A. 11A, will receive preliminary comments on a possible readoption of N.J.A.C. 4A:6-1, 2, 3, 4 and 5, due to expire on January 4, 1993.

PROPOSALS

N.J.A.C. 4A:6-1 through 5 contain rules on leaves of absence for merit system employees, including vacation, sick and administrative leaves; sick leave injury; military leave; other types of paid leave for specific purposes; family leave; and unpaid leaves of absence. Those sections also contain provisions on hours of work, which are primarily applicable to employees in State service. They further provide rules governing Supplemental Compensation on Retirement (SCOR), a lump sum payment program for State employees who are retiring. In addition, N.J.A.C. 4A:6-1 through 5 include rules on training, career development, the employee advisory service and the performance assessment review (PAR) program.

Interested persons may submit written comments on the possible readoption of N.J.A.C. 4A:6-1, 2, 3, 4 and 5.

Submit comments by August 19, 1992 to:

Janet Share Zatz
Director
Division of Appellate Practices
CN 312
Trenton, New Jersey 08625

This is a notice of pre-proposal for a rule (see N.J.A.C. 1:30-3.2). Readoption of these rules must still comply with the rulemaking provisions of the Administrative Procedures Act, N.J.S.A. 52:14B-1, et seq., as implemented by the Office of Administrative Law Rules for Agency Rulemaking, N.J.A.C. 1:30.

(c)

MERIT SYSTEM BOARD

Equal Employment Opportunity and Affirmative Action

Proposed Readoption with Amendments: N.J.A.C. 4A:7

Authorized By: the Merit System Board, Anthony J. Cimino, Commissioner, Department of Personnel.

Authority: N.J.S.A. 10:5-12, 11A:1-2(d), 11A:2-6(b), 11A:7-1 through 7-9, 7-11 through 7-13.

Proposal Number: PRN 1992-309.

Public hearings concerning the proposed readoption with amendments will be held on:

Thursday, August 6, 1992 at 6:00 P.M.
Cherry Hill High School East
Kresson Road
Cherry Hill, New Jersey

Monday, August 10, 1992 at 6:00 P.M.
Paramus Catholic High School
425 Paramus Road
Paramus, New Jersey

Wednesday, August 12, 1992 at 5:30 P.M.
Department of Personnel Training Center
600 College Road East
Plainsboro, New Jersey

Please call the Regulations Unit at (609) 984-0118 if you wish to be included on the list of speakers.

Submit written comments by August 19, 1992 to:

Janet Share Zatz
Director of Appellate Practices
Department of Personnel
CN 312
Trenton, New Jersey 08625

The agency proposal follows:

Summary

Pursuant to Executive Order No. 66(1978), N.J.A.C. 4A:7 expires on October 5, 1992. The Merit System Board has reviewed the rules and, with the following exceptions, has determined them to be necessary, reasonable and proper for the purpose for which they were originally promulgated, as required by the Executive Order.

Subchapter 1 includes general provisions on equal employment opportunity for groups protected by the State Law Against Discrimination, prohibition of discriminatory inquiries in a preemployment application and prohibition of sexual harassment in State service. Proposed amend-

ments prohibit discrimination based on sexual orientation, as required by P.L.1991, c.519.

Subchapter 2 provides for the responsibilities of the Division of Equal Employment Opportunity and Affirmative Action and establishes the Equal Employment Opportunity Advisory Commission. Subchapter 3 concerns appointing authority responsibilities for affirmative action and sets forth discrimination appeal procedures.

In order to reflect the terminology of the Americans with Disabilities Act, 42 U.S.C. 12101 *et seq.*, the term "disabled" has been incorporated throughout this chapter.

Social Impact

The proposed readoption with amendments continues to demonstrate a logical organization of the rules which will allow for the rules to be readily, easily and correctly applied. The chapter contains language prohibiting discrimination based on sexual orientation, as noted above, to be consistent with recently enacted law. Furthermore, the policy to provide equal employment opportunities consistent with both State and Federal laws has remained in full force. The rules will have an overall positive social impact on all users of the merit system rules in that N.J.A.C. 4A:7 will remain logically organized, understandable and reflective of current law, and ensure civil rights protections against discrimination based on sexual orientation.

Economic Impact

It is estimated that the overall economic impact of the proposed readoption with amendments will be minimal since this chapter essentially sets procedures for implementing the statutory responsibilities of the Department of Personnel and State agencies in the area of equal employment opportunity and affirmative action.

However, this chapter should continue to reduce costly litigation, by ensuring fair and effective administrative review of discrimination complaints. In addition, the clarity and simplicity of the proposal will continue to minimize the amount of inquiries and controversies requiring agency action.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required since this proposed readoption with amendments will have no effect on small businesses as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 *et seq.* The proposal will regulate employment in the public sector.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 4A:7.

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

4A:7-1.1 General provisions

(a) There shall be equal employment opportunity for all persons in, or applicants for the career, unclassified and senior executive services, regardless of race, creed, color, national origin, sex, **affectional or sexual orientation**, age, marital status, religion, or handicap/**disability**, except where a particular qualification is specifically permitted and is essential to successful job performance. See N.J.A.C. 4A:4-4.5 on bona fide occupational qualifications.

(b) Equal employment opportunity includes, but is not limited to, recruitment, selection, hiring, training, promotion, transfer, work environment, layoff, return from layoff, compensation and fringe benefits. Equal employment opportunity further includes policies, procedures and programs for recruitment, employment, training, promotion, and retention of minorities, women and handicapped/**disabled** persons. **Equal employment opportunity but not affirmative action is required with respect to persons identified solely by their affectional or sexual orientation.**

(c) Handicapped/**disabled** persons shall include any person who has a physical or mental impairment which substantially limits one or more major life activities; has a record of such an impairment; or is regarded as having such an impairment. See 29 U.S.C. 706 and 42 U.S.C. 12101 *et seq.* See also N.J.A.C. 4A:4-2.14 for accommodation and waiver of examinations for handicapped/**disabled** persons.

(d) The following race/ethnic categories shall be used by the Department of Personnel:

1. W: "White, not of Hispanic origin" means persons having origins in any of the original peoples of Europe, North Africa or the Middle East;

2. B: "Black, not of Hispanic origin" means persons having origins in any of the Black racial groups of Africa;

3. H: "Hispanic" means persons of Mexican, Puerto Rico, Cuban, Central or South America or other Spanish culture or origin, regardless of race;

4. I: "American Indian or Alaskan Native" means persons having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition; and

5. A: "Asian or Pacific Islander" means persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or Pacific Islands. This area includes, for example, China, Japan, Korea, the Phillipine Islands and Samoa.

4A:7-2.1 Division responsibilities: State service

(a) The Division of Equal Employment Opportunity and Affirmative Action (Division of EEO/AA) shall develop, implement and administer an equal employment opportunity and affirmative action program for all State employees in the career, senior executive and unclassified services. Such program shall:

1. Ensure that each State agency's equal employment opportunity and affirmative action goals for minorities, women and handicapped/**disabled** persons are in accordance with the Standard for Determining Underrepresentation of Women and Minorities in New Jersey State Government, and are related to their population in the New Jersey labor market as determined by the relevant federal census;

2. Ensure that each agency complies with all laws and rules relating to equal employment opportunity and oversee that the purposes of this subchapter are implemented through the agency affirmative action officers;

3. Seek correction of discriminatory policies, practices and procedures;

4. Recommend appropriate sanctions for non-compliance to the Commissioner;

5. Review State personnel policies, practices and procedures, and where appropriate, eliminate artificial barriers to equal employment opportunity;

6. Act as liaison with federal, state and local enforcement agencies;

7. Perform such other duties as prescribed by law and these rules.

4A:7-2.2 Department of Personnel responsibilities: State service

(a) The Department of Personnel, through the Division of EEO/AA, shall:

1. Ensure that minorities, women and handicapped/**disabled** persons are among the pool of applicants for all vacant positions in the career, unclassified and senior executive services.

2. Review its rules, selection devices and testing procedures to eliminate those which are discriminatory;

3. Analyze job specifications to eliminate artificial barriers to employment;

4. Review all certification dispositions for compliance with this chapter;

5. Review all discrimination complaints under Title VII of the Civil Rights Act of 1964, evaluate trends and recommend appropriate policy changes;

6. Transmit to the Governor, at least semi-annually, progress reports on affirmative action in all State agencies; and

7. Perform such other duties as prescribed by law and these rules.

4A:7-3.1 Appointing authority responsibilities

(a) In local service, an appointing authority may establish equal employment opportunity and affirmative action programs. Upon request, the Division of EEO/AA shall advise and assist local appointing authorities in the development of such programs.

(b) Each State agency shall:

1. Ensure equality of opportunity for all of its employees and applicants seeking employment[.];

2. Appoint at least one person as the affirmative action officer with the responsibility for affirmative action and equal employment

opportunity, who shall serve on a full-time basis, unless otherwise requested by the agency head and approved by the Commissioner and Director of the Division of EEO/AA[.];

3. Submit an affirmative action plan to the Director for approval, which shall include, but not be limited to, a policy statement, organization of the agency, a description of how the plan is communicated to its employees, an analysis of the workforce and job categories, goals and timetables and specific remedial action to meet its goals[.];

4. Submit to the Director quarterly affirmative action reports and an annual update of its affirmative action plan which shall include an evaluation of the goals set for the prior year, the goals for the upcoming year and the number, subject matter, time for processing and disposition of all discrimination complaints filed with the agency[.];

5. Make a good faith effort to meet the affirmative action goals and timetables set forth in its affirmative action plan and updates. Any agency which fails either to achieve or make a good faith effort to achieve its goals may be subject to sanctions and penalties[.];

6. Ensure that minorities, women and handicapped/disabled persons are considered for employment opportunities where the need for aggressive efforts have been identified[.];

7. Explore and, where appropriate, implement innovative personnel policies to enhance equal employment opportunity and affirmative action.

(a)

MERIT SYSTEM BOARD

Political Subdivisions

Proposed Readoption with Amendments: N.J.A.C. 4A:9

Authorized By: The Merit System Board, Anthony J. Cimino, Commissioner, Department of Personnel.

Authority: N.J.S.A. 11A:2-6(d), 11A:3-1(a), 11A:6-3, 11A:6-5 and 11A:9-1 et seq.

Proposal Number: PRN 1992-310.

Public hearings concerning the proposed readoption with amendments will be held on:

Thursday, August 6, 1992 at 6:00 P.M.
Cherry Hill High School East
Kresson Road
Cherry Hill, New Jersey

Monday, August 10, 1992 at 6:00 P.M.
Paramus Catholic High School
425 Paramus Road
Paramus, New Jersey

Wednesday, August 12, 1992 at 5:30 P.M.
Department of Personnel Training Center
600 College Road East
Plainsboro, New Jersey

Please call the Regulations Unit at (609) 984-0118 if you wish to be included on the list of speakers.

Submit written comments by August 19, 1992 to:

Janet Share Zatz
Director of Appellate Practices
Department of Personnel
CN 312
Trenton, New Jersey 08625

The agency proposal follows:

Summary

Pursuant to Executive Order No. 66(1978), N.J.A.C. 4A:9 expires on October 5, 1992. The Merit System Board has reviewed the rules and, with the following exceptions, has determined them to be necessary, reasonable and proper for the purpose for which they were originally promulgated, as required by the Executive Order.

N.J.A.C. 4A:9-1 concerns procedures applicable to political subdivisions adopting Title 11A, New Jersey Statutes, by referendum. In accordance with Title 11A, it provides for classification of positions in

the jurisdiction and further provides that seniority rights of employees determined to be in the career service shall be based upon their continuous service with the political subdivision. It also reflects the statutory provision that career service employees who have held their positions for at least one year prior to the adoption of Title 11A shall have permanent status as of the date of adoption. Finally, the rules provide a method for setting the date for the accrual of vacation and sick leave entitlements.

N.J.A.C. 4A:9-1.2 addresses procedures applicable to jurisdictions subject to Title 11A through consolidation or legislation. This rule also reflects statutory provisions concerning the status and seniority rights of employees. In conjunction with repropoed new rule N.J.A.C. 4A:4-7.11 (see reproposal elsewhere in this issue of the New Jersey Register) the Board has proposed amendments to N.J.A.C. 4A:9-1.2 to clarify that prior to consolidation, a political subdivision may determine to abolish positions which are no longer necessary due to consolidation. Adversely affected employees of a civil service jurisdiction which is consolidated will have layoff rights.

Social Impact

These rules are intended to explain the status and rights of employees in political subdivisions which become subject to Title 11A. During the past five years, these rules have assisted appointing authorities, employee representatives and the Department of Personnel in several situations where functions of non-civil service jurisdictions were consolidated with civil service jurisdictions. The proposed amendments would clarify questions that have arisen in these matters, and would provide uniformity with respect to the rights of employees who are adversely affected by the consolidation of functions.

Economic Impact

These rules generally reflect statutory provisions concerning employees of political subdivisions which became subject to Title 11A. Therefore, no substantial economic impact from these rules is expected.

The proposed amendments provide that employees need not be retained prior to consolidation. The Board believes these amendments merely clarify existing prerogatives. Nevertheless, such amendments could be considered helpful to political subdivisions seeking economy and efficiency through consolidation of functions or regionalization of services.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required since this proposed readoption would have no effect upon small businesses as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed readoption and amendments would regulate employment in the public sector.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 4A:9.

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

4A:9-1.2 Jurisdictions subject to Title 11A, New Jersey Statutes, by consolidation or legislation

(a) This rule applies to political subdivisions which are subject to Title 11A, New Jersey Statutes through consolidation of governmental functions or by legislation.

(b) When functions of two or more political subdivisions are consolidated, and any one of the political subdivisions shall be operating under Title 11A, New Jersey Statutes, at the time of such consolidation, the other political subdivision or subdivisions shall be deemed to have adopted Title 11A, New Jersey Statutes with regard to the combined functions.

(c) The Commissioner shall provide for classification of all positions in the jurisdictions following such consolidation or enactment of legislation.

(d) Any employee who has been employed by the new jurisdiction, holds a position allocated to the career service and [who] has been continuously employed by [that] the former jurisdiction for a period of at least one year prior to the effective date of such consolidation or legislation, including any such employee on an approved leave of absence, shall be considered a permanent employee under Title 11A, New Jersey Statutes and these rules as of that date, except as may be provided in such legislation.

PROPOSALS

Interested Persons see Inside Front Cover **MILITARY AND VETERANS' AFFAIRS**

(e) Seniority calculations for employees determined to be permanent under (d) above shall be based upon the length of their continuous service with the political subdivision.

(f) Vacation and sick leave entitlements under Title 11A, New Jersey Statutes, for employees determined to be permanent under (d) above shall be based upon seniority and shall be effective on the effective date of consolidation or legislation.

(a)

MERIT SYSTEM BOARD

Violations and Penalties

Proposed Readoption: N.J.A.C. 4A:10

Authorized By: The Merit System Board, Anthony J. Cimino,
Commissioner, Department of Personnel.

Authority: N.J.S.A. 11A:2-6, 11A:2-11(e), 11A:2-23, 11A:4-5,
11A:10-1 through 10-5, 11A:11-2.

Proposal Number: PRN 1992-311.

Public hearings concerning the proposed readoption will be held on:

Thursday, August 6, 1992 at 6:00 P.M.

Cherry Hill High School East

Kresson Road

Cherry Hill, New Jersey

Monday, August 10, 1992 at 6:00 P.M.

Paramus Catholic High School

425 Paramus Road

Paramus, New Jersey

Wednesday, August 12, 1992 at 5:30 P.M.

Department of Personnel Training Center

600 College Road East

Plainsboro, New Jersey

Please call the Regulations Unit at (609) 984-0118 if you wish to be included on the list of speakers.

Submit written comments by August 19, 1992 to:

Janet Share Zatz

Director of Appellate Practices

Department of Personnel

CN 312

Trenton, New Jersey 08625

The agency proposal follows:

Summary

Pursuant to Executive Order No. 66(1978), N.J.A.C. 4A:10 expires on November 2, 1992. The Merit System Board has reviewed the rules and has determined them to be necessary, reasonable and proper for the purpose for which they were originally promulgated, as required by the Executive Order. Although no changes are proposed, it is noted that necessary amendments have been made since this chapter was first adopted in 1987.

Subchapter 1 describes the types of actions considered to be violations of Title 11A, New Jersey Statutes. N.J.A.C. 4A:10-1.2 also summarizes provisions of Federal law known as the Hatch Act.

Subchapter 2 sets forth the remedies and methods of enforcement available to the Department of Personnel. Included within this subchapter is the rule, N.J.A.C. 4A:10-2.2, specifying the process where an appointing authority, after initiating the examination process, fails to use the resulting employment list.

Finally, Subchapter 3 describes the salary disapproval enforcement mechanism. This process is initiated when a State or local agency has made an appointment in violation of merit system laws and rules.

Social Impact

This chapter continues to provide a clear statement of activities which are violative of merit system law, as well as a guide to the methods for securing compliance with the law. While providing the Department of Personnel with a wide array of enforcement mechanisms, the rules offer those subject to an enforcement action the opportunity to formally and informally respond prior to a final action of the Merit System Board. Overall, this chapter will continue to have a positive social impact by using fair and effective methods to ensure compliance with the law.

Economic Impact

These rules provided a mechanism for the Department of Personnel to recoup needless expenditures for producing employment lists that are not used by appointing authorities. Further, the rules authorize the Department of Personnel to collect penalties for violations of merit system law. Although the Department has received revenue under these provisions during the past five years, the primary purpose of this chapter remains to secure compliance with the law.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required since this proposed readoption would have no effect upon small businesses as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed readoption regulates employment in the public sector.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 4A:10.

MILITARY AND VETERANS' AFFAIRS

(b)

DIVISION OF VETERANS' ADMINISTRATIVE SERVICES

New Jersey Veterans' Memorial Homes Admission Criteria

Proposed New Rules: N.J.A.C. 5A:5

Authorized By: Richard J. Bernard, Sr., Deputy Commissioner
Veterans' Affairs, Department of Military and Veterans' Affairs.

Authority: P.L. 1988, c.444; N.J.S.A. 38A:3-2.2, 38A:3-2b, 38A:3-6.4, 38A:3-6.5, 38A:3-6.6, 38A:3-6.8, 38A:3-6.9, 38A:3-6.12.

Proposal Number: PRN 1992-302.

Submit written comments by August 19, 1992 to:

Harold Smith

Administrative Division

New Jersey Department of Military

and Veterans' Affairs

CN 340

Trenton, New Jersey 08624-0340

The agency proposal follows:

Summary

The New Jersey Veterans' Memorial Homes at Menlo Park, Paramus, and Vineland are the three long term care facilities owned and operated by the State of New Jersey and under the jurisdiction of the Adjutant General of the Department of Military and Veterans' Affairs through its Division of Administrative Services and its Facility Advisory Council appointed by the Governor.

These facilities have been established to provide for the long term care needs of New Jersey veterans and eligible others requiring health care in such facilities.

The facilities operate as an entitlement offered to eligible veterans and their eligible others for health care maintenance. The purpose of the proposed new rules is to provide a standard admission criteria for all facilities operated by the Department and a revised maintenance fee computation formula consistent with the higher admission limits.

Subchapter 1 of the proposed new rules provides the purpose of the chapter, to establish requirements for eligibility for admission, pre-admission screening, admission review and implementation, computation of the care maintenance fee for New Jersey veterans' facilities, and the bases for discharge or transfer from such facilities. Subchapter 2 sets forth definitions of terms used throughout the rules and the eligibility standards for admission. Subchapter 3 provides the requirements for pre-admission screening of applicants. The admission review policy is established under subchapter 4. Subchapter 5 establishes the care maintenance fee computation, including general requirements, the fee formulae for single and married residents and financial responsibilities of residents. Subchapter 6 provides the bases for transfer or discharge of a resident.

Social Impact

The Department of Military and Veterans' Affairs provides medical and long term nursing care to meet the health needs of the New Jersey veterans and eligible others. Services provided to both current and future residents, regardless of their ability to pay, are as follows:

Medical evaluation and treatment programs administered by facility physicians;

Long term care nursing services;

Long term residential living arrangements;

Nutritionally balanced meals and prescribed diets, as necessary, to meet individual health care needs;

Rehabilitation programs;

Recreational and socialization programs;

Volunteer programs;

Referral, information and education services for benefits and programs;

Advocacy services;

General welfare and financial services; and

Psycho-social therapies.

The proposed new rules concerning the admission criteria and calculation of the care maintenance fee will have no impact on the veterans' home residents who were admitted prior to the effective date of the rules.

The proposed rules will have an impact on the community veteran (eligible others) who requires nursing home services by increasing the means eligibility criteria Resident Fee schedule. This amendment will provide services to a larger veteran and eligible others customer population.

The rules allow residents of the New Jersey Veterans' Memorial Homes to retain a larger portion of their income than would be allowed under a Medicaid facility, but provides for a more realistic share of costs to be paid by the resident.

This rule will not affect current residents in the areas of calculation of the maintenance fee and restriction of the personal needs allowance account. All other rules will apply.

Economic Impact

The proposed new rules will have no adverse impact on the Veteran Home Residents who were admitted prior to the effective date of the rules. New residents will pay a greater percentage of the costs of their care. This will reduce the publicly supported funding necessary.

The proposed rules increase the limit of accountable assets from \$7,500 to \$15,000 for a single applicant and \$15,000 to \$40,000 for a married applicant. Once admitted, a resident will be able to accumulate an additional \$5,000. This money will be added to the accountable assets thus increasing the amount from \$15,000 to \$20,000 for a single resident and from \$40,000 to \$45,000 for a married resident.

The proposed new rule will change the care maintenance fee (payment for services) from 60 percent of the monthly income minus allowable deductions to 80 percent of the monthly income minus allowable deductions, with a minimum fee of \$100.00 monthly. Further, residents will be assessed 10 percent of the remaining balance which will be deposited into the residents' Welfare Fund. This fund will be used solely for the benefit of all residents living in the facility. Residents having no income and no financial assets will be subsidized not less than \$35.00 per month from State general funds generated from the collection of resident care and maintenance fees as promulgated by the Adjutant General.

Regulatory Flexibility Statement

The proposed new rules apply to the three State-operated veterans long term care facilities known as Menlo Park, Paramus and Vineland Veterans' Memorial Homes and others as built. These facilities are owned by the State of New Jersey and under the jurisdiction of the Adjutant General of the Department of Military and Veterans' Affairs through its Division of Administrative Services and its Facility Advisory Council approved by the governor. Therefore, as no requirements are imposed upon small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., a regulatory flexibility analysis is not required.

Full text of the proposed new rules follows:

CHAPTER 5 NEW JERSEY VETERANS' FACILITIES

SUBCHAPTER 1. GENERAL PROVISIONS**5A:5-1.1 Purpose**

The purpose of this chapter is to establish requirements for eligibility for admission, pre-admission screening, admission review and implementation, computation of the care maintenance fee for New Jersey veterans' facilities, and the bases for discharge or transfer from such facilities.

SUBCHAPTER 2. ELIGIBILITY CRITERIA**5A:5-2.1 Definitions**

The words and terms, as used in this chapter, shall have the following meanings. All other words shall be given their ordinary meaning unless the content of their use clearly indicates otherwise.

"Accountable assets" means any item that has a determined value and is owned solely by the applicant or spouse, or owned jointly with spouse or others and must be spent down or liquidated and used toward payment of the resident's care and maintenance.

"Admission" means the procedure for entering one of the New Jersey veterans' memorial facilities.

"Aid and attendance" means supplemental income provided by the U.S. Department of Veterans' Affairs for extended care services.

"Allowable deductions" means those approved items which will be subtracted from the gross income when calculating admission eligibility.

"Asset determination" means an investigation and evaluation of the financial circumstances of a person applying for admission to a New Jersey veterans' memorial facility.

"Care and Maintenance" means the actual cost of services for an individual in one of the veterans' facilities.

"Community spouse" means the married spouse of the individual who is residing in a New Jersey veterans' memorial facility.

"Conservatorship" means the appointment of a person by the court to manage the financial affairs of a conservatee. A "conservatee" is one who has not been judicially declared incompetent, but who by reason of advanced age, illness, or physical infirmity, is unable to care for or manage his or her property or who has become unable to provide for himself or herself or others dependent upon him or her for support.

"Dependent" means a child of the Veteran Home Resident who is under the age of 21 or a child of any age who is blind or totally and permanently disabled. In the event that the child does not have a determination from the Social Security Administration of blindness or disability, the blindness or disability shall be evaluated by the Disability Review Section of the Division of Medical Assistance and Health Services in accordance with the provisions of N.J.A.C. 10:71-3.13.

"Durable power of attorney" means a designation and appointment of another in writing conveying specific powers to that attorney in fact and showing the intent of the principal that the authority conferred shall be exercisable notwithstanding the disability or incapacity of the principal at law or later uncertainty as to whether the principal is dead or alive.

"Eligible others" are as follows:

1. "Spouse" means the person married to an individual who has been honorably discharged from the active military of the United States, provided that the spouse is not less than 50 years of age, has been married to such person for a period of not less than 10 years, and meets the New Jersey residency requirement as described in paragraph 1 of the definition of "veteran" below.

2. "Surviving spouse" means the widow or widower of a person who died an honorable death while in the active military service of the United States, or who was a disabled veteran at the time of death, provided that the surviving spouse was the person's spouse at the time of the person's service or was married to the person not less than 10 years prior to the date of application and has not married since the person's death, and provided that the surviving

spouse has been a resident of New Jersey for at least two years prior to the date of application.

3. "Parent" means the mother or father of a person who was a resident of New Jersey at the time of service entry, and who died an honorable death in time of war or emergency while in the active military service of the United States, provided that the parent has been a resident of New Jersey for at least two years prior to the date of application.

"Guardian" means a person who has been entrusted as the legal representative of one who has been adjudicated incompetent by a court of law and requires a legal representative to act on their behalf for all matters.

"Guardianship" means the process by which an individual is appointed the legal representative of another person who has been adjudicated incompetent by a court of law and requires a legal representative to act on their behalf for all matters.

"Income" means all revenue received by resident for a given period. Includes funds received for labor or services, social security, pensions, aid and attendance, rental of property, the proceeds of business or enterprises and investments.

"Medically needy applicants" means those individuals who cannot be maintained in the community because of the need for additional support and care to meet their physical, medical and psychosocial needs.

"Needy veteran" means an individual who is without sufficient financial ability to provide for their support and necessary care in the community.

"Net income" means the total gross income received, minus allowable deductions.

"New resident" means those individuals admitted after the effective date of this chapter.

"Non-accountable assets" means those items of determined value that are owned solely by the applicant or spouse, or owned jointly with spouse or others and will not be spent down or liquidated and used toward payment of resident's care and maintenance. The following are considered non-accountable assets:

1. The primary residence and any appurtenance thereto;
2. All of the household effects therein; and
3. An automobile if there is a community spouse.

"Personal needs account" means an account maintained at the veterans' facility for deposit of the personal funds of the resident and which will be considered part of the accountable assets.

"Personal needs allowance" means a set amount received by a resident for individual use and spending.

1. A resident whose source of monthly income exceeds \$100.00 will retain a minimum of \$100.00 for personal needs.

2. A resident whose source of monthly income does not exceed \$100.00 will retain all of their monthly income.

3. A resident who has no source of funds will be provided a monthly allowance for personal needs of \$50.00.

"Representative Payor" means a designated person or institution responsible for the payment of the resident's financial obligations.

"Resident" or "veterans' facility resident" means an individual residing in a New Jersey veterans' memorial facility.

"Resident fee" means the monthly charges billed by the veterans' facility to the resident for their cost of care and maintenance.

"Spend down" means that which occurs when accountable assets exceed the maximum amount allowed and are liquidated and spent towards the actual care and maintenance cost. This process will continue as long as the accountable assets exceed the maximum amount allowed.

"Veteran" means:

1. A person who has been honorably discharged from the active military service of the United States and has been a resident of New Jersey for at least two years prior to the date of application; or

2. A person who was a citizen of the State of New Jersey at the time of entrance into the active military service of the United States, and who is qualified for admission except for the required period of State residence. Preference shall be given to persons who have been residents of the State for a period of at least two years prior to application.

"Veterans' facility" means any home, institution, hospital, or part thereof, the admission to which is under the jurisdiction of the Department of Military and Veterans' Affairs, being the facilities at Menlo Park, Parmus, Vineland, and such other veterans' facilities as may be developed.

"Welfare Fund" means an account established at each facility pursuant to N.J.S.A. 38A:3-6.16 for the specific purpose of accepting monies that will be spent for and on behalf of residents' programs, special events and services. This fund will provide for and maintain a quality of life which might otherwise not be possible for the residents and shall be administered by the Adjutant General in accordance with the provisions of N.J.S.A. 38A:3-6.16.

5A:5-2.2 Admission eligibility

(a) Eligibility for admission to the New Jersey veterans' memorial facilities is considered on financial and medical needs. The following individuals, in order of priority, are eligible for admission consideration:

1. A New Jersey needy veteran, being one who does not exceed the maximum accountable assets from all sources, but meets the New Jersey residency requirement as described in paragraph 1 of the definition of "veteran" in N.J.A.C. 5A:5-2.1.

2. A needy veteran, being one who does not exceed the maximum accountable assets from all sources but does not meet the New Jersey residency requirement as described in paragraph 1 of the definition of "veteran" in N.J.A.C. 5A:5-2.1.

3. Needy eligible others, as set forth in no priority order in (a)3i through iv below being those whose accountable assets do not exceed the maximum allowable assets.

- i. Spouse;
- ii. Widow;
- iii. Gold Star Parent; and
- iv. Dependent others; and

4. Those who exceed the maximum allowable assets, who shall still be eligible for admission, but shall be required to pay the actual cost of care and maintenance.

(b) The non-needy applicants in (a)4 above shall be defined by their financial assets; however, those who are defined as medically needy will be admitted on a bed available basis determined upon receipt of the completed and dated application.

(c) All accountable assets shall be spent down or liquidated and used to pay resident's actual care and maintenance until:

1. A single applicant's maximum accountable assets do not exceed \$15,000 from all sources of accountable assets; or

2. A married couple's maximum accountable assets do not exceed \$40,000 from all sources of accountable assets.

(d) Admission eligibility is contingent upon a facility's ability to meet the applicant's individual health care needs which will be reviewed and determined by the Admission Committees of each facility and bed availability. The applicant shall also sign a statement that he or she will accept placement in the facility designated by the Adjutant General, and that he or she will abide by the rules, regulations and discipline of the facility to which admitted.

(e) The following shall be denied admission into a New Jersey veterans' memorial facility:

1. Applicants who are active substance abusers, exhibit active psychiatric problems or exhibit behavioral actions which may pose a danger to self or others;

2. Applicants who require treatment beyond the facilities' ability to meet the applicants' individual health care and psychological needs; and

3. Applicants who refuse to sign the required statement of compliance under (d) above.

(f) An approved applicant may be subject to reevaluation in the following circumstances:

1. A more than six months lapse from the time of application, before admission;

2. A change in medical or psychological status; or

3. An omission of significant medical or financial information.

(g) Criteria for admitting applicants with special needs are as follows:

1. Any applicant who is adjudicated legally incompetent is required to have a legal guardian.

i. A copy of the guardianship document shall be submitted with the application prior to admission being scheduled.

2. Any applicant who has a conservatorship shall submit a copy of the document prior to admission being scheduled.

3. Any applicant who has a durable power of attorney for both medical and financial matters shall submit a copy of the document for guardianship criteria to be waived. The document shall be notarized, witnessed and signed by the applicant while competent.

SUBCHAPTER 3. PRE-ADMISSION SCREENING OF APPLICANTS

5A:5-3.1 Sequence of screening activities

(a) The admission to a veterans' memorial facility shall be as follows:

1. To establish basic eligibility of all applicants, the following documentation and information reviews are required:

i. Service history:

(1) Proof of other than dishonorable discharged; and

(2) A completed "Request Pertaining to Military Records" (Standard Form 180);

ii. Social history:

(1) A birth certificate;

(2) Marital status verification; and

(3) Verification of residency;

iii. Medical status:

(1) An Application for Medical Benefits (VA 10-10);

(A) Medicare Part A and B; and

(B) Other health insurances;

(2) A Veterans Administration Medical Certificate (VA 10-10m);

(3) A Veterans Administration Referral for Community Nursing Home Care (10-1204);

(A) This requirement applies only if the applicant is currently under VA care or in a nursing home under VA contract; and

(4) A Medical History Release Request;

iv. Financial eligibility:

(1) All assets will be reviewed and considered in determining financial eligibility;

(2) Non-accountable assets will not be considered in determining accountable assets;

(3) All financial transactions and transfer of resources, which have occurred within 18 months preceding the date of application, will be reviewed and considered as accountable assets;

(4) The value of all assets will be determined as of the date of application and revalued on the date of admission; and

(5) Income from all sources shall be disclosed. Income shall be verified by submitting the most recent copy of the Federal and State Income Tax Reports and other such documents as may be required;

v. Verification of admission eligibility as defined in N.J.A.C. 5A:5-2.1; and

vi. Other:

(1) Verification of funeral arrangements;

(A) Burial insurance not to exceed \$10,000;

(2) Submission of advance directives for health care, if desired by the applicant, such as:

(A) An advance directive;

(B) A proxy directive;

(C) An instruction directive;

(D) A combined directive; and

(3) Appointment of a representative payor, if desired by the applicant.

2. Applicants shall be eligible for admission consideration upon the completion of the documentation and information for the following:

i. Service history;

ii. Social history;

iii. Medical status;

iv. Financial eligibility; and

v. Admission eligibility.

SUBCHAPTER 4. ADMISSION REVIEW AND IMPLEMENTATION

5A:5-4.1 Admission review policy

(a) It is the policy of the New Jersey veterans' memorial facilities to have an admission committee review all completed and tentatively approved applications for appropriateness of placement. A tentatively approved application is one which has produced all required documents and meets admission and financial eligibility requirements. In addition to financial eligibility, the following areas will be considered in all applications for admission and may be grounds for rejection:

1. Medical and psychosocial behaviors;

2. Past medical history;

3. Present medical condition;

4. Evaluation of medical acuity levels;

5. Treatments/care required to meet the applicant's individual health care and psychological needs;

6. An applicant's participation in active substance abuse; and

7. Whether an applicant poses danger to self or others.

(b) If the committee rejects an applicant, the facility will provide written notice of denial and the reason for denial within 14 days to the applicant or representative.

(c) Approved applicants will be placed on the waiting list. The waiting list process is as follows:

1. All completed applications with the required documentation will be timed and dated when received and prioritized in accordance with N.J.A.C. 5A:5-2.1.

2. Once the applicant is approved for admission, his or her name will be placed on the bottom of the approved waiting list. An applicant, who is awaiting guardianship, will remain on the waiting list in sequence but can not be admitted until the guardian is appointed.

3. There will be no consideration for by-passing approved applicants on the waiting list except when bed availability is based on gender.

4. If an approved applicant refuses admission at the time offered, the applicant will be placed at the bottom of the waiting list. If offered admission a second time and refuses, the applicant will be taken off the list and may be barred from reapplying for a period of six months.

5. The waiting list is a confidential document; numerical assignment will be provided when requested.

SUBCHAPTER 5. CARE MAINTENANCE FEE COMPUTATION

5A:5-5.1 General requirements for computing monthly resident fee

(a) At the time of admission and annually thereafter, based on a determined date, the computation of the monthly resident fee is calculated with the resident or representative payor. The calculation is determined by review of Federal and State Income Tax Returns and all financial statements and transactions. Upon the effective date of this rule, the resident fee will be based on 80 percent of the net income for all residents admitted thereafter. Those individuals residing in the facilities prior to the effective date will have the resident fee based on 60 percent of the net income.

(b) The resident fee will be based on 80 percent of the net income, not to exceed the established monthly care rate set by the Adjutant General annually.

(c) Residents admitted on or after the effective date of these rules will be required to pay a welfare refund fee not to exceed 10 percent of the balance of their monthly income, excluding all allowable deductions and the care maintenance fee payment. These monies will be deposited in the facility's welfare fund. The remainder of the net income will be returned to the resident for personal use. Residents admitted before the effective date of these rules will continue to pay one percent of earned interest on this savings account as a welfare fund fee.

(d) Payment for the resident fee is due the first of each month.

(e) At the time of admission, a resident will be assessed charges for that month pro-rated according to the date of admission.

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(f) At the time of discharge, there will be no reimbursement to the resident or resident's estate for pre-paid care and maintenance fees.

5A:5-5.2 Formula for computing single resident's monthly resident fee based on an 80/20 percentage

(a) The monthly resident fee for a single 80/20 resident is based on the total gross income, minus allowable deductions. This figure is the net income. Eighty percent of the net income will be the resident fee charged. An additional 10 percent of the balance will be deposited in the Welfare Fund of the facility. The remainder of the net income will be deposited in the resident's personal needs account.

(b) The allowable deductions for a single resident are as follows:

1. The personal needs allowance;
2. Health insurance premiums;
3. Life insurance/burial accounts: This insurance will have had to be in effect prior to the date of application. The face value of the policy shall not exceed \$10,000. Life insurance will be considered in lieu of a burial account; and
4. Other expenses as may be individually approved by the Deputy Commissioner of the Department of Military and Veterans' Affairs.

5A:5-5.3 Formula for computing a married resident's monthly resident fee based on an 80/20 percentage

(a) The monthly resident fee for a married resident is based on the total personal income of the resident, minus allowable deductions. This figure is the net income. Eighty percent of the net income will be the resident fee charged. An additional 10 percent of the balance will be deposited in the welfare fund of the facility. The remainder of the net income will be deposited in the resident's personal needs account.

(b) The resident fee will be based solely on the applicant's income.

(c) The community spouse must divulge all sources of their monthly income in order to file for consideration of allowable deductions. Allowable deductions will be offset by the community spouse's monthly income before the applicant's monthly income will be considered. In the event that each individual of the marriage is a resident, the resident fee for each will be calculated as for a single resident. Failure to make a full and complete disclosure will constitute a breach of the facility regulations and may be grounds for removal as provided for in N.J.S.A. 38A:3-6.9.

(d) The allowable deductions for a married resident are as follows:

1. Personal needs allowance;
2. Health insurance premiums;
3. Rent/primary residence first mortgage: The mortgage must have been in effect 30 months prior to the date of application. Verification of mortgage payment schedule is required. The actual cost of property taxes and insurance for the primary residence will be deducted equally over the 12 month period. Verification shall be required;
4. Food deductions shall be \$200.00 for the community spouse and \$130.00 per additional dependent per month;
5. Heat/electric deduction shall be based on preceding year usage and cost. The deduction will be divided equally over the 12 month period;
6. Water/sewage deduction shall be the actual annual cost. The deduction will be divided equally over the 12 month period;
7. Automobile/transportation deduction shall be \$150.00 per month;
8. Clothing deduction shall be \$50.00 per month per dependent;
9. Telephone deduction shall be (\$25.00) per month;
10. Trash disposal deduction shall be the actual annual cost. The deduction will be divided equally over the 12 month period;
11. Home maintenance deduction shall be \$50.00 per month;
12. Life insurance/burial accounts: The life insurance shall have had to be in effect one year prior to the date of application. The face value of the policy shall not exceed \$10,000. Life insurance will be considered in lieu of a burial account. This deduction can be considered for both the applicant and spouse with verification of policies and payment schedule;

13. Guardianship/advance directives: The actual cost of legal fees up to a maximum of \$2,400 may be deducted. This deduction will be divided into 24 monthly installments, which will only be permitted as long as the resident resides in the veterans' memorial facility. This deduction will only be approved for a guardianship hearing/advance directive protocol which was processed no later than one year prior to the date of application. Verification of cost and date of action shall be required; and

14. Other extraordinary expenses as may be individually approved by the Deputy Commissioner of the Department of Military and Veterans' Affairs.

(e) No deduction beyond the approved listing shall be permitted until all accountable assets, to include the personal needs account, are depleted.

5A:5-5.4 Financial responsibilities for veterans' facility resident

(a) An eligible applicant who desires admission and whose assets are in excess of the allowable assets may be admitted on a bed available basis. They will be billed for and required to pay the actual cost of care and maintenance until their resources meet the accountable asset maximum.

(b) Once admitted, a resident will be able to accumulate accountable assets of \$5,000. This money will be added to the accountable assets; thus, increasing the amount from \$15,000 to \$20,000 for a single resident and from \$40,000 to \$45,000 for a married resident.

(c) When an account exceeds the allowable maximum, the resident will be billed and required to pay the actual cost of care and maintenance until the allowable asset limit is reached.

(d) The resident will be responsible for all financial obligations for services not provided by the facility. This includes, but is not limited to:

1. Transportation;
2. Medical appointments;
3. Hospitalization;
4. Specialized services/programs/treatments;
5. Adaptive equipment;
6. Diagnostic services;
7. Other outside services as requested by the resident; and
8. Deductible fees not covered by medical insurances.

(e) The facility will not accept responsibility for any nonpayment of debts incurred by a resident including health care costs.

(f) All personal property of the resident is the responsibility of the resident or guardian. The facility assumes no responsibility and will not reimburse a resident for loss or damage of personal items.

SUBCHAPTER 6. RESIDENT TRANSFER OR DISCHARGE

5A:5-6.1 Transfer or discharge of a resident

(a) Any resident may be removed from a veterans' facility on being restored to an ability to promote his or her own support and welfare in the community, or for immorality, or for fraud or willful misrepresentation, or refusal to abide by the rules, regulations and discipline of the veterans' facility, as well as:

1. In an emergency, with notification of the resident's physician, next of kin or guardian;
2. For medical reasons or to protect the resident's welfare or the welfare of others;
3. For nonpayment of fees, in situations not prohibited by law; or
4. Expiration of the resident.

HEALTH

(a)

DIVISION OF EPIDEMIOLOGY, ENVIRONMENTAL & OCCUPATIONAL DISEASE CONTROL

Consumer Health Services

Sanitation, Handling, Shipping, and Shucking of Shellfish

Depuration of Hard Shell and Soft Shell Clams

Proposed Readoption: N.J.A.C. 8:13

Authorized By: Frances J. Dunston, M.D., M.P.H.,

Commissioner, Department of Health.

Authority: N.J.S.A. 24:2-1.

Proposal Number: PRN 1992-314.

Submit comments by August 19, 1992 to:

Gary J. Wolf, Coordinator

FDA/Shellfish Project

Food and Milk Program

CN 369

Trenton, New Jersey 08625-0369

The agency proposal follows:

Summary

Pursuant to Executive Order No. 66(1978), N.J.A.C. 8:13, Shellfish, expires on September 8, 1992. The Department of Health (hereafter, the Department) 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.

Shellfish, which include raw clams, oysters, and mussels, have been involved in numerous disease outbreaks over the years, including viral gastroenteritis and infectious hepatitis. The potential health hazard to the consumer is greatly increased because shellfish are often eaten raw and through their natural processes shellfish concentrate deleterious substances such as chemicals, pesticides, and pathogenic organisms. Because of the increased risk of illness associated with shellfish and the special handling requirements inherently necessary with this product, the Department needs to continue to retain specific rules for the sanitary handling, shucking, and distribution of shellfish.

N.J.A.C. 8:13-1 pertains to certification and sanitation of shellfish handling, shipping, and processing facilities. The subchapter (Sanitation, Handling, Shipping and Shucking of Shellfish) was filed and became effective on July 9, 1974 as R.1974 d.185. The rules have functioned well in protecting the health of the public by providing the sanitary and recordkeeping standards for the handling, storage, and distribution of shellfish. These requirements additionally have served the State in substantially meeting the guidelines of the National Shellfish Sanitation Program which allow the shipment of raw shellfish products in interstate commerce. A summary of each section in subchapter 1 follows:

N.J.A.C. 8:13-1.1 provides definitions of the words and terms used throughout this subchapter.

N.J.A.C. 8:13-1.2 establishes those that must comply with the provisions of the subchapter and who must apply for certification and/or approval by the Department to operate a shellfish establishment within the State; prohibits the harvesting of shellfish from areas condemned by the Department of Environmental Protection and Energy; and prohibits the shipment of shellfish to New Jersey from non-certified sources.

N.J.A.C. 8:13-1.3 establishes shellfish dealer certification requirements and defines those that must be certified by the Department.

N.J.A.C. 8:13-1.4 establishes and specifies the sanitary requirements that must be met for certification and the sanitary operation of a shellfish establishment.

N.J.A.C. 8:13-1.5 specifies the water supply requirements for the shellfish establishments.

N.J.A.C. 8:13-1.6 states that toilet wastes be disposed of in compliance with requirements established by the Department.

N.J.A.C. 8:13-1.7 establishes the requirements for the cleaning and sanitizing of equipment and utensils used in the processing of shellfish.

N.J.A.C. 8:13-1.8 prohibits any person from working in a shellfish establishment who is ill or infected with communicable disease, or has infected wounds.

N.J.A.C. 8:13-1.9 specifies that shellstock must be washed free of mud and other material after harvesting.

N.J.A.C. 8:13-1.10 requires the washing of shucked shellfish and specifies the type of packing container to be used.

N.J.A.C. 8:13-1.11 establishes requirements for the packing of shucked shellfish including time and temperatures controls, as well as labeling requirements.

N.J.A.C. 8:13-1.12 refers to the sanitary handling, manufacturing, and storage of ice for use within a shellfish establishment.

N.J.A.C. 8:13-1.13 provides the recordkeeping requirements for receipt as well as for the sale of shellfish in order to trace shellfish to the source of harvest, and specifies the time period for shellfish shipping tag retention and requires the tagging of shellfish by the harvester.

N.J.A.C. 8:13-1.14 states the requirements for the packing and shipping of shellstock including the types of containers and tagging specifications.

N.J.A.C. 8:13-1.15 states that any certificate or permit issued pursuant to the rules may be revoked for any violation of Title 24 of the Revised Statutes or any applicable rule or regulation of the Department.

Subchapter 2. Depuration of Hard Shell and Soft Shell Clams

This subchapter pertains to the purification of hard and soft shell clams utilizing the depuration process. Depuration involves the taking of market size shellfish harvested from "marginally polluted waters" and placing them in an environmentally controlled purification system (man-made tanks with controlled water quality), where the shellfish are able to purge or cleanse themselves of accumulated pollutants through natural biological processes. The shellfish remain in the tank system for a minimum of 48 hours and upon meeting the acceptable bacteriological quality, they can be marketed.

The provisions of this subchapter were adopted pursuant to the authority of N.J.S.A. 24:2-1 and were filed on April 17, 1978 as R.1978 d.127 to become effective on May 1, 1978. Definitions and changes to the original subchapter were proposed and become effective on August 2, 1982. Revisions were again proposed and adopted, becoming effective on January 21, 1986. The first amendments established requirements that the licensed depuration plant must utilize the services of a governmental laboratory for bacteriological analysis of depurated shellfish rather than private laboratories. Additionally changes in the January 1986 readoption included: specific cleaning schedule requirements, sampling schedule requirements, clarifying the provisions for transporting clams to the depuration plant, as well as several other minor wording changes which relates to recordkeeping. Departmental review of the hard and soft shell clam depuration operations in the State indicated that the regulatory requirements existing at that time could be easily circumvented without the knowledge of the Department. Past regulatory actions taken by the Department confirmed this and thus placed consumers at a significant risk of contracting viral and bacterial illness associated with consumption of shellfish taken from marginally polluted waters.

Hearings held before an Administrative Law Judge in March 1988 substantiating serious regulatory infractions resulted in the Department taking action to suspend and revoke the State's only hard shell clam depuration plant certification. In December 1988, representatives made up of the Department of Health and Department of Environmental Protection having shellfish regulatory responsibilities recommended the temporary suspension of all hard clam depuration until the rules governing the program could be revised.

This resulted in a moratorium on Departmental approval of any new depuration plants and the repeal of the existing soft clam depuration rules under N.J.A.C. 8:13-2 as well as the repeal of the "Hard Shell Clam Depuration Pilot Program" under N.J.A.C. 7:17 which was jointly promulgated by the Departments of Health and Environmental Protection. The Department then consolidated the hard and soft shell clam depuration requirements and promulgated new rules under N.J.A.C. 8:13-2, which are currently in effect.

The revised rules consolidated the hard clam and soft shell clam depuration requirements under N.J.A.C. 8:13-2 in order to simplify the regulatory process for depuration plants and provide potential applicants with a single comprehensive set of requirements for constructing and operating a shellfish depuration plant. These rule revisions also reflected full operational status of the program by both departments, based upon the comprehensive nature of the changes being proposed, including a plant verification study and stringent preoperational and operational requirements.

Simultaneously the Department of Environmental Protection adopted new requirements covering the harvesting and transportation aspects of the depuration program under their permit rules N.J.A.C. 7:12-1.1-2, 9.1,

9.6, 9.11, 9.13 and 9.14. Each departments' rules were harmonized and a permanent steering committee was created, made up from representatives from each department having regulatory responsibility to insure consistency in establishing shellfish depuration policies and developing enforcement procedures.

The existing rules under this subchapter give the Department the tools necessary to closely monitor the operations of shellfish depuration plants and provide the increased accountability for shellfish harvested and processed. These rules continue to provide the consumer additional assurances that the shellfish would be safely depurated. A summary of each section in subchapter 2 follows:

N.J.A.C. 8:13-2.1 establishes the definitions for the words and terms used throughout this subchapter.

N.J.A.C. 8:13-2.2 indicates that depuration plants shall conform to N.J.A.C. 8:13-1, the general rules governing sanitation, shipping, and shucking of shellfish, and to the food laws established under N.J.S.A. 24:2.

N.J.A.C. 8:13-2.3 states that all clams harvested from special restricted waters must be depurated for at least 48 hours, but no more than 72 hours, and must meet the bacteriological standards set forth under N.J.A.C. 8:13-2.21 prior to being distributed and/or sold.

N.J.A.C. 8:13-2.4 sets forth the rule of the Shellfish Resource Recovery Steering Committee (SRRSC) and, also provides the criteria for submitting a depuration plant application to the SRRSC for consideration by the Departments of Health and Environmental Protection and Energy.

N.J.A.C. 8:13-2.5 identifies the steps necessary to obtain a provisional shellfish certification for the purpose of depuration; establishes requirements for a certified depuration plant operator (DPO); and establishes the requirement for a plant verification study prior to receiving provisional certification and final certification.

N.J.A.C. 8:13-2.6 states the requirements for final certification which includes the completion of a process verification study conducted during the winter and summer seasons. A record of satisfactory compliance of the critical control activities established under N.J.A.C. 8:13-2 is also required before a full operational permit can be issued.

N.J.A.C. 8:13-2.7 states that the certificate holder be restricted to the sale of depurated clams only and that violations of N.J.S.A. 24:2 and/or the critical control activities defined in the subchapter may result in suspension or revocation of the certificate.

N.J.A.C. 8:13-2.8 specifies that the plant be located near the harvest site and adjacent to seawater of proper quality and quantity.

N.J.A.C. 8:13-2.9 concerns installation of video surveillance systems and provisions for three-day storage areas, as well as process support requirements.

N.J.A.C. 8:13-2.10 establishes the use of harvester allocation tags which are designed to enable the Department to monitor and control shellfish received for depuration and specifies the harvest containers and transportation requirements.

N.J.A.C. 8:13-2.11 specifies the storage procedures including temperature controls.

N.J.A.C. 8:13-2.12 establishes the parameters for the source seawater and process water to ensure that bacteriological, chemical, and physical water quality standards are maintained.

N.J.A.C. 8:13-2.13 indicates that the process tanks have a lid to prevent unauthorized removal of shellfish during depuration. This rule also sets forth requirements for the installation of the plant water piping network, valves, fittings, and flow measuring devices, and establishes the depuration tank specifications.

N.J.A.C. 8:13-2.14 establishes the requirements for the clam processing containers in that they shall be noncorrosive, nontoxic, and allow processed seawater to pass easily in all directions.

N.J.A.C. 8:13-2.15 indicates the requirements for the seawater purification system, including design and monitoring controls. The section also establishes ultraviolet light cleaning and maintenance requirements.

N.J.A.C. 8:13-2.16 sets the requirements and specifications for the process water temperature recording device. The device shall have a recording chart capable of recording water temperatures in a continuous reading for the 48 to 72 hour depuration process, and must be constructed so that the device cannot be manipulated.

N.J.A.C. 8:13-2.17 requires that plant capacity controls be established in order to prevent over harvesting above the plant capacity through the use of harvester allocation tags, and sets limits on a daily harvest to prevent the plant exceeding their rated capacity.

N.J.A.C. 8:13-2.18 contains requirements regarding the carryover of clams for processing from one day to the next.

N.J.A.C. 8:13-2.19 sets forth the requirements to account for the destruction of "culled" shellfish which cannot be sold and establishes culling and washing procedures.

N.J.A.C. 8:13-2.20 specifies that all equipment shall be properly washed and sanitized within three hours after a process is completed. The seawater reservoirs shall be flushed after each process and shall be sanitized at least weekly.

N.J.A.C. 8:13-2.21 establishes hard clam bacteriological standards which are consistent with U.S. Food and Drug Administration's standards.

N.J.A.C. 8:13-2.22 indicates that a government laboratory shall be used for the bacteriological analysis of depurated shellfish, and establishes the time period for sampling and amount of samples to be taken. The rule states that no clams shall be packed and shipped prior to the plant receiving acceptable laboratory results.

N.J.A.C. 8:13-2.23 requires that copies of records be submitted by the plant operator via a telefacsimile machine, in order to prevent delays which would inhibit the Department's ability to discover discrepancies.

N.J.A.C. 8:13-2.24 sets forth specific requirements for the information to be provided by the harvester and establishes the use of a time clock for verification of date and time of harvesting and receipt of the shellfish.

N.J.A.C. 8:13-2.25 requires the depuration plant operator to provide each harvester with a receipt which must meet specifications established by the Department of Environmental Protection and Energy.

N.J.A.C. 8:13-2.26 requires the use of a waterproof shellfish shipping tag and establishes a specific designation for a depuration plant denoted by the letters DP.

N.J.A.C. 8:13-2.27 states that a video surveillance system be installed and operated to observe the critical control activities of the plant, and specifies the location of the monitoring equipment and that the cost of the purchase, installation, and maintenance of the equipment will be borne by each operating depuration plant.

Social Impact

Once readopted, the rules will continue to provide reasonable standards to regulate the shellfish industry in New Jersey. Failure to readopt these rules would jeopardize the safety and sanitary conditions of shellfish facilities with the State.

New Jersey is a major shellfish producing state with distribution throughout the New York-Philadelphia metropolitan area, as well as numerous other receiver states. On occasion, shellfish processed in New Jersey have been found to exceed the microbiological standards for this potentially hazardous food, thereby increasing the risk of illness. There is a definite need to prevent the consumer from suffering the consequences of contracting gastroenteritis or, more serious, infectious hepatitis.

The surveillance and inspection of shellfish depuration plants for compliance with strict standards of operation established under these rules are an indispensable part of the Department's efforts to ensure that safe shellfish are being offered for sale. Failure on the part of the depuration plant operator to purify the shellfish that are being harvested from polluted shellfish growing areas could result in serious disease outbreaks.

The public benefits which would be derived are the prevention of food borne illness and enhanced public confidence in the regulatory controls to ensure the safety of shellfish, a potentially hazardous product. Additionally, these rules can greatly reduce the risk of unsafe and adulterated shellfish reaching the consumer; identify and prevent shellfish with unsatisfactory quality from reaching New Jersey consumers and consumers from other states, and provide a means to trace contaminated products before a serious disease outbreak could occur.

Economic Impact

The National Shellfish Sanitation Program (NSSP), which is a cooperative Federal-state program, requires the shellfish industry to meet and maintain strict sanitary requirements and to obtain certification from the state of origin for the interstate shipment of shellfish. New Jersey's shellfish program activities must comply with the national program standards so that the State can maintain Federal endorsement, which allows the industry to ship shellfish interstate. Failure to readopt these rules could cause a loss of Federal endorsement and prevent New Jersey's shellfish plants from shipping to other states, thereby crippling the industry and creating a loss of many jobs.

The initial cost of developing a depuration facility have been estimated by the New England Fisheries Development Association to vary from \$133,000 to \$290,000, depending upon the capacity of the processing

facility and not including cost for the land. Construction costs were estimated to be approximately \$40.00 per square foot. There may be differences in construction costs in the State of New Jersey, which would account for some variation. The NEFDA has estimated that, for a 25,000 square foot building, at three production capacities, the costs would be:

Number of bushels/week	Equipment	Construction
200	\$ 33,000	\$100,000.00
400	\$ 61,500	\$119,000.00
800	\$118,000	\$172,000.00

The depuration plants are required to have the process water sampled and monitored continuously. The depurated shellfish must also be sampled and tested, with every 48-hour batch, prior to sale. The depuration plants must also install a video monitoring system, in their facilities, with remotes located at the Department of Health and at the Department of Environmental Protection and Energy. The laboratory tests of the 48-hour batch sample are done by a local government testing lab at an approximate cost of \$100.00 per sample. The installation of a video monitoring system may cost approximately \$11,000. There would be additional cost for the telephone charges at those times when the State of New Jersey was monitoring the facilities. It is possible to add the monitoring of the water to the video system for an increase in cost of approximately \$12,000. (If not connected to the video equipment, the water quality monitoring system would be included in the estimated equipment costs listed above.) The visual records require a continuing expense for VCR tape, which can be purchased by volume.

The initial cost of developing a facility for the handling, shipping and shucking of shellfish are much less than the costs for a depuration plant. The rules for a shellfish shipping facility require a building (which could be a very simple structure), a washing area, to be maintained at a specified level of cleanliness, plumbing adequate for processing needs, a cooled storage area, handwashing facilities for workers, and a table on which to sort the shellfish. Heated facilities are not necessary. The recordkeeping required can be done with a simple ledger system, or a home computer, and without professional assistance. There are additional requirements for those facilities which engage in shucking and shipping, made necessary by the increased need for sanitation and food protection once the shellfish are separated from their shells. There are approximately 16 shellfish shucking and repacking operations. Of these 16 firms, approximately six utilize mechanical shucking procedures. Of these six, approximately three of the shellfish shucking firms process (can) the products part of a food packing process, and these facilities have additional internal controls related to wholesale food preparation requirements, which are not part of these rules.

Regulatory Flexibility Analysis

The rules proposed for readoption regulate the handling of shellfish and the depuration of hard shell and soft shell clams for human consumption. Most businesses in this industry are small businesses, as the term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Those businesses which are not small businesses engage in the processing of shellfish as an adjunct to their wholesale food processing plants. The Summary above sets forth the requirements imposed on small businesses, and the costs resulting from the rules which are imposed on such businesses are set forth in the Economic Impact above. It should be noted that the Department has accommodated small business to the extent that the monitoring system for a depuration facility, while allowing the lowest cost for the processor, can continue to meet enforcement criteria. For example, the monitoring camera is able to transmit the image on a regular telephone line, for the cost of a telephone call.

Because the maintenance of the specified standards is required for State and national public health, no additional differentiation based upon business size has been offered in the rules.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 8:13.

(a)

DIVISION OF HEALTH FACILITIES EVALUATION Standards for Licensure of Residential Health Care Facilities

Proposed Readoption: N.J.A.C. 8:43

Authorized By: Frances J. Dunston, M.D., M.P.H.,
Commissioner, Department of Health (with approval of the
Health Care Administration Board).

Authority: N.J.S.A. 26:2H-1 et seq., specifically 26:2H-5.

Proposal Number: PRN 1992-316.

Submit comments by August 19, 1992 to:

Robert J. Fogg
Director, Standards and Quality Assurance
Health Facilities Evaluation
New Jersey State Department of Health
CN 367
Trenton, New Jersey 08628-0367

The agency proposal follows:

Summary

N.J.A.C. 8:43, Residential Health Care Facilities, contains rules for the licensure of residential health care facilities (RHCFs). Although the Division of Health Facilities Evaluation and Licensing developed a completely revised manual of standards for residential health care facilities during 1991, the Department agreed to participate in a study of the economic impact of the revised new rules, in response to concerns expressed by members of the Residential Health Care Advisory Committee who assisted with the revision of the chapter.

The final report of the study of the impact of the revised Manual of Standards on New Jersey Residential Health Care Facilities has been completed. The report provides a database that describes the costs of RHCF services and the financial status of residential facilities, with attention paid to variations by facility size and location. In addition to assessing the costs of current operations, the study projects the impact of the revised standards on the RHCF industry as a whole as well as the differences in impact for different sized facilities and facilities in different regions of the state.

The study indicates that the RHCFs which participated in the study already meet at least half of the revised standards, with an average of 85 percent of the revised standards currently being met. Therefore, many facilities may not experience any significant financial impact if the revised rules are adopted. According to the study, however, some of the standards which are not being met may be costly to implement, and some of the facilities which were included in the study expect the revised standards to have a substantial financial impact.

The fully revised N.J.A.C. 8:43 incorporates newer terminology and more specific language to render the rules more objective, measurable, and enforceable, while also reflecting current trends in the provision of residential health care. Changes were made in the format of the rules in order to make the manual more consistent with licensure standards for other health care facilities, and to make them easier to use as a part of the survey process. Most of these changes, which update and improve the licensure standards, will not increase costs to facilities, since they are based upon concepts already reflected in the current manual, N.J.A.C. 8:43, or already in use throughout the residential health care industry. However, due to the Department's commitment to consider all of the implications of the recently completed cost impact study, it will not be possible to propose and adopt the revision of the rules prior to the expiration date of November 19, 1992. It is, therefore, imperative that the effectiveness of N.J.A.C. 8:43 be maintained until the study has been fully evaluated. The Department needs the existing rules to accomplish its legal mandate of assuring that all residential health care providers offer a safe and effective level of care to their residents.

The proposed readoption for a two-year period will avert the scheduled November 19, 1992 expiration of the licensure rules and will also ensure that the revised rules are responsive to the needs of both residents and providers of residential health care.

N.J.A.C. 8:43, Residential Health Care Facilities, became effective October 27, 1965, and was promulgated by the New Jersey Department of Institutions and Agencies, which is no longer in existence. The responsibility for the licensure and regulation of health care facilities was transferred from the New Jersey State Department of Institutions

and Agencies to the New Jersey State Department of Health in 1971 by the Health Care Facilities Planning Act, N.J.S.A. 26:2H-1 et seq. All provisions of this chapter were adopted pursuant to authority of N.J.S.A. 26:2H-1 et seq. and were filed and became effective November 19, 1974, as R.1974 d.319 (see 9 N.J.R. 396(c) and 472(e)).

Internal review and evaluation by the Department and by the Residential Health Care Advisory Committee indicated that this chapter has been effective in assisting the Department to carry out the functions mandated by the Health Care Facilities Planning Act. These rules are necessary for the Department to effect its legal mandate to protect the health, safety and well-being of the residents in the residential health care facilities in New Jersey. The rules in N.J.A.C. 8:43 are essential for the regulation of residential health care facilities to assure the minimum quality of care and the provision of required services.

N.J.A.C. 8:43-1, Introduction, contains six sections: Definitions, Objectives of residential health care facility, Qualifications of operator, applicant or administrator, Application procedure, Denial of application, and Name of residential health care facility. Some of the terms which are used in chapter 43 are defined in this section. Among the objectives of a residential health care facility which are delineated is the requirement for the facility to provide a substitute home for all residents, with continuous supervision. Personal and financial requirements for an operator are specified, and the licensure application approval process is detailed, as well as reasons for denial of application and action against a license. The requirement for the facility to implement all the conditions imposed in the Certificate of Need approval letter is also contained in subchapter 1.

Building requirements are included in N.J.A.C. 8:43-2. The subchapter addresses location of a suitable site for the residential health care facility, structural requirements, local approvals which must be obtained, and floor plans. An office conference with the Department must take place after local approvals are secured, and representatives of the Department must inspect the building prior to occupancy. Detailed requirements for resident bedrooms, toilets and baths, living and recreation rooms, dining rooms, corridors and stairways, and adequate storage space are specified. The subchapter also addresses environmental issues, including requirements for heating, lighting, ventilation, and physical maintenance of the facility.

The importance of effective fire protection measures is emphasized in subchapter 3, Fire Protection. Each residential health care facility must have an approved automatic fire detection system. Specifications for horizontal fire zoning, dividing the building into separate areas by horizontal smoke and fire partitions, are listed. Two satisfactory and easily available means of egress must be provided for residents, in accordance with the rules in this subchapter. Specifications for stair enclosures, dumbwaiter and laundry chutes, elevators and elevator shafts are listed. Requirements for fire prevention in such hazardous areas as the kitchen and laundry are spelled out. Fire escape specifications are detailed. Guidelines for patient or resident smoking are included in the subchapter. Residential health care facilities must cooperate with local fire departments and request their assistance in periodic fire and safety inspections as well as fire drills which are conducted at specified intervals. Advice or interpretation of fire protection standards of the chapter is to be obtained from the State fire marshal. Automatic fire alarm and detection systems must be comprised of components listed by either Underwriter's Laboratory, Inc., or Factory Mutual Engineering Laboratories, and so labeled, and every installation must be inspected by the State fire marshal's office.

N.J.A.C. 8:43-4 delineates requirements for administration of the facility. Admission policies are stated, including rules concerning the type of residents suitable for admission to the residential health care facility. Recreation and diversion activities must be provided by the facility. Policies for privacy, privileges, visiting, mail service and telephone service are also delineated. Personnel policies are detailed, including a requirement for at least one responsible person to be on the premises at all times to provide necessary supervision. In facilities with 24 or more licensed beds, a person must be on the premises to provide active supervision of all residents 24 hours per day, with a minimum of one hour of supervision for each resident during a 24-hour period. Each facility must maintain records and information regarding each resident. Any major occurrence or incident must be reported to the Department as specified. Provisions for storage of medications and drugs in a suitable cabinet must be made by the facility. Requirements for accident prevention, housekeeping, sanitation, and laundering of residents clothing and linens are given. Distribution of monthly personal needs allowance to

each resident who receives Supplemental Security Income or General Public Assistance must take place in accordance with the rules specified in this subchapter, and written records of disbursements must be maintained.

Personal care services which each resident must receive are listed in N.J.A.C. 8:43-5. Rules for assuring that each resident maintains personal hygiene, is assisted as needed, and has appropriate and sufficient clothing are included. Each resident must be provided with an appropriately furnished sleeping area. Arrangements are to be made at the time of each resident's admission to ensure that a designated physician and dentist can be called in case of illness. The resident may be cared for during an illness for up to one week in the facility. Each resident must have an annual medical examination. The use and storage of prescription medicines must be supervised.

N.J.A.C. 8:43-6 contains rules for the provision of dietary services to residents. The facility has the responsibility to develop policies and procedures for planning, preparing, and serving meals, purchasing food, supervising residents at mealtime, and providing therapeutic diets in accordance with the admission policy of the facility. The administrator is responsible for providing food and drink with regard for the nutritional and therapeutic needs of residents. Requirements for menus, meal times, assistance of residents, recipes, work schedules and a plan for kitchen cleaning operations are listed. A daily food guide is included, to assist the facility to prepare nutritionally adequate meals.

The rights of each resident are delineated in N.J.A.C. 8:43-7. The facility is responsible for establishing and implementing written policies regarding the rights of residents. Resident rights are to be conspicuously posted in the facility and each resident is to be informed of these rights. Resident rights must include the right to privacy, the right to be treated with consideration and respect, and the right to exercise civil and religious liberties.

N.J.A.C. 8:43-8 describes the health maintenance and monitoring services which are to be provided to residents. A professional nurse must direct the health maintenance and monitoring services. At least one professional nurse must be available at all times. Each resident is to be provided with a minimum of 0.20 hours of registered professional nursing care per week.

Recent amendments to N.J.A.C. 8:43-4, Administration, and N.J.A.C. 8:43-7, Resident rights, as well as new rules at N.J.A.C. 8:43-4, all of which became operative on April 1, 1992, ensure that each resident is informed of his or her rights under New Jersey law to make decisions concerning the right to refuse medical care and the right to formulate an advance directive and to receive information about or assistance in preparation of advance directives.

Social Impact

The readoption of N.J.A.C. 8:43 will have social impacts on the Department, residents and residential health care facilities. In accordance with the Health Facilities Planning Act, N.J.S.A. 26:2H-1 et seq., the Department has the responsibility to promote the health and safety of the residents of the State. Licensure rules are one of the means by which the Department monitors the quality of the health care services provided to residents in residential health care facilities. The quality of health care, to a great extent, depends upon the organization and effectiveness of the health care services provided. N.J.A.C. 8:43 contains essential definitions and qualifications of residential health care providers, building requirements, fire protection rules, requirements for administration of the facility, personal care services to be provided to residents, rules for dietary services, resident rights, and requirements for health maintenance and monitoring services. These rules promote and support quality care and continuity of care for residents.

If these rules were not readopted, the social impact resulting from the loss of this rule would have serious consequences for residents of residential health care facilities. For example, without licensure rules the nature and purpose of residential health care facilities would be fundamentally altered. Without definitions, as specified in N.J.A.C. 8:43, rules could be misinterpreted, which might adversely affect the life and safety of residents. The absence of rules regarding the required services of a residential health care facility could have serious consequences for residents because essential services would not be ensured. Elimination of the rules relating to the qualifications of the administrator and staff could have a deleterious effect both on the safety of the residents and on the quality of care provided. Failure to retain qualified, competent staff capable of discharging their responsibilities in a timely, conscientious manner might jeopardize the welfare of residents.

Residential health care facilities represent a relatively low-cost means by which adults 18 years of age or over can be cared for in a home-like environment. The current trend toward de-institutionalization of chronically ill, long-term patients to a more home-like milieu has greatly enhanced the importance of residential health care facilities as an alternative in the health care delivery system. Continuation of the rules for licensure of residential health care facilities will therefore result in the availability of needed facilities for those residents who require this type of care. Failure to readopt N.J.A.C. 8:43 could jeopardize the quality of services provided in residential health care facilities because there would be no regulatory mechanism. The readoption of N.J.A.C. 8:43 would help to ensure that residents are being provided with adequate care in a home-like atmosphere suited to their needs and requirements and conducive to the maintenance of their self-respect and dignity. Readoption would also allow sufficient time for the Department, with the assistance of the Residential Health Care Advisory Committee, to revise the current rules and to make them clearer, more specific, more responsive to the needs of residents and providers of residential health care, more consistent with current trends in residential health care, and more enforceable.

Economic Impact

In preparation for proposal of a new manual of licensure standards, the Center for Health Policy Studies conducted a study in which the costs of residential health care facilities were evaluated during the latter part of 1991. Financial data were supplied by a sample group of New Jersey residential health care providers, although these data were not audited by the Department. Cost centers identified in the study included operating expenses (repairs, maintenance, food, laundry, recreation expenses), facility (depreciation of equipment and buildings, rentals, mortgage), salaries (of all personnel, including administrators and owners), fringe benefits (health insurance, pension, profit sharing, payroll taxes), other costs (consulting fees, advertising, legal/professional fees, dues/memberships, subscriptions and taxes other than payroll taxes), and miscellaneous expenses (any expense not otherwise included). Based on the information reported in the study, it was found that the total mean cost per resident per day varies regionally, with the North-Central-Suburban region the lowest, at \$37.10; the Southern region next, with \$38.50; and the Northern Urban region the highest, at \$43.78. Within these categories, additional variation is seen; for example, fringe benefits are highest (\$5.56) in the North-Central-Suburban region, and the lowest (\$2.67) in the Southern region. For all facilities, the per-resident mean cost is \$39.60 per day, or \$14,454.00 per year. The median cost is \$30.00 per day, or \$10,950.00 per year.

Costs per resident per day also vary with facility size, with those facilities serving 100 or more residents showing the lowest cost (\$30.53), those serving 50 or less, second, and those serving 51 to 100 residents the highest (\$56.24). There are a large number of facilities with low costs, but the smaller number of facilities with high costs have costs that are substantially higher than most facilities. The range from lowest to highest cost per day is \$117.66.

Operating expenses as a percentage of total per resident per day costs are consistent at 28 to 30 per cent, as are facility costs, at 19 percent.

Costs are not expected to be changed as a result of the readoption of this chapter.

Failure to adopt N.J.A.C. 8:43 could have serious consequences with a concomitant economic impact. For example, the definitions provided in N.J.A.C. 8:43-1 define the residents who may be admitted to a residential health care facility, thus preventing the admission of patients who require a high level of care who may be in jeopardy and, as a result, experience higher health care costs. Without rules regarding the required services in a residential health care facility and the qualifications of the administrator and staff there would be no assurance that the required services will be provided in an organized and efficient manner by competent staff and would be cost-effective.

Furthermore, without rules for residential health care facilities, residents might be placed in facilities providing more intensive and more expensive health care than that provided in a residential health care facility. Without residential health care facilities, potential residents might receive fragmented care or no care, which would ultimately increase the cost of care. Inadequate care to residents in residential health care facilities would increase the cases of illness and disease requiring costly care. Therefore, it is imperative that these rules be readopted.

Regulatory Flexibility Analysis

The Department acknowledges that most of the 172 residential health care facilities currently licensed have fewer than 100 full-time employees, and may, therefore, be considered small businesses as the term is defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed readoption of this chapter will not change any of the requirements upon the regulated public. The rules contain licensure requirements, as well as basic requirements for the care and supervision of the residents, in a homelike atmosphere. Building, safety, admission, personnel, patient record, census, visiting and mail requirements are delineated, as well as all other aspects of care in the facility, such as the reporting of major occurrences or incidents. These requirements will not change as a result of this proposal. The costs of these requirements are delineated, by cost center, in the Economic Impact statement. The rules do contain certain exceptions for facilities with less than 24 licensed beds. For example, N.J.A.C. 8:43-4.6, Personnel, requires fewer staff to provide active supervision of residents in facilities with less than 24 beds than is required in larger facilities. These exceptions were designed to minimize any adverse economic impact on small businesses.

The Department has determined that compliance with the requirements of this chapter is necessary for the preservation of public health and safety, and has made no other exceptions based upon business size.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 8:43.

(a)

DIVISION OF PUBLIC HEALTH AND ENVIRONMENTAL LABORATORIES

Blood Bank Fees; Laboratory Charges

Proposed Amendments: N.J.A.C. 8:45-1.3 and 2.1

Authorized By: Frances J. Dunston, M.D., M.P.H.,

Commissioner, Department of Health.

Authority: N.J.S.A. 45:9-42.30, 26:1A-33 and 26:2A-4.

Proposal Number: PRN 1992-315.

A public hearing on the proposed amendments will be held on Friday, August 21, 1992 at 11:00 A.M. at:

Health and Agriculture Building
Room 106
John Fitch Plaza
Trenton, New Jersey

Submit written comments by August 21, 1992 to:

Shahiedy I. Shahied, Ph.D., Laboratory Administrator
State Department of Health, Room 400
CN 360
Trenton, N.J. 08625-0360

The agency proposal follows:

Summary

The New Jersey Department of Health has historically provided public health and clinical laboratory improvement services to assure that all residents of New Jersey have access to quality, efficient and cost effective analytical laboratory services. These services are technologically complex to perform and require specially trained staff as well as special and expensive technical equipment and reagents.

In order to maintain the current level of quality and cost effectiveness in laboratory services, amendments to this chapter include revised Public Health analytical, specimen transportation kit, and blood bank licensure fees are proposed. The last rule adoption relating to laboratory services was April 1, 1990.

The New Jersey State Department of Health is responsible for the licensure and inspection of all clinical laboratories in New Jersey. Under this chapter, highly trained professionals inspect laboratory facilities to assure testing proficiency. Currently the rules provide for the following:

Subchapter 1. Licensure of Clinical Laboratories
N.J.A.C. 8:45-1.1 Initial licensure of clinical laboratory
N.J.A.C. 8:45-1.2 Annual renewal of licensure
N.J.A.C. 8:45-1.3 Licensure fees
N.J.A.C. 8:45-1.4 Proficiency testing fees
Subchapter 2. Laboratory Charges
N.J.A.C. 8:45-2.1 Fees; generally

In accordance with the recently adopted amendments to the Blood Banking Licensure Act (N.J.S.A. 26:2A-4) contained in P.L. 1991, c.461, it is necessary to take action that will adjust N.J.A.C. 8:45-1.3, Licensure fees. The Act now stipulates maximum and minimum fees, based on the number of units transfused and/or collected. Additionally, the Act now authorizes the Commissioner to periodically increase fees to reflect State costs pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., that is, via the rulemaking process.

In the area of Public Health analytical laboratory services, the Department of Health provides a wide range of testing services applicable to both the general population and specifically to newborns in New Jersey. Through this testing, diseases of public health importance are either identified or confirmed. As an example, currently under N.J.A.C. 8:45, newborns are screened by the Inborn Errors of Metabolism Laboratory Program for phenylketonuria, hypothyroidism, galactosemia, sickle cell and other hemoglobinopathies; infants with abnormal results are followed until disposition (confirmed diagnosis/rule out); and affected infants are entered into comprehensive treatment.

The goal of the follow-up program in Special Child Health Services is to identify all affected infants before damage can occur and to assure that these infants are linked with a treatment center within nationally established timelines, in many cases prior to one month. In addition, certain treatment services are supported, in part, by SCHS, including the purchase of special metabolic formula for children with PKU, to assure the availability and accessibility of essential specialized care.

These diseases have enormous impact on the health of the citizens of New Jersey, as well as long-term health care which would be required if such diseases are not identified and remedial action followed. Sophisticated new instrumentation which allows for more rapid and accurate diagnosis and the increasing costs of laboratory reagents and supplies requires the fees for certain services be increased. These services are tests for inborn errors of metabolism, such as PKU, T4, Galactosemia and sickle cell (from \$19.00 to \$27.00); toxoplasmosis (from \$12.00 to \$15.00); rubella (from \$9.00 to \$10.00) and water bacteriology tests (from \$10.00 to \$15.00). The fees for mycology testing have been deleted because the Department no longer performs such tests. The laboratory fees for syphilis and for the confirmation of syphilis have been deleted since the Department has determined that it lacks the authority to charge a fee for syphilis tests.

The Department is proposing to amend N.J.A.C. 8:45-1.3, Licensure fees, and 2.1, Fees; generally, in order to adjust fees, and include a fee for specimen transport kits not previously offered, in order to maintain these critical public health services.

Social Impact

The Division of Public Health and Environmental Laboratories has historically provided quality Clinical Laboratory Improvement Services and Public Health Laboratory Services to New Jersey citizens and clinical laboratories for many years. These services are made available to help ensure that the citizens of New Jersey are provided with accurate and current laboratory services.

The benefit of these laboratory services will be realized by clinical laboratories, physicians, clinicians and the general public from newborns to adults. The Clinical Laboratory Improvement Program is designed to monitor the quality of private and hospital laboratory analyses while the Public Health Laboratory Services provide actual analytical testing.

As a result of these Divisional activities, the quality of private and hospital analytical services will be maintained to help insure those activities are meeting defined standards and new public health threats are being evaluated and addressed through available analytical services.

Projected reaction to these rule changes may include both positive and negative elements. Laboratories and clinicians may express negative concern regarding the increased financial burden of these analytical charges.

Economic Impact

These proposed amendments could affect all clinical laboratories, hospitals, physicians, third party insurance payments and the general public through the projected increases in laboratory fees and proficiency testing charges.

The funding impact will be experienced in two ways: (1) all agencies utilizing the Department of Health laboratory services will be required to identify funding sources for increased support; (2) the Department of Health, despite severe fiscal constraints, will be able to continue to offer quality laboratory services as well as expand its base of available services.

Administrative mechanisms will have to be set in place by submitting agencies to deal with the increased costs, forecasting of required laboratory services, changes in forms and ordering procedures, etc. Due to the link to third party payment system, it is difficult to assess the direct economic impact which will be felt by the general public.

Social/monetary savings are also difficult to measure. Since failure to adopt these rules could result in the Department of Health's inability to maintain some laboratory services, the social impact could be devastating. The public health cost in terms of delays in the identification of diseases, some of which result in mental retardation or death, represents an immense cost, both socially and monetarily, which cannot be accurately measured.

Regulatory Flexibility Analysis

Some health care providers, such as physicians and clinical laboratories, may be small businesses as the term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. No additional recordkeeping is required by these rules, but health care providers may find additional recordkeeping necessary in order to track the purchase and provision of analytical and laboratory services.

These rules will impose compliance requirements related to new and increased fees for the analytical and laboratory services provided by the State of New Jersey. Such fees will not entail the need for capital expenditures or additional professional services for small businesses. They will entail annual compliance costs, which will vary according to the size of the health care provider and the amount of analytical testing requested from the State.

Small business exemptions will not be permitted under these rules. The transfusion services and collection center license fees, which apply to all blood banks in New Jersey, are on a sliding scale, with increased fees for a higher number of transfusions/collections. The rules (fees) will be applied uniformly, and will become operative November 1, 1992.

Full text of the proposed amendments to the rule follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

8:45-1.3 Licensure fees

(a) (No change.)

(b) Pursuant to N.J.S.A. 26:2A-4, the following blood bank licensure fees shall be effective November 1, 1992:

1. Transfusion Services:

Number of Transfusions	Fee
0-1,000	\$200.00
1,001-2,000	300.00
2,001-3,000	400.00
3,001-4,000	500.00
4,001-5,000	600.00
5,001- +	700.00

2. Collection Centers:

Number of Collections	Fee
0- 200	\$ 250.00
201- 1,500	500.00
1,501- 3,000	750.00
3,001- 5,000	1,000.00
5,001-10,000	1,250.00
10,001-15,000	1,500.00
15,001-25,000	1,600.00
25,001-35,000	1,700.00
35,001-50,000	1,800.00
50,001- +	1,900.00

3. Other Blood Bank Services:

Type	Fee
Collection Site	\$100.00
Broker	200.00
Industrial Blood Bank	200.00
Home Transfusion Service	200.00

8:45-2.1 Fees; generally

(a) [Commencing April 1, 1990] **Effective November 1, 1992**, the following [changes will be made in the] fee-for-service cost structure **shall apply to the** [, Division of Public Health and Environmental Laboratories,] New Jersey State Department of Health:

HIGHER EDUCATION

PROPOSALS

Laboratory Test	
Inborn Errors of Metabolism (PKU, T4, Galactosemia, Sickle Cell)	[\$19.00]27.00
[RPR Syphilis]	[\$8.00]
Toxoplasmosis	[\$12.00]15.00
[HATTS, FTA-ABS (Confirmatory syphilis)]	[\$8.00]
Rubella Screen	[\$9.00]10.00
Blood Lead	\$12.00
Mycobacteriology (TB)	\$30.00
Water Bacteriology	[\$10.00]15.00
Bacteriology Culture	\$30.00
Susceptibility Studies (TB)	\$30.00
Isolation of Special Pathogens	\$30.00
Parasitology	\$15.00
[Mycology]	[\$25.00]
Lyme Disease	\$20.00

(b) [Commencing April 1, 1990,] **Effective November 1, 1992**, the following [newly established] **additional** fee-for-service charges [will go into effect] **shall also apply**:

Bacteriology	
Lyme Disease	\$20.00
Specimen Transport Kits (each kit)	\$ 1.00

HIGHER EDUCATION

(a)

STUDENT ASSISTANCE BOARD

Student Assistance Programs

Student Assistance Board; General Provisions For

All Programs Administered by the Student Assistance Board; Tuition Aid Grant Program; Garden State Scholarships; Public Tuition Benefits Program; Garden State Graduate Fellowship Program; Veterans Tuition Credit Program; Vietnam Veterans Tuition Aid Program; Paul Douglas Teacher Scholarship Program

Proposed Readoption with Amendments: N.J.A.C. 9:7 Proposed Repeals: N.J.A.C. 9:7-7 and 8.

Authorized By: Student Assistance Board, M. Wilma Harris, Chairperson.

Authority: N.J.S.A. 18A:71-15.2, 18A:71-15.3, 18A:71-26.8, 18A:71-48, 18A:71-76.6, 18A:71-77, 18A:71-15.3, Title V, Part E of the Higher Education Act of 1965, as amended by the Human Services Reauthorization Act of 1984, 20 U.S.C. 1119d-8 and the Higher Education Technical Amendments Act of 1987.

Proposal Number: PRN 1992-275.

Submit comments by August 19, 1992 to:

Brett E. Lief
Administrative Practice Officer
Department of Higher Education
20 West State Street
CN 542
Trenton, NJ 08625

The agency proposal follows:

Summary

Pursuant to Executive Order No. 66(1978), N.J.A.C. 9:7 expires on February 28, 1993. The Department of Higher Education and the members of the Student Assistance Board, in consultation with representatives of the higher education community, have reviewed the rules proposed for readoption and determined them to be necessary, reasonable and proper for the efficient operation of the financial aid programs for which they were originally promulgated, as required by the Executive Order.

In 1978, the Student Assistance Board was created (N.J.S.A. 18A:71-15.1 et seq.), N.J.A.C. 9:7-1, to administer designated State grant and scholarship programs. In addition, the Board was given the responsibility of establishing eligibility, application and payment requirements for the student assistance programs enacted at that time and for all subsequent programs legislated under its authority. The Board was also given the authority to create a Student Advisory Committee composed of student representatives from the various college sectors in New Jersey and whose purpose is to advise the Board on the effects of policy and regulations; suggest alternative policy and provide a means of communication between the Board and students. The proposed amendment to the creation of the Student Advisory Committee would allow for the election of the committee's "Chairperson" and "Vice Chairperson" from a more diversified pool of committee members by deleting the requirement of degree completion within one academic year of their selection. This deletion from the rule is also in accordance with a statutory amendment (P.L.1991, d.500) to N.J.S.A. 18A:71-15.1 which was signed into law in January 1992.

The proposed amendments to the General Provisions, N.J.A.C. 9:7-2, for the overall administration of State grant and scholarship programs are primarily intended to provide clarification in the rules in such areas as student eligibility as it pertains to New Jersey residency, independent student status, award payments and refunds and the proper procedure to initiate an appeal of the determination of that eligibility. Additional clarification is also included in the proposed amendments for verification of family financial data, award combinations and the student's total allowable financial aid package as well as institutional verification and standards for satisfactory academic performance and progress. The proposed amendments do not change the intended substance of the rules but merely provide a better understanding for students and institutions of the necessary requirements in qualifying and maintaining State financial assistance. In addition, other general technical changes have been made to provide for consistency in the overall terminology throughout the subchapter. The subchapter's title has also been revised, as part of the proposed amendments, to read: "General Provisions for Tuition Aid Grant and Garden State Scholarship Programs," for the purpose of clarification. In keeping with the above, the following specific rules within N.J.A.C. 9:7-2 are being cited with a brief explanation for the proposed amendments as presented in this readoption.

N.J.A.C. 9:7-2.2(a)1: Additional text has been added to clarify students' continued residency status and to protect the eligibility of those students who received State grants or scholarships before their parents' change of domicile outside of New Jersey.

N.J.A.C. 9:7-2.4: The term "State financial assistance," in combination, has been added throughout N.J.A.C. 9:7 for clarity and consistency whenever specific reference is being made to financial assistance in the form of State grants and scholarships rather than Federal or institutional aid.

N.J.A.C. 9:7-2.6(b)7iii: If a U.S. citizen does not meet the general definition of an independent student, he or she must submit documentation to the financial aid administrator to support the independent status. By deleting this subparagraph foreign nationals will be treated in the same manner as U.S. citizens. This deletion does not deny the right of foreign nationals to be considered independent but merely equalizes their treatment for independent student status with that of U.S. citizens.

N.J.A.C. 9:7-2.7: The deletion and replacement of the word "will" with the word "may" is to clarify for students and institutions that not every student's file is verified through the comparison of information reported on income tax returns and other documentation. Rather, the verification process is made on a case-by-case basis.

N.J.A.C. 9:7-2.9: In accordance with a resolution passed by the Board of Higher Education, the Garden State Distinguished Scholars award was renamed the Edward J. Bloustein Distinguished Scholars award in recognition of the educational contributions made by Dr. Bloustein and his support and promotion of academic excellence as President of Rutgers, The State University, for more than 18 years. In keeping with this resolution, all references within N.J.A.C. 9:7-2 and 4 to the Distinguished Scholars award have been so amended. The deletion of veterans and POW/MIA awards from the enumerated combinations of State financial assistance is due to the fact that administrative responsibility and rulemaking for these programs have been transferred to the Department of Military and Veterans Affairs. The Urban Scholars award has been added since it is a separate and distinct component of the Garden State Scholarship Program with its own academic requirements for qualification and in itself may be combined with other State

financial assistance. This also holds true for a Garden State Scholars award, which has also been amended to reflect its proper title. The phrase "cost of attendance" has been added at N.J.A.C. 9:7-2.9(c) to replace the terms student budget or cost of education in response to institutional recommendations for clarity and consistency. Finally, because of the requirements of the Federal Title IV student aid programs, this additional text is being included in the subsection to address situations where the student is receiving both State and Federal financial assistance.

N.J.A.C. 9:7-2.10(b): Because institutional academic progress requirements do not change annually, this additional rule text permits institutions to provide copies of such standards only when changes occur and deletes the provision for submission every academic year. This proposed amendment reduces the administrative burden on the participating institutions.

N.J.A.C. 9:7-2.10(c): The changes in this subsection are being made because many institutional requirements were not as strict as the standards outlined in N.J.A.C. 9:7-2.10. This proposed amendment will ensure that institutional standards will meet these minimum requirements.

N.J.A.C. 9:7-2.11(a)1: The addition of a "bilingual" curriculum to the enrollment status of students at four-year colleges provides consistency with the same qualifying curricula for award payments at two-year colleges.

N.J.A.C. 9:7-2.11(footnote 1): The additional text which cites N.J.A.C. 9:11-1.8 refers to the New Jersey Administrative Code governing the EOF program. By deleting the reference to special EOF approval, it provides flexibility for changes, deletions and additions in the EOF administrative rules without affecting the rules governing State grant and scholarship programs.

N.J.A.C. 9:7-2.11(footnote 2): This footnote clarifies the requirement that students in a bilingual (ESL) curriculum must meet the same credit hour courses as other students in a remedial/developmental curriculum. By deleting the reference to noncredit courses, institutions may give this credit benefit to students enrolled in a remedial/developmental or ESL curriculum based on the credit hours for all courses whether they are defined as college level credit or noncredit.

N.J.A.C. 9:7-2.12(c): This proposed amendment provides clarification of the refund period when a student reduces his or her full-time course load and aligns the terminology with that used in college catalogs.

N.J.A.C. 9:7-2.12(d): In accordance with institutional recommendations, this sentence is being deleted since it does not provide any further clarification to this subsection but rather only adds confusion to the refund issue being presented.

N.J.A.C. 9:7-2.13: Since students are notified many months prior to actual college attendance that they are eligible to receive State grants and/or scholarships, they have already provided information concerning their college "choice" upon which their potential award amount, in part, is based. This proposed amendment clarifies the requirement that students must notify the Office of Student Assistance when their college "choice" has changed both prior to and/or during enrollment.

N.J.A.C. 9:7-2.16(b): The State's Single Audit Act was implemented by the Department of Higher Education in July 1990 when it provided a Grants Compliance Supplement for institutions. This proposed amendment provides compliance with this Act and includes the requirement that a copy of the audit report must be submitted to the Office of Grants and Scholarships.

N.J.A.C. 9:7-2.17: This proposed new rule has been added to the subchapter to clarify the program jurisdiction of the rules contained therein.

It should be noted that a notice of administrative correction published elsewhere in this issue of the New Jersey Register rectifies the omission from the Code of N.J.A.C. 9:7-2.3(b) and the retention of certain deleted text in N.J.A.C. 9:7-2.11(b).

The Tuition Aid Grant (TAG) Program (N.J.S.A. 18A:71-41 et seq.), N.J.A.C. 9:7-3, provides awards to New Jersey residents who enroll as full-time undergraduate students in any approved college or university in New Jersey. The amount of the grant differs in value by college sector and takes into consideration the student's financial need, the tuition charged by the institution, the cost of college attendance, and available appropriations. These grants are renewable annually based upon financial need and satisfactory academic progress. The proposed amendments further clarify the factors taken into consideration in determining the value of a student's TAG and also provide consistency in terminology.

The Garden State Scholarship (GSS) Program (N.J.S.A. 18A:71-26.1 et seq.), N.J.A.C. 9:7-4, provides awards to students who demonstrate high academic achievement, without regard to financial need, based upon their secondary school class rank or a combination of secondary school rank and Scholastic Aptitude Test (SAT) scores or secondary school grade point average (GPA). Recipients must be New Jersey residents and attend an approved New Jersey college or university as full-time undergraduate students. If sufficient funds are available, students may qualify for an additional scholarship award based upon their financial need. The GSS Program provides awards to students in three program categories including Edward J. Bloustein Distinguished Scholars, Urban Scholars and Garden State Scholars, each of which have been clarified within the proposed amendments including their eligibility and academic requirements. The following specific rules within N.J.A.C. 9:7-4 are being cited with a brief explanation for the proposed amendments as presented in this re adoption.

N.J.A.C. 9:7-4.1: As previously addressed in the summary for proposed amendments to N.J.A.C. 9:7-2.9, the Distinguished Scholars program category has been changed to the Edward J. Bloustein Distinguished Scholars. In addition, since there are three separate and distinct program components within the Garden State Scholarship Program, each has been properly designated and listed in the order of consistency with their presentation in other subchapter rules which specify eligibility and academic requirements.

N.J.A.C. 9:7-4.2(b): The addition of "grade point average" is needed since this subsection is presenting a general overview of all the various academic components that are considered for all three program categories under the Garden State Scholarship Program. Since grade point average is a requirement specific to the Urban Scholars category, it must be included when listing all academic requirements.

N.J.A.C. 9:7-4.2(c)1 and 2; (d)1; (g)1: The proposed amendments to these subsections do not represent any change to the academic requirements as already stipulated therein. Rather the proposed amendments are merely rearranging the academic criteria and recodifying rule text to reflect the order of award selection activities as well as combining several requirements into one paragraph to provide additional clarification that students must meet more than one academic criterion in order to qualify.

N.J.A.C. 9:7-4.2(i): This subsection enables the institutional presidents to designate scholarships for additional categories of students who do not ordinarily meet the eligibility criteria. However, even though this provision has been included in this rule for years, it has never been used and is now being deleted.

N.J.A.C. 9:7-4.3(b): Students may receive scholarship awards for up to a "total" of four or five years of undergraduate programs of study regularly requiring four or five academic years respectively for completion. Since this subsection refers to the number of years a student's scholarship may be "renewed," the correct number of years for renewal is "three or four." Therefore, an amendment is proposed to correct this mistaken impression.

N.J.A.C. 9:7-4.3(c): New text has been added to clarify the procedural requirement that students must provide notification to the Department. If a student does not officially notify the Department of his or her transfer to another eligible New Jersey institution, there is a chance that the award would not be renewed for lack of such information.

The Public Tuition Benefits (PTB) Program (N.J.S.A. 18A:71-77 et seq.), N.J.A.C. 9:7-5, provides free tuition for a child or surviving spouse of a member or officer of various police, fire, law enforcement, and civil defense agencies killed in the performance of his or her duties. An eligible child or spouse who wishes to attend any public institution of higher education in New Jersey may enroll as an undergraduate student and have their tuition paid by the State while in good standing at that college or university. Such child or spouse may also attend any independent institution in New Jersey; however, the annual value of their grant cannot exceed the highest tuition charged at a New Jersey public institution. Recipients must enroll on at least a half-time basis in an undergraduate degree program and do not have to demonstrate financial need for these awards. The proposed amendments include minor technical changes and provide for consistency with statutory language. N.J.A.C. 9:7-5.8 deletes the word "dependent" when describing the eligibility of a child. Since N.J.S.A. 18A:71-77 does not restrict beneficiaries to dependents but rather "any child or surviving spouse . . .", the reference to a dependent child is being deleted.

The Garden State Graduate Fellowship Program (N.J.S.A. 18A:71-26.2), N.J.A.C. 9:7-6, continues to provide fellowships to those

students who have previously qualified for awards and are pursuing their education on a full-time basis at a New Jersey graduate school in a degree program in the arts and humanities. Fellowship recipients must remain residents of New Jersey and awards are renewed without regard to financial need. The proposed amendment represents a minor technical change to one of the program's rules.

The Veterans Tuition Credit Program and Vietnam Veterans Tuition Aid Program, N.J.A.C. 9:7-7 and 9:7-8, both of which provide educational benefits to eligible veterans, are being deleted to reflect the transfer of administrative responsibility and rulemaking for these two programs to the Department of Military and Veterans Affairs (DMVA) (see P.L.1991, d.273). The transfer of veterans' tuition assistance programs to the DMVA was undertaken to afford veterans and their dependents the convenience of being serviced for all available entitlements by a single State agency.

The Paul Douglas Teacher Scholarship Program (N.J.S.A. 18A:71-15.3, Title V, Part E of the Higher Education Act of 1965, as amended by the Human Services Reauthorization Act of 1984, 20 U.S.C. 1119d-8, and the Higher Education Technical Amendments Act of 1987), N.J.A.C. 9:7-9, is a Federally funded program with no matching state fund requirement. This program was established by Congress to encourage highly qualified students to pursue teaching careers. Eligible students must be residents of New Jersey and enrolled or plan to enroll in an accredited college or university on a full-time basis in a degree program leading to a teaching certificate. The proposed amendment reflects a minor technical change in one of the program's rules.

Social Impact

These rules were enacted to provide financial assistance to New Jersey residents who wish to pursue their college education. They establish criteria for student eligibility, outline the academic standards for qualification, and specify the determination of award amounts as well as renewal eligibility and payment. The proposed amendments provide clarification, simplify interpretation and allow for consistency in the terminology outlining the requirements for qualifying and maintaining eligibility for State grants and scholarships.

Under the provisions of the need-based programs, the ability of the student and of the student's family to pay for college expenses is evaluated through the analysis of information provided on a financial aid form. The ability to pay is compared to the student's estimated college expenses and awards are then made to help bridge the difference between the ability to pay and the estimated cost. As a result, the grants are awarded to eligible students so that the neediest receive maximum benefits.

Several of the student assistance programs, which include the Edward J. Bloustein Distinguished Scholars, Urban Scholars, Garden State Scholars and Graduate Fellowship Programs, recognize the high academic achievements of New Jersey residents and provide awards to students for attendance at New Jersey public or independent institutions. These programs represent an example of the State's interest in and commitment to fund academically qualified students. Other special programs of financial aid recognize the needs of certain students and provide award benefits to dependents of emergency service personnel killed in the line of duty as well as students who wish to pursue their careers in the teaching field.

All State financial assistance programs which are governed by these rules, with the exception of the Paul Douglas Teacher Scholarship Program, require the utilization of grant and scholarship monies for attendance only at approved colleges and universities in New Jersey. As a result, State monies are concentrated within New Jersey and help to foster the educational system within the State.

General public reaction to these programs of financial assistance has been very favorable. Studies which have been conducted on the impact of the various programs indicate that they have permitted individuals to attend college who might have otherwise been unable to attend due to a lack of the necessary finances. The conditions which prompted the creation of these programs by the Legislature continue to exist and have been made more severe by the current national economic situation.

If these rules are not readopted, these needed student assistance programs would cease to operate despite enabling statutes which delegate the administration of the programs to the Student Assistance Board. As a result, thousands of students would be faced with severe hardships in meeting their college expenses and may be forced to increase their loan indebtedness or drop out of college altogether.

Economic Impact

In fiscal year 1992, it is estimated that the Tuition Aid Grant Program, which is the major program of student assistance in New Jersey, will provide awards to approximately 40,800 undergraduate students for a total estimated expenditure of \$83,776,000. Awards range in value from \$400.00 to a maximum of \$4,580 a year based on the student's need and tuition charges at New Jersey colleges and universities. Funds are derived primarily from State appropriations and a Federal State Student Incentive Grant allocation of approximately \$1,665,000.

The Garden State Scholarship Program continues to meet some of the financial requirements of New Jersey's academically qualified students by offering merit and need-based awards which range in value from \$500.00 to \$1,000 a year. It is estimated that for the 1992-93 academic year a total of 10,800 freshman and renewal students will be aided for a total State funded expenditure of \$10,172,000 under the Edward J. Bloustein Distinguished Urban and Garden State Scholars program categories.

The Public Tuition Benefits Program during the past 11 academic years has on average aided 20 or more students annually through the payment of their full tuition charges at New Jersey public institutions, and at independent colleges an amount equal to the highest tuition charged at a New Jersey public institution, for a total estimated State expenditure of \$38,000 for the current fiscal year.

The Garden State Graduate Fellowship Program did not receive an appropriation for initial fellowships for the 1990-91 or 1991-92 academic year; however, State funding was received to grandfather fellowship recipients in accordance with program rules. Approximately 50 Fellows have continued to be paid for the 1991-92 academic year, with 28 receiving an annual stipend of \$6,000 and 22 Fellows receiving \$7,500 due to the increase in the annual fellowship award in 1989-90.

The Paul Douglas Teacher Scholarship Program is funded in total from Federal sources. The regulations governing the program do not require participating state agencies to match any portion of the Federal allocation. Eligible students who wish to pursue a teaching career may receive an annual award worth up to \$5,000. It is estimated that for fiscal year 1992, 95 students will receive awards totalling \$470,000.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required because the rules proposed for re adoption 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 were enacted to provide financial assistance to New Jersey residents who wish to pursue their college education. The rules establish criteria for student eligibility, award amounts, renewal and payment.

Full text of the proposed re adoption may be found in the New Jersey Administrative Code at N.J.A.C. 9:7.

Full text of the proposed repeals may be found in the New Jersey Administrative Code at N.J.A.C. 9:7-7 and 8.

Full text of the proposed amendments to the re adoption follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

9:7-1.2 Creation of Student Advisory Committee

The Student Assistance Board shall create a Student Advisory Committee whose purpose shall be to advise the Student Assistance Board on the effect of Board policy and regulations; suggest alternative policy and regulations to the Board; and provide a means of communication between the Student Assistance Board and students. The Student Assistance Board shall initially appoint a nine member Student Advisory Committee from nominations provided by the student government associations of each individual college in New Jersey. The nine members, all of whom shall be full-time students, shall consist of two students from independent colleges, two students from Rutgers, The State University, two students from the State colleges, one student from the New Jersey Institute of Technology, and two students from the county colleges. Students representing each sector shall be chosen such that in any given year one of the representatives shall complete his[] or her degree requirements within one academic year from the time of his[] or her selection and one shall be of lower class rank. Members of the Student Advisory Committee shall serve one year terms and their appointments may be renewed according to the initial appointment process.

The Student Advisory Committee shall elect a [Chairman] **Chairperson** and Vice [Chairman] **Chairperson** from among its members one of whom shall be a student at an independent institution and one of whom shall be a student at a public institution[, and each of whom shall complete their degree requirements within one academic year from the time of their selection]. The [Chairman] **Chairperson** and Vice [Chairman] **Chairperson** shall serve as voting members on the Student Assistance Board. In the event of a vacancy on the Student Advisory Committee, the Student Assistance Board may fill the vacancy in the same manner as the original appointment.

**SUBCHAPTER 2. [GENERAL PROVISIONS FOR ALL PROGRAMS ADMINISTERED BY THE STUDENT ASSISTANCE BOARD]
GENERAL PROVISIONS FOR TUITION AID GRANT AND GARDEN STATE SCHOLARSHIP PROGRAMS**

9:7-2.1 Undergraduate enrollment

Students must be enrolled or plan to be enrolled as full-time undergraduate students matriculated in a curriculum leading to a degree or certificate in an eligible institution as defined in N.J.S.A. 18A:71-47 in order to be eligible for student assistance[, with the exception of Garden State Fellowships which are reserved for graduate students meeting the same enrollment criteria (see N.J.A.C. 9:7-6)]. Students possessing an undergraduate degree (either a Baccalaureate or Associate degree) are not eligible for student assistance at that degree level. Certification of full-time status is the responsibility of the enrolling institution based on the current institutional definition of full-time status and subject to review and approval by the Student Assistance Board.

9:7-2.2 Residency

(a) Students must be legal residents of New Jersey for a period of not less than 12 consecutive months immediately prior to receiving a grant. The residence of a student is defined in terms of domicile. Domicile is defined as the place where a person has his or her true, fixed, permanent home and principal establishment, and to which, whenever he[/] or she is absent, he[/] or she has the intention of returning.

1. A dependent student as defined in N.J.A.C. 9:7-2.6 is presumed to be a legal resident of the [State] state in which his or her parent(s) or guardian(s) is a resident. A dependent student whose parent(s) or guardian(s) is not a legal resident of New Jersey is presumed to be in the State for the temporary purpose of obtaining an education. However, any dependent student who is domiciled in this State and enrolled in an institution of higher education in New Jersey shall continue to be eligible for New Jersey financial assistance despite his or her supporting parent(s) or guardian(s) change of domicile to another [State] state, while such student continues to reside in New Jersey during the course of each academic year. **The student's eligibility continues only if the student received a State grant or scholarship for at least one semester before the parent(s)' or guardian(s)' change of domicile to another state.**

(b) Residence established solely for the purpose of attending a particular college cannot be considered as fulfilling the definition of domicile. When in question, a student must demonstrate proof of residence by presenting the following documents: driver's license, voter registration form, tax return(s), or other suitable proof. The Office of Student Assistance, Department of Higher Education shall determine the state of residence for any individual whose residency is not certain. Institutions may [provide information to substantiate] **be asked by the Office of Student Assistance to certify and maintain documentation on the student's claim of legal New Jersey residence[.] and provide the documentation, if needed, to substantiate an appeal.**

9:7-2.3 Foreign nationals

(a) A foreign national must present affirmative evidence that he or she is not in the United States for the temporary purpose of obtaining an education. Such evidence must include documentation from the United States Immigration and Naturalization Service that

the student may remain permanently in this country and such evidence must be placed in the student's file. The student must:

1. Be the holder of an Alien Registration Receipt Card form I-151 or I-551; or

2. Be the holder of an [approval] **Approval** Notice from the Immigration and Naturalization Service form I-181 stating that the non-citizen has applied and met the requirements for Permanent Resident status; or

3-5. (No change.)

(b) (No change.)

9:7-2.4 Determination of eligibility for and value of student assistance

In order to receive a need-based award students must have demonstrated financial need through submission of a financial aid form approved by the Student Assistance Board in accordance with annually established deadline dates. Students may not receive **State financial** assistance under the programs administered by the Student Assistance board if they owe a refund on a grant or scholarship previously received from a state or Federal program through any institution or are in default on any loan made under any state or Federal student financial assistance program at any institution. Students owing a refund on a grant or scholarship or who are in default on a loan may receive State financial assistance if they make arrangements acceptable with the appropriate office to repay the debt.

9:7-2.5 Student notification

Students [will] **shall** be notified of grant eligibility through the Student Eligibility Notice issued by the Office of Student Assistance, Department of Higher Education. The amount of the grant is subject to change based on the annual level of appropriations and other resources available to the student (see N.J.A.C. 9:7-2.9). The institution's written notification to the student regarding State [student] **financial** assistance shall contain a clause indicating the State is not responsible for funding of the grant in the event of fraudulent, inaccurate or misleading information.

9:7-2.6 Dependent/independent student defined

(a) (No change.)

(b) Except as provided in (c) below an individual meets the requirements of this section if such individual:

1.-6. (No change.)

7. Is a student for whom a financial aid administrator makes a documented determination of independence by reason of other unusual circumstances. For purposes of receiving State [student] **financial** assistance as an independent student due to unusual circumstances, at least one of the following criteria must be met:

i.-ii. (No change.)

[iii. The student is from a foreign country but has established permanent residency in the United States, is a refugee or has received political asylum, and complies with the provisions of (b)6 above except for the resource requirement set forth therein. For the purposes of eligibility under this subparagraph, the student's parents must reside outside of the United States.]

[iv.]iii. The student has been separated from his or her parents and comes from a documented background of historical poverty as set forth in N.J.A.C. 9:11-1.5 (or as attested to by a social service agency or respected member of the student's community and acceptable to the director of the applicable student assistance program within the Department of Higher Education), is living with a relative who is providing support to the student, and complies with the provisions of (b)6 above except for the resource requirement set forth therein.

[v. The student was considered as an independent student for the purposes of New Jersey State student assistance programs during the 1986-87 academic year, and complies with the provisions of (b)6 above except for the resource requirement set forth therein. This provision will be effective for the 1987-88 academic year only.]

[vi.]iv. The student's economic and personal circumstances are of such a unique or unusual nature that denial of independent student status would create an unjust hardship upon the student. Eligibility under this subparagraph is subject to the approval of the director

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of the applicable student assistance program within the Department of Higher Education.

(c)-(e) (No change.)

9:7-2.7 [Income tax verification] Verification of family financial data

Students upon request must provide an authorization to the Department of Higher Education, Office of Student Assistance, which permits the release of Internal Revenue Service and/or State income tax returns for verification purposes. Financial data provided on the financial aid form [will] **may be verified by the Department and/or institution** through the comparison of information reported on income tax returns[,] **and other documentation.** Discrepancies will require the re-evaluation of the student's eligibility. Students as well as institutions will be notified if an adjustment in the value of aid is required.

9:7-2.8 Renewal eligibility and filing

Students must apply to renew their need-based [student] **State financial** assistance through the annual filing of a financial aid form in accordance with N.J.A.C. 9:7-2.4. [In addition, filing of the financial aid form is also required to participate in the Vietnam Veterans Tuition Aid Program.] To receive a renewal of State **financial** assistance, students must continue to meet all program eligibility requirements as contained in these rules and applicable statutes.

9:7-2.9 Award combinations and overawards

(a) Students receiving New Jersey State [student aid] **financial assistance** funds may receive combinations of a Tuition Aid Grant, [a] **an Edward J. Bloustein Distinguished Scholars award**, [veterans awards, a POW/MIA award,] a Public Tuition Benefits award, **an Urban Scholars award**, a Garden State [Scholarship] **Scholars award**, [or] **and an Educational Opportunity Fund grant. However,** [Students] **students** cannot simultaneously hold an Educational Opportunity Fund grant and a Garden State [Scholarship grant] **Scholars award** in any single semester.

(b) State grants, [and] scholarships and other financial [aid] **assistance** cannot exceed the student's cost of attendance as determined by the institution.

(c) If the total amount of [aid] **financial assistance, including State assistance**, exceeds the student's [need] **cost of attendance** by more than \$200.00, an adjustment to some portion of the aid package is required. A student's **total aid may be limited to financial need (as defined in Title IV of the Higher Education Act of 1965, P.L. 89-329 including all subsequent amendments and supplements) if financial assistance includes a Stafford loan and/or campus-based Title IV funds.** The first adjustment, **wherever possible**, should be made to reduce student loans, then to any institutional aid (including Federal campus-based programs) and lastly, to State awards.

9:7-2.10 Verification of enrollment and academic performance

(a) (No change.)

(b) Each institution shall provide copies of its minimum standards for academic performance and **satisfactory academic** progress to the Department of Higher Education [at the beginning of each academic year]. **Thereafter, institutions are required to provide copies of such standards when changes occur.**

(c) The Student Assistance Board shall recognize minimum standards for academic performance and satisfactory academic progress that an institution adopts for determining State financial [aid] **assistance** eligibility if these standards are the same as or stricter than the [institution's] standards [for students not receiving State financial aid.] **outlined in this section.**

(d) Students receiving State financial [aid] **assistance** under the student [aid] **assistance** programs administered by the Student Assistance Board shall remain in good academic standing as defined by the institution which they are attending.

(e) Students receiving State financial assistance under the student [aid] **assistance** programs administered by the Student Assistance Board shall meet the following [statewide] **Statewide** minimum standards of academic progress:

1. After earning the first 12 college-level credits, all students receiving **State financial** assistance shall earn either an additional 12 college-level credits during every semester in which they receive

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State financial assistance, or a minimum of 24 college-level credits during every academic year of payment.

2. The number of award payments students may receive in order to earn their first 12 college-level credits depends on their level of preparation for college work and the admission policy of their institution:

i. Students in the Educational Opportunity Fund (EOF) Program, at any institution, may receive up to three semesters of payments to earn the first 12 college credits or up to four payments to earn the first 24 credits. The definition of college credits is subject to the provisions of N.J.A.C. [9:12-1.11.]9:11-1.10.

ii.-iii. (No change.)

(f) (No change.)

(g) The academic standing and progress of all students receiving **State financial** assistance must be monitored by institutions at least once a year, prior to the fall semester.

(h) Students who fail to achieve the above minimum standards shall be ineligible to receive **State financial [aid] assistance** under the programs administered by the Student Assistance Board until such time as the institution certifies that they are in good academic standing and are achieving satisfactory academic progress.

(i) Students and institutions shall have the right to appeal the denial of **State financial [aid] assistance** based upon these guidelines through the established appeal procedures (see N.J.A.C. 9:7-2.15).

9:7-2.11 Payments

(a) The maximum number of semester award payments which students may receive are as follows:

1. Tuition Aid Grant Program:

Enrollment Status		Maximum Semesters for Award Payments
TWO-YEAR COLLEGES:	Regular 2-Year Program	5
	Remedial[-]/Developmental or Bilingual (ESL) Curriculum	6
	[Curriculum] EOF Program	6/8 ¹
FOUR-YEAR COLLEGES:	Regular 4-Year Program	9
	County College Transfers/Remedial/Developmental/Bilingual Curriculum	10 ²
	5-Year Program	11/12 ³
	EOF Program	12 ¹

¹[With special EOF approval.] As stipulated in N.J.A.C. 9:11-1.8.

²Remedial/Developmental or Bilingual (ESL) Curriculum must contain the equivalent of 18 or more [noncredit courses.] **credit hours of remedial or bilingual (ESL) courses.**

³County College Transfer, [or] Remedial/Developmental or Bilingual (ESL) curriculum.

i. Students shall not receive more than nine semesters of payment unless they are enrolled in a five-year program, receiving assistance under the EOF Program, transferred from a county college to a four-year college or were required to take **the equivalent of 18 or more credit hours of noncredit remedial, [or] developmental, or bilingual (ESL) courses.**

ii.-iii. (No change.)

2. All Other State Student Assistance Programs:

Enrollment Status		Maximum Semesters for Award Payments
TWO-YEAR COLLEGES:	Regular 2-Year Program	5
	Remedial/Developmental or Bilingual (ESL)	6
FOUR-YEAR COLLEGES:	Regular 4-Year Program	8
	Regular 5-Year Program	10

(b) Payments will be made by the Department of Treasury [to] **for** eligible students in equal installments over the regular academic year, the number of installments corresponding to the number of

school terms. Deadline dates shall be established annually by the **Student Assistance Board** to comply with the State's fiscal year and to allow for academic term expenditure control. The Student Assistance Board [may elect to] shall provide payment directly to institutions on behalf of student recipients. Listings of eligible students to be credited [will accompany the payments to institutions] shall also be provided to each institution.

9:7-2.12 [Refunds] Award adjustments/refunds

(a) If a refund is due a student under the institution's refund policy and the student received **State financial [aid] assistance** under any State student financial assistance program, the institution shall multiply the institutional refund by the following fraction to determine the amount to be refunded to the State: amount of **State financial assistance** (minus work earnings) awarded for the payment period divided by the total amount of financial aid (minus work earnings) awarded for the period.

(b) (No change.)

(c) The above formula shall be applied if a student reduces his [or her academic course load to less than full-time prior to the [date full tuition liability is required by the institution] end of the institutional refund period. However, if the student reduces his [or her academic course load to less than full-time after the [date full tuition liability is due to the institution,] end of the institutional refund period, a refund to the State is not [necessarily] required.

(d) If a combination of State student funds has been packaged for the student and a refund is due the State, a prorated amount is applied to each of the State programs in the student's **State financial [aid] assistance** package. [If the combination of State awards packaged for the payment period is less or equal to the tuition charged for that term, the student cannot receive State assistance greater than the tuition charged for the enrollment period.]

(e) If a cash disbursement has been made by an institution for non-institutional costs from any **State financial assistance** program, and it is determined by application of the institution's refund policy and the above formula that a refund should be paid to the State, the institution shall endeavor to collect the overpayment from the student and return it to the State. If this effort is unsuccessful, the institution shall notify the Office of Student Assistance of the amount owed for each **State financial assistance** program. Non-institutional costs may include but are not limited to room and board, books and supplies, transportation, and miscellaneous expenses.

(f) (No change.)

9:7-2.13 Student's obligation to report changes in institution or financial status

Any changes in college [attendance] **choice** or family financial status which occur after the Student Eligibility Notice has been issued to the student must be reported immediately, in writing by the student, to the Office of Student Assistance, Department of Higher Education, in order that the student's continued eligibility may be evaluated and prompt payment provided. Institutions may report these changes on behalf of the student.

9:7-2.14 Check endorsements

All checks issued to institutions by the Department of the Treasury[, whether to students or colleges,] must be negotiated within 90 days of their issuance. Checks are automatically cancelled if not cashed within 90 days.

9:7-2.15 Appeals

If, for any reason a student, his [or her family or an institution feels that the application of these rules results in an unfair determination of eligibility, an appeal shall be filed with the [Student Assistance Board] **Department of Higher Education, Office of Student Assistance**, within 60 days of notification of **eligibility or ineligibility**. Appeals should be in the form of a letter addressed to the [Chairman, Student Assistance Board, Attention: Appeals Officer,] **Appeals Committee, in care of the Director of the Office of Student Assistance, New Jersey Department of Higher Education, CN 540, Trenton, New Jersey 08625**, and shall contain the student's

full name, social security number, college of attendance, and a description of the basis for the appeal. **Appeals will be considered on the basis of this appeals process approved by the Student Assistance Board.**

9:7-2.16 Accounting and auditing standards

(a) (No change.)

(b) As part of the institution's periodic audit by an independent accounting firm, and in accordance with the **State Single Audit Act Policy**, State student assistance programs shall be included to insure compliance with Student Assistance Board rules, and a copy of the audit report must be provided to the **Department of Higher Education, Office of Grants and Scholarships**. The Department reserves the right to conduct its own institutional audit.

(c) (No change.)

9:7-2.17 General provisions; applicability

General provisions provided in N.J.A.C. 9:7-2 shall pertain in their entirety to the Tuition Aid Grant and the Garden State Scholarship Programs administered by the Student Assistance Board. Applicable general provisions for other student financial assistance programs are cited in their subchapters.

9:7-3.1 Determination of eligibility for and value of student assistance

The information on the financial aid form [will] shall be evaluated by employing the methodology used to calculate the New Jersey Eligibility Index (NJEI). The evaluation results in an estimate of the family or student's ability to contribute to the cost of education. This estimate is then used to determine eligibility for and value of the Tuition Aid Grant.

9:7-3.2 Tuition Aid Grant [award table] Award Table

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

(e) The value of the student's grant may change dependent upon appropriated funds, the student's [college budget] **cost of attendance** and other **State financial [aid] assistance**. The student will be notified of any change in his or her grant.

9:7-3.5 Part-time students

(a) Eligibility for Tuition Aid Grants [will] shall be extended on an annual basis to part-time students upon the approval of the Student Assistance Board and the Board of Higher Education depending on the level of appropriated funds.

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

(d) Payments to eligible students [will] shall be counted for the purpose of the requirements set forth in N.J.A.C. 9:7-2.11 as one-half a semester of payment.

(e) (No change.)

9:7-4.1 Program categories

(a) The Garden State Scholarship Program shall provide for grants to undergraduate students in the following program categories:

1. [Garden State Scholars; and] **Edward J. Bloustein Distinguished Scholars;**
2. [Distinguished Garden State Scholars.] **Urban Scholars; and**
3. **Garden State Scholars.**

9:7-4.2 Academic requirements

(a) (No change.)

(b) The academic requirements for Garden State Scholarships shall include secondary school ranking in the graduating class and/or a combination of the secondary school ranking and combined Scholastic Aptitude Test (SAT) scores or grade point average. Where SAT scores are not available, the appropriate equivalent from the American College Testing (ACT) Program may be used.

(c) **Edward J. Bloustein Distinguished [Garden State] Scholars** shall be selected on the basis of the following criteria:

1. Class rank [within the top 10 percent] of **one, two or three** in the graduating class at the end of the junior year; [and] or
2. [SAT scores of 1,200 or above] **Class rank within the top 10 percent of the graduating class** at the end of the junior year; or] **with combined SAT scores of 1,200 or above at the end of the junior year.**

[3. Class rank of one, two or three in the graduating class at the end of the junior year.]

(d) Distinguished [Garden State Scholars who are identified as] Urban Scholars attending secondary schools within the Type A and B school districts as determined by the New Jersey Department of Education shall be selected on the basis of the following criteria:

1. Class rank within the top 10 percent of the graduating class at the end of the junior year[; and] **with a grade point average (GPA) of at least 3.0 on a scale of 4.0 (or an equivalent scale) at the end of the junior year.**

[2. Grade point average (GPA) of at least 3.0 on a scale of 4.0 (or an equivalent scale) at the end of the junior year.]

(e) Students from each school selected pursuant to (d) above shall be ranked among the students selected at that school according to the following formula and the highest ranking students will be offered scholarships:

1. Academic qualification for a scholarship is determined by an Academic Index (AI). The AI is derived by combining two factors, secondary school GPA and rank in class which will be weighted equally. The formula for combining the two factors is:

$$AI = (GPA \times 37.5) + [2](\text{Converted Rank} \times 2)$$

2. The converted rank shall be determined from the table set forth in (h)ii below.

(f) For students selected pursuant to (d) and (e) above, each school located within a Type A and B school district [will] **shall** receive that proportion of the total available scholarships which reflects the size of the graduating class at the end of the junior year as compared to the total number of students in the graduating classes from all schools within Type A and B districts at the end of the junior year.

(g) Garden State Scholars shall be selected on the basis of the following criteria:

1. Class rank within the top 20 percent of the graduating class at the end of the junior year[; and] **with combined SAT scores of 1000 or above at the end of the junior year, or through the January administration of the SAT in the senior year in the event that funds permit a second-round selection of awards.**

[2. SAT scores of 1,000 or above at the end of the junior year, or through the January administration of the SAT in the senior year.]

(h) Garden State Scholars shall be ranked according to the following formula and the highest ranking students will be offered scholarships [at] **based on information as of the end of the junior year[; with additional]. Additional scholarships may be offered during the [second half of the] senior year dependent upon available appropriations.**

1. Academic qualification for a scholarship is determined by an Academic Index (AI). The AI is derived by combining two factors, the **combined** SAT scores from the College Entrance Examination Board and a converted secondary school rank in class. The formula for combining the two factors is:

$$AI = \frac{\text{Verbal} + \text{Math SAT scores}}{10} + [2] (\text{Converted Rank} \times 2)$$

i. SAT scores: Verbal and math scores are to be weighed equally. Where SAT scores are not available, the appropriate equivalent from the ACT Program may be used. The highest verbal score from any administration may be combined with the highest math score from any administration.

ii. Rank in class: In order to weigh secondary school rank equally with **combined** SAT scores, the converted rank is multiplied by two. Conversion of the secondary school rank to a standardized score is necessary in order to combine it equally with the **combined** SAT scores which have also been standardized. The following table gives the converted rank multiplied by two, which is the figure to be combined with the test score sum in the AI formula given in this subsection.

SECONDARY SCHOOL RANK CONVERSION TABLE

Percent Standing	Converted Rank × 2	Percent Standing	Converted Rank × 2	Percent Standing	Converted Rank × 2
00-01	= 150	13-14	= 122	44-47	= 102
02	= 142	15-16	= 120	48-52	= 100
03	= 138	17-18	= 118	53-56	= 98
04	= 136	19-21	= 116	57-60	= 96
05	= 134	22-24	= 114	61-64	= 94
06	= 132	25-27	= 112	65-68	= 92
07	= 130	28-31	= 110	69-72	= 90
08	= 128	32-35	= 108	73-75	= 88
09-10	= 126	36-39	= 106		
11-12	= 124	40-43	= 104		

[(i) Up to 10 percent of freshman Garden State Scholars awards may be provided to students, including students who do not meet the criteria set forth in (g) above, if these students are recommended by the president of a New Jersey college or university.]

9:7-4.3 Eligibility requirements

(a) Garden State Scholarship recipients shall attend an eligible New Jersey institution of higher education as defined by N.J.S.A. 18A:71-26.5.

(b) Scholarship awards shall be renewable for up to [four or five] **three or four** years of undergraduate programs of study regularly requiring four or five academic years respectively for completion. In order to be eligible for a renewal award the student shall continue to achieve satisfactory academic progress pursuant to N.J.A.C. 9:7-2.10 and demonstrate continued financial need, if applicable.

(c) Garden State Scholarship recipients who transfer to another eligible New Jersey institution may transfer their awards provided they have demonstrated satisfactory academic progress **and have notified the Department in writing in accordance with applicable procedures.**

(d) Students may not simultaneously hold [a Garden State] **an Edward J. Bloustein Distinguished Scholars award and an Urban Scholars award and/or a Garden State Scholars award.**

9:7-4.4 Award amounts

(a) (No change.)

(b) **Edward J. Bloustein Distinguished** [Garden State] **Scholars and Urban Scholars** shall receive annual awards of up to \$1,000 without regard to financial need based upon their academic performance as determined pursuant to N.J.A.C. 9:7-4.2(c), (d), and (e). If sufficient funds are available, the award may be increased up to an additional \$1,000 based upon the student's New Jersey Eligibility Index (NJEI) pursuant to N.J.A.C. 9:7-3.1 and 3.2 according to the following table:

NJEI	Additional Amount of Grant				Rutgers Univ.
	County Colleges	State Colleges	Independent Institutions	NJIT & UMDNJ	
Under 1500	\$1000	\$1000	\$1000	\$1000	
1500- 2499	500	1000	1000	1000	
2500- 3499	250	500	1000	1000	
3500- 4499	250	500	500	500	
4500- 5499	250	250	500	500	
5500- 6499	0	250	500	250	
6500- 7499	0	250	250	250	
7500- 8499	0	0	250	250	
8500- 9499	0	0	250	250	
9500-10499	0	0	250	0	
Over 10499	0	0	0	0	

(c)-(d) (No change.)

9:7-4.5 Award combinations

(a) All scholarship recipients may be eligible for assistance under the Tuition Aid Grant Program **if they complete the required financial aid application.**

(b) **Edward J. Bloustein Distinguished** [Garden State] **and Urban Scholars** may be eligible to receive an Educational Opportunity Fund grant.

9:7-4.8 Renewal of scholarships

(a) Students receiving undergraduate scholarship assistance will continue to receive [aid] **State financial assistance** provided they continue to meet all of the eligibility criteria as stipulated in the statute and in the rules adopted by the Student Assistance Board.

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

9:7-5.1 General provisions

General provisions for all programs administered by the Student Assistance Board (N.J.A.C. 9:7-2) which pertain to residency (2.2), foreign nationals (2.3), payments (2.11), [refunds] **award adjustments/refunds** (2.12), check endorsements (2.14), **appeals** (2.15), and accounting and auditing standards (2.16) shall be in effect for the Public Tuition Benefits Program.

9:7-5.8 Period of eligibility

Eligibility to receive tuition benefits shall be limited to eight years from the date of the death of the member or officer in the case of a widowed spouse or eight years following graduation from secondary school in the case of a [dependent] child. Recipients shall not be eligible for more than eight semesters of payment for full-time enrollment or the equivalent for half-time enrollment. Payment for half-time enrollment shall count as one half a semester of payment. Students enrolled in a program of study normally requiring five years to complete shall be eligible for 10 semesters of payment.

9:7-6.2 General provisions

General provisions for all programs administered by the Student Assistance Board (N.J.A.C. 9:7-2) which pertain to residency (2.2), foreign nationals (2.3), verification of enrollment and academic performance (2.10), payments (2.11), [refunds] **award adjustments/refunds** (2.12), check endorsements (2.14), **appeals** (2.15), and accounting and auditing standards (2.16) shall be in effect for the Garden State Graduate Fellowship Program.

SUBCHAPTER 7. [VETERANS TUITION CREDIT PROGRAM] (RESERVED)

SUBCHAPTER 8. [VIETNAM VETERANS TUITION AID PROGRAM] (RESERVED)

9:7-9.1 Rules and statutes incorporated by reference

(a)-(b) (No change.)

(c) The provisions of the following sections of subchapter 2 of this chapter, N.J.A.C. 9:7-2.2 residency, 2.3 foreign nationals, [2.11 payments,] 2.14 check endorsements, 2.15 appeals and 2.16 accounting and auditing standards, governing the programs administered by the Student Assistance Board shall also apply to this program unless they are inconsistent with or otherwise excepted within the provisions of this subchapter.

HUMAN SERVICES

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Transportation Services Manual, Livery Services, Including Reimbursement; Invalid Coach Services
Proposed Amendments: N.J.A.C. 10:50-1.1, 1.2, 1.3, 1.4, 1.6, 1.7 and 2.1

Proposed Repeal and New Rule: N.J.A.C. 10:50-2.2

Authorized By: Alan J. Gibbs, Commissioner, Department of Human Services.

Authority: N.J.S.A. 30:4D-6b(15); 30:4D-7, 7a, b and c; 30:4D-12, 42 CFR 440.170(a).

Agency Control Number: 92-P-1.

Proposal Number: PRN 1992-313.

Submit comments by August 19, 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 proposed amendments concern the Transportation Services Manual, N.J.A.C. 10:50. The proposed amendments are primarily focused on livery services and reimbursement for these services. The Division is amending its reimbursement methodology for livery services.

With respect to reimbursement for livery services, the Division's current method is to reimburse providers based upon a one way/round trip methodology for each recipient transported, plus a per-mile rate.

The proposed new methodology is based upon a per-mile amount of \$1.00 per mile (see HCPCS procedure code Y0251). (The term HCPCS refers to the Health Care Financing Administration common procedure coding system.) If additional recipients are transported from a common point of departure to a common point of destination, then a flat rate of \$3.00 is reimbursable for each additional recipient transported. This rate is reimbursable only once per person/per trip, either on a one-way or round-trip basis.

The purpose of these revisions is to recognize that livery service is for ambulatory recipients. Therefore, fee-for-service for livery services is limited to a loaded mile component only. The loading charge component is being removed because those Medicaid recipients that use livery service(s) are ambulatory.

There are also other changes associated with the proposal. A vehicle used to provide livery service shall not be more than eight model years old, rather than six model years old as currently prescribed.

There is also a provision in the proposed amendments at N.J.A.C. 10:50-1.3(a)4iv that providers of livery service carry a certificate of insurance which shall include coverage for workers' compensation and employers' liability insurance in addition to automobile liability insurance. This is a new requirement for the enrollment of livery service providers in the New Jersey Medicaid program. The purpose of the requirement is to ensure that potential livery service providers are in compliance with existing New Jersey State law regarding workers' compensation. All businesses operating in New Jersey with at least one employee must obtain workers' compensation. Information regarding workers' compensation may be obtained by contacting the Division of Workers' Compensation, New Jersey Department of Labor, CN 381, Trenton, New Jersey 08625-0381.

With respect to the transportation certification form, the proposed amendments to N.J.A.C. 10:50-1.7 require that this form shall be retained on file at the provider's place of business and made available for review by staff of the Division of Medical Assistance and Health Services and/or its agent(s). Failure to retain the form, or possession of an incomplete form, may result in recoupment as indicated in N.J.A.C. 10:49-9.6(b). The proposed new rule text appeared in the May 4, 1992 issue of the New Jersey Register, 24 N.J.R. 1728(b); 1748.

The proposed amendments also include several instances in which rule text is recodified, without change, from one section to another. For example, definitions of "loaded mile," "transportation reimbursement allowance," and "waiting time" are recodified to the definitions section, N.J.A.C. 10:50-1.2, from N.J.A.C. 10:50-1.6(a). Also, rule text regarding the higher reimbursement rate for trips by ground ambulance and invalid coach in excess of 15 miles one way is recodified without change, to N.J.A.C. 10:50-1.6(e) from N.J.A.C. 10:50-1.6(a)1iii.

At N.J.A.C. 10:50-1.4(b)3, an invalid coach service can not be provided to a patient using a ventilator, in accordance with New Jersey State Department of Health rules, adopted at N.J.A.C. 8:40-4.1(b); see 24 N.J.R. 119(a) and 133, published January 6, 1992.

With respect to HCPCS codes contained in N.J.A.C. 10:50-2.1(b), the Division requires certain modifiers be used when transportation providers submit claims (to Medicaid) for payment.

The modifiers numbered 1 and 2, "22" and "XA," are already codified at N.J.A.C. 10:50-2.2. The modifiers numbered 3 and 4, "XE" and "76," are new with these proposed amendments. All modifiers used by transportation providers are now codified at N.J.A.C. 10:50-2.1(b).

The use of modifier "22" allows ground ambulance and invalid coach service to indicate the trip was in excess of 15 miles one way.

The use of modifier "XA" indicates the base allowance for an invalid coach transporting a Medicaid recipient to and/or from a nursing facility.

The use of modifier "XE" indicates a ground ambulance not covered by Medicare (Title XVIII).

The use of modifier "76" can be used by any transportation provider to indicate a repeat procedure. The Medicaid program defines a repeat service as the same service being provided on the same day to the same recipient.

In N.J.A.C. 10:50-2.2, the HCPCS procedure codes are being repealed and replaced as new rules. HCPCS codes and text are listed in alphanumeric order under the appropriate headings as follows: Ambulance Service, N.J.A.C. 10:50-2.2(a); Invalid Coach Service, N.J.A.C. 10:50-2.2(b); and Livery Service, N.J.A.C. 10:50-2.2(c). Revisions in the new rules are as follows.

N.J.A.C. 10:50-2.2(b) contains two new HCPCS procedure codes, Y0002 and Y0002 22. The new codes are for invalid coach mileage, for the purpose of distinguishing between invalid coach mileage and ambulance mileage, with no change in current reimbursement amounts.

HCPCS procedure code Y0075 is proposed for invalid coach oxygen, for the purpose of distinguishing between invalid coach oxygen and ambulance oxygen. There is no change in the reimbursement amount for the provision of oxygen.

N.J.A.C. 10:50-2.2(c) contains two new HCPCS procedure codes, Y0251 and Y0252, including descriptions and maximum fee allowances. The new codes reflect the proposed reimbursement methodology and reimbursement amounts for livery service as noted in N.J.A.C. 10:50-1.6(d). HCPCS procedure codes Y0250, Y0255, and Y0260 are deleted because they represent the old livery service rates and are no longer applicable.

Social Impact

These proposed amendments potentially impact on all Medicaid recipients who need transportation to obtain medical services. There would be greater impact upon ambulatory recipients because they would qualify for the livery service mode of transportation. The Division expects the social impact to remain constant because there is no change in the availability of transportation services.

These proposed amendments impact upon providers of transportation services. Providers are no longer required to attach the certification form to the claim form when submitting a claim to Medicaid. However, providers are required to maintain this form in their files and make it available to the Division and/or its agents. All transportation providers are subject to this requirement.

With respect to livery service providers, the permitted age of the vehicle has changed from a six year old vehicle to an eight year old vehicle. The reimbursement methodology has changed but this is discussed in the Summary above and Economic Impact below. The rate change, as discussed below, impacts only on livery service providers.

Economic Impact

The Division's expenditures for transportation services were approximately \$21,000,000 (Federal-State share combined) in calendar year 1991. Approximately \$3,500,000 was spent on livery services.

It is estimated that there will be a gross cost savings of \$566,000 (\$283,000 State share) under the proposed amendments if provider billing practices for livery services remain constant.

There is no cost to the Medicaid recipient for transportation services.

The economic impact of the proposed new rate methodology upon livery service providers will vary, depending on the number of recipients being transported and the length of the trip. The revised methodology will result in lower Medicaid payments for shorter trips and higher Medicaid payment for longer trips.

The proposed amendment increasing the allowable model age of a vehicle permits providers to keep livery service vehicles for a longer period of time and, therefore, providers will expend funds for newer vehicles less frequently.

There is no economic impact on providers of ambulance or invalid coach services because their rates are not being changed by the proposed amendments.

Regulatory Flexibility Analysis

The proposed amendments impose reporting, recordkeeping, paperwork or other compliance requirements upon transportation providers, some of which may be considered small businesses under the terms of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. There are reporting, recordkeeping and compliance requirements pursuant to N.J.S.A. 30:4D-12 imposed on each class of transportation providers—ambulance, invalid coach, and livery. This portion of the Medicaid statute requires Medicaid providers to keep sufficient records to indicate the name of the recipient receiving the service, date and nature of service, and any other additional information as may be required by regulation. In general, the requirements are similar but there is differentiation between the three provider groups because the nature of the patient being transported is different. Recipients transported by ambulance are seriously ill and may require immediate transport. Recipients transported via invalid coach are not always fully ambulatory. Livery service transport is used for ambulatory recipients. With respect to these proposed amendments, all providers are required to prepare and maintain in their possession a certification document. The proposed amendments ease the burden upon providers to the extent that providers do not have to submit a certification document with the claim form, thereby allowing providers to keep the original certification document in their files. All providers are now required to enter the vehicle fleet number (livery) or the vehicle recognition number (ground ambulance and invalid coach) on the hard copy claim form. This requirement is necessary to facilitate claim processing.

With respect to the HCPCS codes, there are no additional recordkeeping or reporting requirements. Livery service providers have been entering HCPCS codes on claim forms and will continue to do so. The mechanics of entering the HCPCS codes on the claim form has not changed. The proposed amendment affects the reimbursement associated with the HCPCS codes.

There could be capital costs associated with the proposed amendments pertaining to the requirement that livery service providers provide workers' compensation and employers' liability insurance as well as automobile liability insurance. Livery service providers should already be providing this coverage for their employees. With respect to the need to hire "professional staff," all transportation providers must hire licensed and/or specialized personnel in accordance with licensure requirements established by other state agencies, such as the New Jersey Division of Motor Vehicles, or the New Jersey State Department of Health. The proposed amendments do not require transportation providers to hire accountants to maintain records, file claims, etc. unless they choose to do so.

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

10:50-1.1 Scope

This [manual] **chapter** describes the policies and procedures of the New Jersey Medicaid Program for reimbursement of approved providers of transportation services. Questions about this [manual] **chapter** may be directed to any Medicaid District Office (MDO) listed in N.J.A.C. 10:49 Appendix or to the Division of Medical Assistance and Health Services, CN-712, Trenton, New Jersey 08625-0712.

10:50-1.2 Definitions

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

... **"Loaded mile"** means mileage accrued when a vehicle is actually carrying a Medicaid recipient.

... **"Transportation reimbursement allowance"** means that claims are paid on a fee-for-service basis, as indicated in N.J.A.C. 10:50-2, HCFA Common Procedure Coding System (HCPCS).

"Waiting Time" means that period of actual time, in increments of 15 minutes, beginning 30 minutes following delivery of the recipient to his or her destination, for ground ambulance and invalid coach service.

10:50-1.3 General policies for participation

(a) The approval process for becoming a transportation service provider is as follows:

1. Each transportation provider must be individually approved for each type of service provided. The Division of Medical Assistance and Health Services, Department of Human Services, in conjunction with the [fiscal agent] **Fiscal Agent** for the New Jersey Medicaid Program, must approve each provider before reimbursement can be made to that provider for a transportation service.

2. Medicaid Provider Application (Form FD-20), Provider Agreement (Form FD-62), and Ownership and Control Interest Disclosure Statement (HCFA-1513) may be obtained from the [fiscal agent] **Fiscal Agent** for the New Jersey Medicaid Program.

3. (No change.)

4. A potential provider seeking approval to provide livery service shall attach to the Medicaid Provider Application (Form FD-20) the following documents, each of which shall bear the name and address of the livery company or the company's principal owner(s), for each vehicle in the provider's fleet:

i.-ii. (No change.)

iii. A photocopy of the vehicle registration bearing the classification "Livery", issued by the New Jersey Division of Motor Vehicles. **A potential provider shall also indicate on the photocopy of the vehicle registration the respective vehicle fleet number;**

iv. A Certificate of Insurance, including a 10-day notice of cancellation, listing as Certificate Holder: State of New Jersey, Division of Medical Assistance and Health Services, CN-712, Trenton, New Jersey 08625-0712. **The Certificate of Insurance shall indicate coverage for Workers' Compensation and Employers' Liability Insurance; and Automobile Liability Insurance;** and

v. A photocopy of an Operator License for each driver, issued by the New Jersey Division of Motor Vehicles.

[(1) A potential provider shall also indicate on the photocopy of the vehicle registration the respective vehicle fleet number.]

5. An approved provider of livery service shall forward to the [fiscal agent] **Fiscal Agent** for the New Jersey Medicaid Program photocopies of the above-mentioned documents (license, registration and insurance) when the documents are renewed on an annual basis, and when additional livery service vehicles are added to a provider's fleet. A provider shall also forward written notification to the [fiscal agent] **Fiscal Agent** when a livery service vehicle is taken out of service.

6.-7. (No change.)

8. The completed provider agreement, disclosure statement, and/or provider application shall be submitted to the [fiscal agent] **Fiscal Agent** [for the New Jersey Medicaid Program].

9. [Once approved, the applicant will receive a Medicaid provider number and an initial supply of pre-printed claim forms from the fiscal agent for the New Jersey Medicaid Program.] **Once approved, the applicant will receive the following from the Fiscal Agent: a Medicaid provider number; a Transportation Services Manual; an initial supply of claim forms; and, if applicable, an initial supply of prior authorization forms.**

(b) (No change.)

10:50-1.4 Services covered by the New Jersey Medicaid Program

(a) Ground ambulance service is a covered service under the following conditions:

1.-2. (No change.)

3. When the use of any other method of transportation is medically contraindicated and the service is provided as specified in New Jersey State Department of Health rules N.J.A.C. 8:40 [-5.1 and 6.1] -5 and 6.

4. The ambulance crew shall comply with the duties of staff as specified in New Jersey State Department of Health rules N.J.A.C. 8:40-6.27.

5.-6. (No change.)

(b) Invalid coach service is a covered service under the following conditions:

1.-2. (No change.)

3. In accordance with New Jersey State Department of Health rules, as indicated in N.J.A.C. 8:40-4.1(b) invalid coach service shall not be provided to a patient who requires (based upon current medical condition or past medical history):

i.-iv. (No change.)

v. An automatic ventilator or whose breathing is ventilator-assisted;

Recodify existing v.-viii. as vi.-ix. (No change in text.)

4.-5. (No change.)

(c) Livery service is a covered service under the following conditions:

1.-2. (No change.)

3. Vehicle requirements are as follows:

i. [The] A vehicle used to provide livery service shall not be more than [six] **eight** model years old at the time the service is provided and shall have a seating capacity of not less than five nor more than 10 persons, inclusive of the driver. Each vehicle used to provide livery service shall be licensed, registered, and insured as indicated in N.J.A.C. 10:50-1.3(a)4.

ii.-iv. (No change.)

4.-5. (No change.)

10:50-1.6 Reimbursement policy

[(a) The following definitions shall apply for the purpose of reimbursement:

1. "Loaded mile" means mileage accrued when a vehicle is actually carrying a Medicaid recipient. Mileage for ground ambulance, invalid coach, and livery service is measured by odometer from the point at which the recipient enters the vehicle to the point at which he or she exits the vehicle.

i. In a multiple-load situation for ground ambulance service and invalid coach service, the charge for loaded mileage and waiting time is applicable to one recipient only. Reimbursement is limited to the distance traveled by the recipient whose place of departure and destination represent the greatest distance. No mileage charge is permitted for additional recipients whose distance traveled lies between these two points.

ii. For livery service, the amount reimbursable for vehicle mileage accrued is on a per-person basis. However, when two or more recipients are transported in the same vehicle at the same time from the same departure point to the same destination point, mileage may only be charged for one recipient.

iii. For trips by ground ambulance and invalid coach in excess of 15 miles one way, loaded mileage is reimbursable beginning with the first mile, at a higher rate as indicated in N.J.A.C. 10:50-2, HCFA Common Procedure Coding System (HCPCS). The higher rate of reimbursement is applicable to both the one way trip and to the return trip.

(1) When billing for trips in excess of 15 miles one way, the HCFA Common Procedure Coding System (HCPCS) procedure codes used to identify mileage charges must be followed by the modifier "22", as indicated in N.J.A.C. 10:50-2, HCFA Common Procedure Coding System (HCPCS).

2. "Transportation reimbursement allowance" means that claims are paid on a fee-for-service basis, as indicated in N.J.A.C. 10:50-2, HCFA Common Procedure Coding System (HCPCS). For HCPCS procedure codes and maximum fee schedule, see N.J.A.C. 10:50-2.

The least expensive mode of transportation suitable to the recipient's needs is to be used.

3. "Waiting time" means that period of actual time, in increments of 15 minutes, beginning 30 minutes following delivery of the recipient to his or her destination, for ground ambulance and invalid coach service. There is no reimbursement for waiting time on round trips, and it is limited to a maximum of one hour on one-way trips. Waiting time is applicable to one recipient only in a multiple-load situation. An explanation of the need for waiting time shall be attached to the claim (Form MC-12).]

(a) The least expensive mode of transportation suitable to the recipient's needs is to be used.

(b) Mileage for ground ambulance, invalid coach, and livery service is measured by odometer from the point at which the recipient enters the vehicle to the point at which the recipient exits the vehicle.

(c) In a multiple-load situation for ground ambulance service and invalid coach service, the amount reimbursable for loaded mileage accrued is only applicable to one recipient. Total mileage is equivalent to the total distance traveled by the recipient from point of departure to point of destination. No allowance is reimbursable for any mileage accrued by additional recipients in the multiple-load situation.

(d) For livery service, the amount reimbursable for loaded mileage accrued is only allowed on a per-person basis when the points of departure or destination for the additional recipients transported are different from those of the first recipient. When two or more recipients are transported in the same vehicle at the same time from a common point of departure to a common point of destination, mileage shall only be reimbursed for one recipient.

1. Only the flat rate of \$3.00 is reimbursable for each additional recipient transported in a multiple-load situation. The flat rate is only applicable when all recipients are transported in a multiple-load situation from a common point of departure to a common point of destination. This rate is only reimbursable once per person/per trip, either on a one way or round trip basis.

(e) For trips by ground ambulance and invalid coach in excess of 15 miles one way, loaded mileage is reimbursable beginning with the first mile, at a higher rate as indicated in N.J.A.C. 10:50-2, HCFA Common Procedure Coding System (HCPCS). The higher rate of reimbursement is applicable to both the one way trip and to the return/round trip.

(f) There is no reimbursement for waiting time on round trips, and it is limited to a maximum of one hour on one-way trips at the point of destination, not at the point of departure. Waiting time is only applicable to one recipient in a multiple-load situation.

Recodify existing (b)-(h) as (g)-(m) (No change in text.)

[(i) The appropriate modifier shall be entered on the Transportation Claim (Form MC-12) when billing for the following services:

1. Mileage, ground ambulance and invalid coach service, in excess of 15 miles one way (see N.J.A.C. 10:50-1.6(a) and 10:50-2, HCFA Common Procedure Coding System (HCPCS)); and

2. Base allowance, invalid coach service, when a Medicaid recipient is transported to or from a nursing facility (see N.J.A.C. 10:50-1.5(f) and 10:50-2, HCFA Common Procedure Coding System (HCPCS)).]

Recodify (j)-(l) as (n)-(p) (No change in text.)

10:50-1.7 Transportation certification

[A transportation certification form shall be used in conjunction with the "Transportation Claim" (Form MC-12) when billing for ambulance, invalid coach, and livery service.]

(a) The Fiscal Agent Billing Supplement contains a sample transportation certification form and instructions for the form's proper completion. [At a minimum, the] The elements appearing on the sample transportation certification form shall appear on [the] all certification forms furnished and prepared by the transportation provider.

(b) The transportation certification form shall be retained on file at the provider's place of business and shall be made available for review upon request by staff of the Division of Medical Assistance and Health Services or the Division's Fiscal Agent. If a transporta-

tion certification form is not on file for each service, Medicaid reimbursement for the service is subject to recoupment, as indicated in N.J.A.C. 10:49-9.6(b).

(c) The vehicle fleet number (livery) or the vehicle recognition number (ground ambulance and invalid coach) that corresponds to the vehicle used to provide the respective transportation service shall be entered on the "Transportation Claim" (Form MC-12) in Item 18 (REMARKS) when submitting hard copy claims to the Division's Fiscal Agent for ground ambulance, invalid coach, and livery service.

10:50-2.1 Introduction

(a) (No change.)

(b) The following modifiers shall accompany the appropriate HCPCS procedure codes when applicable:

1. "22" Mileage, ground ambulance and invalid coach service, in excess of 15 miles one way (see N.J.A.C. 10:50-1.6(e)).
2. "XA" Base allowance, invalid coach service, when a Medicaid recipient is transported to or from a nursing facility (see N.J.A.C. 10:50-1.5(f)).
3. "XE" Non-Medicare-covered service—to indicate that a ground ambulance service provided to a Medicare/Medicaid recipient is NOT reimbursable by Medicare because the place of destination is a physician's office, a clinic, or a dialysis facility, etc. Use modifier "XE" following all applicable HCPCS procedure codes when billing Medicaid for the non-Medicare-reimbursable service; an Explanation of Medicare Benefits statement is not required.
4. "76" Repeat procedure—same day—to indicate that the service duplicates a service previously rendered to the same recipient on the same day. Use modifier "76" following all HCPCS procedure codes when billing for the repeat service. Do NOT use the modifier to bill for the first service. Failure to use modifier "76" to indicate a second service on the same date of service will result in the denial of the second service as a duplicate. Likewise, affixing modifier "76" to both services will cause the claims to deny as duplicates.

[10:50-2.2 HCPCS code numbers and maximum fee schedule

HCPCS Mod. Code	Description	Maximum Fee Allowance
(a) AMBULANCE SERVICE		
A0010	Ambulance Service, Basic Life Support (BLS) Base Rate, Emergency Transport, One Way	\$30.00
A0222	Ambulance Service, Return Trip, Transport	30.00
A0040	Ambulance Service, Air, Helicopter Service, Transport	†B.R.
†B.R.—By Report		
(b) INVALID COACH SERVICE		
A0130	Non-Emergency Transportation: Wheelchair Van	20.00
	NOTE: Invalid Coach Service, One Way, Per Patient	
Y0060	Invalid Coach Service, Round Trip, Per Patient	40.00
	XA—Invalid Coach Service(s) to/from a nursing facility.	
	NOTE: The modifier "XA" must be used when a patient is transported to/from a nursing facility by invalid coach.	
Y0070	Extra crew differential, one way	10.00
Y0065	Extra crew differential, round trip	20.00
(c) LIVERY SERVICE		
Y0250	One Way, Per Passenger	5.00
Y0255	Round Trip, Per Passenger	10.00

NOTE: Waiting time is not reimbursable for livery service.

PROPOSALS

Interested Persons see Inside Front Cover

HUMAN SERVICES

(d) MILEAGE

A0020 Ambulance Service, (BLS) Per Mile, Transport, One Way 1.00

NOTE: For Medicaid reimbursement purposes, mileage both one way and return/round trip is payable at \$1.00 per loaded mile in both the ambulance and invalid coach.

Maximum
Fee Allowance
Effective Date
8/1/88 5/1/89

A0020-22 Ambulance Service, (BLS) Per Mile Transport, One Way 1.20 1.50

NOTE: The higher rate is applicable for trips in excess of 15 miles one way, beginning with the first mile. The higher rate is reimbursable for ambulance and invalid coach services and is applicable to both the one way and to the return trip.

HPCPS Code Description Maximum Fee Allowance

Y0260 Livery Service, Per Mile, Per Passenger 0.50

(e) WAITING TIME—AMBULANCE SERVICE—ONE WAY TRIP ONLY

Y0005 Waiting Time—Ambulance Service—One Way Trip Only
¼ hour 2.50
½ hour 5.00
¾ hour 7.50
1 hour 10.00

NOTE: Reimbursable only on one way trips and only after 30 minutes have elapsed. It is reimbursable in ¼ hour increments. Maximum reimbursement for waiting time is \$10.00 (1 hour).

(f) WAITING TIME—INVALID COACH SERVICE—ONE WAY TRIP ONLY

Y0010 Waiting Time—Invalid Coach Service—One Way Trip Only
¼ hour 1.25
½ hour 2.50
¾ hour 3.75
1 hour 5.00

NOTE: Reimbursable only on one way trips and only after 30 minutes have elapsed. It is reimbursable in ¼ hour increments. Maximum reimbursement for waiting time is \$5.00 (1 hour).

(g) OXYGEN

A0070 Ambulance Service, Oxygen, Administration and Supplies, Life Sustaining Situation 12.00 per occurrence
Invalid Coach Service—Oxygen 12.00 per occurrence]

10:50-2.2 HPCPS procedures codes and maximum fee schedule

HPCPS Mod. Code Description Maximum Fee Allowance

(a) AMBULANCE SERVICE

A0010 Ambulance Service, Basic Life Support (BLS) Base Rate, Emergency Transport, One Way \$30.00

A0020 Ambulance Service, (BLS) Per Mile, Transport, One Way 1.00

A0020 22 Ambulance Service, (BLS) Per Mile, Transport, One Way 1.50

NOTE: The higher rate is applicable for trips in excess of 15 miles one way, beginning with the first mile. The higher rate is applicable to both the one way and to the return trip.

A0040 Ambulance Service, Air, Helicopter Service, Transport B.R.

A0070 Ambulance Service, Oxygen, Administration and supplies, Life sustaining situation 12.00 per occurrence

A0222 Ambulance Service, Return Trip, Transport 30.00

Y0005 Waiting Time—Ambulance Service—One Way Trip Only
¼ hour 2.50
½ hour 5.00
¾ hour 7.50
1 hour 10.00

NOTE: Reimbursable only on one way trips and only after 30 minutes have elapsed. It is reimbursable in ¼ hour increments. Maximum reimbursement for waiting time is \$10.00 (1 hour).

(b) INVALID COACH SERVICE

A0130 Non-Emergency Transportation: Wheelchair Van 20.00

NOTE: Invalid Coach Service, One Way, Per Patient

Y0002 Invalid Coach Service, Per Mile, One Way and Round Trip 1.00

Y0002 22 Invalid Coach Service, Per Mile, One Way and Round Trip, in excess of 15 miles one way 1.50

NOTE: The higher rate is applicable for trips in excess of 15 miles one way, beginning with the first mile. The higher rate is applicable to both the one way and to the round trip.

Y0010 Waiting Time—Invalid Coach Service—One Way Trip Only
¼ hour 1.25
½ hour 2.50
¾ hour 3.75
1 hour 5.00

NOTE: Reimbursable only on one way trips and only after 30 minutes have elapsed. It is reimbursable in ¼ hour increments. Maximum reimbursement for waiting time is \$5.00 (1 hour).

Y0060 Invalid Coach Service, Round Trip, Per Patient 40.00

Y0065 Extra crew differential, round trip 20.00

Y0070 Extra crew differential, one way 10.00

Y0075 Invalid Coach Oxygen 12.00 per occurrence

(c) LIVERY SERVICE

Y0251	Per loaded mile, only one recipient per trip NOTE: This rate may be applied to additional recipients ONLY when the points of departure or destination are different from those of the first recipient.	1.00
Y0252	Flat rate, each additional recipient NOTE: Only this rate is reimbursable for each additional recipient transported in a multiple-load situation from a common point of departure to a common point of destination. This rate is only reimbursable once per person/ per trip, either on a one way or round trip basis.	3.00

(a)**DIVISION OF YOUTH AND FAMILY SERVICES****Adoption Assistance and Child Welfare Act of 1980 Requirements****Proposed Readoption with Amendment: N.J.A.C. 10:131**

Authorized By: Alan J. Gibbs, Commissioner, Department of Human Services.

Authority: N.J.S.A. 30:4C-4 and 30:1-12.

Proposal Number: PRN 1992-305.

Submit comments by August 19, 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

Pursuant to Executive Order No. 66(1978), N.J.A.C. 10:131 will expire on December 7, 1992. The Division of Youth and Family Services proposes to readopt this chapter with only one technical change, that is, the address from which the Child Welfare Services Plan may be obtained.

Federal law (the Adoption Assistance and Child Welfare Act of 1980, P.L. 96-272) requires states to set forth specific goals as to the maximum number of children who will remain in foster care for more than 24 months for each fiscal year. This requirement is consistent with the intent of the Federal legislation to improve services to children and their families, reducing the number of children removed from their families and increasing the number of children returned to their families from out-of-home placements. This requirement is also consistent with the goal of the Division under N.J.S.A. 30:4C-1 et seq., to provide all children with permanency planning. New Jersey has established that during Federal fiscal year 1983 and thereafter, no more than 2,150 children will remain in foster care for more than 24 months.

Social Impact

This readoption will continue New Jersey's compliance with the requirements of Federal law, and will permit the further receipt of Federal funds for child welfare services. This readoption will also state the child welfare services goals regarding the maximum number of children who will remain in foster care for more than 24 months, and will state the availability of the State Child Welfare Services Plan, developed through the State child welfare services planning process.

The State child welfare services planning process is a vehicle for the State to evaluate on an on-going basis its own performance in meeting and upgrading its standards in the area of child welfare services, specifically, prevention of out-of-home placement; prevention of child abuse and neglect; and reunification of children in out-of-home placements with their families.

Economic Impact

Readoption of these rules will continue New Jersey eligibility for Federal funds in the child welfare services area by fulfillment of Federal requirements. No direct or indirect impact on families served under programs partially or fully funded with Federal funds is anticipated.

Regulatory Flexibility Statement

The proposed readoption with an amendment does not impose any reporting, recordkeeping, or other compliance requirements on small businesses, as the term is defined by the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Accordingly, a regulatory flexibility analysis is not required. The proposed readoption with an amendment is intended to continue compliance with the Federal requirement to set forth specific goals as to the maximum number of children who will remain in foster care for more than 24 months.

Full text of the proposed readoption can be found in the New Jersey Administrative Code at N.J.A.C. 10:131.

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

10:131-1.1 State Child Welfare Services Plan

New Jersey develops an annual State Child Welfare Services Plan. Copies of the State Child Welfare Services Plan may be obtained from:

Division of Youth and Family Services
Office of Policy, Planning and Support
[One South Montgomery Street]
50 East State Street
CN 717
Trenton, New Jersey 08625-0717

LAW AND PUBLIC SAFETY**(b)****DIVISION OF CONSUMER AFFAIRS****STATE BOARD OF MARRIAGE COUNSELOR EXAMINERS****Annual License Fees and Charges****Proposed Amendment: N.J.A.C. 13:34-1.1**

Authorized By: State Board of Marriage Counselor Examiners,

Jeannette Balber, Executive Director.

Authority: N.J.S.A. 45:1-3.2 and 45:8B-13.

Proposal Number: PRN 1992-320.

Submit written comments by August 19, 1992 to:

Jeannette Balber, Executive Director
State Board of Marriage Counselor Examiners
Post Office Box 45007
Newark, New Jersey 07101

The agency proposal follows:

Summary

The Board of Marriage Counselor Examiners is proposing amendments to its fee schedule, N.J.A.C. 13:34-1.1, in order to cover increased investigative and program costs associated with the administration of the Board. The proposed amendments include a biennial license fee increase from \$130.00 to \$200.00.

All professional licensing boards within the scope of Subtitle 1 of Title 45 are required to be self-funding; that is, operating costs must be met through licensing and other fees. N.J.S.A. 45:1-3.2 also requires the boards to assess fees which are estimated not to exceed the amounts required to fund board operations. The proposed fee schedule will implement these statutory requirements and will prevent a fiscal loss to the Board. In the unlikely event excess funds are raised during any biennial licensing period, they will be carried over for the benefit of the Board.

Amendments are also proposed to reflect a determination of the Division of Consumer Affairs to create within the Division a uniform method of assessing and collecting professional board fees. In that regard, certain fees have been renamed: "application fee" replaces both

"examination of credentials" and "reexamination of credentials" and "late renewal fee" replaces "license revival fee." The proposal also designates an initial license fee and prorates that amount on an annual basis for the benefit of individuals who apply during the second year of a biennial renewal period. Additional format changes include an amendment to paragraph (a)6 to reflect the biennial, rather than annual, renewal fee, and amendments to paragraph (a)7 to delete unnecessary explanatory text. Reference to photocopying charges has been deleted since these charges are governed by N.J.S.A. 47:1A-1, the Right to Know Law. Finally, in order to accurately and specifically identify the actual elements for which the board incurs expenses, two new fees have been added: a duplicate license fee and a change of address fee.

Social Impact

Pursuant to N.J.S.A. 45:8B-1 et seq., the Board of Marriage Counselor Examiners is charged with the obligation of regulating the profession of marriage counseling in order to protect the public from unprofessional or unauthorized practice. The Board's administrative responsibilities under the statute include evaluating applicants for licensure and permits, investigating complaints and initiating appropriate disciplinary and enforcement actions. The new fee schedule, which will affect all current and potential licensees, will allow the Board to continue to protect the public health, safety and welfare by ensuring professional competence and the maintenance of high professional standards.

Economic Impact

The proposed fee increases should yield revenues sufficient to cover the rising expenses generated by the Board's statutory obligations and will enable the Board to continue to be self-funding, as required by N.J.S.A. 45:1-3.2.

The proposed fee increases will have a direct economic impact on Board licensees and permittees, who will be required to pay higher fees. The Board points out, however, that the fees proposed to be amended have not been raised in over seven years and that these increases are necessary to prevent a fiscal loss to the Board. To the extent the increases may be passed along to the client as a cost of doing business, the costs of professional services to the consumer may be increased.

Regulatory Flexibility Analysis

If, for the purposes of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., marriage counselors are deemed to be "small businesses" within the meaning of the statute, the following statements are applicable.

The Board of Marriage Counselor Examiners licenses approximately 1,040 individuals and issues permits to approximately 10 individuals annually. The proposed amendments, which constitute a general increase in the Board's fee schedule, do not involve any reporting or recordkeeping nor do they necessitate the retention of professional services for compliance. Rather, compliance requirements consist of paying increased licensing fees according to the new schedule. Since the fees have been set at the lowest amount that will cover the Board's operating expenses, the intent of the Regulatory Flexibility Act to minimize adverse economic impact upon small businesses has been implemented.

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

13:34-1.1 Annual license fees and charges

(a) There shall be paid to the State Board of Marriage Counselor Examiners the following fees:

- | | |
|---|------------|
| 1. Examination of credentials, which shall not be subject to refund | \$ 50.00 |
| 2. Reexamination of credentials, not subject to refund | \$ 25.00] |
| 1. Application fee | \$ 75.00 |
| 2. Initial license fee | |
| i. If paid during the first year of a biennial renewal period | \$200.00 |
| ii. If paid during the second year of a biennial renewal period | \$100.00 |
| 3. Examination fee | \$225.00 |
| 4. Verification of licensure | [\$ 10.00] |
| | \$ 25.00 |
| 5. Temporary permit | [\$ 50.00] |
| | \$ 75.00 |

- | | |
|--|------------|
| 6. License renewal fee, biennial | [\$ 65.00] |
| | \$200.00 |
| 7. Reinstatement fee | [\$100.00] |
| | \$125.00 |

[i. Upon verification acceptable to the Board that an individual has not practiced marriage or family counseling in private practice or otherwise practiced in New Jersey or used a previously issued New Jersey license in any manner, the annual license renewal fee during the inactive period will be waived. The fee to be paid, under these conditions, is the annual license renewal fee for the current period, \$65.00, the reinstatement fee, \$100.00, and the late license fee, \$50.00, if appropriate.

ii. In the absence of the above verification, the annual license renewal fee, \$65.00 for each year since last paid, is required in addition to the license reinstatement fee, \$100.00.

iii. The late renewal penalty or license revival fee shall be \$50.00 in addition to the annual license renewal fee of \$65.00.

8. License revival fee (for late license renewals) \$50.00

9. Photocopies: \$1.00 service charge plus \$1.00 for each page up to and including the first five pages and \$0.50 per page for every page thereafter.]

8. Late renewal fee

[10.]9. Replacement wall certificate

\$ 40.00

10. Duplicate license fee

11. Change of address

\$ 25.00

(a)

DIVISION OF CONSUMER AFFAIRS

State Board of Social Work Examiners Fees

Proposed New Rule: N.J.A.C. 13:44G-14.1

Authorized By: State Board of Social Work Examiners, Joseph P. Bordo, President.

Authority: P.L.1991, c.134 (N.J.S.A. 45:15BB-11).

Proposal Number: PRN 1992-301.

Submit written comments by August 19, 1992 to:

Leslie Aronson, Executive Director
State Board of Social Work Examiners
Post Office Box 45033
Newark, New Jersey 07101

The agency proposal follows:

Summary

The Social Workers' Licensing Act of 1991, P.L.1991, c.134 (N.J.S.A. 45:15BB-1 et seq., the "Act"), established the State Board of Social Work Examiners in the Division of Consumer Affairs. The Act requires the new Board to prescribe, pursuant to the provisions of N.J.S.A. 45:1-3.2, charges for certifications, licensures, renewals and other services performed by the Board. Accordingly, the Board of Social Work Examiners is proposing its first rule, N.J.A.C. 13:44G-14.1, in order to establish a fee schedule. Detailed regulations outlining qualification, education, experience and training requirements are currently being developed by the Board and will be proposed in a forthcoming issue of the New Jersey Register.

All professional licensing boards within the scope of Subtitle 1 of Title 45 are required to be self-funding; that is, operating costs must be met through licensing and other fees. N.J.S.A. 45:1-3.2 also requires the boards to assess fees which are estimated not to exceed the amounts required to fund board operations. The proposed fee schedule implements these statutory requirements. In the unlikely event excess funds are raised during any biennial licensing period, they will be carried over to the next biennial period for the benefit of the Board.

Social Impact

The proposed fee schedule, which will affect all potential licensees of the Board of Social Work Examiners, will enable the Board to discharge its statutory obligations under the Social Workers' Licensing Act of 1991. Among the Board's obligations under the Act are setting qualification, education, training and experience standards; evaluating

applicants for licensure and certification; and regulating the practice of social work. The proposed fee schedule will provide the Board with the minimum financial resources necessary to discharge its responsibility to protect the public health and welfare by promoting high standards of professional performance for those presently practicing as social workers and for those who will be licensed or certified to do so.

Economic Impact

The proposed fee schedule should yield revenues sufficient to cover the expenses generated by the Board's many statutory obligations: evaluation of applicants for licensure and certification; issuance of licenses and certificates; investigation of complaints; initiation and prosecution of disciplinary actions; and addressing issues relevant to the practice of social work.

A direct economic impact is imposed on Board licensees, who will be required to pay a \$75.00 application fee and the initial licensing or certification fee. The initial fee for a licensed clinical social worker is \$220.00; for a licensed social worker, \$160.00; and for a certified social worker, \$100.00. These initial fees have been prorated for the benefit of individuals applying during the second year of a biennial renewal period. These individuals will be required to pay only one-half of the initial fee for the one year remaining in the biennial period. Renewal fees are the same as initial licensing and certification fees. The proposed fee schedule also establishes late renewal and reinstatement fees as well as other miscellaneous charges to cover Board administrative expenses. An examination fee is not included in the fee schedule, as applicants will be required to pay this fee directly to the Board-approved testing service. While the Board is aware of the financial hardships faced by many individuals during the current economic recession, as stated above it is required by statute to raise funds to cover operating expenses. The Board has endeavored to keep the proposed fees at the minimum level necessary to cover estimated expenses.

The proposed fee schedule does not impose direct costs upon the public or the social work client. While the proposed rule may have an indirect impact on the public to the extent the proposed fees may be passed along to the client as a cost of practice, the Board cannot estimate with any certainty at this time whether the rule will result in indirect costs to the public.

Regulatory Flexibility Analysis

The Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., requires the Board to give a description of the types and an estimate of the number of small businesses to which the proposed rule will apply. The Act defines a small business as "any business which is resident in this State, independently owned and operated and not dominant in its field, and which employs fewer than 100 full-time employees." On the assumption that the Act is applicable to individual practicing social workers, the following analysis applies:

The Board anticipates that a total of approximately 12,000 individuals will be licensed or certified as social workers, approximately 4,000 in each of the three categories of social workers: licensed clinical social worker, licensed social worker, and certified social worker. The proposed rule does not involve any reporting or recordkeeping, nor does it necessitate the retention of professional services for compliance. The only compliance requirement is completing the application form and paying the appropriate licensing or certification fee in a timely manner. Since the fees have been set at the lowest amount that will cover the Board's operating expenses, the intent of the Regulatory Flexibility Act to minimize adverse economic impact has been implemented.

Full text of the proposed new rule follows:

SUBCHAPTER 14. FEES

13:44G-14.1 Fees

(a) Charges for licensure, certification and other services are:

1. Application fee \$75.00
2. Initial clinical license fee:
 - i. If paid during the first year of a biennial renewal period 220.00
 - ii. If paid during the second year of a biennial renewal period 110.00
3. Initial license fee:
 - i. If paid during the first year of a biennial renewal period 160.00
 - ii. If paid during the second year of a biennial renewal period 80.00

4. Initial certification fee:

- i. If paid during the first year of a biennial renewal period 100.00
- ii. If paid during the second year of a biennial renewal period 50.00
5. Clinical license renewal fee, biennial 220.00
6. License renewal fee, biennial 160.00
7. Certification renewal fee, biennial 100.00
8. Late renewal fee 100.00
9. Reinstatement fee 150.00
10. Endorsement fee 75.00
11. Duplicate wall certificate 40.00
12. Change of address 25.00
13. Verification of licensure/certification 40.00
14. Verification of continuing education credits 40.00

(a)

DIVISION OF CONSUMER AFFAIRS BUREAU OF SECURITIES

Bureau of Securities Rules

Proposed Readoption with Amendments: N.J.A.C.

13:47A-1 through 11

Proposed Repeal: N.J.A.C. 13:47A-4.3

Authorized By: A. Jared Silverman, Chief, Bureau of Securities.

Authority: N.J.S.A. 49:3-67(a).

Proposal Number: PRN 1992-319.

Submit written comments by August 19, 1992 to:

A. Jared Silverman, Chief
Bureau of Securities
153 Halsey Street
Newark, New Jersey 07101

The agency proposal follows.

Summary

The Bureau of Securities makes this proposal in order to: (1) readopt existing rules with some revisions prior to their expiration on October 5, 1992, pursuant to Executive Order No. 66(1978), and (2) specifically modify existing rules to allow New Jersey to fully participate in the Central Registration Depository (CRD) Phase II.

A. Readoption of rules

Pursuant to Executive Order No. 66(1978), the Bureau's current regulations automatically sunset on October 5, 1992. Without readoption or promulgation of new rules, the Bureau would be without rules after that date. The current rules include rules adopted as recently as 1990. These rules are included in those proposed for readoption without amendment. Specifically, the rules proposed for readoption without amendment are N.J.A.C. 13:47A-2 concerning investment advisors, 13:47A-6 concerning qualified issuers, 13:47A-7.2 through 7.4 concerning miscellaneous definitions, 13:47A-10 concerning securities offerings and 13:47A-11 concerning forms. As amended, the Bureau considers these rules to be reasonable, necessary and proper for the purpose for which they were originally promulgated.

B. CRD Phase II

CRD is a joint venture of the North American Securities Administrators Association (NASAA) and the National Association of Securities Dealers (NASD). NASAA is the organization of the state, provincial and territorial securities administrators in the United States, Canada and Mexico, who are responsible for investor protection and efficient functioning of the capital markets at the grassroots level. NASD is an industry organization of securities dealers which has, among other things, certain self-regulatory powers granted to it by Federal statute.

The CRD System provides information about NASD registered securities broker-dealers and their agents (or sales representatives). CRD also provides a place where a single registration statement may be filed electronically by broker-dealers and agents to effectively apply for registration in any state, province or territory that participates in the System. Currently, 47 states participate in CRD Phase II.

While New Jersey has allowed agents to register through CRD (Phase I), broker-dealers have had to register by filing a paper application with

the Bureau. This means that while broker-dealers can file one application with the CRD to apply for registration in 47 states, they have had to file a separate non-uniform application to register in New Jersey.

By this proposal, the Bureau seeks to revise its rules to allow New Jersey to fully participate in CRD. This will permit broker-dealers to apply for registration in New Jersey using the uniform CRD process, reduce the industry's regulatory costs and streamline the registration process.

The benefit to the Bureau will be that registrations will be less paper intensive. While the Bureau currently has read-access to some parts of the broker-dealer applications filed with CRD, it currently accepts only paper applications. The proposed amendments will allow the Bureau to take full advantage of the automation provided by the CRD and will move the Bureau closer to the eventual goal of a paperless registration.

The Bureau believes that the vast majority of the broker-dealers registered in New Jersey are NASD members and therefore are eligible to participate in CRD Phase II. They may indeed be using CRD for registration in other states.

However, certain broker-dealers are not NASD members and are not eligible to participate in CRD Phase II. As a result, the proposed amendments in certain cases continue to allow direct filing with the Bureau. Ideally, the older provisions would have been deleted, but some broker-dealers will still have to register directly with the Bureau. This necessitates the retention of the older provisions.

N.J.A.C. 13:47A-1.1 through 1.13 are the broker-dealer regulations where most of the substantive changes embodied in this proposal occur. N.J.A.C. 13:47A-3.1 and 3.2 deal with agents. The agent provisions have been amended to reflect the Bureau's current practice of registering agents of NASD member firms via CRD. N.J.A.C. 13:47A-4.1 through 4.3 deal with securities examinations. Since New Jersey currently relies on examinations given by NASD and does not give its own, these provisions have been amended to reflect that N.J.A.C. 13:47A-5.1 through 5.3 are amended because they deal with renewals of registration, including broker-dealer registrations. The amendments will allow the renewals to be processed through the CRD. N.J.A.C. 13:47A-7.1 has been changed to allow for use of the Consent to Service of Process on the CRD's form, and N.J.A.C. 13:47A-7.5 is amended to take into account CRD filed applications when expediting an application. N.J.A.C. 13:47A-7.6 through 7.8 are transition rules. N.J.A.C. 13:47A-8.1, concerning penalty assessment, has had technical amendments.

Social Impact

A. General readoption

As noted below in the Economic Impact, the rules proposed for readoption will serve the investing public by maintaining the Bureau's ability to regulate the securities industry and take enforcement action against those who would defraud the public or fail to disclose the information to potential investors necessary for the investor to make an informed investment decision. The Uniform Securities Law (1967), N.J.S.A. 49:3-47 et seq. and the rules implementing the Law help maintain the confidence in and the integrity of the securities markets and securities industry in New Jersey.

B. CRD Phase II Amendments

The streamlining and simplification of the registration process should benefit investors in improved service from the Bureau and the industry as a result of less resources being devoted to the administrative function of processing registrations. Both the Bureau and the industry will be freed up to do other things with their resources than generate, review and process applications. Possibly, the industry could pass some of these saved transaction costs onto investors. The public will benefit from a more responsive Bureau because a large administrative burden on the Bureau will have been removed by these regulations.

Economic Impact

A. General readoption

The Bureau of Securities is the State agency charged with the protection of investors through enforcement of N.J.S.A. 49:3-47 et seq. That statute, known as the Uniform Securities Law (1967), P.L. 1967, c.93, gives the Bureau the power to license and regulate the business activities of broker-dealers, investment advisors and issuers of securities who are offering, selling, or purchasing or advising others on the value of securities. The goal of the Law is investor protection through disclosure to investors of material information about a potential investment. This

allows an investor to make an informed decision free of fraud and other manipulations by members of the securities business. The law allows the Bureau to assess penalties and take other enforcement action against violators of the law, including court action. The State regulation of the securities industry exists concurrently with the jurisdiction of the Federal Securities and Exchange Commission. The State regulation provides a necessary enforcement component of the regulatory scheme for the securities industry. The rules proposed for readoption with amendments permit the Bureau to implement the provisions of the statute. Without these regulations, the Bureau would be unable to fulfill its statutory mandate of investor protection.

The Uniform Securities Law requires broker-dealers, investment advisors, agents and qualified issuers to file with the Bureau of Securities, and keep current, a registration application to be licensed and do business within the State. The information contained in these applications must be amended as necessary by the registrant to keep the information current and accurate. Ninety-nine percent of the registered broker-dealers and agents will have less of a burden in filing and amending their applications after promulgation of these rules because the rules allow them to file centrally and electronically with the CRD. Investment advisors and qualified issuers will continue to file and amend their registration applications directly with the Bureau of Securities because electronic filing currently is unavailable for these registrants.

B. CRD Phase II Amendments

Utilization of CRD's uniform, electronic filing will streamline and simplify the broker-dealer registration process for the industry and for the Bureau. This should result in less regulatory cost for the broker-dealers. The use of uniform forms and filing standards, and one electronic filing to apply for registration nationwide, will greatly benefit broker-dealer applicants. The Bureau should be able to process the broker-dealer applications more efficiently. Administrative costs to the Bureau should decrease or at least not increase. This may allow the Bureau to divert some resources from registration functions to enforcement functions.

There are no changes to the registration fee structure in this proposal, except that those broker-dealers filing their applications via the CRD will pay the fee for New Jersey along with the fees for other states directly to the NASAA/CRD. The CRD then will divide up the fees and pay the amounts due to the various states. This system of payment allows the broker-dealers to maintain an account with the CRD that the CRD draws upon as appropriate. The CRD then sends one check and a list of payees to each state periodically. The administrative burdens for the broker-dealers and the states are greatly reduced.

Failure to adopt these amendments will result in continued administrative burdens upon the State both for the processing of the individual paper broker-dealer applications and for the fees. The Bureau currently registers approximately 1600 broker-dealers on a biennial basis. Without CRD, broker-dealers would have to continue to file a separate application and fees in New Jersey in addition to the application and fees filed with the CRD. Adoption of these amendments would not dilute or impair in any way the State's right to review an application or request additional information from an applicant before allowing the applicant to be registered. Likewise, the State continues to receive the fees from applicants.

There will be a temporary reduction in Bureau revenues in the year immediately following adoption of the proposed amendments. Applicants registering by CRD will pay one-half of the biennial fee each year. The second half of the fee will not be due and payable until the beginning of the second year. Currently, the entire fee is paid at the time of initial registration the first year.

Regulatory Flexibility Analysis

The proposed rules will establish mechanisms whereby broker-dealer applicants for registration in New Jersey may file their applications and fees for registration with the CRD instead of filing a paper application directly with the Bureau of Securities in Newark. These mechanisms, along with the use of uniform forms and the requirement of one filing to perfect registration nationwide is an attempt to decrease the burden on the industry in general and on small businesses as defined in the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. There are no additional reporting or recordkeeping requirements imposed by these proposed rules above those currently required to effectuate a registration. Most applicants will see a reduction in their paperwork as a result of these rules, by virtue of the electronic filing via the CRD.

While some of the broker-dealers registered with the Bureau of Securities are small businesses, the Bureau currently has no definitive way to determine which of its registrants are small businesses, as defined by the aforementioned Act. The registration requirements and associated costs are mandated by State law, are the same for small and large businesses and are similar to Federal requirements governing the securities industry. Professional services of attorneys and accountants may be required for certain aspects of the application process, but the impact of these regulations upon the need for professional services is marginal, since New Jersey is only one of more than 60 North American jurisdictions requiring the registration of businesses and persons involved in the securities industry. The registration requirements are outlined in paragraph 2 of part A in the Economic Impact section. There are some lesser requirements or exemptions from registration by statute for certain small businesses engaged in certain limited securities transactions. There is no need to duplicate the statutory provisions in the rules.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 13:47A. (OFFICE OF ADMINISTRATIVE LAW NOTE: N.J.A.C. 13:47A-9, 15, 16, 17, 18, 19 and 20, which currently appear in the New Jersey Administrative Code, expired September 6, 1987, as they were not proposed for readoption at that time (see 19 N.J.R. 1471(a)). They were, however, inadvertently retained in the Code, and will be deleted therefrom upon adoption of this proposal.)

Full text of the proposed amendments and repeal follow (additions indicated in boldface **thus**; deletions indicated by brackets [thus]):

13:47A-1.1 Application for registration for NASD members

(a) Any person who is a member of the National Association of Securities Dealers, Incorporated (NASD), desiring to transact business in the State of New Jersey as a broker-dealer shall file an application with the Bureau of Securities by filing the application with the NASAA/NASD Central Registration Depository (CRD) on the [a] form designated [N.J. Form SB-1 as set forth in N.J.A.C. 13:47A-11.1 (Broker-dealer application (SB-1))] as Form BD, Uniform Application for Broker-Dealer Registration, or any successor form to the Form BD prescribed by the CRD for filing a broker-dealer application. [Such application shall be accompanied by the following:] The requisite registration fee shall be submitted with the application filed with the CRD in the amount of \$250.00 for each year of the two year registration term for the broker-dealer (for a total of \$500.00), plus \$10.00 for each officer, director or partner doing business in the State of New Jersey. Failure to pay the entire \$500.00 fee plus additional required fees, as above, within the billing time limits established by the Bureau or by the CRD, shall be a ground for immediate revocation of the registration. The application filed with the CRD shall be supplemented by direct filing with the Bureau of Securities of any additional information required by the Bureau Chief. The 30 day time period for review of an application will not commence until the applicant files all documents or material facts specified and required. The following additional information shall be required to be filed with the Bureau of Securities for all broker-dealer applications and no application shall be deemed complete until all of the following are properly submitted, unless the requirements are waived by the Bureau Chief:

1. A consent to service of process executed by the applicant as set forth in N.J.A.C. 13:47A-7.1;

2. A consent to service of process executed by each officer, director, general partner or limited partner of the applicant who is to act as an agent in the State of New Jersey, as set forth in N.J.A.C. 13:47A-7.1; [and]

3. [A certified] Certified financial statements[,] as set forth in N.J.A.C. 13:47A-1.3, 1.4 and 1.5; [The application shall also be accompanied by a check or money order payable to the State of New Jersey, Bureau of Securities, in the amount of \$500.00 plus \$10.00 for each officer, director or partner doing business in the State of New Jersey.]

4. A statement of minimum net capital as set forth in N.J.A.C. 13:47A-1.6;

5. A statement of the nature and location of each business in which the applicant has engaged during the preceding five years; and

6. Any additional information requested by the Bureau Chief.

(b) The applicant shall [also] submit to the Bureau of Securities as part of the application an identification photograph of each partner, officer or director, unless the applicant is a member of and has current photographs on file with the New York Stock Exchange, American Stock Exchange, another major stock exchange, or the [National Association of Securities Dealers, Incorporated] NASD; and has granted written permission to the [Chief of the] Bureau [of Securities] Chief, or his or her duly designated representative, to examine without notice any filings made by the applicant with such exchange or association.

(c) The applicant, if a natural person, shall [also] submit [in connection with the aforesaid Form SB-1] to the Bureau of Securities as part of the application, two (non-criminal) fingerprint cards (one State Police card and one Federal Bureau of Investigation card) with impressions taken by a recognized law enforcement agency.

(d) The applicant, if a corporation or partnership, shall [also] submit [in connection with the aforesaid Form SB-1] to the Bureau of Securities as part of the application, two applicant (non-criminal) fingerprint cards (one State Police card and one Federal Bureau of Investigation card) for each officer, director, controlling person or partner with all of the impressions taken by a recognized law enforcement agency [for each officer, director, controlling person or partner].

(e) Subsections (c) and (d) [of this section] above shall not apply to an applicant who is a member of the New York Stock Exchange, [or] the American Stock Exchange or the NASD.

(f) If, during the pendency of the application, it appears to the Bureau Chief that the application may contain a misrepresentation, may omit a document or material fact, or contains any statement which may be, at the time and in the light of the circumstances under which it is made, false or misleading in any material respect, the Bureau Chief, in his or her discretion, may notify the applicant of the deficiency by letter. A deficiency letter shall require the applicant to perfect the application by amending or supplementing the information previously submitted within 21 days after the issuance of the deficiency letter; withdraw the application; or subject itself to further action of the Bureau Chief by Order or otherwise. If the applicant elects to perfect the application within 21 days, the amendment or supplement by the applicant shall postpone the effectiveness of the application for 30 days after the applicant perfects the application. The Bureau Chief may elect, in his or her discretion, to act without issuing a deficiency letter.

13:47A-1.2 Application for registration for persons not eligible for registration via CRD

Any person desiring to transact business in the State of New Jersey who is not a member of the NASD or who is not otherwise eligible to register via the CRD pursuant to N.J.A.C. 13:47A-1.1, shall file all of the information required by N.J.A.C. 13:47A-1.1 and in the same form required by that section directly with the Bureau of Securities at its current office address. The application shall be accompanied by a check or money order payable to the State of New Jersey, Bureau of Securities, in the amount of \$500.00, plus \$10.00 for each officer, director or partner doing business in the State of New Jersey.

13:47A-[1.2]1.3 Financial reports to [accompany] supplement application

(a) An application for registration as a broker-dealer [shall include] must be supplemented by a concurrent filing directly with the Bureau of Securities of a certified statement of the applicant's financial condition as of a date within 60 days of the application; provided, however, if the applicant has been engaged in business for one year or more preceding the date of the application, a certified financial statement as of the end of its last fiscal period, along with an unaudited balance sheet as of a date within 60 days of the application may be submitted directly to the Bureau concurrently with the filing of the application for registration. The concurrent filing will be considered to be a necessary part of the registration application, whether the application is filed via the CRD for NASD members, or directly with the Bureau for non-NASD members.

(b) The balance sheet must be signed by a principal or officer of the applicant and must be notarized.

13:47A-[1.3]1.4 Annual financial report

[(a)] Every registered broker-dealer must file with the Bureau Chief an annual certified report of financial condition during each calendar year. Said report will be due not later than 60 days after the termination date of each report; provided that reports for any two consecutive years shall not be as of termination dates within four months of each other. [(b)] Requests for extensions of time for the filing of the report must be made in writing to the Bureau Chief in advance of the due date[s].

13:47A-[1.4]1.5 Preparation and contents of financial statements

(a) Financial statements and reports required of registered broker-dealers under [this Act] N.J.S.A. 49:3-47 et seq., including the financial statement filed with the application for initial registration, shall consist of a balance sheet supported by an analysis of the trading and investment inventories and shall be prepared by a certified public accountant or a public accountant who shall be in fact independent.

(b) Complete copies of Form X-17A-5, as filed with the Securities and Exchange Commission, or copies of the New York Stock Exchange Financial Questionnaire may be filed [in compliance] to comply with the[se] requirements of this section.

(c) The analysis of the trading and investment inventories required by [subsection] (a) [of this Section] above shall have attached thereto, and made a part thereof, a statement under oath by the broker-dealer which [statement] shall set forth those securities within said trading and investment inventories which have not been registered under the Securities Act of 1933 (1933 Act), or which are not subject to, or are exempted from the registration requirements of the [Securities Act of] 1933 Act and the rules and regulations promulgated thereunder other than by reason of section 3(a) of [such] the 1933 Act and the rules and regulations promulgated under [said] section 3(a) of the 1933 Act.

13:47A-[1.5]1.6 Minimum net capital

(a) No registration as a broker-dealer shall be issued unless the applicant therefor has a minimum net capital of \$10,000 or has posted with the Bureau of Securities a surety bond in the amount of \$10,000, except as set forth in (b) and (c) below. Under all subsections of this section, if the applicant has been in business for less than one year, the statement of minimum net capital submitted as part of the broker-dealer application must include a written statement of the applicant's source of capital.

(b) No registration as a broker-dealer shall be issued to an applicant engaged exclusively in the sale of investment company shares unless the applicant therefor has a minimum net capital of \$5,000, or has posted with the Bureau of Securities a surety bond in the amount of \$5,000. The statement of minimum net capital submitted as part of the broker-dealer application must include a written statement that the applicant purchases or sells solely investment company shares in order to qualify under this subsection.

(c) No registration as a broker-dealer shall be issued to an applicant having custody of clients' funds or securities unless such applicant has a minimum net capital of \$25,000 or has posted with the Bureau of Securities a surety bond in the amount of \$25,000. The statement of minimum net capital submitted as part of the broker-dealer application must include a written statement that the applicant has custody of clients' funds or securities, if such is the case.

(d) Computation of net capital shall be in accordance with rules promulgated by the Securities and Exchange Commission, unless the Bureau Chief prescribes otherwise by rule or order.

(e) Reporting of net capital by a broker-dealer shall be made as part of the application for registration with the CRD in the case of broker-dealers eligible for such registration. If the CRD registration form does not provide for reporting of net capital as set forth in this section, or if the registration is filed directly with the Bureau of Securities because CRD registration is not available to the applicant, then the reporting of net capital shall be made by a supplemental filing made directly to the Bureau of Securities concurrently with the broker-dealer application.

13:47A-[1.6]1.7 Bonds

(a) The bonds required to be filed under [section 1.5] N.J.A.C. 13:47A-1.6 (Minimum net capital) [of this Subchapter] shall provide for suit thereon by third parties for any cause of action under [Section 71, Chapter 93, Laws of 1967] N.J.S.A. 49:3-71, for loss and damages, and shall be in the form designated N.J. SB-7 as set forth in N.J.A.C. 13:47A-11.10. The bond shall be for a term of two years, but the right to bring an action under [such] the bond for losses sustained while it was in force shall continue for two years from the date of the sale upon which [such] the action is based.

(b) The bond may provide for termination provided, however, that 90 days' notice thereof is served in writing upon the [Chief of the] Bureau [of Securities] Chief; and[,] provided further, that the right to bring an action for losses sustained while it was in force shall continue for two years from the date of the sale upon which [such] the action is based.

13:47A-[1.7]1.8 Cash or securities in lieu of bond

In lieu of the bonds required by [Section 1.5] N.J.A.C. 13:47A-1.6 (Minimum net capital) [of this Subchapter], the applicant may deposit cash or securities with the [Chief of the] Bureau [of Securities] Chief, and the amount thereof shall be determined by the Bureau Chief having due regard for the amount of the bond required and the nature of the securities furnished. No securities other than those listed on the New York Stock Exchange or the American Stock Exchange will be accepted, except that mutual funds may be accepted in certain cases, in the discretion of the Bureau Chief.

13:47A-[1.8]1.9 Change of status; submission of form

(a) A registered broker-dealer who is registered with New Jersey via the NASAA/NASD CRD shall file [with the Bureau of Securities a form designated N.J. Form SB-4, as set forth in N.J.A.C. 13:47A-11.4 and promulgated herewith] an amendment with the CRD on the amendment form prescribed by the NASAA/NASD CRD whenever [it changes] any of the following events occur:

1. Its firm name is changed;
2. Its principal office address is changed; [or]
3. The address of a branch office within the State of New Jersey[.] is changed;

[(b) Such form shall be filed no later than 20 days after the occurrence named therein and shall be accompanied by a check or money order in the amount of \$5.00 for each change listed.

(c) A registered broker-dealer shall file with the Bureau of Securities a form designated N.J. Form SB-4, as set forth in N.J.A.C. 13:47A-11.4, whenever a]

4. A new officer, director or partner is elected or admitted to the firm. [Such form] This shall be [accompanied] supplemented by a [rider] direct filing with the Bureau of a document setting forth the home address and 10 year business history of the officer, director or partner and a check or money order in the amount of \$5.00 for each individual listed[.]. The form shall be filed no later than 20 days after the occurrence named therein.]

5. It commences the employment of an agent currently effectively registered in the State of New Jersey. This amendment shall be filed no later than five days after the commencement of such employment;

6. A partner, officer or director of the registered broker-dealer resigns, retires or otherwise terminates his or her affiliation with the broker-dealer. No filing fee is required for this type of amendment, unless the NASAA/NASD CRD prescribes otherwise;

7. The registered broker-dealer terminates the employment of an agent. This amendment shall be filed within five days of the termination. No filing fee is required for this type of amendment, unless the NASAA/NASD CRD prescribes otherwise;

8. Subsections (d), (e), and (f) below require an amendment to be filed; or

9. Any other event has occurred that would require an amendment to the Form BD Uniform Application for Broker-Dealer Registration.

(b) A registered broker-dealer that is registered pursuant to N.J.A.C. 13:47A-1.2 (registrants not eligible for registration via the CRD and therefore registered directly with the Bureau of Securities) shall file directly with the Bureau at its current office address, a

form designated N.J. Form SB-4, as set forth in N.J.A.C. 13:47A-11.4, whenever it changes any of the information set forth in (a) above. Alternatively, the broker-dealer may use the same form required by the CRD to file an amendment directly with the Bureau in lieu of filing the Form SB-4, whenever it changes any of the information set forth in (a) above.

(c) Such amendment to the CRD or N.J. SB-4 form, as applicable, shall be filed no later than 20 days after the occurrence named therein, unless otherwise specified in (a) above. The amendment filed with the CRD shall be accompanied by the fee, if any, prescribed by the NASAA/NASD CRD for amendments. Filing of a N.J. SB-4 form as required by (b) above shall be accompanied by a check or money order in the amount of \$5.00 for each change listed, unless otherwise specified in (a) above.

(d) A registered broker-dealer shall file with the Bureau of Securities a [form designated New Jersey Form] N.J. Form SB-4 form, as set forth in N.J.A.C. 13:47A-11.4 or file with the CRD the equivalent CRD amendment form and fee as prescribed by the NASAA/NASD CRD, [Whenever] whenever any changes occur regarding the original answers to question 5 on its original N.J. SB-1 broker-dealer application as to arrests, conviction of any crime, disciplinary actions by any administrative body, restraints, injunctions, suspensions, revocations, denials, judgments based on fraud, as to the registrant or any partner, officer or director, within 20 days of the occurrence named [therein] in the form. Such [form] N.J. Form SB-4 shall be accompanied by a check or money order in the amount of \$5.00.

(e) [A registered broker-dealer shall file with the Bureau of Securities a form designated New Jersey form SB-4, as set forth in N.J.A.C. 13:47A-11.4, when it commences the employment of an agent currently effectively registered in the State of New Jersey, no later than five days after the commencement of such employment. The form must be accompanied by a check or money order in the amount of \$5.00.] For a registered broker-dealer that has filed its broker-dealer application with the CRD on Form BD that has had any changes occur regarding the answers in its original Form BD application as to arrests, conviction of any crime, disciplinary actions by any administrative body, restraints, injunctions, suspensions, revocations, denials, judgments based on fraud, as to the registrant or any partner, officer or director shall file an amendment with the CRD fully disclosing the details of the changes within 20 days of the occurrence named in the amendment. Such amendment shall be accompanied by the fee, if any, prescribed by the NASAA/NASD CRD for amendments. In the event that the CRD amendment form does not allow for full detailed disclosure of the details of the changes, as required by the Uniform Securities Law (1967), N.J.S.A. 49:3-47 et seq. and these rules, the registrant shall make full detailed disclosure of the changes by a supplemental filing directly to the Bureau of Securities at its current office address.

[(f) A registered broker-dealer shall file with the Bureau of Securities a form designated New Jersey form SB-4, as set forth in N.J.A.C. 13:47A-11.4, whenever a partner, officer or director resigns, retires, or otherwise terminates his affiliation, within 20 days of the occurrence named therein. No filing fee is required.

(g) A registered broker-dealer shall file with the Bureau of Securities a form designated New Jersey form SB-4, as set forth in N.J.A.C. 13:47A-11.4, when it terminates the employment of an agent within five days of the occurrence named therein. No filing fee is required.

(h) A registered broker-dealer shall not file the form designated New Jersey form SB-4 when it is submitting the application for the initial registration of an agent commencing with the registrant.]

[(i)](f) A registered broker-dealer, if a corporation or partnership, shall file with the Bureau of Securities or the CRD, whichever is applicable, two applicant (non-criminal) fingerprint cards (one State Police card and one Federal Bureau of Investigation card) with all of the impressions taken by a recognized law enforcement agency, for each officer, director, controlling person or partner who commences any employment or affiliation with said registered broker-dealer no later than five days after the commencement of such employment or affiliation.

(g) A registered broker-dealer that filed its broker-dealer application directly with the Bureau of Securities shall not file the N.J. Form SB-4 when it is submitting the application for the initial registration for an agent commencing with the registrant, but shall register that agent by submitting a Consent to Jurisdiction form directly to the Bureau of Securities no later than five days after the commencement of such employment or affiliation. [(j) Subsection (h) of this Section shall not apply to any said] An officer, director, controlling person or partner of the registered broker-dealer may submit their initial agent application by use of the N.J. Form SB-4, if that person [who] has filed an applicant fingerprint card with the Bureau of Securities or with the CRD [an applicant fingerprint card]. All other registered broker-dealers must submit their initial agent applications via the CRD in accordance with the requirements of the CRD.

[(k) Subsection (h) of this Section shall not apply to a registered broker-dealer who is a member of the New York Stock Exchange or American Stock Exchange.]

13:47A-[1.9]1.10 Maintenance of books and records

All broker-dealers shall keep at their principal place of business, open to inspection of the Bureau of Securities of the State of New Jersey, all books and records required to be kept by the Securities and Exchange Commission or by the Bureau of Securities.

13:47A-[1.10]1.11 Withdrawal of broker-dealer registration

(a) A [registered] broker-dealer registered in New Jersey via the CRD shall file a Form BDW or any successor form to the Form BDW prescribed by the CRD [with the Bureau of Securities a form designated N.J. Form SB-10, as set forth in N.J.A.C. 13:47A-11.13] when it desires to withdraw its registration as a broker-dealer in the State of New Jersey. Such request for withdrawal will become effective 30 days after filing with the [Bureau of Securities] CRD.

(b) A broker-dealer registered in New Jersey by direct filing with the Bureau of Securities because it is not eligible for registration via the CRD shall file directly with the Bureau a form designated N.J. Form SB-10, as set forth in N.J.A.C. 13:47A-11.13, when it desires to withdraw its registration as a broker-dealer in the State of New Jersey. Such request will become effective 30 days after filing with the Bureau.

13:47A-[1.11]1.12 Display of name

The name of the registered broker-dealer shall appear on the door or window of any branch or sales office operated within the State of New Jersey.

13:47A-[1.12]1.13 Application for successor

(a) A broker-dealer registered in New Jersey via the CRD shall file the forms or amendments as required by the CRD to effectuate registration in New Jersey of a successor to the registered broker-dealer. The filing shall be accompanied by the fee, if any, prescribed by the CRD for such filings.

(b) A [registered] broker-dealer registered in New Jersey by direct filing with the Bureau of Securities because it is not eligible for registration via the CRD may file [an application] directly with the Bureau [of Securities] an application on a [form designated New Jersey form SB-1, as set forth in N.J.A.C. 13:47A-11.1, for] Form BD, Uniform Application for Broker-Dealer Registration, accompanied by all of the information required by N.J.A.C. 13:47A-1.1 and in the same form as required by that section to effectuate the registration of a successor. Such application shall be marked "SUCCESSOR APPLICATION" in the upper right-hand corner by the registrant, and shall be accompanied by a consent to service of process executed by the applicant. There shall be no filing fee for the successor application.

13:47A-3.1 [Application for registration] Agents of Broker-Dealers and Qualified Issuers

(a) Any person desiring to act in the State of New Jersey as an agent of a registered broker-dealer registered directly with the Bureau of Securities or as an agent of a qualified issuer shall file an application with the Bureau of Securities on a form designated [New Jersey form] N.J. Form SB-3, as set forth in N.J.A.C. 13:47A-11.3. [(b)] Such application shall be accompanied by:

1. A consent to service of process executed by the applicant; [and]
 2. Two applicant non-criminal fingerprint cards (one State Police card and one FBI card) with impressions taken by a recognized law enforcement agency[.]; and

[3. Paragraph (b)2 above shall not apply to an applicant who is employed as an agent of a member of a self-regulatory organization as that term is defined in Section 26 of the Securities Exchange Act of 1934 as amended (15 U.S.C.A. 78c(a)(26)) and who has submitted fingerprints as part of an application reviewed by and passed upon by such self-regulatory organization. (c) A] 3. A check or money order made payable to the State of New Jersey, Bureau of Securities, in the amount of \$60.00 [must also accompany the application forms].

(b) Any person desiring to act in the State of New Jersey as an agent of a broker-dealer registered in New Jersey via the NASAA/NASD CRD shall file an application for registration as an agent with the CRD on the agent application form prescribed by the NASAA/NASD CRD. The agent application shall be accompanied by a consent to service of process executed by the applicant; fingerprint cards as required by the NASAA/NASD CRD; and payment in the form prescribed by the CRD of \$30.00 for each year of the two year registration period (for a total of \$60.00).

13:47A-3.2 Change of status; agents; submission of form.

(a) A registered agent who previously filed their application for registration directly with the Bureau of Securities shall file, directly with the Bureau of Securities, a form designated [New Jersey form] N.J. Form SB-5, as set forth in N.J.A.C. 13:47A-11.5, whenever [he] the agent changes [his: 1. Names] their name or [2. Home] home address[. (b) Such form shall be filed no later than 20 days after the occurrence named therein and shall be accompanied by a check or money order in the amount of \$5.00 for each change listed. (c) A registered agent shall file with the Bureau of Securities a form designated N.J. Form SB-5, as set forth in N.J.A.C. 13:47A-11.5] and whenever a change in the answers to question 13 on his original application for registration occurs, as to arrests, convictions of any crime, disciplinary actions by any administrative body, restraints, injunctions, suspensions, revocations, denials, or judgments based on fraud[.]. The N.J. Form SB-5 must be filed within 20 days of the occurrence named therein[. Such form shall] and be accompanied by a check or money order in the amount of \$5.00 for each change listed under this subsection. [(d) A registered agent shall file with the Bureau of Securities a form designated N.J. Form SB-5, as set forth in N.J.A.C. 13:47A-11.5, whenever] Whenever [he] an agent terminates or commences employment with a broker-dealer or issuer, the agent must file the N.J. Form SB-5 within five days of the [occurrence] termination or commencement. [Such form must be accompanied by a check or money order in the amount of \$5.00 if] If more than 30 days elapses between the date of termination and the commencement with the new broker-dealer or issuer, the form must be accompanied by a check or money order in the amount of \$5.00.

(b) A registered agent who previously filed for registration in New Jersey by filing an application with the NASAA/NASD CRD shall file an amendment with the CRD on the amendment form prescribed by the NASAA/NASD CRD whenever any of the events occur that are set forth in above (a). The amendment shall be filed in accordance with the time limits set forth in (a) above and shall be accompanied by the fee prescribed by the CRD for such amendments.

13:47A-4.1 Examinations for broker-dealers and investment advisors

No officer, director, partner or individual affiliated with a broker-dealer or investment advisor applying for registration in this State who will participate in management either as an investment advisor or in the offering or selling of securities either within or from this State, shall be so registered unless they have taken and successfully passed a securities examination approved by the Chief of the Bureau of Securities and offered by an independent self-regulatory group of the securities industry registered with the Securities and Exchange Commission, or taken and successfully passed a securities examination given by a state whose examination is recognized by the Bureau

of Securities of the State of New Jersey[, or who has taken and successfully passed a securities examination given by the Bureau of Securities of the State of New Jersey].

13:47A-4.2 Examinations for agents

No person may apply for registration as an agent in the offering or selling of securities, either within or from this State, unless he shall have taken and successfully passed a securities examination approved by the Chief of the Bureau of Securities and offered by an independent self-regulatory group of the securities industry registered with the Securities and Exchange Commission, or taken and successfully passed a securities examination given by a state whose examination is recognized by the Bureau of Securities of the State of New Jersey[, or who has taken and successfully passed a securities examination given by the Bureau of Securities of the State of New Jersey].

[13:47A-4.3 Application for examination

Any person desiring to apply for the New Jersey Securities examination must file with the Bureau of Securities a form designated "Application for New Jersey Securities Examination", as set forth in N.J.A.C. 13:47A-11.18. Such form must be accompanied by a check or money order made payable to the State of New Jersey, Bureau of Securities in the amount of \$15.00.]

13:47A-[4.4]4.3 Requests for waiver

(a) Requests for waiver of examination requirements will be considered only on the basis of knowledge, training and experience in the securities field. Any person requesting waiver must have been continuously active in the securities field for a period of at least two full years prior to the filing of the application.

(b) Requests for waiver must be submitted in writing directly to the Bureau Chief and [made part of] requested simultaneously with the application for registration [to be] filed with the CRD or the Bureau, as appropriate.

13:47A-5.1 Expiration date

Registration of a broker-dealer, investment advisor or agent shall expire on December 31 of the calendar year [next ensuing] following the year in which the registration became effective, unless revoked.

13:47A-5.2 Application for renewal

(a) A broker-dealer registered in New Jersey via the CRD that desires to apply for the renewal of its registration shall file the forms prescribed by the CRD to effectuate a renewal. Such application shall be accompanied by payment in the form prescribed by the CRD of \$250.00 for each year of the two year renewal term (for a total of \$500.00) plus \$10.00 for each partner, officer or director of the applicant doing business in New Jersey. Failure to pay the entire \$500.00 fee plus additional required fees, as above, within the billing time limits established by the Bureau or by the CRD, shall be a ground for immediate revocation of the registration.

[(a)](b) A [registered] broker-dealer [desiring] registered in New Jersey via direct registration with the Bureau of Securities that desires to apply for the renewal of its registration shall file on the form designated [New Jersey form] N.J. Form R-1, as set forth in N.J.A.C. 13:47A-11.14, issued to the registrant by the Bureau of Securities. Such application shall be accompanied by a check or money order made payable to the State of New Jersey, Bureau of Securities, in the amount of \$500.00 plus \$10.00 for each partner, officer or director of the applicant doing business in New Jersey.

[(b)](c) A registered investment advisor desiring to apply for the renewal of its registration shall file on the form designated [New Jersey form] N.J. Form R-1A, as set forth in N.J.A.C. 13:47A-11.15, issued to the registrant by the Bureau of Securities. Such application shall be accompanied by a check or money order made payable to the State of New Jersey, Bureau of Securities, in the amount of \$100.00.

(d) An agent registered in New Jersey via the CRD that desires to apply for the renewal of his registration shall file the forms prescribed by the CRD to effectuate a renewal. Such application shall be accompanied by payment in the amount of \$60.00 in the form prescribed by the CRD.

[(c)](e) [A registered] An agent [desiring] registered in New Jersey via direct registration with the Bureau of Securities that desires to apply for the renewal of his registration shall file on the form designated [New Jersey form] N.J. Form R-2, as set forth in N.J.A.C. 13:47A-11.16, issued by the Bureau of Securities in the name and registration number of the agent. Such application shall be accompanied by a check or money order made payable to the State of New Jersey, Bureau of Securities in the amount of \$60.00.

13:47A-5.3 Filing for renewal

(a) Applications for renewal will be issued by the Bureau of Securities during the month of October for investment advisors, qualified issuers, and for non-NASD member broker-dealers and their agents registered directly with the Bureau of Securities and must be filed by the registrant directly with the Bureau of Securities, not less than 30, nor more than 90, days before the December 31 expiration date of current registration[s], except as provided by the transition rule in N.J.A.C. 13:47A-7.7(e) for applicants that wish to renew their New Jersey registration via the CRD.

(b) Broker-dealers and agents currently registered in New Jersey via the CRD shall renew their applications in accordance with the requirements prescribed by the CRD and shall accompany the application with the fee prescribed by these regulations in the form prescribed by the CRD.

[(b)] (c) Any person who fails to apply for the renewal of its registration during the period specified in (a) above or by the CRD in connection with renewal under (b) above must make a new application for registration as set forth in [Subchapters 1 and 2 of this Chapter] these rules and may not submit the renewal application forms [which are] issued by the Bureau of Securities.

13:47A-7.1 Consent to service of process

(a) The irrevocable consent appointing the Bureau Chief or his or her successor in office as attorney to receive service of any lawful process in any noncriminal suit, action or proceeding against him shall be filed directly with the Bureau Chief [on form], for registrants whose application is or was filed directly with the Bureau of Securities, by filing concurrently with the application the Form SB-6I for [(individual); form] Form SB-6C for [(Corporation);] corporations or SB-6P for [Partnership], partnerships as the case may be, as set forth in N.J.A.C. 13:47A-11.6, 7 and 8.

(b) For broker-dealer applications for registration in New Jersey filed via the CRD a fully executed page 1 (Execution Page) of the Form BD Uniform Application for Broker-Dealer Applications or a successor form as prescribed by the CRD may be filed with the CRD to fulfill the requirement of (a) above for the broker-dealer.

(c) All nonbroker-dealer registrants and those broker-dealers not registered with New Jersey via the CRD must continue to file the Consent to Service of Process directly with the Bureau of Securities, as set forth in (a) above.

13:47A-7.5 Expediting applications

Pursuant to Section 49:3-57(a) of the Uniform Securities Law (1967), applications become effective on noon on the 30th day after filing with the Bureau of Securities. Applications filed with the CRD to effectuate registration in New Jersey will become effective on noon on the 30th day after notice to the Bureau of Securities by the CRD that the application has been filed with the CRD. Any applicant desiring an earlier effective date must submit a written request to expedite to the Bureau Chief, such request to be made a part of the application and the applicant's permanent file. Acceleration is not automatic, and in no case shall an application become effective in less than five full business days after having been filed with the Bureau of Securities.

13:47A-7.6 Effectiveness of registrations filed with the CRD

Filing an application for registration with the CRD does not in any way impair the authority of the Bureau of Securities to require that additional information be filed with the Bureau or the CRD, nor does it in any way impair the Bureau's authority to deny, suspend, postpone or revoke any registration in accordance with the provisions of the Uniform Securities Law (1967) and the regulations promulgated under that Law. Allowing registrants to file their appli-

cations with the CRD, if they are eligible to do so, is for the convenience of the registrant and the Bureau, but is not intended to impair or substitute any other person's discretion or decision making authority for that of the Bureau of Securities in reviewing and acting upon applications.

13:47A-7.7 Transition rule for registrants currently registered with the Bureau of Securities and new registrants

(a) Registrants registered with the CRD in other states (at the time these amended rules take effect) who wish to include a registration in New Jersey may do so by filing an amendment with the CRD to the Form BD Uniform Application for Broker-Dealer Registration to include New Jersey as one of the states it is registered. These registrants must also include in the amendment filing any other information required by N.J.A.C. 13:47A-1.1 or 1.9. The information required by N.J.A.C. 13:47A-1.1 and 1.9 may be filed as a supplement to the amendment filed with the CRD or by a separate supplemental filing made directly to the Bureau of Securities at the same time the amendment is filed with the CRD.

(b) Registrants not registered with the CRD in other states (at the time these amended rules take effect), but who are registered in New Jersey via Form SB-1 who wish to extend their registration to other states, while retaining registration in New Jersey, may file an initial Form BD Uniform Application for Broker-Dealer Registration with the CRD to register in New Jersey and those other states in which it is eligible. These registrants must also supplement their Form BD registration with the information required by N.J.A.C. 13:47A-1.1 and 1.9. The information required by N.J.A.C. 13:47A-1.1 and 1.9 may be filed as a supplement to the initial registration filed with the CRD or by a separate supplemental filing made directly to the Bureau of Securities at the same time the initial application is filed with the CRD.

(c) Registrants not registered with the CRD in other states (at the time these amended rules take effect), who are registered in New Jersey via Form SB-1 and who are not eligible for registration via the CRD, but wish to retain registration in New Jersey, may renew their application for registration upon expiration directly with the Bureau of Securities in accordance with N.J.A.C. 13:47A-5.2(b).

(d) New applicants who are not registered either directly with the Bureau of Securities or via the CRD (at the time these amended rules take effect), must file their application for registration with the CRD in accordance with N.J.A.C. 13:47A-1.1, if they are eligible to do so. Only those new applicants who are not eligible for filing with the CRD may file their applications directly with the Bureau of Securities in accordance with N.J.A.C. 13:47A-1.2.

(e) Registrants registered with the CRD in other states (at the time these amended rules take effect), and who are registered in New Jersey via Form SB-1 shall file a Form BD, Uniform Application for Broker-Dealer Registration, or any successor form to the Form BD prescribed by the CRD for filing a broker-dealer application no later than 30 days prior to the expiration of its current registration as set forth in N.J.A.C. 13:47A-5.1. The registrant shall henceforth file all amendments required by N.J.A.C. 13:47A-1.9 directly with the CRD, as prescribed by the CRD. The amendment filed with the CRD shall be accompanied by the fee, if any, prescribed by the CRD for amendments. Notwithstanding the 90 day provision of N.J.A.C. 13:47A-5.3, a broker-dealer may file its Form BD application with the CRD prior to 90 days before expiration of its registration. However, the fee will not be waived. The new registration will run from the date the Form BD application, as supplemented by information filed directly with the Bureau is approved by the Bureau, until it expires on December 31 of the year next ensuing the year in which the registration became effective in accordance with N.J.A.C. 13:47A-5.1.

(f) Registrants who wish to withdraw their registration in New Jersey (at the time these amended rules take effect), those applicants shall apply for withdrawal in accordance with N.J.A.C. 13:47A-1.11(a) or (b), as appropriate.

13:47A-7.8 Filing of information with the CRD

Any information filed by an applicant as part of a registration application that is filed with the NASAA/NASD CRD shall be con-

sidered to have been filed with the BUREAU of Securities in accordance with N.J.A.C. 13:47-7.5, unless the information is required by these rules to be filed directly with the Bureau of Securities at its current office address. If the information is required to be filed directly with the Bureau of Securities, then filing the information with the CRD will have no effect and the information will be considered as "not filed."

13:47A-8.1 Assessment

A registrant who fails to file with the Bureau of Securities [within the time prescribed in] or the CRD (as limited by N.J.A.C. 13:47A-7.8) any information required by N.J.A.C. 13:47A-1.9 (change of status), or any fee, annual report, financial report or statement as required by the Uniform Securities Law (1967) or the rules [and regulations] promulgated thereunder, within the time prescribed by the Law and the rules, [a change of status form or fee or an annual report or financial report and statement,] shall be assessed a penalty of \$10.00 for each late filing.

STATE

(a)

DIVISION OF ELECTIONS

Notice of Extension of Comment Period Distribution of State Voter Registration Forms through Public Agencies

Proposed New Rules: N.J.A.C. 15:10-7

Proposed Amendment: N.J.A.C. 15:10-1.5

Take notice that the Division of Elections of the Department of State is extending until August 19, 1992 the period for public comment on proposed new rules N.J.A.C. 15:10-7 and the proposed amendment to N.J.A.C. 15:10-1.5, published in the March 2, 1992 New Jersey Register at 24 N.J.R. 736(a).

Last year, the Legislature by creating P.L. 1991, c.318 required the Secretary of State to implement a program distributing voter registration forms through public agencies.

In this year's budget, the Legislature eliminated the new voter registration appropriation in the Governor's budget which funded the Agency Based Voter Registration Program. As of the date of submission of this notice for publication (June 29, 1992), the budget process to support this and other programs remains ongoing. Since the status of funding to implement this program has not been finally resolved; this Department is hereby notifying the public that the comment period will be extended for 30 days.

Please submit written comments by August 19, 1992 to:

Midge Trainor, Director
Division of Elections
CN 300
Trenton, NJ 08625

TREASURY-TAXATION

(b)

DIVISION OF TAXATION

Public Utility Corporations

Proposed Amendments: N.J.A.C. 18:22-1.3, 3.3, 6.1, 8.1, 9.2, 9.6 and 10.1

Proposed Repeal: N.J.A.C. 18:22-6.3

Proposed Repeal and New Rule: N.J.A.C. 18:22-6.2

Authorized By: Leslie A. Thompson, Director, Division of Taxation.

Authority: N.J.S.A. 54:50-1.

Proposal Number: PRN 1992-303.

Submit comments by August 19, 1992 to:

Nicholas Catalano
Chief Tax Counselor
Division of Taxation
CN 269
Trenton, NJ 08646

The agency proposal follows:

Summary

The proposal amends the public utility tax rules, N.J.A.C. 18:22, to bring them into conformance with changes made to the public utility tax statutes by P.L.1991, c.184. P.L.1991, c.184 altered the method of calculating public utility taxes for energy companies, as well as the schedule for payment of these taxes for energy companies and telecommunication companies.

Primarily, the new law changed the tax on gas and electric light, heat and power corporations from a tax on gross receipts to a tax based on sales of units of therms of gas or kilowatt hours of electricity. Under a procedure specified by statute, the rate of taxation is to be calculated by the Board of Public Utilities, in consultation with the Division of Taxation.

Additionally, the new law requires payment of the taxes by April 1 of the current year for the affected companies.

Social Impact

The proposed new rule, amendments and repeals should have a beneficial impact by eliminating conflicts between the existing public utility tax rules and the changes in the law made by P.L.1991, c.184. By informing taxpayers of the Division's interpretation of the statutory changes, the new rule, amendments and repeals should assist tax administrators in complying with the new requirements.

Economic Impact

P.L.1991, c.184 was anticipated to increase State revenues by requiring payment of public utility taxes in the current calendar year rather than the subsequent year. The proposed new rule, amendments and repeals are designed to bring the rules into conformance with the legislative changes to the statutes and should, therefore, have no significant economic impact beyond that resulting from the referenced statutory changes.

Regulatory Flexibility Analysis

The proposed new rule and amendments describe customer service classes, corresponding therms of gas, or kilowatt hours of electricity, specify the definition of public street to clarify that installations of lines or mains before and after February 19, 1991, are treated differently, and establishes schedules for the payment of taxes due under N.J.S.A. 54:50-1, as amended by P.L.1991, c.184.

These proposed amendments impose compliance requirements on all taxpayers subject to the public utility tax statutes, whether or not they are small businesses, as the term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The new rule, amendments and repeals implement requirements imposed by P.L.1991, c.184; therefore, any exemption for small businesses would not be in compliance with applicable statutes.

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

18:22-1.3 Definitions

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

...
"Class" means any segment, grouping or other division of an electric company's or gas company's customers which is established for the purpose of charging rates for electric or gas service. Any such class shall be designed to be in the residential class category or nonresidential class category.

1. With respect to electric companies, "residential class category" means any class established by an electric company which generally includes customers taking electric service under rate schedules that are primarily residential in nature; and "non-residential class category" means any class established by an electric company which generally includes customers taking electric service under rate schedules that are primarily nonresidential in nature.

2. With respect to gas companies, "residential class category" means any class established by a gas company which generally includes customers taking natural gas service under rate schedules that are primarily residential in nature; and "nonresidential class category" means any class established by a gas company which generally includes customers taking gas service under rate schedules that are primarily nonresidential in nature.

... "Corresponding therms of gas" or "corresponding kilowatthours of electricity" means all therms of gas or kilowatthours of electricity from the taxpayer's business over, on, in, through or from the whole of its lines or mains, excluding therefrom, however:

1. Any therms of gas or kilowatthours of electricity as may have been sold and furnished to another public utility which is also subject to either the payment of a tax based upon gross receipts or the payment of a unit-based tax applied to therms of gas or kilowatthours of electricity;

2. Any kilowatthours of cogenerated electrical energy resold by the taxpayer to a producing cogenerator where produced; and

3. Any therms of natural gas sold by the taxpayer to a cogenerator and separately metered for use in a cogeneration facility.

... "Public street, highway, road or other public place" means any street, highway, road or other public place which is open and used by the public, even though the same has not been formally accepted as a public street, highway, road or other public place [and]. For purposes of computing the tax in connection with lines or mains installed after February 19, 1991, the term includes without limitation dead end streets, cul-de-sacs, alleys, water or riparian ways, and non-restricted roadways, such as extended residential, commercial or recreational facility driveways, or dead end streets, cul-de-sacs or alleys which are connected to public roadways and are for access to or the use of supermarkets, shopping malls, planned communities (such as apartment complexes and condominium developments), commercial enterprises, and recreation facilities (such as marinas, golf clubs, drag strips, etc.) and the connecting roads within or around the above facilities whether these roadways shall be located on public or on private property. The term "public street, highway road or other public place" shall not include restricted residential communities that control, by way of a permanently manned gate, access to or through said community.

18:22-3.3 Payment; due date

(a) [Each] For years prior to 1992, each taxpayer must pay the tax due the State under the Act on or before May 1 of the tax year.

(b) Commencing in 1992, payment of the tax due shall be made on or before April 1. Advance payments are due as follows: on or before April 1, 1993, 50 percent of the taxpayer's tax liability in 1993; and on or before April 1, 1994 and on or before April 1 of each year thereafter, an amount equal to the taxpayer's tax liability in the current year.

1. In the calculation of the tax due, the taxpayer shall be entitled to a credit in the amount of the tax paid as a partial payment in the preceding year and shall be entitled to the return or credit against taxes due and payable in the next year of any amount so paid which shall be found to be in excess of the total amount payable.

Recodify (b) as (c) (No change in text.)

18:22-6.1 Payment of tax; installments

(a)-(b) (No change.)

(c) For the calendar years 1992, 1993, and 1994, payment of all taxes due shall be remitted to the Director on or before April 1. For calendar year 1995 and each calendar year thereafter taxes shall be remitted in the following manner: payment of the estimated tax liability on or before April 1 of the tax year and payment of the remaining tax liability, if any, on or before April 1 of the next following year.

(d) For those utilities which have had a liability greater than \$20,000 for any one tax in the immediate preceding year of liability, the payment of tax shall be received by electronic funds transfer on or before 12:00 P.M. E.S.T. of the date established for payment.

For those not subject to the electronic funds transfer provision, payment is due and payable on the date established for payment.

18:22-6.2 [Collection of delinquent taxes] Administration and collection

[Any delinquent taxes are collected in the same manner and subject to the same discounts, interest and penalties as other taxes, and the same proceedings available for the collection of personal taxes against other corporations or individuals are applicable to the collection of the excise taxes imposed under the Act and payable to any municipality.]

The administration, collection and enforcement of the taxes payable by each taxpayer under the Act and any advance payment or payment of estimated tax liability required with regard to these taxes shall be subject to the provisions of the State Tax Uniform Procedure Law, N.J.S.A. 54:48-1 et seq.

Statutory Reference

As to [discounts, interest and penalties] administration and collection, see N.J.S.A. 54:30A-24.

18:22-6.3 [Lien] (Reserved)

[The taxes payable by each taxpayer under the Act become and remain a first lien on the property and assets of such taxpayer on and after the date the same became payable.]

Statutory Reference

As to liens, see N.J.S.A. 54:30A-24.]

18:22-8.1 Information required on returns; due dates

(a) (No change.)

(b) Every taxpayer [must] shall, on or before February 1 of the tax year, return to the Director a statement showing:

1-2. (No change.)

3. Every taxpayer operating both gas and electric facilities [must] shall supply the information required by this subsection so that its gross receipts and sales of units from gas and electric operations are shown separately.

4. Commencing with the statement to be returned on or before February 1, 1992, gas and electric light, heat, and power corporation taxpayers shall return a statement of the corresponding therms of gas and the corresponding kilowatthours of electricity sold in this State in the preceding year itemized separately for classes in the residential class category and the nonresidential class category.

(c) (No change.)

18:22-9.2 Excise tax payable to State; rates

(a) In addition to the excise taxes payable to municipalities ([Section] N.J.A.C. 18:22-10.1 (Computation of tax) [of this Chapter]) every [taxpayer] street railway, traction, sewerage, and water corporation [must] shall pay excise taxes to the State for the franchise to operate and conduct business within the State and to use the public streets, highways, roads or other public places in the State, at the following rates:

Recodify (a)-(b) as 1. and 2. (No change in text.)

3. Commencing in 1992, every gas and electric light, heat and power corporation using or occupying the public streets, highways, roads, or other public places in this State shall, annually, pay an excise tax for the privilege of exercising its franchises and using the public streets, highways, roads, or other public places in this State as follows:

i. In 1992, unit-based taxes due upon the corresponding therms of gas and corresponding kilowatthours of electricity sold by such taxpayers in this State for the classes in the residential class category and the nonresidential class category in the preceding year.

ii. Commencing in 1995, unit-based taxes shall be due upon such units so sold in the current year. The rate of taxation for units sold in each class by each taxpayer shall be separately calculated by the Board of Public Utilities, in consultation with the Director.

18:22-9.6 Payment due; date

(a) The taxes due under the Act prior to 1993 are payable on or before May 1 of the tax year.

(b) In 1993, 50 percent of the taxpayer's liability is due April 1, 1993. Commencing in 1994 and each calendar year thereafter, the taxpayer shall make a payment of estimated tax liability for the current year on or before April 1 of that year. The payment shall not be less than the amount of taxes paid by the taxpayer in the preceding year. The taxpayer shall, on or before April 1 of the next following year, file a final tax form sufficient to demonstrate the taxpayer's liability, if any, and pay the amount of any remaining tax liability. The taxpayer shall be entitled to the refund or credit against taxes due and payable in the next year, of any of the estimated tax payment which is in excess of the total amount payable.

18:22-10.1 Computation of tax

(a) In addition to the excise taxes payable to the State ([Section] N.J.A.C. 18:22-9.2 (Excise tax payable to the State; rates) [of this Chapter]) every [taxpayer] **railway, traction, sewerage and water corporation** must pay, to the municipalities in which it operates, taxes for the privilege of exercising its franchises and for the use of the public streets, highways, roads or other public places at the following rates:

Recodify existing (a)-(b) as **1. and 2.** (No change in text.)

(a)

DIVISION OF TAXATION

Transfer Inheritance and Estate Tax

Proposed Amendments: N.J.A.C. 18:26-3.2, 6.4 and 11.20

Proposed Repeals: N.J.A.C. 18:26-11.21 through 11.28

Authorized By: Leslie A. Thompson, Director, Division of Taxation.

Authority: N.J.S.A. 54:50-1.

Proposal Number: PRN 1992-304.

Submit comments by August 19, 1992 to:

Nicholas Catalano
Chief, Tax Services
Division of Taxation
CN 269
Trenton, NJ 08646

The agency proposal follows:

Summary

The proposed amendments make certain changes related to the procedures for releasing the contents of decedents' safe deposit boxes. Prior to the adoption of this proposal, the contents of a decedent's safe deposit box could be released by a financial institution only after an inventory of the box's contents was conducted by a representative of the Division and a release was delivered by the Division to the institution. After adoption of the proposal, the Division will issue a blanket consent to release in the form of a letter from the Director to all institutions which serve as custodians of safe deposit boxes. The Division will no longer conduct inventories of safe deposit boxes and the contents of the boxes may be released without Division inspection. As a result of this change, the rules dealing with the inventory and inspection process are being repealed.

The proposal also makes a technical correction to N.J.A.C. 18:26-3.2(a) to make it consistent with the Federal formula for computing the allowable State death tax credit. By reason of the enactment of N.J.S.A. 46:3-17.2, New Jersey now recognizes a tenancy by the entirety in personal property. N.J.A.C. 18:26-6.4 is being amended to treat tenancy by the entirety in personal property the same as tenancy by the entirety in real property. This will eliminate an inconsistency with N.J.S.A. 46:3-17.1. N.J.S.A. 46:3-17.1 recognizes a tenancy by entirety in personal property, but such property is not exempt from tax, in accordance with N.J.S.A. 54:34-1(f), as are certain other personal items.

Social Impact

Adoption of the proposed repeals and amendments should simplify and speed up the administration of estates. Processing the handling of a decedent's estate by the executor or administrator should be simplified

as to time and convenience. Institutions with safe deposit boxes will be relieved of certain responsibilities related to the opening of decedents' safe deposit boxes.

Economic Impact

There would be no significant economic impact because the inheritance taxes would be the same. Costs of estate administration may be reduced, since those who would have hired professionals, such as attorneys and tax consultants, will no longer have inventory and inspection rules imposed upon them. There will be some savings to the State in costs of administration and manpower, since the procedure for releasing the contents of decedents' safe deposit boxes has been streamlined, and will require less Division time.

Regulatory Flexibility Statement

The proposed amendments and repeals 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. N.J.A.C. 18:26 applies to individuals as they are affected by transfer and inheritance estate taxes. Accordingly, a regulatory flexibility analysis is not required. The proposal only makes a change in the administration of the transfer inheritance tax which is applicable to the estates of certain decedents, in that the contents of safe deposit boxes may be released without the previously-required inspection by the Division.

Full text of the proposed repeals may be found in the New Jersey Administrative Code at N.J.A.C. 18:26-11.21 through 11.28.

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

18:26-3.2 Amount and nature of tax

(a) (No change.)

Example [(1)]

Mr. "A", a New Jersey resident, died on July 16, [1988] **1992**, having a [net] taxable estate of \$700,000 for Federal estate tax purposes. The credit allowable for state taxes under the Federal estate tax law was [\$10,000] **\$18,000**, the amount actually paid to New Jersey for inheritance taxes was \$6,000. The New Jersey estate tax due is [\$4,000] **\$12,000**.

(b)-(d) (No change.)

18:26-6.4 Tenancy by the entirety

(a) The transfer of real property **or personal property** in this State held by a husband and wife as tenants by the entirety to the surviving spouse is not taxable for New Jersey inheritance tax purposes.

[(b) The State of New Jersey does not recognize a tenancy by the entirety in personal property, therefore, such property is not exempt under New Jersey Inheritance Tax Law except as provided by the provisions of N.J.S.A. 54:34-1(f), Stock or certificates in a cooperative housing corporation.]

1. See N.J.S.A. 46:3-17.2, effective P.L. 1987, c.357.

18:26-11.20 Release of safe deposit box contents

No safe deposit company, trust company, bank or other institution may deliver or transfer any securities, deposits or other assets contained in a safe deposit box within its control or possession which belongs to or stands in the name of a resident decedent, principal of a one person corporation or in the joint names of a resident decedent and one or more other persons, unless a release is obtained from the Transfer Inheritance Tax [Bureau] **Branch. A blanket release will be issued to safe deposit companies, trust companies, banks and other institutions which will allow for release of the contents of all safe deposit boxes without inspection by the Division.**

OTHER AGENCIES

(a)

NEW JERSEY ECONOMIC DEVELOPMENT AUTHORITY

Local Development Financing Fund

Proposed New Rules: N.J.A.C. 19:31-7

Authorized By: New Jersey Economic Development Authority,

Richard L. Timmons, Assistant Deputy Director.

Authority: N.J.S.A. 34:1B-1 et seq., specifically N.J.S.A.

34:1B-5(k) and (l) and 34:1B-36 et seq.

Proposal Number: PRN 1992-321.

Submit comments by August 19, 1992 to:

Gary Nadler, Manager of Administration

New Jersey Economic Development Authority

CN 990

Trenton, NJ 08625

The agency proposal follows:

Summary

An Act known as the Local Development Financing Fund Act, P.L. 1983, c.190 (N.J.S.A. 34:1B-36), established a loan fund within the Department of Commerce and Economic Development. That Department subsequently promulgated rules (N.J.A.C. 12A:12-2) to implement the Act, on April 18, 1988. On June 12, 1990, the Commissioner of the Department, pursuant to the Act, designated the New Jersey Economic Development Authority ("Authority") to fully administer the loan fund. As the rules originally promulgated by the Department of Commerce and Economic Development will expire on September 21, 1992, the Authority is proposing new rules describing the program which it now administers.

The purpose of the Act was to encourage economic development in specifically designated municipalities by providing supplemental financial assistance to certain commercial and industrial projects. These rules describe conditions of eligibility for the financial assistance, the procedure for applying for same, and the Authority's process of, and criteria applied in, evaluating and approving applications.

Social Impact

The social impact of this program is positive. The fund provides a source of capital which would otherwise not be available, for the development of eligible commercial and industrial projects in distressed urban areas of the State, where such development is urgently needed. This development should help to alleviate problems such as chronic high levels of unemployment in these areas, and hopefully will stimulate further economic growth and revitalization in these communities.

Economic Impact

The economic impact of this program is positive for the communities where it can be utilized, and therefore positive for the State as a whole. By stimulating economic development, the program will help to increase tax ratables to the benefit of the communities, and the resulting creation of jobs will increase spendable income in these areas, which will benefit other local businesses.

The cost of the program to the State is relatively small, as the program is a revolving loan fund which was initially financed through the issuance of bonds pursuant to the Community Development Bond Act.

Applicants for assistance from the Fund will be required to pay a non-refundable application fee of \$500.00, and to bear the costs of preparing the application, which includes the information to be provided in the benefit statement under N.J.A.C. 19:31-7.3(c), evidence of private source or other public funding financing commitments, evidence of all requisite environmental permits, and a plan for the utilization of minority and women contractors and equal opportunity for employment in connection with the project.

Regulatory Flexibility Analysis

Small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., have applied for financial assistance under this program in the past, and will likely continue to do so in the future. The costs to such businesses, consisting of those factors discussed in the Economic Impact above, will vary based upon the projects for which assistance is sought. While professional services of an economic analysis

or planning nature may be utilized by such businesses in the preparation of the assistance application, such is not required under the program. This program is intended as a beneficial tool to be used by businesses in New Jersey, including small businesses, and the burden of compliance with the guidelines of the program should be considered minimal in relation to the benefit to the businesses which utilize it. Therefore, no differentiation in or exceptions to the requirements have been included for small businesses.

Full text of the proposed new rules follows:

SUBCHAPTER 7. LOCAL DEVELOPMENT FINANCING FUND

19:31-7.1 Applicability and scope

The rules in this subchapter are promulgated by the New Jersey Economic Development Authority to implement "The New Jersey Local Development Financing Fund Act" (P.L. 1983, ch. 190). This Act established the Local Development Financing Fund, a special depository fund for the purpose of providing financial assistance to certain commercial and industrial projects in certain municipalities who sponsor these projects.

19:31-7.2 Definitions

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

"Act" means the New Jersey Local Development Financing Fund Act (P.L. 1983, c.190) as amended and supplemented.

"Eligible project" means a project which has been approved by the Authority to receive financial assistance from the Local Development Financing Fund.

"Eligible project costs" means the costs of planning, developing, executing and making operative, an industrial or commercial redevelopment project. Eligible project costs include:

1. The cost of purchasing, leasing, condemning, or otherwise acquiring land or other property, or an interest therein, in the designated project area or as necessary for a right-of-way or other easement to or from the project area;

2. The cost incurred for, or in connection with, or incidental to, acquiring and managing the land, property or interest;

3. The cost incurred for, or in connection with, the relocating and moving of persons displaced by acquisition;

4. The cost of development or redevelopment, including:

- i. The comprehensive renovation or rehabilitation of the land, property or interest;

- ii. The cost of equipment and fixtures which are part of the real estate, and the cost of production machinery and equipment necessary for the operation of the project;

- iii. The cost of energy conservation improvements designed to encourage the efficient use of energy resources, including renewable and alternative energy resources and cogenerating facilities; and
- iv. The disposition of land or other property for these purposes;

5. The cost of demolishing, removing, relocating, renovating, altering, constructing, reconstructing, installing or repairing any land or any building, street, highway, alley, utility, service or other structure or improvement;

6. The cost of acquisition, construction, reconstruction, rehabilitation or installation of public facilities and improvements necessary to the project; and

7. The cost incurred or incidental cost including, but not limited to:

- i. Administrative, appraisal and economic analysis;

- ii. Engineering service;

- iii. Planning service;

- iv. Design service;

- v. Architectural service;

- vi. Surveying service; and

- vii. Other professional service.

"Financial assistance" means, but is not limited to, loans, loan guarantees, grants, secondary mortgages, and equity participation provided by the fund.

"Fund" means the Local Development Financing Fund.

"Municipality" means a New Jersey municipality qualifying for aid pursuant to the State formula for State aid to municipalities (see N.J.S.A. 52:27D-178) for services and to offset property taxes.

"Project" means an industrial or commercial enterprise within a municipality that would not be undertaken in its intended scope but for the assistance provided for under the Act and these rules.

"Sponsor" means the governing body of a municipality or, with the approval of the government of the municipality, a local development corporation, community development corporation, municipal port authority, or governing body of a county, or, with the approval of the government of a county, a county development corporation or other public entity designated by the Authority as a sponsor (see N.J.S.A. 40:68A-29).

19:31-7.3 Application for financial assistance

(a) Each application for financial assistance from the Fund shall be accompanied by a non-refundable application fee of \$500.00.

(b) Each application for financial assistance from the Fund shall be accompanied by evidence of the support of the municipality in which the project is located. For purposes of these rules, evidence of municipal support shall mean an approved resolution of the governing body of the municipality.

(c) Each application for financial assistance from the Fund shall be accompanied by a benefit statement prepared by the applicant. The benefit statement shall address:

1. The number of permanent jobs to be created in the municipality in which the project is located, excluding the period of construction or development;

2. The number of jobs preserved by the completion of the project in the case of an existing enterprise;

3. The increase in the valuation of real property in the municipality as a result of the completion of the project;

4. Whether the project will result in the maintenance or provision of at least the same number of housing units at comparable rates as exists prior to the undertaking of the project;

5. Whether the project will be located in an area targeted for economic development and receiving Federal State and/or local development assistance under other programs;

6. The extent to which the project will contribute to an economic revitalization of the municipality and/or the region;

7. The extent to which the project will advance State and/or regional planning and development strategies; and

8. The extent to which the location of the project is accessible to and promotes the use of public transportation.

(d) Each application for financial assistance from the Fund shall be accompanied by evidence of private source or other public source financing commitments.

(e) Each application for financial assistance from the Fund shall be accompanied by evidence of all requisite Federal and/or State environmental permits necessary for the project.

(f) Each application for financial assistance from the Fund shall be accompanied by a plan for the utilization of minority and women contractors and equal opportunity for employment in connection with the project (see N.J.A.C. 19:31-7.6).

19:31-7.4 Financial assistance

(a) No more than 20 percent of the total financial assistance provided from the Fund shall be in the form of grants or other non-lending assistance.

(b) The total amount of financial assistance provided to project applicants in any county during any year shall not exceed 20 percent of the appropriation made during that year to the Fund.

(c) No financial assistance from the Fund shall be granted to an individual applicant project unless at least 50 percent of the total eligible project cost consists of private resources. For purposes of these rules, private resources shall include, but are not limited to:

1. Conventional private sector mortgages;

2. Purchase money mortgages;

3. Industrial Revenue Bonds;

4. Leases;

5. Loans guaranteed by the Federal Small Business Administration, or similar loan guarantees of other governmental and/or quasi-governmental entities; and

6. Equity investments in the project.

(d) The Fund shall provide loans in the form of permanent subordinate mortgage financing for eligible project cost at or below market rates of interest, as determined by the Authority (see N.J.A.C. 19:31-7.5(c)).

(e) The applicant shall secure interim financing on all projects involving construction, unless the Authority agrees otherwise in writing. The interim lender shall assume full responsibility for monitoring the construction of a project and for its timely completion. The interim lender may be the first mortgage lender or another experienced, qualified construction lender and shall be approved by the Authority.

(f) The applicant shall have such equity in the project as the Authority may deem appropriate to insure the applicant's ability to repay the loan from the Fund.

(g) The applicant shall certify in writing that it is unable to provide additional funds in the project beyond its stated commitment and that without assistance from the Fund the project would be economically unviable and unable to proceed.

(h) Assistance other than loans from the Fund may be approved where the Authority deems such assistance necessary to the success of the project. Such assistance shall not be provided for projects that can be funded by loans.

19:31-7.5 Terms of financial assistance

(a) The minimum loan amount from the Fund shall be \$50,000 and the maximum loan amount from the Fund shall be \$2,000,000.

(b) The term of a loan from the Fund can be up to 25 years.

(c) The interest rate on a loan from the Fund will be the lower of one-half of the Federal Discount Rate at the time of approval or at the time of the loan closing, with a minimum of five percent.

19:31-7.6 Evaluation of applications

(a) The Authority shall evaluate and rank each application for financial assistance considering the following factors:

1. The number of unemployed persons in the municipality in which the project is located;

2. The number of permanent full-time jobs to be created and/or maintained directly by the project, excluding the period of construction or development;

3. The number of jobs preserved by the completion of the project for an existing enterprise that otherwise would leave the State;

4. The increase in the valuation of real property in the municipality as a result of the completion of the project;

5. The percentage of the total eligible project costs to be financed from private and/or other public sources;

6. Whether the project results in the maintenance or provision of at least the same number of housing units at comparable rates that exist prior to the undertaking of the project within the municipality or surrounding area;

7. Whether the project will be located in an area targeted for economic development and/or will be receiving Federal, State and/or local development incentives under other programs;

8. The extent to which the project will contribute to an economic revitalization of a municipality or region, and will promote or add to the rehabilitation of the physical environment of the immediate area or municipality in which it is to be located;

9. The degree to which the project will facilitate the advancement of State or regional planning development strategies;

10. The extent to which the locations of the project are accessible to and/or promote the use of public transportation;

11. The degree of support for, participation in, and/or consultation about the project, within the community in which the project will be located;

12. The likelihood that the project will create and/or preserve private sector jobs, which will last for a period of at least two years; and

13. The likelihood that the project will result in providing a significant increase in the real property tax base of the municipality in which the project is located.

(b) After the evaluation and ranking is completed, the projects will be presented to the members of the Authority for their review and approval.

19:31-7.7 Minority and women business set-aside plans and requirements

(a) Each project approved to receive financial assistance from the Fund shall set a target level of the aggregate project construction costs for the purpose of providing contracting opportunities for minority businesses and women businesses.

(b) The developer and/or general contractor of the project shall identify the minority and/or women businesses that will participate in the project by construction trade, together with the contract sum to be paid to each minority business.

(c) In determining the target level and compliance therewith, a developer and/or general contractor must proceed in accordance with N.J.A.C. 12A:10-2.

19:31-7.8 Rescission of financial assistance from the Fund

(a) The Authority may at its discretion rescind part or all of the financial assistance from the Fund when it has become evident after the granting of financial assistance that:

1. The commitment of other financial resources from private sources has been withdrawn;

2. The project is judged no longer capable of repaying the Fund for the financial assistance it has received;

3. The project is judged incapable of achieving its target requirement, pursuant to N.J.A.C. 19:31-7.7, or that the project is not employing good faith efforts to achieve the requirements under N.J.A.C. 19:31-7.7; or

4. The participants in the project are found not to be of a good moral character. Such a finding may be based on convictions of felony offenses or any other conduct of the applicant which may be viewed in a nonfavorable light by a reasonable person.

(b) Upon determination of the Authority that financial assistance from the Fund shall be rescinded, the Authority shall send a certified letter to the applicant and the sponsor informing them of the rescission.

(a)

CASINO CONTROL COMMISSION

Accounting and Internal Controls

Exchange of Coupons for Gaming Chips at Gaming Tables

Proposed Amendments: N.J.A.C. 19:45-1.1, 1.2, 1.16, 1.18, 1.20, 1.33 and 1.46

Authorized By: Casino Control Commission, Joseph A. Papp, Executive Secretary.

Authority: N.J.S.A. 5:12-69(a), 70(f), (g) and (l); 99(a)(4)-(a)(9), 100(k) and 102(m)(3).

Proposal Number: PRN 1992-317.

Submit comments by August 19, 1992 to:

Seth Brilliant, Assistant Counsel
Casino Control Commission
Tennessee Avenue and the Boardwalk
Atlantic City, NJ 08401

The agency proposal follows:

Summary

These proposed amendments would permit coupons to be redeemed at gaming tables in exchange for gaming chips, in accordance with recent amendments to section 100(k) of the Casino Control Act, N.J.S.A. 5:12-100(k) (see P.L.1992, c.9). Current coupon redemption programs are limited to coupons which can be redeemed only for coin or slot tokens. These proposed amendments would permit similar coupon redemption programs for table games.

As part of the proposed amendments, references to coupons would be added to N.J.A.C. 19:45-1.16(a), 1.18 and 1.20 to permit coupons to be exchanged for gaming chips at the gaming tables, and to be placed into the drop boxes now used for the deposit of cash, counterchecks

and other items. The definitions of "table game drop" and "table game win or loss" in N.J.A.C. 19:45-1.1 are amended to include coupons and the definition of "coupon" are added to cross-reference the coupon redemption programs described in N.J.A.C. 19:45-1.46.

N.J.A.C. 19:45-1.33(h)7 is amended to provide that any coupon placed in the drop box (including coupons which have expired, are counterfeit, or are otherwise invalid) must be included as gross revenue. Proposed amendments to N.J.A.C. 19:45-1.18(b) and 1.33(h)6 require that a coupon must be cancelled in the count room during the counting process if it has not already been cancelled at the gaming table upon acceptance by the dealer.

The proposed amendment to N.J.A.C. 19:45-1.33(h)4 would include coupons in the count room process, and N.J.A.C. 19:45-1.33(h)6 as amended includes a coupon-counting procedure that mirrors the currency-counting procedure in the preceding paragraph, (h)5. As amended, N.J.A.C. 19:45-1.33(h)8 incorporates coupons into the Master Game Report, and the proposed amendment to N.J.A.C. 19:45-1.46(l) includes a reference to the Master Game Report. Lastly, N.J.A.C. 19:45-1.46(i) is amended to incorporate many of the above-noted coupon requirements and to cross-reference the requirements of N.J.A.C. 19:45-1.18.

The proposed amendments also make several minor changes that simplify and clarify the rules in question (see N.J.A.C. 19:45-1.18(a)2, 1.33(h)5 and 1.33(h)13(i)), or which make technical corrections (see N.J.A.C. 19:45-1.2(c)3 (addition of gaming chips)). These proposed amendments would also delete the arrangement currently described in N.J.A.C. 19:45-1.18(a)3 for retaining 50 and 25 cent coins and adding them to the gaming table inventory. Such coins should be placed in the drop box. If small denominations of coin are needed at a gaming table, the coin will be obtained from the cage and carried in the table inventory, pursuant to N.J.A.C. 19:45-1.20.

Social Impact

These proposed amendments should create new marketing and promotional opportunities for casino licensees, which could be used to interest patrons in table games.

Economic Impact

To the extent that coupon programs for table games create increased interest in the games, it is anticipated that these proposed amendments may have a favorable economic impact upon casino licensees. However, because of the expenses that may be involved in providing such coupons, the actual economic impact of these proposed amendments upon the casino industry cannot be predicted with certainty.

Regulatory Flexibility Statement

These proposed amendments would affect only casino licensees, none of which is a "small business" as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16, et seq. Accordingly, no regulatory flexibility statement is required.

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

19:45-1.1 Definitions

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

...

"Coupon" means a document which is issued in accordance with the coupon redemption and complimentary distribution programs in N.J.A.C. 19:45-1.46(a).

...

"Table game drop" means the sum of the total amount of currency, [and] coin **and coupons**, and the total amounts recorded on issuance copies of Counter Checks removed from a drop box.

"Table game win or loss" means the amount of gaming chips and plaques and cash won from patrons at gaming tables less the amount of gaming chips, plaques and coins won by patrons at gaming tables. The table game win or loss is determined by adding the amount of cash, **coupons**, the amount recorded on the Closer, [and] the totals of amounts recorded on the Credits, and issuance copies of Counter Checks removed from a drop box, and subtracting the amount recorded on the Opener and the total of amounts recorded on Fills removed from a drop box.

...

19:45-1.2 Accounting records

(a)-(b) (No change.)

(c) The detailed, supporting and subsidiary records shall include, but not necessarily be limited to:

1.-2. (No change.)

3. Records supporting the accumulation of the costs and number of persons, by category of service, for regulated complimentary services. Such records shall include, on a daily basis, the name of each person provided with complimentary services, the category of services provided, the retail value of the aggregate of each category of service provided to such person, and the person authorizing the receipt of such service. A copy of this record shall be submitted to the Division of Gaming Enforcement's office located on the casino premises no later than two days subsequent to its preparation. Excepted from this requirement are the individual names of persons authorizing or receiving complimentary tickets for theatre or other entertainment events with a face value of less than \$25.00, parking, beverages served in bars and the casino or complimentary services or items, including cash, gaming chips or slot tokens, issued pursuant to a complimentary distribution program regulated by N.J.A.C. 19:45-1.46.

4.-9. (No change.)

19:45-1.16 Drop boxes and slot cash storage boxes

(a) Each gaming table in a casino shall have attached to it a metal container known as a "drop box" in which shall be deposited all cash, coupons exchanged at the gaming table for gaming chips and plaques, issuance copies of Counter Checks exchanged at the gaming table for gaming chips and plaques, duplicate Fill and Credit Slips, Requests for Credit forms, Requests for Fill forms, and Table Inventory forms. Each drop box shall have:

1. (No change.)

2. A separate lock securing the drop box to the gaming table[s], the key to which shall be different from each of the keys to locks securing the contents of the drop box;

3. A slot opening through which currency, coins, coupons, forms, records, and documents can be inserted into the drop box;

4. (No change.)

5. Permanently imprinted or impressed thereon, and clearly visible from a distance of 20 feet, a number corresponding to a permanent number on the gaming table to which it is attached and a marking to indicate game and shift, except that emergency drop boxes may be maintained without such number or marking, provided the word "emergency" is permanently imprinted or impressed thereon and, when put into use, are temporarily marked with the number of the gaming table and identification of the game and shift, and provided further, that the casino obtains the express written approval of [a] the Commission [inspector] before placing an emergency drop box into use.

(b) Each bill changer in a casino shall have contained in it a metal container known as a "slot cash storage box" in which shall be deposited all cash inserted into the bill changer. Each slot cash storage box shall have:

1.-3. (No change.)

4. An asset number at least two inches in height, permanently imprinted, affixed or impressed on the outside of the slot cash storage box which corresponds to the asset number of the slot machine to which the bill changer has been attached, except that emergency slot cash storage boxes may be maintained without such number, provided the word "emergency" is permanently imprinted, affixed or impressed thereon, and when put into use, are temporarily marked with the asset number of the slot machine to which the bill changer is attached, and provided further, that the casino obtains the express written approval of [a] the Commission [inspector] before placing an emergency slot cash storage box into use.

(c)-(d) (No change.)

19:45-1.18 Procedure for accepting cash and coupons at gaming tables

(a) Whenever cash or a coupon is presented by a patron at a gaming table for exchange for gaming chips [and] or plaques[, the following procedures and requirements shall be observed]:

1. The cash or coupon shall be spread on the top of the gaming table by the dealer or [boxman] boxperson accepting it in full view of the patron who presented it and the casino supervisor assigned to such gaming table;

2. The amount of the cash or coupon shall be verbalized by the dealer or [boxman] boxperson accepting it in a tone of voice calculated to be heard by the patron who presented [the cash] it and the casino supervisor assigned to such gaming table; and

3. Immediately after an equivalent amount of gaming chips or plaques has been given to the patron, the cash or coupon shall be taken from the top of the gaming table and placed by the dealer or [boxman] boxperson into the drop box attached to the gaming table; except that fifty cent (\$.50) and twenty-five cent (\$.25) coins may be retained in the table inventory in lieu of gaming chips of like denominations].

(b) A casino licensee may, in its discretion, require the coupon to be cancelled upon acceptance by the dealer or boxperson, in a manner approved by the Commission, so as to preclude its subsequent use.

19:45-1.20 Table inventories

(a) Whenever a gaming table in a casino is opened for gaming, operations shall commence with an amount of gaming chips, coins and plaques to be known as the "table inventory" and no casino shall cause or permit gaming chips, coins or plaques to be added to, or removed from, such table inventory during the gaming day except:

1. In exchange for cash, coupons, or issuance copies of Counter Checks presented by casino patrons in conformity with the provisions of N.J.A.C. 19:45-1.18 and 1.25;

2.-5. (No change.)

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

19:45-1.33 Procedure for opening, counting and recording contents of drop boxes and slot cash storage boxes

(a)-(g) (No change.)

(h) Procedures and requirements for conducting the count shall be the following:

1.-3. (No change.)

4. The contents of each drop box or slot cash storage box shall be segregated by a count team member into separate stacks on the count table by each denomination[s] of coin [and], currency and coupon, and by type of form, record[,] or document, except that the Commission may permit the utilization of a machine to automatically sort currency by denomination;

5. Each denomination of coin and currency shall be counted separately by one count team member who shall place individual bills and coins of the same denomination on the count table in full view of a closed circuit television camera, after which the coin and currency shall be counted by a second count team member who is unaware of the result of the original count and who, after completing this count, shall confirm the accuracy of [his or her] the total, either [orally] verbally or in writing, with that reached by the first count team member, except that the Commission may permit a casino licensee to perform an aggregate count by denomination of all currency collected in substitution of the second count by drop box or slot cash storage box if the Commission is satisfied that the original count is being performed automatically by a machine that counts and automatically records the amount of currency and that the accuracy of the machine has been suitably tested and proven. The Commission will permit the utilization of currency counting machines if prior to the start of the count, in the presence of a Commission inspector, the count room supervisor shall:

i.-vii. (No change.)

6. Each denomination of coupon shall be counted separately by one count team member, who shall place individual coupons of the same denomination on the count table in full view of a closed circuit television camera. As the coupons are counted by the first count team member, any coupon which has not been cancelled upon acceptance pursuant to N.J.A.C. 19:45-1.18(b) shall be cancelled, in a manner approved by the Commission, so as to preclude its subsequent use. The coupons shall be counted by a second count team

member who is unaware of the results of the original count and who, after completing this count, shall confirm the accuracy of the total, either verbally or in writing, with that reached by the first count team member. The second count team member shall, in addition to verifying the count, verify that all coupons being counted have been properly cancelled.

7. Any coupon placed in the drop box shall be counted and included as gross revenue, pursuant to N.J.S.A. 5:12-24, without regard to the validity of the coupon.

[6.]8. As the contents of each drop box are counted, one count team member shall record on a Master Game Report or supporting documents, by game, table number, and shift, the following information:

i.-iv. (No change.)

v. **The serial number and amount of each coupon;**

vi. **The total amount of coupons counted by denomination;**

vii. **The total amount of all denominations of coupons;**

Recodify existing v.-xiii. as viii.-xvi. (No change in text.)

[7.]9. After the contents of each drop box [is] are counted and recorded, one member of the count team shall record by game and shift on the Master Game Report, the total amount[s] of currency [and], coin[,], and coupons, Table Inventory Slips, Counter Checks, Fills, and Credits counted, and win or loss, together with such additional information as may be required on the Master Game Report by the Commission or the [establishment] casino licensee.

[8.]10. Notwithstanding the requirements of [(h)6 and (h)7] (h)8 and (h)9 above, if the casino licensee's system of internal [accounting] controls provides for the recording on the Master Game Report or supporting documents of Fills, Credits, Counter Checks and Table Inventory Slips by cage cashiers prior to commencement of the count, a count team member shall compare for agreement the totals of the amounts recorded thereon to the Fills, Credits, Counter Checks and Table Inventory Slips removed from the drop boxes.

[9.]11. (No change in text.)

[10.]12. Notwithstanding the requirements of [(h)6 and (h)7] (h)8 and (h)9 above, if the casino licensee's system of internal [accounting] controls provides for the count team functions to be comprised only of counting and recording currency [and], coin and coupons, accounting department employees with no incompatible functions shall perform all other counting, recording, and comparing duties [herein] required by this section.

[11.]13. After preparation of the Master Game Report [and/or] or Slot Cash Storage Box Report, each count team member shall sign the reports attesting to the accuracy of the information recorded thereon.

(i) Procedures and requirements at the conclusion of the count [for each gaming shift] shall be the following:

1. All cash [removed from the drop boxes or slot cash storage boxes] shall be immediately presented in the count room by a count team member to a reserve cash cashier who, prior to having access to the information recorded on the Master Game Report or the Slot Cash Storage Box Report and in the presence of a count team member and the Commission inspector, shall recount, either manually or mechanically, the cash received and attest by signature on the Master Game Report and Slot Cash Storage Box Report, if applicable, the amount of cash received; after which the Commission inspector shall sign the reports evidencing his or her presence during the count and the fact that both the cashier and count team have agreed on the total amount of cash counted.

2. The Master Game Report, after signing, and the Requests for Fills, the Fills, the Requests for Credits, the Credits, the issuance copies of the Counter Checks, [and] the Table Inventory Slips and coupons removed from drop boxes shall be transported directly to the accounting department and shall not be available to any cashiers' cage personnel. All coupons shall be received and processed by the accounting department in the manner set forth in N.J.A.C. 19:45-1.46(l).

3. (No change.)

4. If the casino licensee's system of internal [accounting] controls does not provide for the forwarding from the cashiers' cage of the originals of the Fills, Credits, Requests for Credits, and the

Requests for Fills, and the issuance copies of the Counter Checks directly to the accounting department, the originals of all such slips recorded, or to be recorded, on the Master Game Report shall be transported from the count room directly to the accounting department.

(j) (No change.)

19:45-1.46 Procedure for control of coupon redemption and other complimentary distribution programs

(a) The procedures contained in (c) through (n) below shall apply to casino licensees offering coupon redemption programs which entitle patrons to redeem coupons for complimentary cash, gaming chips or slot tokens [including, but not limited to complimentary cash or slot tokens] issued in connection with bus and other complimentary distribution programs. No complimentary cash, gaming chips or slot tokens may be distributed by a casino licensee under any coupon redemption program that does not comply with the requirements of this section.

(b) Detailed procedures controlling all programs entitling patrons to complimentary cash or slot tokens not regulated by (a) above shall be submitted by the casino licensee to the Commission and Division at least 15 days prior to implementing the program. The procedures for all such programs shall be deemed acceptable by the Commission unless the casino licensee is notified in writing to the contrary. Detailed procedures controlling all programs entitling patrons to complimentary items or services other than cash or slot tokens shall be prepared prior to implementation as an accounting record by the casino licensee. Complimentary items or services, including cash or slot tokens, distributed through programs regulated by this subsection shall be reported in accordance with the procedures contained in [(l) and (n)] (m) and (o) below.

(c) Each coupon, or part thereof, issued by a casino licensee shall only be redeemable, at the licensee's option, for a specific amount of cash, gaming chips or slot tokens, or any combination thereof.

(d)-(h) (No change.)

(i) A coupon redeemable for gaming chips shall be redeemed only at the gaming tables on the casino floor, and only by dealers and boxpersons, who shall accept the coupon in exchange for the stated amount of gaming chips and shall deposit the coupon into a drop box upon acceptance, in accordance with N.J.A.C. 19:45-1.18. All such coupons shall be designed and printed so that the denomination of the coupon is clearly visible from the closed circuit television system when accepted at a gaming table and deposited in a drop box.

Recodify existing (i)-(j) and (j)-(k) (No change in text.)

[(k)](l) All documentation, unused coupons, voided coupons and redeemed coupons maintained in conformity with (g), (h), [and] (i) and (j) above shall be forwarded on a daily basis to the accounting department, where they shall be:

1. (No change.)

2. Examined for proper calculation, summarization and recording on documentation, including, without limitation, the Master Game Report, if applicable;

3.-5. (No change.)

[(l)](m) Each casino licensee shall file a monthly report with the Commission and Division which shall include the following information:

1. For all programs regulated by (a) above, each casino licensee shall list by type of coupon, the total number of coupons used, the total number of coupons redeemed, the total value of the complimentary cash, gaming chips or slot tokens given to patrons in redemption of coupons and any liability to patrons remaining on unredeemed coupons; and

2. (No change.)

Recodify existing (m) as (n) (No change in text.)

[(n)](o) In addition to the monthly report required to be filed in [(l)](m) above, the casino licensee shall accumulate both the dollar amount of and the number of persons redeeming coupons pursuant to (a) above, and the dollar amount of and the number of persons receiving complimentary items or services pursuant to (b) above, and shall include this information on the quarterly complimentary report required by N.J.A.C. 19:45-1.9. Complimentary items or services,

including cash, gaming chips and slot tokens, distributed through programs regulated by this section shall not be subject to the daily complimentary reporting requirements imposed pursuant to N.J.A.C. 19:45-1.2.

ENVIRONMENTAL PROTECTION AND ENERGY

(a)

DIVISION OF FISH, GAME AND WILDLIFE

Fish and Game Council

1993-94 Fish Code

Proposed Amendments: N.J.A.C. 7:25-6

Authorized By: Fish and Game Council, Cole Gibbs, Chairman.

Authority: N.J.S.A. 13:1B-30 et seq. and 23:1-1 et seq.

DEPE Docket Number: 30-92-06.

Proposed Number: PRN 1992-318.

A public hearing concerning the proposed amendments will be held on:

Tuesday, August 11, 1992, at 7:30 P.M.
Assumpink Wildlife Conservation Center
Eldridge Road
Assumpink Wildlife Management Area
Robbinsville, New Jersey 08691

Submit written comments by August 19, 1992 to:
Robert McDowell, Director
Division of Fish, Game and Wildlife
New Jersey Department of Environmental Protection
and Energy
CN 400
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The Fish Code (Code), N.J.A.C. 7:25-6, states when, by what means, at which location, in what numbers and at what sizes, fish may be pursued, caught, killed or possessed.

The proposed amendments to N.J.A.C. 7:25-6 for the 1993-94 fishing season are as follows:

1. Opening day of the 1993-94 trout season has been set for April 10, 1993. All of the dates, throughout the Code, which are dependent on this date have been adjusted accordingly.
2. The trout stocked portion of the Raritan River has been extended 0.2 miles downstream to the Nevius Street bridge.
3. Swartswood Lake and the Manasquan Reservoir will remain open to fishing during the pre-season closure for trout stocking which applies to most other trout stocked waters. The closed season for trout, however, would still apply for these waters and any trout taken during this period must be released.
4. The fly-fishing only regulations for the Big Flat Brook (not including the Blewitt Tract) and the Ken Lockwood Gorge of the South Branch of the Raritan River have been extended through the winter until the pre-season closure for trout stocking in 1994.
5. The size limits for brown trout and rainbow trout at Merrill Creek Reservoir have been set at 15 inches.
6. Fishermen will be limited to a daily possession limit of 25 fish in total for those species not specifically covered by a separate daily possession limit.
7. The size limit for both largemouth bass and smallmouth bass has been standardized at 12 inches for all waters, with an 18 inch limit during a restrictive harvest season which will extend from April 1 through June 15. The possession limit during the restrictive harvest season will be one bass of either species (one in total). During the remainder of the year the possession limit remains at five bass of either species (five in total).
8. A regulation has been proposed which would make the wanton waste of fish illegal. The regulation requires that any fish which are intentionally killed by the fishermen must be removed from the waters from which it was taken and adjacent lands and properly disposed of.
9. The regulations for the striped bass hybrid in the Delaware River have been made consistent with those for striped bass and with those of Pennsylvania. These include a one fish daily possession limit, a 36

inch size limit and a closed season extending from January 1 through February 28 throughout the river with an additional closure extending from April 1 to May 31 downstream of the Trenton Falls.

10. In N.J.A.C. 7:25-6.19(a), proposed for recodification as 6.20(a), the phrase "except as provided in N.J.A.C. 7:25-6.13(e) through (n)" is deleted as inconsistent with the purpose of this section to establish separate size and creel limits for the Delaware River.

11. N.J.A.C. 7:25-6.9(b)4 and 5, which reference Merrill Creek Reservoir as a Major Trout Stocked Lake, are deleted, as Merrill Creek Reservoir is now a Trophy Trout Lake under N.J.A.C. 7:25-6.8.

Social Impact

There are several significant changes in the proposed 1993-94 Fish Code. These are as follows:

1. The Council proposes a maximum daily limit of 25 fish per fisherman, for previously unregulated species, based on the following findings: 1) sufficient evidence exists to suggest that the intense, and increasingly effective, angling effort exerted on most of New Jersey's public waters has resulted in the effective cropping off of the larger size classes and with each succeeding year, the average size of the population grows smaller with younger fish dominating the population; and 2) New Jersey's freshwater fishery resource cannot support a subsistence fishery and that such an angling objective does not constitute a responsible or desirable management approach for the public good, or the perpetuation of the resource. The Council is aware that some opposition to the rule may arise from those fishermen who habitually take unlimited numbers of these species of fish or from those who believe that overprotection of certain species could result in a general decline in major game species. However, based on its annual evaluation of the relevant scientific data, the Council finds that the imposition of a maximum daily limit furthers the legislative mandate to ensure the sustained viability of the freshwater fishery, and that the public's long-term recreational and social gains from the sustained viability of the resource far outweigh any short-term negative social impact which may arise.

2. The Council finds that increasing the size limit for smallmouth bass to 12 inches is needed to properly manage this species and to aid in the enforcement of the regulations governing bass. The largemouth bass and the smallmouth bass are difficult to tell apart and having different size limits in different waters creates confusion with no significant fish management benefit to offset the problems generated by such confusion. Moreover, public opinion to date has supported stricter regulations, particularly for bass. The Council notes that this limitation will result in a virtual catch and release fishery for this species in certain smaller rivers and streams, and therefore may generate some opposition from those fishermen who habitually take smallmouth bass for consumption purposes. However, the Council finds that the effective regulation and sustained viability of the resource and the long-term public recreational and social gains resulting therefrom far outweigh any short-term, negative social impacts.

3. The Council finds that the reimposition of the restrictive harvest season for largemouth bass and the creation of a restrictive harvest season for smallmouth bass is a necessary limitation to ensure the effective regulation and continued viability of these species. The Council acknowledges that these restrictions will have some effect on certain bass tournament rules. For example, bass tournaments often require contestants to bring fish back to a central location for weighing. Under this rule, a fisherman is limited to the possession of one bass during the restrictive harvest season, and therefore prohibited from transporting any additional bass to the weighing station, although they are kept alive and will be subsequently released, because these additional fish are considered to be in the fisherman's "possession" and therefore reflect a violation of the one bass restriction. Although the Council acknowledges that opposition to this rule may arise from bass tournament sponsors or contestants, the Council finds that the effective regulation and sustained viability of these species create long-term public recreational and social benefits which outweigh any short-term negative social impacts. Moreover, the Council finds that bass tournament sponsors could institute alternative rules, such as a contestant mix and match or an honor system, which permit the release of the fish at the time of, and place of, capture, without the violation of the one bass possession restriction.

4. Some fishermen may fear that releasing a hooked fish, which subsequently dies as a result of being hooked and handled, would constitute a violation of the new wanton waste regulation. This is not the intent of this regulation and it has been specifically written to exempt those situations where the fisherman has made a good faith effort to release a fish alive. The intent of the regulation is to prohibit fishermen

from deliberately killing fish and leaving them lie in the stream/lake or along the shoreline.

Economic Impact

No specific, significant economic impact or detriment is expected to arise from the proposed amendments since they are primarily a continuation, after annual review, of the existing freshwater fisheries program.

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 these amendments would not impose reporting, recordkeeping, or other compliance requirements on small businesses, because small businesses are not regulated by N.J.A.C. 7:25-6.

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

SUBCHAPTER 6. [1992-93] 1993-94 FISH CODE

7:25-6.2 Definitions

The following words and terms shall have the following meanings, unless the context clearly indicates otherwise.

...

"Fathom" shall mean a unit of measure equal to six feet.

...

7:25-6.3 Trout Season and Angling in Trout Stocked Waters

(a) Except as provided in N.J.A.C. 7:25-6.4, 6.6 to 6.9, 6.18, 6.19, and (i) below, the trout season for [1992] **1993** shall commence 12:01 A.M. January 1, [1992] **1993** and extend to midnight March [22, 1992] **21, 1993**. The trout season shall re-open at 8:00 A.M. Saturday, April [11, 1992] **10, 1993** and extend to include March [21, 1993] **20, 1994**.

(b) Except as provided in N.J.A.C. 7:26-6.4, 6.6 and 6.7 and (i) below, it shall be unlawful to fish for any species of fish from midnight March [22, 1992] **21, 1993** to 8:00 A.M. on April [11, 1992] **10, 1993** in ponds, lakes or those portions of streams that are listed herein for stocking during [1992] **1993**.

(c) (No change.)

(d) Except as provided in N.J.A.C. 7:25-6.6 to 6.9, in trout-stocked waters for which in-season closures will be in force, waters will be closed from 5:00 A.M. to 5:00 P.M. on dates indicated, provided that in the event of emergent conditions, the Division may suspend stocking of any or all of the following:

1. Big Flat Brook—100 ft. above Steam Mill Bridge on Crigger Road in Stokes State Forest to Delaware River—April [17, 24] **16, 23, 30**; May [1, 8, 15, 22, 29] **7, 14, 21, 28**.

2. Black River—Route 206 Chester, to the posted Black River Fish and Game club property at the lower end of Hacklebarney State Park—April [16, 23, 30] **15, 22, 29**; May [7, 14, 21, 28] **6, 13, 20, 27**.

3. Manasquan River—Route 9 bridge downstream to Bennetts Bridge, Manasquan Wildlife Management Area—April [13, 20, 27] **12, 19, 26**; May [4, 11, 18, 25] **3, 10, 17, 24**.

4. Metedeconk River, N. Br.—Aldrich Road Bridge to Ridge Avenue—April [13, 20, 27] **12, 19, 26**; May [4, 11, 18, 25] **3, 10, 17, 24**.

5. Metedeconk River, S. Br.—Bennetts Mills Dam to twin wooden foot bridge, opposite Lake Park Boulevard, on South Lake Drive, Lakewood—April [13, 20, 27] **12, 19, 26**; May [4, 11, 18, 25] **3, 10, 17, 24**.

6. Musconetcong River—Lake Hopatcong Dam to Delaware River including all main stem impoundments, but excluding Lake Musconetcong, Netcong—April [17, 24] **16, 23, 30**; May [1, 8, 15, 22, 29] **7, 14, 21, 28**.

7. Paulinskill River and E. Br. and W. Br.—[County Route 648] Limecrest Railroad Spur Bridge on E. Br., Sparta Township, and Warbasse Junction Road, Route 663, on W. Br., Lafayette Twp., to Columbia Lake—April [16, 23, 30] **15, 22, 29**; May [7, 14, 21, 28] **6, 13, 20, 27**.

8. Pequest River—Source to Delaware River—April [17, 24] **16, 23, 30**; May [1, 8, 15, 22, 29] **7, 14, 21, 28**.

9. Pohatcong Creek—Route 31 to Delaware River—April [14, 21, 28] **13, 20, 27**; May [5, 12, 19, 26] **4, 11, 18, 25**.

10. Ramapo River—State line to Pompton Lake—April [16, 23, 30] **15, 22, 29**; May [7, 14, 21, 28] **6, 13, 20, 27**.

11. Raritan River, N. Br.—Peapeck Road Bridge in Far Hills to Jct. with S. Br. Raritan River—April [15, 22, 29]; **14, 21, 28**; May [6, 13, 20, 27] **5, 12, 19, 26**.

12. Raritan River, S. Br.—Budd Lake dam through Hunterdon and Somerset Counties to Jct. with N. Br. Raritan River—April [14, 21, 28] **13, 20, 27**; May [5, 12, 19, 26] **4, 11, 18, 25**.

13. Rockaway River—Longwood Lake dam to Jersey City Reservoir in Boonton—April [13, 20, 27] **12, 19, 26**; May [4, 11, 18, 25] **3, 10, 17, 24**.

14. Toms River—Ocean County Route 528, Holmansville, to confluence with Maple Root Branch and Route 70 to County Route 571—April [13, 20, 27] **12, 19, 26**; May [4, 11, 18, 25] **3, 10, 17, 24**.

15. Wallkill River—[W. Mt. Road] **Lake Mohawk Dam** to Route 23, Hamburg—April [13, 20, 27] **12, 19, 26**; May [4, 11, 18, 25] **3, 10, 17, 24**.

16. Wanaque River—Greenwood Lake Dam to Jct. with Pequannock River, excluding Wanaque Reservoir, Monksville Reservoir and Lake Inez—April [17, 24] **16, 23, 30**; May [1, 8, 15, 22, 29] **7, 14, 21, 29**.

(e) (No change.)

(f) Trout stocked waters for which no in-season closures will be in force. Figure in parenthesis indicates the anticipated number of stockings to be carried out from April [13] **12** through May 31, provided that, in the event of emergency conditions, the Division may suspend stocking of any or all of the following:

1.-9. (No change.)

10. Hunterdon County

...

Hakihohake Creek—Holland Township, entire length—[(5)] (2)

11.-12. (No change.)

13. Monmouth County

...

Holmdel Park Pond—Holmdel—[(5)] (3)

...

14. Morris County

...

Drakes Brook—Flanders, entire length—[(5)](3)

...

Passaic River—White Bridge to Dead River—[(6)](4)

...

15.-17. (No change.)

18. Somerset County

...

Raritan River—Jct. of Raritan River N. Br. and S. Br. to [dam at Edgewater Road] **Rt. 206 Bridge**—(4)

...

19. Sussex County

...

Lake Musconetcong—Netcong—[(2)](3)

...

20. (No change.)

21. Warren County

...

Beaver Brook—Silver Lake Dam to Pequest River—[(5)](4)

...

(g) (No change.)

(h) A person shall not take, kill or have in possession in one day more than six in total of brook trout, brown trout, rainbow trout, lake trout or hybrids thereof during the period extending from 8:00 A.M. April [11, 1992] **10, 1993** until midnight May 31, [1992] **1993** or more than 4 of these species during the periods of January 1, [1992] **1993** to midnight March [22, 1992] **21, 1993** and June 1, [1992] **1993** through midnight March [21, 1993] **20, 1994** except as designated in N.J.A.C. 7:25-6.4 to 6.9.

(i) Spruce Run Reservoir [in], Hunterdon County, Swartswood Lake, Sussex County, and the Manasquan Reservoir, Monmouth

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County, will remain open to angling year-round. Trout, if taken during the period commencing at midnight, March [22, 1992] **21, 1993** and extending to 8:00 A.M. April [11, 1992] **10, 1993** must be returned to the water immediately and unharmed.

7:25-6.4 Special Regulation Trout Fishing Areas—Fly-Fishing Waters

(a) From 5:00 A.M. on Monday, April [20, 1992] **19, 1993** to and including [November 30, 1992] **March 20, 1994** the following stretches are open to fly-fishing only, and closed to all fishing from 5:00 A.M. to 5:00 P.M. on the days listed for stocking:

1.-2. (No change.)

(b) Beginning January 1, [1992] **1993** to midnight March [22, 1992] **21, 1993** and from 8:00 A.M. on April [11, 1992] **10, 1993** to midnight March [21, 1993] **20, 1994** the following stretch is open to fly-fishing only, but is closed to all fishing from 5:00 A.M. to 5 P.M. on days listed for stocking:

1. (No change.)

(c)-(d) (No change.)

7:25-6.5 Special Regulation Trout Fishing Areas Seasonal-Trout Conservation Areas

(a) The following stream segments are designated as Seasonal Trout Conservation Areas and are subject to the provisions at (b) below governing these areas during the period of May [25, 1992] **24, 1993** through March [21, 1993] **20, 1994**.

1.-2. (No change.)

(b) (No change.)

7:25-6.6 Special Regulation Trout Fishing Areas—Wild Trout Streams

(a) (No change.)

(b) The following regulations shall apply to the Wild Trout Streams designated at (a) above:

1.-4. (No change.)

5. During the period extending from 8:00 A.M. April [11, 1992] **10, 1993** to September 15, [1992] **1993**, no person shall have in possession while fishing any more than two legally sized dead, creel or otherwise appropriated trout. No trout may be killed or possessed during other times of the year. Any number of trout may be caught provided they are immediately returned to the water unharmed.

6. (No change.)

7:25-6.8 Special Regulation Trout Fishing Areas—Trophy Trout Lakes

(a) (No change.)

(b) The following rules apply to the Trophy Trout Lakes designated at (a) above:

1. [In Round Valley Reservoir, the] **The** minimum size of brown trout and rainbow trout shall be 15 inches [and in Merrill Creek Reservoir the minimum size of rainbow trout shall be 13 inches]. Daily bag and possession limit for brown trout and rainbow trout shall be two in total.

2.-3. (No change.)

4. The season for lake trout shall extend from 12:01 A.M., January 1, [1992] **1993** to midnight, September 15, [1992] **1993** and from December 1, [1992] **1993** to midnight, September 15, [1993] **1994**.

5. (No change.)

7:25-6.9 Special Regulation Trout Fishing Areas—Major Trout Stocked Lakes

(a) The following lakes are designated as Major Trout Stocked Lakes:

1. Canistear Reservoir;
2. Clinton Reservoir;
3. Lake Hopatcong;
4. Monksville Reservoir; and
- [5. Swartswood Lake; and]
- [6.]5. Wawayanda Lake.

(b) The following apply to the Major Trout Stocked Lakes designated in (a) above:

1.-2. (No change.)

3. A person shall not take, kill or have in possession, in one day, more than six in total of brook trout, brown trout, rainbow trout, lake trout or hybrids thereof during the period extending from 8:00 A.M. April[11, 1992] **10, 1993** until May 31, [1992] **1993** or more than four of these species during the periods of January 1, [1992] **1993** to midnight March[22, 1992] **21, 1993** and June 1, [1992] **1993** through midnight March[21, 1993] **20, 1994**. Trout, if taken during the period commencing at midnight, March[22, 1992] **21, 1993** and extending to 8:00 A.M., April[11, 1992] **10, 1993** must be returned to the water immediately and unharmed.

[4. In Merrill Creek Reservoir, the minimum size for lake trout shall be 24 inches and the daily bag and possession limit shall be one; and

5. In Merrill Creek Reservoir, the season for lake trout shall extend from 12:01 A.M. January 1, 1991 to midnight September 15, 1991 and from December 1, 1991 to midnight September 15, 1992.]

7:25-6.10 Baitfish

(a) (No change.)

(b) In waters listed in N.J.A.C. 7:25-6.3 to be stocked with trout, it is prohibited to net, trap or attempt to net or trap baitfish from March [22] **21** to June 15 except where the taking is otherwise provided for. For the remainder of the year, up to 35 baitfish per person per day may be taken with a seine not over 10 feet in length and four feet in depth or a minnow trap not larger than 24 inches in length with a funnel mouth no greater than two inches in diameter or an umbrella net no greater than 3.5 feet square.

(c)-(d) (No change.)

7:25-6.13 Warmwater fish

(a)-(b) (No change.)

(c) [The provision that a person may not take or have in possession more than 25 in total of fish commonly classed as fresh water game and food fish is hereby abolished]. **For those species of fish, which do not have specific daily creel and possession limits, the daily creel and possession limit shall be 25 in total.**

(d) The minimum size of smallmouth bass shall be [9 inches, except 13 inches for Manasquan Reservoir (Monmouth County), Monksville Reservoir (Passaic County), Merrill Creek Reservoir (Warren County) and Round Valley Reservoir (Hunterdon County) and] 12 inches [in the Delaware River and Greenwood Lake] **except that during the period of April 1 through June 15, an 18 inch minimum size limit shall be in effect.**

(e) The minimum size of largemouth bass [in lakes, ponds and reservoirs] shall be 12 inches [and in rivers, streams and other waters it shall be 9 inches], except that [in Lake Hopatcong] during the period of April 1 through June 15, an 18 inch minimum size limit shall be in effect. [There shall be no size limit on largemouth bass in Round Valley Reservoir.]

(f) The daily creel and possession limit for largemouth bass and smallmouth bass shall be five in total except that [in Lake Hopatcong] during the period of April 1 through June 15, the limit [for largemouth bass] is one **in total.**

(g)-(p) (No change.)

7:25-6.16 Closed waters

(a) It is illegal to fish, place any contrivance for the taking of fish, or attempt to catch or kill fish by any manner or means in any fish ladder or within [20] **100 feet, or as posted** feet, of any fish ladder entrance or exit.

(b) (No change.)

7:25-6.18 Wanton waste of fish prohibited

Fish, of any species, taken, by any means, which are purposely killed, become part of the fisherman's daily creel or possession limit and must be removed from the waters from which they were taken, and any adjacent lands, pursuant to N.J.S.A. 23:5-28. This section shall not apply to those fish which are released while still alive, by the angler, and subsequently die as a result of stress or hooking mortality.

7:25-[6.18]6.19 Greenwood Lake

(a) In cooperation with the New York State Department of Environmental Conservation, Division of Fish, Game and Wildlife, the

TRANSPORTATION

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following regulations for Greenwood Lake, which lies partly in Passaic County, New Jersey, and partly in Orange County, New York, are made a part of the New Jersey State Fish and Game Code and will be enforced on the whole lake by the conservation authorities of both States.

1.-4. (No change.)

5. Bow and arrow fishing for carp, suckers, herring, catfish and eels by **properly licensed fishermen**, will be permitted on Greenwood Lake [by properly licensed fisherman].

1. Trout ... Stripped bass × white bass hybrid	Season April [11]10- Sept. 30 [No closed season] Downstream of Trenton Falls— March 1-30 and June 1-Dec. 31 Upstream of Trenton Falls March 1-Dec. 31
--	---

...
2.-7. (No change.)

7:25-[6.20]6.21 (No change in text.)

7:25-[6.19]6.20 Delaware River between New Jersey and Pennsylvania

(a) In cooperation with the Pennsylvania Fish Commission, [except as provided in N.J.A.C. 7:25-6.13(e) to (n),] the following regulations for the Delaware River between New Jersey and Pennsylvania are made a part of the New Jersey State Fish and Game Code and will be enforced by the conservation authorities of each state.

Size Limit	Daily Bag Limit
no minimum	5
[16 inch] 36 inch minimum	[2]1

TRANSPORTATION

(a)

DIVISION OF TRANSPORTATION ASSISTANCE OFFICE OF AVIATION

Licensing of Aeronautical and Aerospace Facilities Proposed Repeal and New Rules: N.J.A.C. 16:54

Authorized By: George Warrington, Deputy Commissioner,
Department of Transportation.

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 6:1-29, and 6:1-43.

Proposal Number: PRN 1992-324.

A public hearing concerning the proposed new rules will be held on Friday, August 7, 1992 at 1:00 P.M. at the New Jersey Department of Transportation Main Office Building, 1035 Parkway Avenue, Trenton, New Jersey.

Submit comments in writing, by August 19, 1992 to:

Charles L. Meyers
Administrative Practice Officer
Department of Transportation
1035 Parkway Avenue
CN 600
Trenton, New Jersey 08625

The agency proposal follows:

Summary

Aviation facilities and activities in the State of New Jersey are subject to regulation by the Department of Transportation, pursuant to the provisions of Titles 6 and 27 of the New Jersey Statutes. Current Department rules pertaining to the "Licensing of Aeronautical Facilities" can be found at N.J.A.C. 16:54. These rules have been in effect for nearly a decade. The Department has determined that they are in need of revision to better reflect current technologies, standards, and procedures.

The Department is proposing new rules to replace the current N.J.A.C. 16:54, Licensing of Aeronautical Facilities, with a new chapter entitled "Licensing of Aeronautical and Aerospace Facilities." The proposed new rules were the subject of a preproposal in the Monday, January 6, 1992, New Jersey Register (see 24 N.J.R. 80(a)).

The Department initiated the preproposal in an effort to obtain the maximum possible public input and to assist in its fact-finding efforts.

The public comment period on the preproposal closed on March 7, 1992. The following persons submitted comments to the docket prior to the deadline:

John Coscia, Chairman, New Jersey Aviation Council; Kristina Hadinger, Esq., Montgomery Township Attorney; Joseph Martin; Monica Gianchiglia, Administrative Officer, Bedminster Township; Dean Maurer and Barry Nixon, for the Mid-Atlantic Aviation Coalition; Paul Wille, Gentle Giant Sport Balloons; Suzanne Nagle, President, New Jersey Association of Airport Owners and Operators; Henry Hill, Esq., representing Princeton Airport; James A. Pauz'e, President, Great Eastern Balloon Association; Johann Schneider, the Balloonary; and Paul and Geraldine Wille, co-chairs, Jersey Shore Balloon Pilots Association; Department of Community Affairs, Construction Code Element.

Public comments were used by the Department in the development and refinement of the proposed rules. The N.J.A.C. citation noted may refer, in a comment, to the citation in the preproposal. In a response, the citation most often refers to the citation in the proposal which follows below.

Summary of Public Comments and Agency Responses:

COMMENT: The requirements at N.J.A.C. 16:54-6.3, 6.4 and 6.5 constitute overregulation when applied to balloonists. Since there is no structural support required for balloon launches, these requirements are not necessary.

RESPONSE: The Department is not attempting to overregulate balloonists, but is attempting to assure the safety of the general public as well as those participating in the activity. In regard to the application of these requirements to balloonists, waivers may be requested.

COMMENT: Ballooning should be treated differently from other aeronautical activities. Balloonists should be licensed, not balloonports.

RESPONSE: The safety of the public during the conduct of aeronautical activities is a major concern of the Department. In this regard, ballooning activities can be treated no differently under the Department's legislative mandate to license all aeronautical facilities. This legislative mandate also precludes the licensing of balloonists in place of licensing balloonports. Balloonports must meet the same stringent standards as all other types of aeronautical facilities.

COMMENT: It would be difficult to license even a few potential balloon sites.

RESPONSE: Balloonports would be licensed with multiple auxiliary sites to accommodate launch requirements. This is now provided in N.J.A.C. 16:54-3.4(e).

COMMENT: References made to local building and fire codes should be revised to conform to the Uniform Construction Code and the Uniform Fire Code.

RESPONSE: The Department agrees. These changes have been made throughout the proposal.

COMMENT: The term "commercial operations" is too broadly defined.

RESPONSE: The Department has deleted the term, as it is no longer applicable to any regulated segment of aviation. The safety of the public dictates that standards be followed whether or not an operation is commercial.

COMMENT: Definitions and requirements for private use and special use airports are necessary.

RESPONSE: The term "private use" is contained within the term "special use", which has been included in this proposal.

COMMENT: The percentage of impervious surface should not be limited to 50 percent for a public use airport.

RESPONSE: This proposal does not address impervious surface coverage, which is a local zoning/land use matter, unless it specifically involves aeronautical areas.

COMMENT: Certain defined aeronautical activities may be appropriate at specific aeronautical facilities, but not others. There are unique traffic, environmental, land use, pollution, public safety and public health concerns which can only be adequately addressed by the local government.

RESPONSE: The definition of aeronautical activity has been revised. Local government input must be considered by the Commissioner in making his decision regarding the licensing and operation of any aeronautical facility.

COMMENT: N.J.A.C. 16:54-1.3 The Department was asked to add to the definition of "aeronautical activity" the following items: aircraft charter; aircraft passenger rides; aircraft sight-seeing rides; FAA medical examinations; FAA written and flight tests; aviation insurance; aircraft storage, that is Tee hangars, conventional hangars, paved or grass tie-downs; aircraft ground management; glider towing; parachute instruction; event photography; and aeronautical facility maintenance and repair.

RESPONSE: The definition has been revised to more accurately reflect the term. However, some recommended activities are not directly aeronautical in nature, and have not been added. These are medical exams and aviation insurance.

COMMENT: All applications should require information about other aeronautical facilities located within 5 miles of the site. This should include air traffic patterns.

RESPONSE: The substance of this recommendation has been incorporated into the rules.

COMMENT: The term "alteration" should not include paving or resurfacing, nor maintenance of existing facilities. Alterations should include changes to the traffic pattern.

RESPONSE: Changes to existing airport facilities must be annotated on the airport's master record maintained at NJDOT Office of Aviation. These changes include paving or surface corrections, as well as any changes to the airfield site. The definition of alteration, therefore, includes such items. Traffic pattern changes are covered by N.J.A.C. 16:54-5.1(d), and require concurrence by the Office prior to implementation.

COMMENT: There should be more flexibility in setting requirements for aeronautical facilities. There should be more leeway in meeting the requirements.

RESPONSE: Many sections of the rules are specific in their requirements for equipment, facilities, and services which must be available at an aeronautical facility. These requirements are even more stringent at public use facilities. These standards were designed to maximize the protection of the general public and those participating in aviation activities. The leeway and flexibility requested in the comments is available. Requests for waivers of specified criteria may be made in accordance with waiver provisions stipulated in this chapter.

COMMENT: Any municipality which is permitted to pass or enforce a local ordinance pertaining to airports or aeronautical activities, should be required to first have such ordinances approved by the Commissioner to ensure that such ordinances are in the best interest of the airport.

RESPONSE: The powers of the Commissioner are outlined in the enabling statute, N.J.S.A. 6:1-1 et seq. When exercising his authority, the Commissioner must consider, among other things, the interests and ordinances of the municipalities. However, ultimate responsibility for supervision over aeronautics within the State rests with the Commissioner, who when necessary, must exercise his preemptive authority in the best interest of public safety and the development of aeronautics in the State.

COMMENT: All aeronautical facility construction projects should be approved solely by the Office of Aviation.

RESPONSE: The Office has never been, and does not intend to become, the sole approving authority for all construction and building projects on aeronautical facilities.

COMMENT: Notice requirements do not take any specific form when discussed in several places in the rules. Recommendations were made to require written notice, hand delivered or sent via certified mail, return receipt requested. Other comments were made regarding the public notice and newspaper requirements, which asked that the official newspaper of the governing body be utilized. One commenter objected to the Director's discretion to waive notice requirements, and to the lack of notice requirement for alterations.

RESPONSE: Where applicable, these recommendations have been included in the proposal at N.J.A.C. 16:54-2.1. The requirement that notice be given in the official newspaper of the municipality, by certified mail with return receipt requested, or by hand delivery has been added. There are certain alterations to aviation facilities which would not require public notice. The waiver of the notice requirement has been limited to certain alterations to existing facilities. Only in such circumstances may the Director waive the notice requirement. The Director evaluates such situations on a case-by-case basis.

COMMENT: The Department received comments on subjects not included in this rulemaking, such as: airport preservation, property tax relief for airports, wetland permit exemptions for airports, and Airport Safety Fund issues.

RESPONSE: These comments do not pertain to the licensing of aircraft, the subject of this proposal. The Department invites the commenters to contact the Office of Aviation regarding their concerns, for possible future discussion.

COMMENTS: Several comments were received regarding the change in terminology from "Airport Hazard Zone" to "Airport Safety Zone".

RESPONSE: The term has been changed to reflect the term now used in the legislation, "Airport Safety Zone".

COMMENT: All definitions should conform to FAA definitions.

RESPONSE: Except where changes were required for purposes of clarification or to meet statutory requirements, all definitions are the same as FAA definitions.

COMMENT: Land use approvals should not have a 90 day time limit. They should reflect the applicable time limits according to existing New Jersey Statutes. Also, notice to municipalities should be formal in nature and require personal service or through certified mail, return receipt requested.

RESPONSE: The time period shown in N.J.A.C. 16:54-2.1 has been revised to 45 days, to coincide with existing requirements for the initial review period. The notice provision has been added.

COMMENT: N.J.A.C. 16:54-2.1(a)1 details the requirements for an application for a new aeronautical facility. There is no comparable section identifying requirements for renewal of a license.

RESPONSE: N.J.A.C. 16:54-2.8 has been revised to reflect the renewal requirements in the same detail as the initial applications.

COMMENT: N.J.A.C. 16:54-2.1(a)2 requires considerable expense to meet the significant requirements, especially for small non-airport facilities, that is, balloonports and parachute drop zones, and for alterations at existing airports where the owner's own money is being spent. Can these requirements be mitigated for alterations? Can the drawings used for building permits satisfy the requirements?

RESPONSE: N.J.A.C. 16:54-2.1(b) allows the applicant to request a waiver of the application requirements. Some of the criteria have been revised to reduce the overall scope and dimensions of the area required for study. The drawings which are used for the building permits may be accepted, based upon a case-by-case evaluation by the Director of the extent of the impact of the planned construction upon aeronautical operations.

COMMENT: Does the requirement in N.J.A.C. 16:54-2.1(a) for a certified legal description require preparation by an attorney?

RESPONSE: No, the metes and bounds do not have to be prepared by an attorney. The legal description may be done, and certified by, a professional engineer or land surveyor. The requirement for the legal description is necessary to verify ownership and to confirm facility boundaries. However, it should be noted that this requirement is not universally applied, but is only applied upon the request of the Director.

COMMENT: Public use facility traffic patterns should prevail over patterns of restricted use and special use facilities.

RESPONSE: Although the Department agrees, in principle, with this comment, we believe that it is inappropriate to include this requirement in the rules since each situation requires an individual determination.

COMMENT: N.J.A.C. 16:54-2.1(a)2 contains a requirement to show traffic patterns. Will the Office please include traffic patterns for all airports within five nautical miles, overflights, altitudes, ground conditions and the presence of development, and appropriateness of the pattern in its consideration for approval or authorization to establish or change a flight pattern?

RESPONSE: The requirement for Office review and approval has been incorporated at N.J.A.C. 16:54-5.1(d) to ensure that all traffic patterns consider the users, the community, and the airport owner, prior to submission to the FAA.

COMMENT: N.J.A.C. 16:54-2.1(a)5 should contain a limitation on the municipal government's authority to delay the application process.

RESPONSE: The rule has been clarified so that initial noncompliance immediately places the application in the position of being a contested case, which will then be submitted for decision in accordance with applicable law and rules.

COMMENT: Form number DA-5 should be numbered DA-9B.

RESPONSE: The Department has changed all forms to conform to this repeal and new chapter. The form number is correct.

COMMENT: Add the term "public health" to N.J.A.C. 16:54-2.5(a).

RESPONSE: This section is specifically dedicated to building construction and meeting existing codes. Adding public health to this section is inappropriate. References to the public safety are made in other sections.

COMMENT: In N.J.A.C. 16:54-2.5, the Office of Aviation reserves the right to specify the methods, standards, and techniques of construction at new or existing aeronautical facilities. Is the Office of Aviation planning to fully implement the Uniform Construction Code or do they plan to write their own code? One commenter objected to the Department's "interference" in building and fire codes.

RESPONSE: It is not the intent of the Office of Aviation to usurp the UCC or the Uniform Fire Safety Code regulations, but to ensure they are followed. The wording in N.J.A.C. 16:54-2.5 has been changed from "specify" to "approve."

COMMENT: N.J.A.C. 16:54-2.8(a). License transfer should require notice to the affected municipality.

RESPONSE: Because licenses are renewed annually the Department believes that this requirement would impose an undue burden upon the license without providing a public benefit not otherwise provided for by these rules.

COMMENT: The Department should renew licenses only after determining that the licensee meets all applicable Federal and State laws, rules and regulations, as well as Commissioner's orders.

RESPONSE: The Department concurs and requires this in N.J.A.C. 16:54-4.1(a) and 2.8(b)2.

COMMENT: In N.J.A.C. 16:54-2.5(a)2, the governing municipal body must be afforded the ability to approve applications for facility changes, just as they are afforded that ability for initial applications.

RESPONSE: This section refers solely to changes to the application itself. In that regard, substantive changes require submission of a new application which is subject to the review process, which includes the governing municipal body. Facility changes have the same review requirements as do new applications.

COMMENT: Can licenses be renewed every two years?

RESPONSE: The Department must comply with statutory requirements, which include a provision for annual renewal. (see N.J.S.A. 6:1-44.1)

COMMENT: The Federal Environmental Protection Administration, New Jersey Department of Community Affairs, and several other agencies are suggested by commenters as those that should be added to N.J.A.C. 16:54-3.1 as agencies whose rules and regulations must be followed.

RESPONSE: N.J.A.C. 16:54-3.1 solely addresses aviation operations which are subject to FAA and NJDOT regulation. If other rules apply, they must be followed; however, the Department does not enforce rules of other agencies.

COMMENT: N.J.A.C. 16:54-3.1(c) does not allow aeronautical facilities to prohibit the use of such facilities by any aircraft which can use it in accordance with FAA certification standards. This contravenes established law and policy.

RESPONSE: The provision cited does allow such prohibition, but only when included as a part of the airport owner/operator's written procedures prepared in accordance with this chapter.

COMMENT: Licensees cannot safeguard against encroachment of unauthorized persons on the actual operating site.

RESPONSE: The rule has been revised to require licensees to provide safeguards acceptable to the office to prevent inadvertent entry by unauthorized persons onto the operating area. Acceptability will vary, depending upon the type of facility, location, and its operations.

COMMENT: N.J.A.C. 16:54-3.1(e) requires facility-written requirements. Is this mandated for all types of facilities?

RESPONSE: Yes, airline facility-written responses are required for all types of aeronautical facilities, as outlined in Subchapter 5.

COMMENT: Volunteer fire companies and rescue squads should be considered adequate for compliance.

RESPONSE: N.J.A.C. 16:54-5.1 contains requirements for listing emergency response procedures. The Department will evaluate the procedures, based on public safety, need and operational requirements. It is possible that some volunteer fire companies and rescue squads may be considered adequate for compliance; however, each circumstance must be evaluated individually.

COMMENT: Local police should be notified of all accidents.

RESPONSE: The Department agrees that local police should be notified, since they normally handle emergency first response. That provision is included.

COMMENT: There is no reason to inspect financial records. Delete that provision from the rules.

RESPONSE: The Office issues financial grants to airports, and must be able to determine the proper use of the funds granted; therefore, it is appropriate to review financial records.

COMMENT: Does N.J.A.C. 16:54-3.2 limit the public use airport to only those things listed? Other uses should be allowed as well.

RESPONSE: The uses listed are those for which the airport is designed and which are usual and customary uses of such facilities. Other uses are not prohibited by this chapter; however, applicable local zoning and land use provisions would have to be complied with.

COMMENT: There is no indication in the preproposal regarding the "grandfathering" of currently-existing facilities or of a time period during which facilities may achieve compliance with these new rules.

RESPONSE: A section has been added at N.J.A.C. 16:54-1.2 to address the time limits allowed for establishing compliance with this chapter.

COMMENT: N.J.A.C. 16:54-3.2(b) requires licensees to establish written procedures to ensure the safety of the general flying public and those using the aeronautical facility. Why not the public safety too?

RESPONSE: This was inadvertently left out. The statutory mandate includes public safety. The wording has been corrected.

COMMENT: In N.J.A.C. 16:54-6.1(e), a temporary license could be granted while a permanent license is applied for. If the municipality involved does not concur in the siting of the facility there, the Office should not issue the temporary license.

RESPONSE: No license is automatically issued. All provisions of this rule must be considered before any license is issued, whether it is temporary or permanent. Local interests expressed by the municipal government must be considered by the Commissioner before any license is issued or rejected.

COMMENT: Temporary licenses issued in accordance with N.J.A.C. 16:54-6.1 should be for 9 months, especially for balloonports. This is necessary when long term commitments for land use are limited.

RESPONSE: Waivers may be requested to cover this situation.

COMMENT: The Department has no right to regulate airman qualifications. That is the province of the FAA. Not permitting student pilots to use temporary facilities, as balloonists often do, would put balloonists out of business.

RESPONSE: Waivers may be requested to cover this situation, where applicable. The Department must insure the safety of the public and of operations at temporary facilities. Due to the temporary nature of the facility, a higher level of qualification is required by the Department in order to meet the statutory obligation to insure the safety of the operation at a temporary facility.

COMMENT: All petitions for exemption should require notice and hearing.

RESPONSE: Not all petitions justify such action; some may be requesting relief from minor requirements and some from major requirements. The Department will grant exemptions based upon its statutory requirements.

COMMENT: Compliance with FAA circulars is required. These are advisory, not mandatory.

RESPONSE: This requirement has been deleted.

COMMENT: At N.J.A.C. 16:54-3.1 and 8.1, there is a requirement that applications be rejected if false statements are made in it. This should apply only in the case of intentional false statements.

RESPONSE: The burden of truth is on the applicant. Any misrepresentation or false statement subjects the application to rejection and the license to suspension. Corrections to the application can be made within 30 days and the license then can be reinstated.

A chapter by chapter summary of the proposed rules follows:

16:54-1. General Provisions

This subchapter lists and defines those types of aeronautical facilities which must be licensed. The rules shall be interpreted in conformity with the laws, rules, and requirements of the Federal Aviation Administration and other federal authorities. This subchapter also provides a detailed listing of definitions applicable to the chapter.

16:54-2. Application for License

This subchapter provides a detailed description and listing of requirements and procedures applicable to the licensing of aeronautical and aerospace facilities. There is a description of the appropriate application forms, requirements for public notice, public hearing and testimony requirements, procedures and standards applicable to application processing and commencement of activities, procedures and requirements applicable to the renewal, transfer, or surrender of a license.

16:54-3. General Requirements

This subchapter outlines requirements of a general nature that apply to licensed facilities. There are general requirements for public use, restricted use, and special use facilities licensed pursuant to the chapter. General requirements include conformance with applicable federal laws, maintaining a safe and hazard-free operating environment, security, fire and rescue, procedures in the event of accidents, access to records and equipment for inspection, posting of license, and general requirements for written standards and procedures for aeronautical activities.

Aeronautical activities subject to written standard procedures include activities related to aircraft operation and use, instruction, maintenance, servicing, and other usually recognized aeronautical activities. Written procedures for these activities are subject to review and approval by the Department in the manner outlined in the subchapter.

A section is "reserved" for future "General requirements for aerospace facilities."

The chapter also outlines additional general requirements which may be applicable for restricted use facilities and special use facilities.

16:54-4. Design Standards

This subchapter outlines applicable design and geometric standards for the various types of aeronautical facilities.

16:54-5. Operational Standards

This subchapter outlines the applicable requirements pertaining to operational standards and how they apply to public use, restricted use, and special use aeronautical facilities.

16:54-6. Temporary Aeronautical Facilities

This subchapter outlines the type of facilities for which temporary licenses may be issued and the application procedures, general requirements, design standards, operational standards, and the applicable license durations.

16:54-7. Petitions for Exemption

This subchapter provides that a person may petition the Commissioner for relief from the provisions of the chapter in the event of exceptional circumstances or hardship.

16:54-8. Liability and Penalty

This subchapter outlines general provisions relating to the violation of any applicable requirement of this chapter and the penalties for violations.

16:54-9. Suspensions, Revocations and Appeals

This subchapter provides that any license issued may be suspended in the interest of public safety. Suspensions or revocations may be appealed. Procedures relating to suspension, revocation, and appeal are outlined.

16:54-10. Powers

This subchapter states that all decisions regarding denial, issuance, renewal, suspension, or revocation of licenses and the regulation of aeronautical activities on aeronautical facilities are the purview of the Commissioner.

Comments of the public and of regulated persons are a valuable resource and are of interest to the Department in the promulgation of these rules. All interested persons are requested to forward their written comments to the Department. Where possible, comments should refer, by N.J.A.C. citation, to the specific area of the rules being commented upon.

Social Impact

Title 6, "Aviation", of the New Jersey Statutes provides that the Commissioner of Transportation shall have a general regulatory authority over all aeronautical and aviation facilities and activities in the State. This authority is administered in conjunction with applicable Federal preemptions to State authority. A responsibility of the Commissioner is to promote and provide for safety and efficiency in aeronautical facilities and activities. The proposed new rules clarify and reaffirm the Department's authorities and responsibilities in the licensing of aeronautical facilities and the aeronautical activities conducted thereon so as to insure the safety of the general public and persons engaged in aviation and aeronautical activities. The rules also implement applicable law pertaining to issues of Federal preemption and coordination of Department licensing procedures with applicable local requirements for zoning, building code, and other permits.

The proposed rules provide for greater input opportunities for interested citizens and local governments. The chapter includes specific provisions pertaining to various forms of public notice, public hearing, and conformance with local permit requirements.

These rules strengthen the role of the Department in the uniform public control and oversight of aeronautical facilities in New Jersey and insure that interests of communities and the non-aviation public are fully considered. The proposed rules will have a positive social impact by providing greater accountability in respect to the operation and oversight of aeronautical activities by the Department and the management of facilities from which they operate. The rules create a uniform system of regulation for aeronautical facilities and activities. They require that each facility set its own standards and enforce operational rules, as well as conforming to the requirements of this chapter. Review and approval of a facility's operating rules and activities standards by the Department is required. The operating rules and activities of each facility must be complied with. The Department believes that this is a forward step in insuring that there are the greatest possible number of safeguards to the public health, safety and welfare.

Economic Impact

The Department of Transportation will incur additional, currently unknown, costs for the review and Department approval of the newly proposed operational standards for aeronautical activities on facilities licensed under the proposed chapter. The additional costs to the Department will be greatest during the first year of development, review, approval, and implementation of aeronautical activity operational rules. Following this first year, costs to the Department for reviewing and approving operational rules should significantly decrease. The Department believes that costs for both aeronautical facilities and the Department would be reduced in respect to the development, review, and approval of operating rules if the aviation industry developed "standardized" operating rules, in lieu of developing wholly unique operating rules on a facility-by-facility basis.

Licensees will incur additional costs in preparing and implementing the procedures. The one-time costs of compliance include preparation of standards and rules and are estimated to be less than \$1,000, if prepared by an outside agent, or less than \$200.00, if prepared in-house. The continuing costs of this compliance are of an upkeep nature and are minimal. Rule references to license application and renewal fees refer to N.J.A.C. 16:63, which will be proposed by the Department in the near future.

Regulatory Flexibility Analysis

There are over 500 aeronautical facilities in New Jersey licensed pursuant to the authority of the Commissioner, as implemented under the existing N.J.A.C. 16:54. The proposed new rules substantially readopt existing reporting and recordkeeping requirements already required; however, a new requirement proposed in the rules is that aeronautical

facilities develop, and the Department of Transportation review and approve, operating rules and activity standards for aeronautical activities that occur upon aeronautical facilities. This new requirement is desirable for the promotion of public safety, good aeronautical practice, and to assure the fullest measure of compliance with applicable Federal, State, and local requirements and/or guidelines. The Department does not believe that the requirements of this chapter would cause a recordkeeping or reporting hardship to any "small business" as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 15:42B-16 et seq. The Department anticipates working closely with the regulated industry to develop, review, and approve the proposed requirement for aeronautical facility operating rules and standards. Other facility and aeronautical activity requirements, such as notice to the public of applications filed with the Office, design, and safety requirements, will involve costs which vary with the particular needs and circumstances of each airport, and the manner in which the applicant or licensee chooses to discharge his or her responsibility. Certain design and application requirements involve the use of professional services, such as engineering and planning, but other uses of professional services would be at the applicant's discretion. For example, operating rules may be written by the facility owner or a member of the staff, or they may be prepared by an attorney or other professional. The Department has made certain accommodations in the rules for special situations, some of which are related to business size. For example, the requirement to post certain information at a facility may, where there is no building or structure, be complied with if the item is posted in the owner's home. Also, for balloon launch sites, the Department will, under one application, grant permission to use one site, with several auxiliary sites, due to the nature of balloon activity.

The Department has determined that, aside from such accommodations for special situations, there should be no differentiation made in the rules which is based upon business size, due to the necessary maintenance of standards to promote public safety, as required by statute.

Full text of the rules proposed for repeal may be found in the New Jersey Administrative Code at N.J.A.C. 16:54.

Full text of the proposed new rules follows:

CHAPTER 54 LICENSING OF AERONAUTICAL AND AEROSPACE FACILITIES

SUBCHAPTER 1. GENERAL PROVISIONS

16:54-1.1 Scope

(a) This chapter lists and defines those types of aeronautical and aerospace facilities which must be licensed by the State of New Jersey and includes the ancillary operations thereon as hereinafter defined; outlines the procedures for obtaining license(s); specifies the licensing requirements which applicants must meet; specifies the minimum acceptable design standards for each type of facility; specifies certain operational standards for each type of facility; specifies the liability and penalty for failure to observe the requirements; and describes the procedure for requesting exemption from these rules.

(b) The rules specified in this chapter, if not in conformity with the laws, rules, and regulations concerning aeronautics set forth by the Federal Aviation Administration or the National Aeronautics and Space Administration, are subject to preemption. If not specifically preempted by Federal standards, the ultimate authority over the regulating and licensing of aeronautical activities and facilities in New Jersey resides with the Commissioner, as provided for in N.J.S.A. 6:1-29 et seq.

16:54-1.2 Applicability

(a) The provisions of this chapter apply to the following types of aeronautical facilities:

1. Fixed wing aeronautical facility:
 - i. Airport—Public Use (land or water);
 - ii. Airport—Restricted Use (land or water); and
 - iii. Airport—Special Use (land or water);
2. Vertical flight aeronautical facility:
 - i. Helipoint—Public Use;
 - ii. Helistop—Restricted Use;

- iii. Helistop—Special Use;
- iv. Vertipoint—Public Use;
- v. Vertipoint—Restricted Use; and
- vi. Vertipoint—Special Use;
3. Lighter than air aeronautical facility:
 - i. Balloonport—Public Use;
 - ii. Balloonport—Restricted Use;
 - iii. Balloonport—Special Use;
 - iv. Airship Base—Public Use;
 - v. Airship Base—Restricted Use; and
 - vi. Airship Base—Special Use;
4. Parachute drop zone aeronautical facility:
 - i. Parachute Drop Zone—Public Use;
 - ii. Parachute Drop Zone—Restricted Use; and
 - iii. Parachute Drop Zone—Special Use;
5. Aerospace facilities (Reserved); and
6. Temporary aeronautical facilities:
 - i. Airship Base;
 - ii. Balloonport;
 - iii. Helistop;
 - iv. Landing Strip;
 - v. Parachute Drop Zone;
 - vi. Vertipoint; and
 - vii. Other.

(b) Effective 180 days after the effective date of this chapter, all license applications and renewal applications shall comply fully with the requirements of N.J.A.C. 16:54-3.2.

(c) Existing aeronautical facilities which do not meet specific physical dimensional criteria or requirements of these revised regulations shall have two years to come into compliance. During that period, the licensee shall either make provisions to comply or petition for an exemption from the criteria as provided for in N.J.A.C. 16:54-7.

(d) Existing aeronautical facilities which do not meet the requirements of these regulations, other than those described in N.J.A.C. 16:54-1.2(b) or (c) shall have one year to come into compliance. During that period, the licensee shall make provisions to comply with the requirement or to petition for an exemption as provided for in N.J.A.C. 16:54-7.

16:54-1.3 Definitions

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

"Aeronautical activity" means any of the following aviation related commercial activities generally provided to the public or any segment thereof, at an aeronautical facility either by the licensee or his tenants or invitees, with or without compensation:

1. Aircraft operations, sales, rental, use, storage, and flight or ground training and examination;
2. Aircraft fueling, servicing, maintenance, repair, parts, construction, and training; and
3. Parachute operations, sales, use, rigging, maintenance, repair, construction, and training.

"Aeronautical facility" means any airport, seaplane base, heliport, helistop, drop zone, blimp mooring mast, balloonport, or vertipoint.

1. The facility includes all property, paving, appliances, structures, seaplane docks, runways, taxiways, seaways, sealanes, aprons, hangars, or safety equipment associated with the aeronautical activities conducted on the premises and property.

"Aerospace facility" is any facility used for the launch or recovery of spacecraft.

"AGL" means above ground level.

"Aircraft" means any contrivance now known or hereafter invented, used or designed for air navigation or flight in the air. It includes, but is not limited to: airplanes, airships, blimps, dirigibles, gyroplanes, gliders, helicopters, hot air or gas balloons, seaplanes, tiltrotors, and ultra lights.

"Airplane" means an engine-driven, fixed-wing aircraft that is heavier than air that is supported in flight by the dynamic reaction of air against its wings.

"Airport" means a designated area of land, water, or both, which is licensed for the landing and takeoff of airplanes and other aircraft, and which may provide facilities for shelter, security, and service of aircraft.

"Airport layout plan (ALP)" means the plan.

"Airport reference point (ARP)" means the centroid of the runways plotted using formulas found in FAA A/C 150-5300-13. The ARP is identified in latitude and longitude to the hundredth of a second.

"Airship" means an aircraft, lighter than air, engine driven that can be steered.

"Airship base" means any area of land or water of defined dimensions licensed for the takeoff and landing of airships.

"Alteration" means any construction, demolition, or modification to the surface, design, or operational areas of an aeronautical facility which affects, increases, or diminishes its operational capabilities.

"Approach/departure path" (pertains to operation of vertical flight aircraft) means a prescribed flight track extending outward and upward from the edge of a landing and takeoff area, along which normal flight is conducted to and from an approved aeronautical facility.

"Air navigation" means the operating, steering, directing, or managing of aircraft in or through the air, and on the ground or water.

"Balloon" means a lighter than air aircraft whose lift is derived from the buoyancy of hot air or certain gases and which is not engine driven.

"Balloonport" means any areas of land or water of defined dimensions licensed for the takeoff of manned, free-flight balloons.

"Building restriction line" means a line that is a specified distance from the centerline of a runway.

"Certified drawing" means a drawing certified as accurate by a licensed land surveyor, licensed professional planner or licensed professional engineer, and bearing the raised seal of the person certifying the drawing.

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

"Crew member" means an individual used to assist in the pre-flight inflation, launch, chase, landing (arrival) and recovery of a balloon; or any person authorized and assigned to perform duties in any aircraft during flight.

"Department" or "DOT" means the New Jersey Department of Transportation.

"Director" means the Director of the Office of Aviation in the New Jersey Department of Transportation.

"Exemption" means relief from a specific provision of this rule permanently or for a specified extended period of time.

"FAA" means the Federal Aviation Administration.

"Free-flight" (pertains to the operation of balloons) means the act of flying a manned balloon which is not tethered to the ground.

"Helicopter" means a rotary wing aircraft that depends principally upon the lift generated by engine-driven rotors rotating on a substantially vertical axis for its primary means of propulsion.

"Heliport" means a dedicated area of defined dimensions, either at ground level or elevated on a structure, designated for the landing or take off of helicopters and used solely for that purpose.

"Helistop" means an area of defined dimensions, either at ground level or elevated on a structure designated for the landing or take off of helicopters, but not limited in use to that sole purpose. Helistops generally provide minimal or no support facilities and may be located in multiple use areas such as parking lots, dock areas, parks, athletic fields or other suitable open areas.

"Landing and takeoff area" (pertains to the operation of helicopters) means a specific area of defined dimensions to which the helicopter approaches for landing or from which it departs, and includes the touchdown area.

"Licensee" means any person(s) whose name appears on the license of, and who is responsible for, or who controls operations at, an aeronautical facility.

"M" means meters, as a unit of measurement.

"MSL" means mean sea level.

"Moored or tethered flight" means the act of operating a balloon secured to the ground by sufficient and suitable means to permit vertical movements where no intention of launch into free-flight exists.

"NASA" means the National Aeronautics and Space Administration.

"Notice to Airmen (NOTAM)" means a notice containing information concerning the establishment, condition, or change in any component, facility, service, or procedure of, or hazard in the National Airspace System, the timely knowledge of which is essential to personnel concerned with flight operations.

"NTSB" means the National Transportation Safety Board.

"Obstruction to air navigation" means an object of greater height than any of the heights or surfaces presented in Subpart C of FAA Regulations Part 77. (Obstructions to air navigation are presumed to be hazards to air navigation unless an FAA study has determined otherwise.)

"Office" means the Office of Aviation in the New Jersey Department of Transportation.

"Parachute drop zone" means an area of defined dimensions, on the earth's surface, designated for the landing of parachutists.

"Parachuting exhibition" means the operation by specially qualified individual(s) engaged in parachuting to a specifically authorized drop zone, for exhibition purposes.

"Public use aeronautical facility" means any area of land, water, or both which is licensed for the landing or take off of aircraft and open to the public for aeronautical operations. Public use aeronautical facilities may be utilized, advertised, and represented as such.

"Reference point" (heliports and helistops only) means a point on the earth's surface, identified in terms of latitude and longitude to the nearest second, from which all linear measurements originate when applying the criteria of this subchapter to helicopter facilities. The facility reference point will always be the exact center of the helicopter touchdown area.

"Restricted use aeronautical facility" means any area of land, water or both, which is licensed for the landing or take off of aircraft under the conditions or restrictions imposed by the Office of Aviation, the licensee, or both.

"Runway" means a defined rectangular area of airport land prepared for the landing or take off of aircraft along its length.

"Runway safety area" means an area in which a runway is symmetrically located and is graded to be smooth and level. These areas are to be maintained in such a condition that aircraft operating thereon may do so, safely with no damage.

"Safety area" means a safety zone that provides an additional obstruction-free surface on all sides of a prescribed helicopter landing and take off area.

"Sealane" means a designated portion of water intended to be used by aircraft designed to operate on water.

"Seaplane base" means any landing area of water (with or without land support facilities) that is licensed for the landing or take off of aircraft that are able to utilize a water surface.

"Shelter" means an enclosed structure to provide for the comfort of persons against rain, wind, sun and adverse water.

"Spaceport" is any aerospace facility.

"Special use aeronautical facility" means any area of land, water or both, which is licensed for the landing and take off of designated aircraft by specified individuals, as authorized by the Office of Aviation.

"Taxiing" means a powered movement of an aircraft on the ground or water from one area to another. This definition includes hover-taxi as well as ground taxi for helicopters depending on the type of landing gear and the surface area being used.

"Taxiway" means a defined pathway established for movement of an aircraft on an aeronautical facility.

"Touchdown area" means a defined part of an aeronautical facility to which a helicopter shall approach and actually alight (or come to a zero forward ground speed hover, from the approach, prior to touchdown or taxiing to another area) and from which helicopter departures shall originate.

"Touchdown pad" means a designated area of an aeronautical facility on which a helicopter will actually alight.

"Vertical flight aircraft" means any aircraft which is capable of vertical or near vertical take off and landing operations including but not limited to rotor wing aircraft, tiltrotor aircraft, tilt wing aircraft, and fan in wing aircraft.

"Vertiport" means any area of land or water or elevated area of defined dimensions licensed for the take off and landing of vertical flight aircraft.

"VFR" means visual flying rules.

"Waiver" means relief from application requirements of this rule or temporary relief from other provisions of this rule for a specified limited time period.

16:54-1.4 Definitions incorporated by reference

Other definitions as described in Title 14 Code of Federal Regulations, Chapter 1 through 199, the FAA Airman's Information Manual and FAA Advisory Circulars are incorporated herein by reference, and all amendments thereto, except where the definitions are inconsistent with this chapter, in which case, this chapter shall control.

SUBCHAPTER 2. APPLICATION FOR LICENSE

16:54-2.1 Application forms for permanent facilities

(a) All persons proposing the opening of a new aeronautical facility, the alteration to, or deactivation or abandonment of, an existing aeronautical facility listed in N.J.A.C. 16:54-1.2 shall:

1. Submit an "Application for Aeronautical Facility License," Form DA-1, and "Aeronautical Facility Agreement," Form DA-2, or "Application for Aeronautical Facility Alteration, Deactivation, or Abandonment," Form DA-3, including all applicable attachments and FAA Form 7480-1 "Notice of Landing Area Proposal" if required. Such application shall include, at a minimum:

i. For Form DA-1 applications, all of the items listed in this section as applicable to the type of facility desired;

ii. For Form DA-3 applications, resubmission of required attachments which are presently on file in the Office of Aviation, with current date (may be waived by the Director);

iii. A description of the expected use and activity level of the new or altered facility;

iv. A certificate or statement from the applicant that he has advised the appropriate governing body in writing, by personal delivery or certified mail, return receipt requested, of his proposed action, as submitted in the application;

v. Additional materials as may be requested by the Director, to substantiate the application; and

vi. The appropriate application fee in accordance with the provisions of N.J.A.C. 16:63.

2. Unless otherwise specified herein, submit a scaled certified plan drawing or an annotated scaled aerial photograph, and a scaled certified profile drawing, showing the specific information required for the specific type of facility.

i. For airports or landing strips, a scale of one inch equals 400 feet shall be used showing:

(1) True north;

(2) Latitude and longitude to the nearest second;

(3) Field elevation (MSL);

(4) Actual length and width, of runway(s);

(5) Magnetic alignment of runway(s) to nearest second;

(6) Location(s) use, and height(s), of structures on or proposed for the facility.

(7) Location(s), use, and height(s) (MSL), of obstruction(s) in the Safety Zone Area if applicable;

(8) Location(s), use, and height(s) (MSL), of obstruction(s), where Safety Zoning does not apply, contiguous to the facility within at least 3,000 feet from the end of each runway and at least 500 feet from each side of the centerline of the runway(s);

(9) Proposed air traffic patterns superimposed on the drawing with pattern altitudes indicated;

(10) Include a listing of all aeronautical facilities located within five miles of the site; and

(11) Facility property lines and municipal boundaries.

ii. For heliports or helistops, a scale of one inch equals 50 feet shall be used, showing:

(1) True north;

(2) Latitude and longitude to the nearest second;

(3) Field elevations (MSL);

(4) Actual dimensions of the touchdown area;

(5) Location(s) and height(s) (MSL) of any obstructions within a radius of 1,000 feet of the reference point;

(6) Location(s) of approach/departure path(s); and

(7) Facility property lines and municipal boundaries.

iii. Also for heliports and helistops, a scale of one inch equals 400 feet shall be used showing:

(1) Location(s) and height(s) (MSL) of any obstructions within a radius of 3,000 feet of the reference point;

(2) Location(s) of approach/departure path(s); and

(3) Facility property lines and municipal boundaries.

iv. For vertiports, a scale of one inch equals 100 feet shall be used, showing:

(1) True north;

(2) Latitude and longitude to the nearest second;

(3) Field evaluation (MSL);

(4) Actual dimensions of the touchdown area;

(5) Magnetic alignment of runway(s) to nearest second; and

(6) Location(s), use, and height(s), of structures on or proposed for the facility.

v. Also for vertiports, a scale of one inch equals 400 feet shall also be used showing:

(1) Location(s), use, and height(s) (MSL), of obstruction(s) in the Safety Zone Area if applicable;

(2) Location(s), use, and height(s) (MSL), of obstruction(s), where Safety Zoning does not apply, contiguous to the facility within at least 3,000 feet from the end of each runway and at least 500 feet from each side of the centerline of the runway(s); and

(3) Proposed air traffic patterns superimposed on the drawing with pattern altitudes indicated.

vi. For balloonports, a scale of one inch equals 100 feet shall be used, showing:

(1) True north;

(2) Latitude and longitude to the nearest second;

(3) Field elevation (MSL);

(4) Actual dimensions of the departure area;

(5) Location(s) and height(s) (MSL) of any obstructions within a radius of 1,000 feet of the center of the proposed facility; and

(6) Facility property lines and municipal boundaries.

vii. For airship bases, a scale of one inch equals 100 feet shall be used, showing:

(1) True north;

(2) Latitude and longitude to the nearest second;

(3) Field evaluation (MSL);

(4) Actual dimensions of the operating area;

(5) Magnetic alignment of runway(s) to nearest second;

(6) Mast location and airship drift clearance; and

(7) Location(s), use, and height(s), of structures on or proposed for the facility.

viii. Also for airship bases, a scale of one inch equals 400 feet shall also be used showing:

(1) Location(s), use, and height(s) (MSL), of obstruction(s) in the Safety Zone Area if applicable;

(2) Location(s), use, and height(s) (MSL), of obstruction(s), where Safety Zoning does not apply, contiguous to the facility within at least 3,000 feet from the end of each runway and at least 500 feet from each side of the centerline of the runway(s);

(3) Proposed air traffic patterns superimposed on the drawing with pattern altitudes indicated; and

(4) Mast location and airship drift clearance.

ix. For parachute drop zones, a scale of one inch equal 400 feet shall be used, showing:

(1) True north;

(2) Latitude and longitude to the nearest second;

(3) Actual dimensions of the drop zone;

(4) Locations, runway alignments, traffic patterns of any other aeronautical facilities within 3,000 feet of the center of the drop zone;

(5) All roads, streets, powerlines, telephone lines, and bodies of water (where any depth at any time exceeds four feet), within 3,000 feet of the center of the drop zone;

(6) All buildings with heights above the drop zone elevation within 1,000 feet of the center of the drop zone; and

(7) All inhabited buildings within 1,000 feet of the center of the drop zone.

x. Parachute drop zones shall also include a listing of all aeronautical facilities located within five miles of the site.

xi. For banner towing facilities, include a sketch of the designated drop and "pick-up" area which shows the air traffic pattern for pick-up and drop of the banner.

xii. For minor alterations at restricted or special use facilities, the engineering certification is not required unless site requirements are such that the Director deems it necessary.

xiii. For abandonment or deactivation of any facility, certified drawings are not required.

3. Upon request by the Director, submit a narrative legal description, certified by a land surveyor or professional engineer licensed by the State Board of Professional Engineers and Land Surveyors as truly describing the site for which a license is requested or held.

4. For an elevated heliport or helistop, submit a certified drawing showing that the load bearing capability structural limits of any structure proposed is sufficient for the type of operations anticipated.

5. If the aeronautical facility premises are not owned by the applicant, the applicant shall:

i. Identify on the license application the owner(s) and any other parties who hold an interest in the property by lease or otherwise, and specify their interest; and

ii. Submit copies of all documents of title or interest to the Office upon request. Prior to licensing, the applicant shall submit written approval for the facility from the person(s) controlling the proposed facility premises.

6. Submit a statement or certificate, issued by the appropriate government body having jurisdiction, that the proposed facility or changes thereto, as submitted in the application, is in conformance or nonconformance with current land use ordinances; and that according to the plans, it can be constructed in accordance with State Uniform Construction Code and Uniform Fire Code. For the purposes of land use and zoning, any aeronautical activity is considered a permitted use at a public use aeronautical facility; and is considered a conditional use at restricted use and special use aeronautical facilities, subject to specific approval by the Office after coordination with, and input from, the appropriate local governing body.

i. If the relevant government authority does not provide such a statement as to land use ordinance compliance or noncompliance within 45 days of the date the application was submitted to them personally or through certified mail, return receipt requested, for response, the applicant shall submit such proof of submission and the application shall be considered to be in full compliance with local land use ordinance requirements for the purpose of this licensure application only;

ii. If the applicant is notified that the proposed facility is contrary to current land use ordinances, the applicant shall submit to the Office a copy of the application for local approval and the final decision which has been made, as well as copies of the certificate or statement of nonconformance, and all relevant provisions of the pertinent ordinances;

7. In addition to the approvals required in (a)6 above, the applicant shall submit copies of permits, applications or if not yet approved, notices of intent, which are required by any other Federal, State, or local agency exercising control of designated land or water area. If only permit applications are submitted, final permits or letters of denial shall be submitted when received.

8. For deactivation or abandonment, or any change that will require relocation, transfer, or eviction of tenants, submit a plan explaining how facility tenants and/or users are to be notified, and what opportunities are available for relocation;

9. Applicants submitting requests under the requirements of N.J.S.A. 16:61 (Safety Fund Grants) are exempt from duplicate DA-1 and DA-2 requirements; and

10. Submit a completed copy of FAA Form 7480-1, "Notice of Proposed Construction or Alteration" (or subsequent form as amended or superseded) at the same time the form is submitted to the FAA.

(b) The applicant may request, in writing, waivers of application requirements to the Office. The Director may approve such waivers based on, but not limited to, the following:

1. Hardship to the applicant; or

2. Demonstrated substantial compliance with the provisions of this chapter; or

3. The scope and magnitude of the item does not require full compliance.

16:54-2.2 Application forms for temporary facilities

(a) All persons proposing to operate temporary aeronautical facilities shall:

1. Submit an Application for Temporary Aeronautical Facility, Form DA-5, including all applicable attachments; and

2. Comply with the provisions of N.J.A.C. 16:54-6.

16:54-2.3 Notice to the public

(a) The applicant shall publish a legal notice as shown in Appendix A, incorporated herein by reference, when required by the Office of Aviation, the text of which will be provided by the Office of Aviation.

1. The legal notice shall be published in at least two newspapers serving the city, township, municipality, county or other political subdivisions.

2. One of the papers shall be the official publication designated by the political subdivision for public notices and the second shall be the newspaper designated as secondary, or, if not so designated, shall be a newspaper circulated widely in that community.

(b) The notice shall contain the text prepared by the Office and shall provide period for public comment and response of not less than 15 days regarding all proposals to construct new aeronautical facilities. At the discretion of the Director, in accordance with N.J.A.C. 16:54-2.1(b), the publication requirements may be waived for a proposed alteration, deactivation or abandonment of an existing facility.

(c) The applicant shall submit, to the Office of Aviation, certified proof of publication in the two newspapers. Where the publication dates differ, the later publication date will be used by the Office in determining the public period for comment.

16:54-2.4 Public hearing testimony

(a) The Commissioner may direct that public hearings and/or informational meetings be held regarding an application for license.

(b) The applicant shall be prepared to provide relevant data and information regarding the application at a public hearing or at any proceeding requested by the Office. The applicant is responsible for preparing a formal transcript of the public hearing to be submitted to the Office. Such hearing or proceeding shall be conducted at no cost to the State of New Jersey.

16:54-2.5 Application processing

(a) All applications for aeronautical facility licenses shall be processed by the Office to ascertain that the minimum requirements of this chapter are met, as well as whether the issuance of such license considers the interest of public health and safety and the development of aeronautics in the State. Factors such as surrounding land uses, local zoning ordinances, topography, noise characteristics of the type of aeronautical equipment to be used, air traffic patterns proposed in the area, and any other relevant information shall be part of the consideration required for such license processing.

1. The Office reserves the right to approve the methods, standards, techniques, and sites to be used in the construction, change, modification, and/or alteration of new or existing aeronautical facilities sufficient to ensure compliance with reasonable engineering practices and to ensure that safety of the public.

2. Any proposed changes to an approved application must be provided to the Director for review and approval before proceeding with the change. Substantive changes, proposed to an already submitted application, which substantially change the impact on the contiguous land area or airspace, cannot be approved and will require the submission of a new application incorporating such changes.

16:54-2.6 Approvals

If the application is approved, the applicant shall receive a license, Form DA-L-1, Aeronautical Facility License, for the facility. If the application is disapproved, the applicant may petition the Commissioner for exemption in accordance with N.J.A.C. 16:54-7, Petition for Exemption.

16:54-2.7 Commencement of activities

No construction, alteration or closure shall occur until the applicant receives written approval from the Director.

16:54-2.8 Renewals

(a) All licenses expire on the last day of the 12th month following the date of issuance.

(b) The Office will renew an aeronautical facility license in accordance with the following procedures:

1. The Office will issue an aeronautical facility renewal, Form DA-4 which includes a facility inspection and certification attachment, to the licensee of record, not less than 30 days prior to the expiration of the current license.

2. Licensees shall conduct a facility inspection using the form provided certifying that the facility is being maintained in compliance with the provisions of this chapter and any conditions stipulated in the license.

3. Licensees shall submit to the Office:

- i. The renewal application, Form DA-4, with any changes annotated thereon,
- ii. The appropriate renewal fee in accordance with the provisions of N.J.A.C. 16:63;
- iii. The completed facility inspection attachment Form DA-4 signed by the licensee.

4. The Office may conduct additional facility inspections to verify the information submitted in the renewal process.

5. The Office will review the submitted renewal materials to determine their compliance.

6. Upon review and determination that the licensee's renewal application, with attachments, is in compliance with this chapter the license will be renewed.

(c) Areas of non-compliance found during the review process will be reported to the licensee for corrective action. Licensees shall submit a plan for corrective action along with a schedule for accomplishing those actions. Renewal of a license may be withheld at the discretion of the Director pending compliance with these rules.

(d) Should the Director withhold a license renewal pending compliance, the licensee may petition the Commissioner for waiver or exemption in accordance with N.J.A.C. 16:54-7.

(e) The Director may extend for up to 90 days, any license issued by the Office, when requested by the licensee or the Office, and when the extension of such license is in the best interest of the public safety and the safety of those using the licensed aeronautical facility.

16:54-2.9 License transfers

(a) Aeronautical facility licenses may be transferred under the following conditions:

1. The licensee shall submit a written request to the Office of Aviation, which includes a letter of intent to transfer ownership or control.

2. The new owner shall, within 30 days of the transfer of ownership or control, submit to the Office, a signed Form DA-2, Aeronautical Facility Agreement, and proof of legal transfer of ownership or control of the facility.

(b) Upon receipt of the documents required by (a) above, the Office may issue an amended license.

(c) Failure to comply with the provisions of this section will result in suspension of the facility license.

16:54-2.10 Abandonment, deactivation and surrender of license

(a) Licensees who wish to deactivate or abandon their facility shall:

1. Submit a completed copy of Form DA-3, Application for Aeronautical Facility Alteration Deactivation or Abandonment, to the Office not less than 30 days prior to the desired date of closure;

2. Submit a copy of FAA Form 7480-1, Notice of Proposed Construction or Alteration, (or subsequent form as amended or superceded) as submitted to the FAA requesting closure;

3. Submit a plan, satisfactory to the Director, explaining how facility tenants and or users are to be notified of the closure and what opportunities are available to them for relocation; and

4. Where applicable, the licensee shall submit a plan detailing how provisions of N.J.S.A. 6:1-94 (c) will be met.

(b) The Director shall determine, within 10 days of receipt of the application, whether the request to deactivate or abandon the facility is in the best interest of the State of New Jersey, the aviation community and the general public.

1. Licensees shall be notified within five days of the Director's decision concerning the application for abandonment or deactivation.

2. The Director may delay the requested closure date pending compliance with the procedures in (a) above.

3. In the event that the Director determines that in the best interests of the State of New Jersey the aeronautical facility should remain open, he will recommend that the Commissioner exercise the authority granted under N.J.S.A. 6:1-95 to acquire the facility.

(c) Licensees who have received approval to deactivate or abandon their facility shall surrender their license to the Office within 30 days after approval of the closure or within 30 days after actual closure, which ever comes later.

(d) Licensees whose license has been suspended or revoked shall immediately surrender their license to the Office or upon demand directly to any duly authorized representative of the Office.

SUBCHAPTER 3. GENERAL REQUIREMENTS

16:54-3.1 General requirements for all aeronautical facilities

(a) All aeronautical facilities and all operations at aeronautical facilities shall conform to the Federal Aviation Regulations of the United States, the laws of the State of New Jersey, the orders issued by the Commissioner, and the rules promulgated by the Department of Transportation.

(b) All licensed aeronautical facilities shall be maintained in a safe and hazard-free condition.

(c) Licensees shall provide safeguards acceptable to the Office to prevent inadvertent entry by unauthorized persons to the aeronautical operating area of the aeronautical facility. These safeguards shall be sufficient to prevent inadvertent entry at all times when flight operations are in progress or when aircraft are being operated or prepared for operations.

(d) Aircraft capable of meeting FAA certification specifications for landing or take off at a specified size aeronautical facility shall not be prohibited from using any public use aeronautical facility of that size or greater, except when such use would violate FAA or DOT rules or regulations, or would conflict with approved written standard procedures prepared by the licensee in accordance with this chapter.

(e) Licensees shall provide the Office with the current name, home address and telephone numbers of the facility manager or responsible official who may be contacted at any time in case of emergency.

(f) Any duly authorized representative of the Office, upon presentation of Department credentials shall be permitted to enter and inspect the premises at any time during scheduled hours of operation. Any such representative shall also be permitted to inspect all records and equipment during the inspection.

(g) The Certificate of License shall be displayed on the premises at all times, and shall be presented for inspection upon demand of any police officer of this State, or any representative of the Office.

(h) If any information found in any license application or any additional information which may be submitted in connection therewith is found to be false, such false statements shall constitute good and sufficient cause for the Commissioner, at his or her discretion, to revoke any license issued based on that application.

(i) Licensees shall not be convicted felons or have multiple suspensions of previous aeronautical licenses.

(j) Licensees shall be residents of New Jersey or shall have an authorized agent registered with the State to act on his behalf.

(k) No buildings, structures, trees, or other permanent or semipermanent obstructions shall be built or located between the building restriction line and the runway.

16:54-3.2 General requirements for all public use aeronautical facilities

(a) Licensees shall establish and enforce written Aeronautical Activity Standards for the management and control of all aeronautical activities conducted at their facility. Such activities may include, but are not limited to:

1. Aircraft: sales, charter, rental, lease, storage, hangaring, tie-down, and aircraft parking;

2. Instruction: aircraft flight and ground instruction of all types, license examinations and proficiency checks, crew member training, parachute jumping training;

3. Maintenance: all types of maintenance, repair, inspection, testing, modification, overhaul, corrosion control or painting on aircraft, engines, systems, avionics, parachutes, or ancillary air or ground support equipment;

4. Servicing: aircraft fueling using fixed, hydrant, mobile or portable equipment; aircraft engine or systems servicing including hydraulics, pneumatics, oxygen, lavatory, catering, electronics, aircraft cleaning; and

5. Other usually recognized aeronautical activities, including any activity specifically approved by the Commissioner.

(b) Written standards required in (a) above shall be reviewed and approved by the Office, as follows. Licensees shall:

1. Notify the Office in writing that such aeronautical activities occur at the facility;

2. Submit copies of the procedures for review; and

3. Open the facility to inspections by any duly authorized representative of the Office during scheduled hours of operation. Office representatives shall also be permitted to inspect all records and equipment. The inspection may include:

i. An evaluation of general compliance with industry standards;

ii. A review of the implementation of the written operating procedures in use or proposed; and/or

iii. A safety inspection of the physical facility.

(c) Licensees shall post the approved Aeronautical Activity Standards in a conspicuous place at the aeronautical facility. Licensees shall provide copies of the approved standards for tenants and those others engaged in aeronautical activities at the facility. Licensees shall make copies available to other users of the facility.

(d) Licensees shall enforce the approved and posted Aeronautical Activity Standards.

(e) Compliance with these Aeronautical Activity Standards shall not relieve the operator of any aeronautical activity from the responsibility to comply with other regulatory requirements.

(f) Licensees shall establish written aeronautical facility General Operating Rules to ensure the public safety, the safety of the general flying public, and the safety of those using the aeronautical facility. Licensees shall submit their proposed rules to the Director for review and approval. Upon approval, the licensee shall distribute the General Operating Rules to all tenants and make the rules available to other users. In addition, the licensee shall post the rules in conspicuous places at the aeronautical facility.

(g) Public use telephones or other means of communication must be available at all times for emergency service notification (fire, police, rescue) and for contact with FAA air traffic facilities. Emergency phone numbers or notification procedures shall be conspicuously posted.

16:54-3.3 General requirements for restricted use aeronautical facilities

(a) Restricted use facilities shall not be open to general public use and shall not be utilized, advertised, or represented as such.

(b) The licensee, or his or her designee, shall be responsible for approving the use of the facility by any individual. Approved users shall be advised of facility conditions or restrictions which may affect aircraft operations.

(c) Aeronautical activities may be conducted on restricted use facilities only upon written request to, and after concurrence by, the Office.

(d) Licensees shall establish written Aeronautical Activity Standards for the management and control of all aeronautical activities authorized to be conducted at their aeronautical facility. Such standards shall be prepared in accordance with the provisions of N.J.A.C. 16:54-3.2.

(e) Licensees may establish written aeronautical facility general operating rules in accordance with the provisions of N.J.A.C. 16:54-3.2(d).

16:54-3.4 General requirements for special use facilities

(a) Special use facilities shall be available only to those persons specifically listed on the license and using only that equipment specifically designated on the license.

(b) Those persons approved to use the facility shall hold, at a minimum, a current FAA Private Pilot certificate with the applicable category, class, and type rating.

(c) Applicants for a special use facility may be required to conduct a flight demonstration, at a licensed public use aeronautical facility, to satisfactorily demonstrate his ability to operate in a space of like dimensions to that proposed in the application.

(d) Aeronautical activities shall not be permitted at these facilities, except when specifically authorized by the license.

(e) Special use facilities which require multiple auxiliary sites will meet the requirements of N.J.A.C. 16:54-2 for each site, unless such requirements are waived by the Director. Each approved auxiliary site will be listed on the facility license.

16:54-3.5 General requirements for aerospace facilities (Reserved)

SUBCHAPTER 4. DESIGN STANDARDS

16:54-4.1 General design standards for all facilities

All licensed and proposed aeronautical facilities shall be designed, constructed, and maintained in accordance with the provisions of N.J.A.C. 16:54-4.2, 4.3, and 4.4, in order to provide for the public safety, the safety of those participating in aviation, and the safety of those using the aeronautical facility.

16:54-4.2 General design standards for public use facilities

(a) Each proposed or licensed public use aeronautical facility shall meet or exceed the minimum standards as specified for the respective type of aeronautical facility.

1. Public use airport (land or water):

i. Public use airports (land) shall have an effective runway length of 1,800 feet (550 meters) and a runway width of 50 feet (15 meters). Public use airports (water) shall have an effective runway length of 3,900 feet (1,200 meters) and a runway width of 250 feet (76 meters). Additional length and width requirements will be as recommended in FAA Advisory Circular 150/5300-13, as may be revised.

ii. Runway safety areas shall be as recommended in FAA Advisory Circular 150/5300-12 as may be revised.

iii. Each runway will have protected airspace consistent with its intended use, as determined by criteria described in FAA Part 77, N.J.A.C. 16:62 and FAA Advisory Circular 150/5300-13, to provide obstacle free aircraft operating areas. This includes clear zones, runway protection zones, side slopes, and transitional surfaces. A minimum approach slope ratio of 20:1 is required.

iv. Operational lighting systems are required for airports operating during hours of darkness. Minimum airport lighting will consist of runway lights, threshold lights and a lighted wind indicator. Runway lights will be spaced not more than 200 feet apart. Additional lighting and visual aids may be required consistent with airport use. FAA

Advisory Circular 150/5340-24, as may be amended, will be used for lighting standards. Water facilities will comply with U.S. Coast Guard and other agencies requirements for lighting of sealanes.

v. Pavement marking will conform to standards of FAA Advisory Circular 150/5340-1, as may be amended, and is mandatory consistent with each runway use classification.

2. Public use heliports:

i. Public use heliports shall be not less than 100 feet by 100 feet or 100 feet in diameter, exclusive of the safety area. This minimum size may limit user access and larger facilities should be considered dependent upon anticipated aircraft size and activity. FAA Advisory Circular 150/5340-2 will be used in designing heliports.

ii. Imaginary surfaces and approach/departure paths will provide protected airspace for two ingrees/egrees routes of not less than an 8:1 ratio.

iii. Lighting and visual aids are required for operation during hours of darkness and shall, at a minimum, provide perimeter lighting and a lighted wind indicator. FAA Advisory Circular 150/5340-2 will be used in determining the extent and location of lighting systems.

iv. Heliport marking will be as required in FAA Advisory Circular 150/5340-2, as may be amended.

3. Public use vertiports:

i. Vertiports shall be not less than 250 feet by 250 feet and shall comply with the criteria of FAA Advisory Circular 150/5340-3, as may be amended.

ii. Lighting and visual aids are required for operation during the hours of darkness.

iii. Vertiport surface markings shall conform to FAA Advisory Circular 150/5340-3 as may be amended.

4. Public use balloonports:

i. A public use balloonport shall be not less than 200 feet by 200 feet or 200 feet in diameter. Obstruction clearance for departures will be determined for a 1:1 slope ratio.

ii. Night operation of balloons will be conducted in accordance with applicable federal aviation regulations and sufficient lighting should be provided on the ground for safety of operation.

5. Public use airship base:

i. The length of an airship base will not be less than one and one-half times the overall length of the largest airship anticipated to use the facility. This measurement will begin at the mooring mast and extend in the direction of the landing path. A 20:1 obstacle-free approach/departure path will be provided.

ii. Lighting must be provided for night operations. This may consist of a flashing beacon on the mooring mast and adequate floodlighting to assure obstruction avoidance.

6. Parachute drop zone:

i. Public use parachute drop zones shall be not less than 1,800 feet in diameter or 1,800 feet along its sides if essentially square in shape.

ii. Night parachuting activities will comply with applicable federal aviation regulations and sufficient ground lighting should be provided to illuminate the center portion of the drop zone.

16:54-4.3 General design standards for restricted use facilities

(a) All restricted use aeronautical facilities shall meet the design requirements set forth in N.J.A.C. 16:54-4.2 for the same type of public use aeronautical facilities.

(b) Restricted use heliports and helistops shall meet the design requirements of FAA Advisory Circular 150/5340-2, as may be amended or superseded.

(c) Waivers or exemptions to specific design criteria may be granted in accordance with N.J.A.C. 16:54-7.

16:54-4.4 General design standards for special use aeronautical facilities

(a) All special use aeronautical facilities shall meet the design requirements set forth in N.J.A.C. 16:54-4.3 for the same type of public use aeronautical facility or shall comply with the provisions of N.J.A.C. 16:54-3.4 and (b) and (c) below.

(b) If any of the design standards cannot be met at a special use aeronautical facility, the applicant or licensee shall submit to the

Office copies of the aircraft manufacturer's performance data for the specific aircraft proposed for use at the facility.

(c) Special use aeronautical facilities will not be licensed, or approved, for use by any aircraft whose minimum performance and operating limits do not permit operations within the available dimensions of the facility.

SUBCHAPTER 5. OPERATIONAL STANDARDS

16:54-5.1 General operational standards

(a) Each licensed aeronautical facility shall prepare and maintain at the aeronautical facility, a facility operations manual which includes the following materials:

1. The facility operating hours and hours attended.

2. Emergency operations information:

i. Emergency notification procedures,

ii. Notification list for use in emergencies with telephone numbers for the facility owner(s), the operator, the local fire department, police, ambulance or emergency medical service, nearest New Jersey State Police Barracks, the NJDOT Office of Aviation, the appropriate FAA Flight Standards District Office, and the NTSB,

3. Emergency procedures to be used in the event of:

i. Fire;

ii. Police or security;

iii. Rescue or emergency medical service response; and

iv. Aircraft accident or incident reporting

4. Facility inspection procedures;

5. Facility air traffic pattern(s);

6. Procedures to use in issuing or cancelling NOTAMs; and

7. Minimum airman qualifications as follows:

i. A student pilot certificate is not an acceptable minimum airman qualification;

ii. For demonstration or exhibition use of a facility, an applicable FAA Commercial Pilot certificate is the minimum acceptable airman qualification; and

iii. For a parachute drop zone for parachute exhibitions, parachutists shall hold a U.S. Parachute Association "C" level qualification or better.

(b) For the purpose of issuing Notices to Airmen in an emergency, licensees shall additionally delegate NOTAM issuing authority to the Office. This delegation shall be made to the FAA Flight Service Station with jurisdiction for the facility.

(c) Licensees or their agents shall report all aircraft accidents or incidents occurring on, or contiguous to, their aeronautical facility, as soon as practicable to the local police, the Office, the FAA Flight Standards District Office (FSDO) with jurisdiction, the NTSB, and the nearest State Police Barracks.

(d) Licensees of all aeronautical facilities shall notify the Office of any proposed changes to air traffic flight patterns for their facility prior to submitting notification to the FAA in accordance with Federal Air Regulation Part 157. The licensee shall receive concurrence from the Office prior to implementing the proposed change.

(e) Licensees may establish noise abatement procedures for their facility. Any proposed procedure or change to existing procedure shall be submitted to the Office for review, coordination with the affected municipality(ies), and approval by the Director prior to implementation.

16:54-5.2 Operational standards for public use aeronautical facilities

(a) All public use aeronautical facilities shall maintain a facility operations manual as required by N.J.A.C. 16:54-5.1(a), with the following additions:

1. An aeronautical facility self-inspection program plan which includes:

i. A checklist of items to be inspected;

ii. A schedule of such inspections;

iii. Notification procedures for discrepancies found; and

iv. Corrective action procedures for discrepancies found;

2. Procedures for the control and use of vehicles on the aeronautical operations area;

3. Winter operations snow and ice control plans;

4. Aircraft recovery plan which includes:
i. Procedures to be used in recovering damaged aircraft located on or near the facility;

ii. A list of recovery equipment and sources of that equipment including telephone contacts; and

iii. A list of firms capable of accomplishing such recovery;

5. A listing of aeronautical activities conducted at the facility, along with a copy of the approved Aeronautical Activity Standards for the facility; and

6. A copy of the approved general operating rules for the facility, as required by N.J.A.C. 16:54-3.2(d).

(b) Licensees of public use aeronautical facilities shall prepare aeronautical operations area ground operating procedures which shall be used by all facility users. Such procedures shall be made a part of the facility general operating rules as required by N.J.A.C. 16:54-3.2.

(c) The Director may require noise abatement procedures to be prepared for a public use aeronautical facility, in accordance with N.J.A.C. 16:54-5.1(d), in the interest of good community relations. Communities which believe they are adversely impacted by aircraft noise from adjacent public use aeronautical facilities may request the Director to take such action.

(d) The licensee of each public use aeronautical facility shall enforce the aeronautical facility's approved general operating rules as required in N.J.A.C. 16:54-3.2(d).

(e) Any use of a public use aeronautical facility which is in violation of the aeronautical facility's approved aeronautical activity standards or the facility's approved general operating rules shall be considered an unlawful use of the aeronautical facility.

(f) Traffic pattern altitudes for public use aeronautical facilities shall not be less than 1000 feet AGL (above ground level), except where required for operational considerations.

16:54-5.3 Operational standards for restricted aeronautical facilities

(a) All restricted use aeronautical facilities shall maintain a facility operations manual as required by N.J.A.C. 16:54-5.1(a), with the following additions:

1. An aeronautical facility self inspection program plan which includes:

i. A checklist of items to be inspected;
ii. A schedule of such inspections;
iii. Notification procedures for checklist discrepancies found; and
iv. Corrective action procedures, if required, for checklist discrepancies found;

2. Procedures for the control and use of vehicles on the aeronautical operations area;

3. Procedures for approving the use of the facility by an individual;

4. Procedures for advising facility users about the conditions of the facility and any restrictions at the facility which might affect aircraft operations;

5. A listing of aeronautical activities conducted at the facility, along with a copy of the approved aeronautical activity standards for the facility; and

6. A copy of the facility general operating rules, in accordance with N.J.A.C. 16:54-3.3(e), if applicable.

(b) The licensee of each restricted use aeronautical facility which has general operating rules written and approved for the facility in accordance with N.J.A.C. 16:54-3.2(d) shall enforce the aeronautical facility's approved general operating rules.

16:54-5.4 Operational standards for special use aeronautical facilities

The Director may require licensees of special use aeronautical facilities to comply with specific provisions of N.J.A.C. 16:54-5.2 or 5.3, or other operational standards, when necessary to promote the public safety, the safety of the general flying public, or the safety of those using the aeronautical facility.

SUBCHAPTER 6. TEMPORARY AERONAUTICAL FACILITIES

16:54-6.1 Temporary licenses

(a) The Office may issue a temporary aeronautical facility license for a special purpose, at a designated area which normally requires no facility preparation, and for a limited period of time which shall not exceed nine months.

(b) Temporary licenses may be issued for the following facilities:

1. Airship base;
2. Balloonsport;
3. Helistop;
4. Landing strip;
5. Parachute drop zone;
6. Vertiport; or
7. Any other facility as may be designated by the Director.

(c) Temporary licenses issued by the Office shall indicate the following:

1. An expiration date not to exceed nine months after the date of issuance;
2. Delineation of approved operations; and
3. All applicable privileges or limitations specified by the Office.

(d) Extensions of temporary licenses may be granted by the Director for a period not to exceed 90 days. Requests for extension shall be submitted to the Office in writing with an explanation for the request.

(e) A temporary license may be issued for a facility in conjunction with an application for permanent license. Such combined requests shall be accompanied by written concurrence of the municipality that such use is permitted pending administrative processing of the formal application. Temporary licenses issued under this rule shall become void:

1. Upon issuance of a permanent license;
2. If the application for a permanent facility is disapproved by the Department; or
3. One year from date of issuance, if the applicant fails to pursue meeting the requirements of this chapter for a permanent license.

16:54-6.2 Application for temporary license

(a) An application for a temporary license shall:

1. Be prepared in compliance with the requirements for a permanent facility of the same type, if it is being submitted as a combined request for a permanent license;

2. Include Application Form DA-5, Application for Temporary Aeronautical Facility License; and

3. Be received by the Office at least 10 working days prior to the requested start date.

(b) Applications shall include:

i. A letter, statement, or certificate from the governing body having jurisdiction, signed by the mayor (or a specifically delegated representative), which states that there is no objection to the issuance of temporary license;

ii. A sketch which includes sufficient detail to demonstrate that the proposed facility is capable of accepting the operation proposed;

i. For banner towing facilities, include a sketch of the designated drop and "pickup" area which shows the air traffic pattern for pickup and drop of the banner.

ii. For parachute drop zones for parachuting exhibitions, the sketch shall include at least a 200 foot by 200 foot clear target/touchdown area and all obstacles and terrain within 1,000 feet of the center of the target/touchdown area;

3. Certification that the areas to be utilized are under the control of the applicant or are being used with the permission of the landowner;

4. A description of the provisions to be made for the safety of those persons in the immediate vicinity of the operation and those participating in the operations;

5. The name, address, and phone number of the person responsible for the conduct of operations at the proposed facility;

6. Aircraft specifications and performance data indicating that the intended operations can be safely conducted in the areas intended for use; and

7. A list of airmen and other persons intending to utilize the facility and their qualifications.

(c) Requests for waivers of application requirements for a temporary facility shall follow the procedures in N.J.A.C. 16:54-2.1(b).

(d) A complete copy of the application and all attachments shall constitute the temporary facility record.

16:54-6.3 General requirements for temporary aeronautical facilities

The general requirements for temporary facilities which are licensed in conjunction with an application for a permanent license shall substantially meet the requirements for permanent facilities, as outlined in N.J.A.C. 16:54-3.

16:54-6.4 Design standards for temporary aeronautical facilities

The design standards for temporary facilities which are licensed in conjunction with an application for a permanent license shall substantially meet the requirements for permanent facilities, as outlined in N.J.A.C. 16:54-4.

16:54-6.5 Operational standards for temporary aeronautical facilities

The operational standards for temporary facilities which are licensed in conjunction with an application for a permanent license shall substantially meet the requirements for permanent facilities, as outlined in N.J.A.C. 16:54-5.

SUBCHAPTER 7. WAIVERS AND EXEMPTIONS

16:54-7.1 General requirements

(a) Applicants or licensees who believe themselves to be adversely affected by any rule of this chapter, and who believe further that exceptional circumstances or hardship warrant a waiver or exemption from a rule, may petition the Director for relief.

(b) Waivers may be requested if the situation requiring the relief is of a temporary nature.

(c) Exemptions may be requested if the situation requiring the relief is of a continuing nature, and which requires permanent or long term relief from a rule.

16:54-7.2 Requests for waiver

(a) Requests for waiver regarding design criteria or facility requirements shall include:

1. A letter marked "Request for Waiver" which states the specific rule from which relief is being requested, along with a complete description of, and reasons for the request;

2. An attached drawing of the facility or appropriate section thereof, which shows the area involved in the request;

3. An attachment, if appropriate, explaining what measures or alternatives will be used to meet the intent of the rule; and

4. An attachment explaining the time period requested for the waiver, and an explanation of how full compliance is planned at the end of the waiver period.

(b) Requests for waiver for matters not covered in (a) above shall include:

1. A letter marked "Request for Waiver" which states the specific rule from which relief is being requested, along with a complete description of, and reasons for the request;

2. An attachment, if appropriate, explaining what measures or alternatives will be used to meet the intent of the rule; and

3. An attachment, explaining the time period requested for the waiver, and an explanation of how full compliance is planned at the end of the waiver period.

16:54-7.3 Petitions for exemption

(a) Petitions for exemption regarding design criteria or other matters for which a Form DA-1 is suitable, shall include:

1. A Form DA-1 with all pertinent attachments as required by N.J.A.C. 16:54-2.1 marked "Petition for Exemption"; and

2. Appropriate attachments which include a complete description of, and reasons for, the proposed exemption, explaining in detail why the rule provisions cannot be met.

(b) Petitions for exemption for matters not covered in (a) above shall include:

1. A letter requesting the exemption marked "Petition for Exemption" and

2. Appropriate attachments which include a complete description of, and reasons for, the proposed exemption, explaining in detail why the rule provisions cannot be met.

16:54-7.4 Filing, decisions, and appeals

(a) Requests for waivers and petitions for exemption shall be filed with the Director. The Director will review the petition and may approve, reject, or modify the exemption.

(b) Rejected requests or petitions which will result in license denial, modification, suspension, or revocation, may be appealed in accordance with the provisions of N.J.A.C. 16:54-9.3.

SUBCHAPTER 8. LIABILITY AND PENALTY

16:54-8.1 Compliance with laws, rules and regulations

Issuance of a license does not relieve the licensee of any other applicable federal, state, or local laws, rules or regulations.

16:54-8.2 License action

Any license issued pursuant to the provisions set forth in this chapter may be modified, suspended, or revoked in the interest of public safety or as a result of a violation of any of the provisions of this chapter and/or any of the provisions of N.J.S.A. 6:1-1 et seq. or the rules promulgated thereunder.

16:54-8.3 Misrepresentation or false statement

(a) Any person who makes a misrepresentation or false statement in any application, interview, or submission of information to the Office, shall be considered to be acting contrary to the provisions of this chapter and Title 6 of the New Jersey statutes.

(b) Any application which is found to contain misrepresentations or false statements shall be rejected and any license issued as a result of that application shall be immediately suspended, pending submission of a corrected application. If corrections are not made within 30 days, the Director may revoke the suspended license.

16:54-8.4 Actions contrary to the rules

Any person who allows, permits, or otherwise knowingly aids and abets the unlicensed or improperly licensed operation of an aeronautical facility, or who allows, permits, or otherwise knowingly aids and abets any other activities, actions, or conditions that are contrary to the requirements of this chapter or N.J.S.A. 6:1-1 et seq. shall be considered to be acting contrary to the provisions of this chapter and shall be considered in violation of the chapter.

16:54-8.5 Penalties for violations

(a) Any person violating any provision of N.J.S.A. 6:1-1 et seq. or these rules shall be subject to a penalty of up to \$1,000 for each violation, in accordance with N.J.S.A. 6:1-59.1.

(b) Any person who operates, conducts, uses, or permits others to operate, conduct, use or employ any aeronautical facility, operation, or activity which is required to be licensed, without such license being issued or renewed as required by this chapter shall be liable to a penalty of up to \$1,000 for each violation, in accordance with N.J.S.A. 6:1-59.1.

SUBCHAPTER 9. SUSPENSIONS AND REVOCATIONS

16:54-9.1 Suspensions

(a) Any license issued pursuant to this chapter may be suspended when, in the interest of public safety or the safety of those participating in aeronautical activities, the Office determines that a violation of this chapter has occurred, or a hazard exists which threatens the safety of the general public or those participating in aeronautical activities.

(b) Any aeronautical inspector or designated representative of the Commissioner may immediately suspend an aeronautical facility license when they deem it necessary to ensure the safety of the general public or those participating in aeronautical activities.

(c) The Office shall notify the licensee of suspension action immediately by the most expeditious means and shall confirm such notice in writing.

(d) Licensees may appeal suspension actions, pursuant to N.J.A.C. 16:54-9.3.

(e) Aeronautical facility licenses which have been suspended shall have the cause abated within the suspension period. Facilities which have not had corrections made during the suspension period shall be presented to the Director, who may extend the suspension or may begin action to revoke the license.

(f) The Director may conduct a hearing concerning any license suspension action, either when requested by the licensee or by the Department.

16:54-9.2 Revocations; appeal of revocation

(a) The Director is authorized to revoke any suspended Aeronautical Facility License when it is determined that it is in the best interest of public safety or the safety of those participating in aeronautical activities.

(b) Licensees shall be notified by the Office, in writing, of the Department's suspension action pending revocation. The licensee shall have 10 days after receipt of such notice to appeal the action in accordance with N.J.A.C. 16:54-9.3. If no appeal is filed within that time period, the license shall be revoked.

(c) Licenses which have been revoked shall not be reinstated. Applicants, including former licensees, shall submit a complete application package for any facility whose license has been revoked.

16:54-9.3 Appeals; generally

(a) Licensees who have had their petition for an exemption denied, their license suspended, or suspended pending revocation, or applicants who have their application for license denied, may appeal the action to the Director for relief. Appeals shall be submitted in writing to the Director within 20 days of notification of the action being appealed.

(b) The Director, within 20 days of receipt of an appeal, shall:

1. Conduct an informal hearing.
2. Uphold the appeal and rescind the action; or
3. Modify the action; or
4. Deny the appeal.

(c) An appeal from the Director's determination can be made before the Office of Administrative Law (OAL) pursuant to N.J.S.A. 52:14(b)-1, et seq., and N.J.A.C. 1:1. If the applicant determines to appeal, the New Jersey Department of Transportation must be notified by certified mail within 14 calendar days from the applicant's

receipt of this Notice of Denial of Permit Application that the applicant is appealing to OAL.

SUBCHAPTER 10. POWERS

16:54-10.1 Authority

Licensing requirements shall not be construed as limiting in any way the power of the Commissioner in regulating the operation of any aeronautical facilities. Decisions regarding denial, issuance, renewal, suspension, or revocation of licenses are within the purview of, and shall ultimately be determined by, the Commissioner.

**APPENDIX A
PUBLIC NOTICE**

Notice of Proposed Aeronautical Facility Licensing

ALL INTERESTED PERSONS are hereby advised that the Office of Aviation, of the New Jersey Department of Transportation, has received an application

from _____ for a license

to establish a _____

at _____.

Accordingly, the Office of Aviation invites written comments or objections regarding this proposed license. All comments or objections must address the issue of the effect of the proposed license upon the public health and safety.

Upon receipt of written comments or objections, and a determination by the Office of Aviation that the proposed licensing is a "contested case", as defined by N.J.S.A. 52:14B-1 et seq., this matter may be scheduled for a public hearing.

The above-named application and all related documents are available for public inspection by appointment between the hours of 9:00 A.M. and 4:00 P.M. at the Office of Aviation, New Jersey Department of Transportation, 1035 Parkway Avenue, Trenton, New Jersey. Telephone (609) 530-2908.

Any interested persons may submit questions or comments, in writing, no later than 30 days from today.

All submissions regarding this matter should be directed to:

Office of Community Involvement
New Jersey Department of Transportation
1035 Parkway Avenue, CN 600
Trenton, New Jersey 08625

RULE ADOPTIONS

AGRICULTURE

(a)

DIVISION OF PLANT INDUSTRY

Insect Control

Dangerously Injurious Insects

Adopted Readoption: N.J.A.C. 2:22

Proposed: May 4, 1992 at 24 N.J.R. 1662(a).

Adopted: June 25, 1992 by the State Board of Agriculture, and
Arthur R. Brown, Jr., Secretary.

Filed: June 26, 1992 as R.1992 d.294, **without change**.

Authority: N.J.S.A. 4:1-21.5, 4:6-20 and 4:71.

Effective Date: June 26, 1992.

Expiration Date: June 26, 1997.

Summary of Public Comments and Agency Responses:

COMMENT: Comments were received from Mr. Thomas Thatcher, a beekeeper. One comment addressed the regulations concerning the Africanized Honeybee. The comment expressed the concern that there be an Africanized Honeybee action plan developed in advance of the bees' possible entry into New Jersey. Additional comments from Mr. Thatcher suggested the establishment of a queen bee certification program and training for New Jersey beekeepers on bee management related to Africanization.

RESPONSE: The New Jersey Department of Agriculture, Division of Plant Industry, has taken an active role in developing a Model National Honeybee Certification Plan and an Africanized Honeybee Action Plan in cooperation with the U.S. Department of Agriculture and the National Association of State Departments of Agriculture. The Department, in cooperation with the State Beekeepers Association, is now considering modifications to the present honeybee regulations.

Full text of the readoption may be found in the New Jersey Administrative Code at N.J.A.C. 2:22.

COMMUNITY AFFAIRS

(b)

DIVISION OF HOUSING AND DEVELOPMENT

Limited Dividend and Nonprofit Housing Corporations and Associations

Readoption with Amendments: N.J.A.C. 5:13

Proposed: May 4, 1992 at 24 N.J.R. 1668(a).

Adopted: June 17, 1992 by Melvin R. Primas, Jr., Commissioner,
Department of Community Affairs.

Filed: June 22, 1992 as R.1992 d.290, **with a technical change**
not requiring additional public notice and comment (see
N.J.A.C. 1:30-4.3).

Authority: P.L.1991, c.431, section 21.

Effective Date: June 22, 1992, Readoption; July 20, 1992,
Amendments.

Expiration Date: June 22, 1997.

Summary of Public Comments and Agency Responses:

No public comments received.

On adoption, the Department is clarifying N.J.A.C. 5:13-1.19 by changing the phrase "hearing before the Office of Administrative Law" to "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."

Full text of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 5:13.

Full text of the adopted amendments follows (addition to proposal indicated in boldface with asterisks ***thus***; deletion from proposal indicated in brackets with asterisks ***[thus]***):

5:13-1.1 Definitions

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

"Act" means the Limited Dividend Nonprofit Housing Corporations or Associations Law, P.L. 1949, c.184, which was repealed by P.L. 1991, c.431, but the requirements of which, and of this chapter, continue to be applicable to housing projects organized and operating under it on or before April 17, 1992.

...

"Gross shelter rent" means the gross rent or carrying charge less the cost of utilities furnished by the project; utilities shall include gas and electricity if supplied by the project, cost of heating fuel, cost of water supplied and sewage charges, if any.

...

"State Deputy Administrator" means the Deputy Administrator of the Public Housing and Development Authority, who is also the Director, Division of Housing and Development, Department of Community Affairs, State of New Jersey.

...

5:13-1.2 Scope

(a) These rules shall apply to and control all housing sponsors formed under the provisions of the Limited Dividend Nonprofit Housing Corporations or Associations Law, P.L. 1949, c.184, as amended (N.J.S.A. 55:16-1 et seq.) and remaining subject to the jurisdiction established under that act in accordance with the "Long Term Tax Exemption Law," P.L. 1991, c.431; provided, however, that the provisions of N.J.A.C. 5:13-2 (Limited Dividend Housing Corporations and Associations as Cooperatives) shall apply only to housing sponsors organized as cooperatives financed under a FHA insured (Section 213) mortgage, and provided further that nothing herein shall be construed to abrogate or set aside such regulatory agreements as have been approved by the Authority prior to the date of these regulations insofar as the provisions thereof are not inconsistent with the regulations.

(b)-(f) (No change.)

5:13-1.4 (Reserved)

5:13-1.19 Rights to hearing

Any person or housing sponsor aggrieved by any such order as may be issued under N.J.A.C. 5:13-1.18 shall be entitled to a hearing ***[before the Office of Administrative Law]*** ***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*.**

(c)

DIVISION OF HOUSING AND DEVELOPMENT

Exemptions from Taxation

One and Two-Unit Residences; Multiple Dwellings

Adopted Repeals: N.J.A.C. 5:22-1 and 2

Proposed: May 4, 1992 at 24 N.J.R. 1669(a).

Adopted: June 17, 1992 by Melvin R. Primas, Jr., Commissioner,
Department of Community Affairs.

Filed: June 22, 1992 as R.1992 d.291, **without change**.

Authority: P.L.1991, c.441, section 19.

Effective Date: July 20, 1992.

Summary of Public Comments and Agency Responses:

No comments received.

ADOPTIONS

Full text of the adopted repeals may be found in the New Jersey Administrative Code at N.J.A.C. 5:22-1 and 2.

(a)

DIVISION OF HOUSING AND DEVELOPMENT

Uniform Construction Code

Licensing of Interns

Adopted Amendment: N.J.A.C. 5:23-5.4

Proposed: May 4, 1992 at 24 N.J.R. 1669(b).

Adopted: June 17, 1992 by Melvin R. Primas, Jr., Commissioner,
Department of Community Affairs.

Filed: June 22, 1992 as R.1992 d.292, **without change**.

Authority: N.J.S.A. 52:27D-124.

Effective Date: July 20, 1992.

Expiration Date: March 1, 1993.

Summary of Public Comments and Agency Responses:

A comment was received from Robert H. Karen, President of the New Jersey Builders Association.

COMMENT: "NJBA believes that the intern program will contribute to high caliber code enforcement officials who possess a formal training background and on-site field training offered in a supervised environment, and will in fact offer job opportunities to persons who would be otherwise excluded from entry-level code enforcement positions."

RESPONSE: The Department concurs.

Full text of the adoption follows.

5:23-5.4 Licenses required

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

(e) Enforcing agencies may establish code enforcement intern positions subject to the following:

1. Persons applying for an intern position with an enforcing agency must be officially registered in accordance with this subchapter with the Department of Community Affairs on the form provided by the Licensing Unit of the Bureau of Technical Services prior to being hired as an intern.

i. Interns shall renew their registration yearly and shall notify the Department of Community Affairs, Bureau of Technical Services, Licensing Unit within one month of any change in employment status prior to accepting any new position and of any change of address. A non-refundable processing fee of \$20.00 is required for the initial Intern Registration Request and for each subsequent renewal request.

2. Persons meeting the following requirements shall be eligible to be employed as interns:

i. Fire protection inspector intern: possession of an associate degree in code enforcement with a major in the fire protection subcode;

ii. Building inspector intern: possession of an associate degree in code enforcement with a major in the building subcode area;

iii. Plumbing inspector intern: possession of an associate degree in code enforcement with a major in the plumbing subcode area; and

iv. Electrical inspector intern: possession of an associate degree in code enforcement with a major in the electrical subcode area.

3. Interns shall be evaluated by their supervisors on a quarterly basis.

i. The evaluation must include a brief description of the intern's code enforcement activities and an assessment of the intern's performance in these activities.

ii. Interns who receive satisfactory evaluation ratings from their supervisors and who occupy enforcing agency intern positions while registered with the Department may use the intern experience toward satisfying the experience requirement for licensure.

iii. The period of intern experience begins at the time a person is hired as a registered intern by an authorized agency.

4. The following conditions apply to work performed by interns:

i. Interns may perform all inspections allowed for a trainee as described in (d)5i and ii above.

ii. In addition, with the written approval of an intern's supervisor, the intern may perform the following types of inspections without the supervisor being present during the inspection:

(1) Reinspections of previously failed documented inspections for one and two family dwellings;

(2) Footing inspections as described in N.J.A.C. 5:23-2.18(b)1i(1) for one and two family dwellings (building inspector interns with written approval of their supervisors only).

iii. An intern shall not act as a subcode or construction official nor sign any permits, stickers, approved plans or inspection reports, except as permitted in (e)5i and ii above.

5. The supervisor of the intern must possess a valid code enforcement license in the same subcode as the registered intern working under his or her supervision.

i. A qualified licensed inspector shall not supervise more than one intern.

ii. Failure of a supervisor to properly oversee a registered intern in accordance with the provisions of this subsection may result in disciplinary action against the supervisor.

iii. The supervisor must complete the quarterly reports and keep a written file on the progress of the intern. This file must include written authorization to perform inspections as listed in N.J.A.C. 5:23-5.4(e)5. At the end of one year of full time internship, the supervisor shall forward notice to the Department of Community Affairs, Bureau of Technical Services, Licensing Unit of successful completion of the internship. If the internship is not for a full year, or is part time, that time may also be documented.

6. To remain employed by an enforcing agency, an intern must pass the appropriate module(s) of the National Certification Test in his or her specific code area within one year of the effective date of employment.

Redesignate existing (e) as (f) (No change in text.)

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(b)

DRUG UTILIZATION REVIEW COUNCIL

List of Interchangeable Drug Products

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

Proposed: May 4, 1992 at 24 N.J.R. 1674(a).

Adopted: June 9, 1992 by the Drug Utilization Review Council,
Robert Kowalski, Chairman.

Filed: June 29, 1992 as R.1992 d.300, **with portions of the proposal not adopted and portions not adopted but still pending.**

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

Effective Date: July 20, 1992.

Expiration Date: February 17, 1994.

Summary of Public Comments and Agency Responses:

The Drug Utilization Review Council received the following comments pertaining to the products affected by this adoption.

COMMENT: In opposition to Blue Ridge Laboratories' sucralfate 1 gm tablets from Lemmon Company. Lemmon informed the Council that Blue Ridge Laboratories is a new subsidiary of Marion Merrell Dow, the innovator of the brand Carafate. Blue Ridge and Rugby Laboratories will collaborate in the manufacturing and distribution of the generic sucralfate product.

Lemmon was concerned that Blue Ridge will delay the distribution of its sucralfate product until another manufacturer receives approval from the FDA. Lemmon suggested that the Council's consideration of Blue Ridge Laboratories' sucralfate should be deferred pending specific marketing commitments. It was Lemmon's understanding that availability of a generic product is a requirement for consideration for inclusion in the Formulary.

RESPONSE: The Council agreed that the availability of generic products should be considered before inclusion in the Formulary. In

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ADOPTIONS

order to prevent confusion in the pharmacy industry, the Council deferred action on Blue Ridge Laboratories' sucralfate product pending verification of its availability.

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 by 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 agreed to defer reviewing Blue Ridge Laboratories sucralfate and diltiazem products pending the receipt of the information outlined by Rugby and verification of product availability to pharmacies.

COMMENT: From Johnson & Johnson (J&J), on behalf of Janssen Pharmaceutica, in opposition to Lemmon Company's loperamide caps 2 mg.

J&J stated that the Council should consider patient factors as well as bioequivalency. J&J reminded the Council that physicians have indicated that they are uncomfortable switching a patient from brand name to generic once control has been attained.

J&J added that patients with chronic diarrhea need consistent and effective medication. J&J claimed that switching patients to a generic loperamide could have a negative effect on their health care, and therefore provide no overall cost savings. J&J requested that the Council reject Lemmon's loperamide product.

RESPONSE: Johnson & Johnson did not provide any conclusive information to show any therapeutic or bioequivalent difference between the brand Imodium and Lemmon's loperamide. The Council unanimously approved Lemmon's loperamide 2 mg capsules as a generic equivalent for the brand Imodium based on the acceptable comparative values of the AUC, T-max and C-max, as well as, acceptable ranges of the 90 percent confidence intervals.

COMMENT: In opposition to Baker Cummins Pharmaceuticals' verapamil extended release 240 mg tablets from Searle.

Searle contended that the product is bioinequivalent based on the single dose study under fed conditions. Searle pointed out that the log transformed 90 percent confidence interval exceeds the acceptable range and that plasma concentration time curves reflect dissimilar plasma levels with the test and reference product. In addition, Searle suggested that specific enantiomer concentrations should be measured to determine bioequivalency of verapamil SR products. Searle requested that the Council reject Baker's verapamil SR product.

RESPONSE: The Council deferred review and action on this product pending FDA approval.

COMMENT: From Purepac Pharmaceutical Company, via telephone and not submitted in writing, noting a typographical error in the May 4, 1992 *New Jersey Register* proposed listing of new additions to the New Jersey Formulary.

Purepac pointed out that its product, gemfibrozil caps 300 mg, was misprinted as "Gemfirbozil caps 300mg". Purepac requested that its product be considered with the correct spelling; gemfibrozil.

RESPONSE: The Council agreed and considered this product under the correct spelling, gemfibrozil 300mg capsules. The Council did not adopt the product because the brand name, Lopid 300 mg capsules, are no longer manufactured or marketed.

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 above. 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:

Albuterol sulfate inh. soln. 0.083%, 3ml	Dey
Albuterol sulfate syrup 2mg/5ml	Lemmon

Baclofen tabs 10mg, 20 mg	Biocraft
Benzoyl peroxide gel 2.5, 5, 10%	Stiefel/Glades
Benzoyl peroxide wash 2.5, 5, 10%	Stiefel/Glades
Cinoxacin caps 250 mg, 500 mg	Biocraft
Doxepin HCl caps 10 mg, 25 mg	Royce
Doxepin HCl caps 50 mg	Royce
Fiorinal caps substitute	Lannett
Granulex spray substitute	Copley
Hydrocortisone acetate supp 25 mg	Able
Iodinated glycerol tabs 30 mg	Able
Hycodan tablet substitute	Daniels
Hydrocortisone lotion 1%, 2.5%	Stiefel/Glades
Ibuprofen tabs 400 mg, 600 mg, 800 mg	Upjohn
Lorazepam tabs 0.5 mg, 1 mg	Royce
Lorazepam tabs 2 mg	Royce
Metaproterenol sulfate syrup 10mg/5ml	Biocraft
Minocycline HCl caps 50 mg, 100 mg	Biocraft
Nifedipine caps 10 mg	Novopharm
Nifedipine caps 10 mg	R.P. Scherer
Nifedipine caps 20 mg	R.P. Scherer
Perphenazine/Amitriptyline HCl tabs 2/10, 2/25	Royce
Perphenazine/Amitriptyline HCl tabs 4/10, 4/25	Royce
Tolmetin sodium capsules 400 mg	Baker Cummins

The following products were not adopted:

Gemfibrozil caps 300 mg	Purepac
Guaifenesin tabs 600 mg	Theraids
Hyoscyamine sulfate oral soln 0.125 mg/ml	Pegasus
Yohimbine tabs 5.4 mg	Royce

The following products were not adopted but are still pending:

Amiloride HCl/HCTZ tabs 5/50	Royce
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	Blue Ridge Labs
Diltiazem tabs 30 mg, 60 mg, 90 mg, 120 mg	Lederle
Diltiazem tabs 30 mg, 60 mg, 90 mg, 120 mg	Mylan
Ketoprofen caps 25 mg, 50 mg, 75 mg	Lederle
Lactulose soln 10g/15ml	Technilab
Metoclopramide HCl syrup 5mg/5ml	Lemmon
Metoprolol tartrate tabs 100 mg	Geneva
Metoprolol tartrate tabs 50 mg	Geneva
Piroxicam caps 10 mg, 20 mg	Royce
Sucralfate tabs 1 g	Blue Ridge Labs
Tetracycline caps 250, 500 mg	Atral
Valproic acid capsules 250 mg	R.P. Scherer
Vancomycin HCl oral soln powder 1g, 2g, 5g	Lederle
Verapamil tabs 240 mg extended release	Baker Cummins

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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: June 9, 1992, by the Drug Utilization Review Council, Robert Kowalski, Chairman

Filed: June 26, 1992 as R.1992, d.295, with portions of the proposal not adopted but still pending.

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

Effective Date: July 20, 1992.

Expiration Date: February 17, 1994.

Summary of Public Comments and Agency Responses:

COMMENT: In opposition to Geneva Pharmaceutical's (formerly Cord Laboratories) tolmetin, McNeil Pharmaceutical stated that to their knowledge this version Tolactin had not received FDA approval.

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RESPONSE: The Council verified that Geneva's tolmetin 400 mg capsules had received FDA approval for marketing with an "AB" therapeutic equivalency rating.

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 a previous Register (see 23 N.J.R. 3334(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 products and their manufacturers were **adopted**:

Loperamide HCL caps 2 mg	Lemmon
Tolmetin caps 400 mg	Cord
Triamterene/HCTZ tabs 37.5/25	Cord

The following drugs were **not adopted but are still pending**:

Albuterol tabs 2, 4 mg	Purepac
Atenolol tabs 50, 100 mg	W-C
Cephalexin 250, 500 mg	Yoshitomi
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) and 24 N.J.R. 948(a).

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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. 1673(a).

Adopted: June 9, 1992 by the Drug Utilization Review Council,

Robert Kowalski, Chairman.

Filed: June 26, 1992 as R.1992 d.296, **without change**.

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

Effective Date: July 20, 1992.

Expiration Date: February 17, 1994

Summary of Public Comments and Agency Responses:

The Drug Utilization Review Council received no comments pertaining to the products affected by this adoption.

Summary of Hearing Officer's Recommendations and Agency Responses:

A public hearing on the proposed additions to the list of interchangeable drug products was held on May 26, 1992. Mark A. Strollo, R.Ph., M.S., served as hearing officer. Ten persons attended the hearing. No comments were offered. The hearing officer recommended that the decisions made be based upon available information. The Council deleted the products specified as "deleted."

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The following products and their manufacturers were **deleted**:

Allopurinol tabs 100 mg, 300 mg	Chelsea
Amitriptyline/perphenazine tabs 10/2	Chelsea
Amitriptyline/perphenazine tabs 10/4	Chelsea
Amitriptyline/perphenazine tabs 25/2	Chelsea
Amitriptyline/perphenazine tabs 25/4	Chelsea
Amitriptyline/perphenazine tabs 50/4	Chelsea
Baclofen tabs 10 mg, 20 mg	PharmBasics
Benzotropine tabs 0.5 mg, 1 mg, 2 mg	PharmBasics
Cefadroxil monohydrate caps 500 mg	Biocraft
Cefadroxil monohydrate caps 500 mg	IBSA
Cefadroxil monohydrate caps 500 mg	Zenith
Cefadroxil monohydrate tabs 1000 mg	Zenith
Chlordiazepoxide HCl caps 5 mg, 10 mg, 25 mg	Mylan
Chlorthalidone tabs 25 mg	Purepac
Clonidine tabs 0.1, 0.2, 0.3 mg	Duramed
Cyproheptadine syrup 2mg/5ml	PharmBasics
Cyproheptadine tabs 4 mg	Duramed
Diazepam tabs 2, 5, 10 mg	Duramed
Diazepam tabs 2 mg, 5 mg, 10 mg	Chelsea
Dipyridamole tabs 25, 50, 75 mg	Duramed
Doxycycline hyclate caps 50 mg, 100 mg	Heather
Doxycycline hyclate tabs 100 mg	Heather
Fiorinal w/codeine #3 caps substitute	Anabolic
Fiorinal w/codeine #3 caps substitute	J. Stevens
Furosemide tabs 20 mg, 40 mg	Heather
Haloperidol tabs 0.5, 1, 2, 5, 10, 20 mg	Duramed
Hycomine ped. syrup substitute	PharmBasics
Hydrochlorthiazide tabs 50 mg	Heather
Hydrocholothiazide tabs 25 mg, 50 mg	Mylan
Hydrocortisone cream 1%	Purepac
Hydroxazine pamoate caps 25, 50, 100 mg	Duramed
Indomethacin caps 25, 50 mg	Duramed
Isosorbide dinitrate tabs 10 mg	Purepac
Meclofenamate tabs 50 mg, 100 mg	Chelsea
Metaproterenol tabs 10 mg, 20 mg	PharmBasics
Methocarbamol tabs 500 mg, 750 mg	Mylan
Methocarbamol tabs 500 mg, 750 mg	Heather
Methychlothiazide tabs 2.5 mg	Mylan
Methylclothiazide tabs 5 mg	PharmBasics
Methyldopa tabs 125 mg, 250 mg, 500 mg	Chelsea
Methylprednisolone tabs 4 mg	Heather
Metoclopramide HCl tabs 10 mg	Chelsea
Oxybutrin tabs 5 mg	PharmBasics
Prazepam caps 15 mg, 30 mg	PharmBasics
Prednisone soln 5mg/5ml	PharmBasics
Probanthine bromide tabs 15 mg	Heather
Propantheline bromide tabs 15 mg	Mylan
Propoxyphene HCl caps 65 mg	Mylan
Propoxyphene NAPS/APAP tabs 100/650	Chelsea
Propoxyphene NAPS/APAP tabs 50/325	Chelsea
Propranolol tabs 10, 20, 40, 60, 80, 90 mg	Duramed
Propranolol tabs 10 mg, 20 mg, 40 mg, 60 mg, 80 mg	Chelsea
Propranolol/HCTZ tabs 40/25, 80/25	Duramed
Sulfamethoxazole/trimethoprim tabs 400/80	Heather
Sulfamethoxazole/trimethoprim tabs 800/160	Heather
Sulfisoxazole tabs 500 mg	Heather
Sulfisoxazole tabs 500 mg	Mylan
Temazepam caps 15, 30 mg	Duramed
Tetracycline HCl caps 250 mg, 500 mg	Heather
Thiothixene HCl caps 2 mg, 5 mg, 10 mg	Chelsea
Timolol tabs 5 mg, 10 mg, 20 mg	PharmBasics
Tolazamide tabs 100, 250, 500 mg	Duramed
Trazadone tabs 50 mg, 100 mg	Chelsea
Trazodone tabs 50 mg, 100 mg	PharmBasics
Verapamil tabs 40 mg	Chelsea
Warfarin tabs 2 mg, 2.5 mg, 5 mg	PharmBasics

(a)

DRUG UTILIZATION REVIEW COUNCIL**List of Interchangeable Drug Products****Adopted Amendments: N.J.A.C. 8:71**

Proposed: January 6, 1992 at 24 N.J.R. 61(a)

Adopted: June 9, 1992, by the Drug Utilization Review Council,
Robert Kowalski, ChairmanFiled: June 26, 1992 as R.1992, d.297, with portions of the
proposal not adopted but still pending.

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

Effective Date: July 20, 1992.

Expiration Date: February 17, 1994.

Summary of Public Comments and Agency Responses:

No comments were received regarding the adopted product.

Summary of Hearing Officer's Recommendations and Agency Responses:

A public hearing on the proposed additions to the list of interchangeable drug products was held on January 27, 1992. Mark A. Strollo, R.Ph., M.S., served as hearing officer. Five persons attended the hearing. Seven comments were offered, as summarized in a previous Register (see 24 N.J.R. 947(b)). The hearing officer recommended that the decisions made be based upon available biodata. The Council adopted the products specified as "adopted," 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 tab 25mg	Geneva
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The following drugs were not adopted but are still pending:

Amoxapine tabs 25mg, 50mg, 100mg, 150mg	Danbury
Atenolol/chlorthalidone tabs 50/25, 100/25	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 tabs 1mg, 2.5mg, 5mg, 10mg	Danbury
Fluphenazine HCl Oral Soln 5mg/ml	Copley
Gemfibrozil caps 300mg	Danbury
Guaifenesin tabs 600mg	DURA
Ibuprofen tabs 300mg	Danbury
Isosorbide Dinitrate tabs 20mg, 30mg, 40mg	Danbury
Loperamide HCl caps 2mg	Danbury
Loxapine succinate caps 5mg, 10mg, 25mg, 50mg	Danbury
Methylprednisolone tabs 4mg, 16mg	Danbury
Metoclopramide HCl tabs 5mg	Danbury
Minocycline HCl tabs 50mg, 100mg	Danbury
Nadolol tabs 40mg, 80mg, 120mg	Danbury
Nitrofurantoin caps 25mg, 50mg, 100mg	Danbury
Nortriptyline HCl caps 10mg, 25mg, 50mg, 75mg	Danbury
Propoxyphene naps/APAP tabs 100/650	Danbury
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
Tramazone HCl tabs 150mg	Danbury

OFFICE OF ADMINISTRATIVE LAW NOTE: See related
notices of adoption at 24 N.J.R. 947(b) and 1897(a).

(b)

DRUG UTILIZATION REVIEW COUNCIL**List of Interchangeable Drug Products****Adopted Amendments: N.J.A.C. 8:71**

Proposed: March 2, 1991 at 24 N.J.R. 735(a).

Adopted: June 9, 1992, by the Drug Utilization Review Council,
Robert Kowalski, ChairmanFiled: June 26, 1992 as R.1992 d.298, with portions of the
proposal not adopted but still pending.

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

Effective Date: July 20, 1992.

Expiration Date: February 17, 1994.

Summary of Public Comments and Agency Responses:The Drug Utilization Review Council received the following comments
pertaining to the products affected by this adoption.

COMMENT: In opposition to the albuterol sulfate solution for inhalation 0.5%, 20ml by Copley Pharmaceutical Co., Schering Laboratories informed the Council that although the FDA has rated this product "AN," no in vivo data has been presented. Schering added that the ANDA for Copley's product was granted by the FDA based solely on in vitro comparison of the contents of the bottle for the generic relative to the innovator. Schering recommended that the Council postpone consideration of Copley's product to allow practitioners to gain experience using the generic formulation.

RESPONSE: At the April 14, 1992 meeting, the Council agreed that Copley's albuterol sulfate solution 0.5% had received an "AN" rating from the FDA. The Council was cognizant that solutions intended for aerosolization that are marketed for use in any of several delivery systems are considered to be pharmaceutically and therapeutically equivalent are encoded "AN." Uncertainty regarding the therapeutic equivalence of aerosolized products arises primarily because of differences in the drug delivery system. Since Copley's product will be utilized in the same drug delivery system (nebulization) as Schering's Proventil solution for inhalation, there should be no difference in the treatment outcome using either product. In addition, both products are manufactured in accordance with Current Good Manufacturing Practice regulations to ensure pharmaceutical equivalency.

Action was not taken on Copley's albuterol sulfate solution 0.5% at the April 14, 1992 meeting because a quorum was not constituted after one Council member recused himself due to a conflict of interest. On June 9, 1992, the Council unanimously approved this product.

COMMENT: In support of Creighton Products Corporation's nortriptyline caps 10 mg, 25 mg, 50 mg, 75 mg, Danbury Pharmacal, Inc. informed the Council that Sandoz is the parent company of Creighton as well as the innovator of the brand Pamelor. Danbury added that it would be the distributor of Creighton's nortriptyline and that Creighton will change its name to Ex-Lax.

Danbury reminded the Council of its precedents with Penn Labs' Dyazide substitute which was accepted in to the Formulary without bioequivalency data and Rugby's Genora substitute for Ortho-Novum manufactured by Syntex which also was included without bioequivalency data with the notation printed in the Formulary "Distributed by Rugby as Genora brand."

Danbury requested the same consideration with the Creighton/Ex-Lax nortriptyline capsules in that no bioequivalency data be required and that a notation be included that the product would be distributed by Schein and Danbury.

RESPONSE: At the April 14, 1992 meeting, the Council verified that Creighton Products Corporation is a wholly owned subsidiary of Sandoz Pharmaceuticals Corporation, the innovator of the nortriptyline capsules brand Pamelor. It was confirmed that Creighton will manufacture its nortriptyline capsules under Sandoz' NDA at the same manufacturing site. Creighton affirmed that its nortriptyline product is the same as Pamelor. In addition, the Council verified that the label will identify Creighton Products Corporation as the manufacturer. (Creighton will not use the name Ex-Lax.)

Action was not taken on Creighton Products Corporation's nortriptyline caps 10 mg, 25 mg, 50 mg, 75 mg at the April 14, 1992 meeting because a quorum was not constituted after one Council member recused himself due to a conflict of interest. On June 9, 1992, the Council was

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informed that Creighton would be withdrawing its application and the Council then agreed to continue to defer taking action.

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 a previous Register (see 24 N.J.R. 1896(a)). 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 "not adopted," and referred the products identified as "pending" for further study.

The following products and their manufacturer were **adopted**:

Albuterol sulfate inhalation soln 0.5%	Copley
Albuterol sulfate tabs 2 mg, 4 mg	Copley

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 0.76 mg/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
Tolmetin tabs 600 mg	Purepac
Trazodone tabs 50 mg, 100 mg, 150 mg	Mutual

OFFICE OF ADMINISTRATIVE LAW NOTE: See related notice of adoption at 24 N.J.R. 1896(a).

(a)

OFFICE OF HEALTH POLICY AND RESEARCH

State Health Plan

Adopted New Rules: N.J.A.C. 8:100

Proposed: April 6, 1992 at 24 N.J.R. 1164(a).

Adopted: June 25, 1992 by Frances J. Dunstan, M.D., M.P.H., Commissioner, Department of Health (with the approval of the Health Care Administration Board).

Filed: June 26, 1992 as R.1992 d.299, **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**.

Authority: N.J.S.A. 26:2H-1 et seq., specifically 26:2H-5 and 26:2H-8.

Effective Date: July 20, 1992.

Expiration Date: July 20, 1997.

OFFICE OF ADMINISTRATIVE LAW NOTE: N.J.A.C. 8:100, the State Health Plan, was proposed by the Department of Health under the authority of P.L. 1991, c. 187. On June 29, 1992, the New Jersey Legislature, overriding Governor Florio's veto of the measure, enacted

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Assembly Bill 1144, amending P.L. 1991, c. 187 concerning the State Health Plan. In order to provide the complete statutory context for this adopted rulemaking, the full text of Assembly Bill 1144 follows:

[SECOND REPRINT]

ASSEMBLY, NO. 1144

STATE OF NEW JERSEY

INTRODUCED MARCH 23, 1992

By Assemblymen SOSA, MIKULAK, Collins, Assemblywoman Anderson, Assemblymen DiGaetano, Oros, Catania, Assemblywomen Farragher, Wright, Assemblymen Kramer, Azzolina, Singer, Cottrell, Assemblywoman Haines, Assemblymen Wolfe, Kavanaugh, Penn, Geist, Felice, Frelinghuysen, Kelly, Assemblywoman Derman, Assemblymen Warsh, Rocco, Corodemus, Assemblywoman Smith and Assemblyman Arnone

AN ACT concerning the State Health Plan and amending P.L.1991, c.187¹ and P.L.1971, c.136¹.

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

1. Section 34 of P.L.1991, c.187 (C.26:2H-5.8) is amended to read as follows:

34. 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 ¹[the basis upon which all certificate of need applications shall be approved. The plan shall be effective beginning January 1, [1992] 1993] an advisory document, which may be considered when certificate of need applications are reviewed for approval. Upon completion of the entire State Health Plan, the State Health Planning Board shall submit the plan to the commissioner and the board for their use on an advisory basis¹.

²Effective May 15, 1992, notwithstanding any other provision of law to the contrary, neither the Health Care Administration Board or the Department of Health shall adopt any regulation which implements any goals, objectives or any other health planning recommendations that have been included in the State Health Plan prepared by the State Health Planning Board.²

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.¹

For each unmet health care service identified in the plan, the plan shall specify the period of time for which a certificate of need for that service shall be valid.

¹[The plan shall be adopted by the Commissioner of Health pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), subject to the approval of the Health Care Administration Board.]¹

b. The State Health Planning Board shall review applications for certificates of need and make recommendations to the Commissioner of Health ¹[in accordance with the State Health Plan], for which purpose it may consider the State Health Plan on an advisory basis¹. (cf: P.L.1991, c.187, s.34)

²Section 8 of P.L.1971, c.136 (C.26:2H-8) is amended to read as follows:

8. 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 (a) the availability of facilities or services which may serve as alternatives or substitutes, (b) the need for special equipment and services in the area, (c) the possible

economies and improvement in services to be anticipated from the operation of joint central services, (d) the adequacy of financial resources and sources of present and future revenues, (e) the availability of sufficient manpower in the several professional disciplines, and (f) such other factors as may be established by regulation. The State Health Plan may also be considered in determining whether to approve a certificate of need application.

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 a public need.¹

(cf: P.L.1991, c.187, s.31)

13. Section 9 of P.L.1971, c.136 (C.26:2H-9) is amended to read as follows:

8. Certificates of need shall be issued by the commissioner in accordance with the provisions of P.L.1971, c.136 (C.26:2H-1 et seq.) and [the State Health Plan and] based upon criteria and standards therefor promulgated by the commissioner. 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 an application is denied, the applicant may appeal the decision to the board. 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 opportunity for hearing. Requests for a fair hearing shall be made to the Department of Health within 30 days of receipt of notification of the commissioner's action. The department shall arrange within 60 days of a request, for fair hearings on all such cases and after such hearing the commissioner or his designee shall furnish the board, the State Health Planning Board and the applicant in writing the hearing examiner's recommendations and reasons therefor. The 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.

For the three-year period beginning January 1, 1992 through December 31, 1994, the commissioner shall limit approval of certificates of need for capital construction projects for hospitals that would be financed by the New Jersey Health Care Facilities Financing Authority pursuant to P.L. 1972, c.29 (C.26:2I-1 et seq.), to a Statewide total of \$225 million per year for all projects, exclusive of the refinancing of approved projects.

For the purposes of this section, capital construction project shall include the purchase of any major moveable equipment as well as any modernization, construction, or renovation project.

[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 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 intention to act contrary to the State Health Plan. If the 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.]¹

(cf: P.L.1991, c.187, s.32)

14. Section 35 of P.L.1991, c.187 (C.26:2H-5.9) is amended to read as follows:

35. There is established a program to provide local health planning on a Statewide basis in a minimum of five specific geographic regions to be designated by the Governor, in consultation with the Commissioner of Health. Each region shall, to the extent possible, include sufficient resources to provide a comprehensive range of health care facilities and services and the designation of each region shall take into account the compatibility of social, economic, transportation and geographic characteristics.

a. Local health planning in each region shall be conducted by a local advisory board approved by the Commissioner of Health, which shall be organized as a nonprofit corporation.

The commissioner shall establish requirements for the composition of the governing body of each corporation and shall specify, under the terms of an agreement with the corporation for the awarding of a grant pursuant to this section, those functions which the board, at a minimum,

shall perform. The commissioner shall award to each corporation a grant of such monies as shall be determined by the commissioner.

The membership of the governing body of the corporation approved as a local advisory board shall be composed of consumers and providers of health care who reside or have their principal place of business within the geographic region designated by the commissioner, except that no less than 51% but no more than 60% of the members shall be persons who are not providers of health care.

b. The local advisory board shall conduct local health planning or its designated region and make recommendations at least annually to the State Health Planning Board for incorporation into the State Health Plan. The local advisory board shall also review certificate of need applications for any proposed project in its region and make recommendations to the Commissioner of Health [in accordance with the State Health Plan].

c. A member of the governing body or employee of the corporation shall not, by reason of his performance of any duty, function or activity required of, or authorized to be undertaken by the corporation, be held civilly or criminally liable if that person acted within the scope of his duty, function or activity as a member of the governing body or employee of the corporation and without gross negligence or malice toward any person affected thereby.

A corporation shall not, by reason of the performance of any duty, function or activity required of, or authorized to be undertaken by the corporation, be held civilly or criminally liable if the member of the governing body or the employee of the corporation who acted on behalf of the corporation in the performance of that duty, function, or activity acted within the scope of his duty, function or activity as a member of the governing body or employee of the corporation, exercised due care and acted without gross negligence or malice toward any person affected thereby.¹

(cf: P.L.1991, c.187, s.35)

¹[2.5] This act shall take effect immediately.

Makes State Health Plan advisory.

EXPLANATION—Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law. Matter underlined thus is new matter.

Matter enclosed in superscript numerals has been adopted as follows:

¹Assembly AHH committee amendments adopted March 30, 1992.

²Senate SHH committee amendments adopted May 4, 1992.

Summary of Public Comments and Agency Responses:

The changes for final adoption include several changes in codification: (1) N.J.A.C. 8:100-4.6 has been divided into two sections, N.J.A.C. 8:100-4.6 and 4.7, and subsequent sections are recodified; (2) In recodified N.J.A.C. 8:100-4.11, Total Quality Improvement Program, a new paragraph (a) has been added, and the proposed subsections (a) through (d) become paragraphs (a)1 through 4. Other sections and subsections are also recodified due to insertion of new material, or deletion of material in the proposal.

Certain recommended changes could not be made on adoption, although the Department has agreed that they are necessary, since they are so substantive as to require additional public notice and opportunity for comment. The Department is proposing these changes in the next available issue of the New Jersey Register.

The specific portions of the text to be amended have not been adopted, but will be repropounded, and are indicated in the rule text, where appropriate, as "(Reserved.)" The comments and responses regarding these portions of the rule text are included in the Summary of Public Comments and Agency Responses which follows, in the order of the occurrence of the text in N.J.A.C. 8:100.

Wherever possible, the opportunity to obtain additional information from educational, professional and community groups has been added, as the Department feels that coordination of such groups is essential to the effective provision of health services. The Department has also responded to the many comments offered by advocates of persons in specific situations which make access to service difficult, such as the disabled, the frail elderly, and other groups, and has modified the rules to improve opportunities for access to service, wherever possible.

COMMENTERS: The following commented on the proposal: Ainora, Catherine A., Vice President, Planning and Marketing, Elizabeth General Medical Center; Aitchison, Kenneth W., President and CEO, Kessler Inst. for Rehabilitation, Inc.; Alexander, Robert J., M.A., C.A.S., Executive Director, Peterson Counseling Center, Inc.; Alcoholics

Anonymous individuals and community members; Alifante, Joseph L., Executive Director, New Jersey Family Planning League, Inc.; Al-Salih, Farouk, Dr., Director of Pediatrics, St. Francis Hospital (Jersey City); Angelucci, Thomas D., Mayor of Stratford; Anthony, Sophia H., M.D., Director, Family Practice Residency Program, Mountainside; Auerbach, Leona; Azzara, Michael, President, Valley Hospital; Baker, Azzan, Neonatologist, Meadowlands Hospital; Barnett, Harry; Bateman, Christopher S., Director, Somerset County Board of Freeholders; Bechtel, Paul, N.J. Licensed Beverage Association; Bennett, Marilyn, Horizon Health Center; Benson, Gordon, M.D., Associate Dean, RWJ Medical School/Camden; Bembry, L., Esquire; Bergen, Stanley S., Jr., M.D., President, UMDNJ; Bernstein, Michael, M.D., Chairman, Medical Education, Overlook Hospital; Black & Minority Health 2000, The State of Black Health; Bosco, Louis G., M.D.; Brand, Michael, M.D.; Brazier, Leonard, Ed.S., Supervisor, Pathological Gambling Program, St. Clares, Riverside; Burlington County Bridge Commission Police; Bridgeton Board of Education; Brill, Robert F., M.D.; Brill, Ann; Brown, Barry D., President, West Jersey Health System; Brown, Linda; Buckwald, Ben, NJ Licensed Beverage Association; Buonanni, Brian F., Executive Vice President, St. Elizabeth Hospital; Burroughs, Robert R., Chief of Police, Westwood, NJ; Campanale, Deloris P., Deputy Municipal Clerk, Woodbridge Township, County of Middlesex; Campagnolo, Mary, M.D., Burlington County Academy of Family Physicians; Canavan, Sister Mary, Chairperson, Board of Trustees of St. Mary's Hospital; Canellis, George W., P.A., Dwyer & Canellis, P.A.; Capelli, John P., M.D., Camden County Medical Society; Caplan, Ronald, Ph.D., Associate Director, LAB IV; Caraballo, Wilfredo, Public Advocate, (by Joseph F. Suozzo, Assistant Director of Litigation); Carmody, Gail; Carroll, James, Acting President, Atlantic Health Systems, Inc.; Carver, David, M.D., Chairman, Dept. of Pediatrics, UMDNJ, RWJMS; Central Jersey Health Care Corporation; Chadwick, Barbara, Freeholder, Bergen County; Chaikin, Sarah; Chamberlain, Mark; Charles, Joseph, State Assemblyman, District 31; Chapin, Janice, Esquire, Senior Staff Attorney, Union County Legal Services Corp.; Chasnoff, Susan, New Jersey Association of Area Agencies on Aging (NJ4A); Chatlos, J. Calvin, Chair, Prevention Committee, Governor's Council on Alcoholism & Drug Abuse; Checchio, Robert A.; Cho, Jung H., Dr., Public Health Coordinator, Camden Co. Div. of Health (presented by Gavin, Catherine E., M.A., R.D.); Cirello, Richard, M.D., Vice President, Mountainside Hospital; Coblentz, Malcolm, M.D., Essex County Medical Society; Cohen, Alan, Chairman, Commissioner's Cardiac Services Committee; Cohen, Bob; Cohen, Miriam, BSN, RNC, Supervisor, Public Health Nursing, County of Middlesex; Collette, Dennis H., President, Newton Memorial Hospital; Connell, Robin, Vice President of Planning, Community Medical Center; Conrad, Ruth; Cooper, Paul S., President, South Jersey Hospital System (supplemented by 8,367 signatures on petitions, fourteen township resolutions and ten miscellaneous letters of support); Corcoran, JoAnn, Pharmacy Technician, Bayshore Hospital; Corman, Randy, State Senator, District 19; Cosder, Frances; Croce, Angelus, Chaplain; Crowley, Peter, New Jersey Licensed Beverage Association; Crudele, James E., M.D.; Cuff, Alice, Member Emeritus, Board of Directors, Caring Alternatives for the Aged; Cumberland County Board of Chosen Freeholders; Cuniglia, Audrey; Cunningham, James E., President, New Jersey Association of Health Care Facilities; Curtis, Robert, President & CEO, Clara Maass Medical Center; Cushman, Jack, Vice President, Board of Directors, MANNA House; D'Allessandro, Beth Anne, Esquire; Dadlez, Christopher M., President and CEO, Monmouth Medical Center; Daly, Claire Myers; DeGennaro, Anthony, M.D., Middletown, N.J.; Delran Emergency Squad, Inc.; Del Mauro, Ronald, President and CEO, St. Barnabas Medical Center; DeLeonardis, John, M.D., Assistant Chief, Bridgeton Division Pediatrics; DeMill, Sherman, Clerk of Session, First Presbyterian Church, Bridgeton; deVelder, Joan; Diamond, Edmund; Diamond, Helen; Dickey, Lois, Community Planner, Bergen Community Health Care; DiDonato, Mary A., RN, BSN; DiGaetano, Paul, State Assemblyman, 36th District; DiGirolamo, Diana, Senior Vice President, Commerce & Industry Association; Doherty, Margaret, Sister, Coordinator of Mission Awareness, St. Mary's Hospital; Dolfman, Michael L., Ph.D., Executive Vice President/Strategic Planning and Marketing, Cooper Hospital/University Medical Center; Donlen, Judy, DNSc, RN, Executive Director, Southern New Jersey Perinatal Cooperative; Donovan, Robert, CEO, Meadowlands Hospital (presented by Helen Kennedy); Dorey, Fred O., M.D., Medical Director, Mid-Atlantic Stone Center; Doyle, James, President and CEO, Chilton Memorial Hospital (supplemented by 3,555 petition signatures); Dunn, Mary; Duriske, Patricia, President, New Jersey State School Nurses Association;

Ebersold, Anne, Sister, Acting Administrator, Mater Dei Nursing Home; Edelman, Norman H., M.D., Dean, Robert Wood Johnson Medical School; Ehrenguber, Patricia, Director of Development, Family Planning Program of Ocean County, Inc.; Ensle-Mondrone, Karen, Rutgers Corp.; Everette, Dorcas, President, Licensed Practical Nurse Association of New Jersey; Falkenberg, Naomi; Fanburg, John D., Esquire, Radiology Society of New Jersey; Farragher, Clare M., State Assemblywoman, 12th District; Fletcher, David A., President, Elizabeth General Medical Center; Florio, Dale J., Princeton Public Affairs Group, Inc., (representing GE Medical Systems); Fordyce, James C., NJ Licensed Beverage Association; Foster, Howard R., D.O., Foster Radiologic Associates, P.A.; Foy, Edward, Ph.D., Director of Research & Development, Newark Renaissance House, Inc.; Fredericks, Raymond F., Senior Vice President, JFK Health Systems, Inc.; Frenkel, Lawrence D., M.D., Councilor, American Academy of Pediatrics/NJ Chapter; Frey, John, Director of Planning and Marketing, Pascack Hospital; Funk, Clarice, Secretary, Eastern Monmouth County Smokers' Rights Association; Furman, Joan, Director of Planning, St. Joseph's Hospital and Medical Center; Garry, Joseph, for State Assemblyman John Kelly, 36th District; Garwin, Harold, Esq., Chairperson, LAB III; Gaetano, Ronald J., R.Ph., Executive Director, Genesis/Union Hospital; Garinello, Lawrence, Vice President, Strategic Planning, Robert Wood Johnson University Hospital; Gavin, Catherine E., Director of Public Health Nutrition Services, Camden County; Gay, Roccolee, R.N.C., M.P.A., L.N.H.A., Executive Board Member, New Jersey Association of Directors of Nursing Administration; Geriatric and Medical Centers, Inc.; Getz, Helen K.; Godfrey, Edythe D., A.A.R.P. Chapter #571; Golden, Thomas, Vice President of Planning, Medical Center of Ocean County; Goldman, Thomas, President, Bayshore Hospital; Goodman, Pat, Dr., Coordinator of Gerontology, Kean College; Gottlieb, Marvin, M.D., Director of Pediatric Department, Hackensack Hospital; Greene, Elizabeth, Director of Perinatal Grants, Monmouth/Ocean Consortium; Greene, Garfield, Rev., Caring Alternatives for the Aged; Grossier, Carolyn; Guida, Frank, Ph.D., Coordinator of Pathological Gambling Research, University of Medicine & Dentistry of NJ, Community Mental Health Center of Piscataway; Hages, Harry, M.D., Director of Pediatric Department, Pascack Hospital; Haggan, Ruth G.; Hall, Lois; Hall, Nancy Gwynn, Chairwoman, Eastern Monmouth County Smokers' Rights Association; Hall, Thomas J.; Hardgrove, Ted, New Brunswick Redevelopment; Hare, George T., M.D., Clinical Professor of Medicine, Head, Division of Geriatric Medicine, UMDNJ/RWJ Medical School at Camden; Hall, Nancy Gwynn, Eastern Monmouth County Smokers' Rights Association; Hatala, Alexander, Chairman, LAB V, and CEO, Our Lady of Lourdes Hospital; Hatfield, Jerome; Hepburn, Mary; Hills, Annette, Camden County League of Women's Voters; Hogan, William, CEO, Helene Fuld Medical Center; Humphrey, Frederick J., II, D.O., Dean UMDNJ-School of Osteopathic Medicine; Hurff, Curtis J., Principal Probation Officer, II & Juvenile Division Supervisor, Salem County Probation Department; Ierardi, Joseph A., President and CEO, Newcomb Medical Center; Ingis, David A., M.D., Vice-President of the Medical Staff, Zurbrugg Hospital; Institute For Human Development; Jadaach, Frances; Jaegar, Eleanor, Executive Director, LAB VI; Johanson, Waldemar, M.D., M.P.H., Chairman, Department of Medicine at UMDNJ-New Jersey Medical School in Newark; Johnson, Jack, Rev., Clergy Association for Pediatric Care, Bayshore Hospital; Johnson, Mark H., Dr., Acting Chairman, Family Medicine, New Jersey Medical School; Kalem, Daniel D., President, Mended Hearts, Inc.; Kaletkowski, Chester B., President & CEO, Memorial Health Alliance; Kane, Daniel, President & CEO, Englewood Hospital; Kaplan Caryn K., Director of Planning, The Mountainside Hospital; Karaban, Thomas V., Chairman & Founder, Rainbow Foundation, Bayshore Hospital; Kauffman, Charles, Licensed Health Officer, Retired, Perinatal Consortium Organization, Monmouth County; Kay, Stephen D., Executive Vice President, Bayshore Community Hospital; Keane, William L., Assistant Administrator, St. Lawrence Rehabilitation Center; Keeler, Louis L., M.D., Medical Director, Mid-Atlantic Stone Center; Kennedy, James J., Mayor, City of Rahway; Kerney, Jane, Vice President, Communication and Planning, Medical Center at Princeton; Kerr-Harold, Jacqueline, Executive Director, Job Haines Home; Kinsler, Phyllis, Executive Director, Planned Parenthood of Monmouth County; Knowles, Harry J., Vice President, Board of Trustees, Elmer Community Hospital; Knox, Pamela, Vice President, Public Relations & Marketing, South Amboy Memorial Hospital; Koch, Florence K.; Kopicki, John R., President/CEO, Muhlenberg Regional Medical Center; Kossow, Jeffrey, M.D., President, Medical Staff, Zurbrugg Hospital; Koval, Bernard G., President & CEO,

Mountainside Hospital (supplemented by 11,627 petition postcards); Kuebler, Eleanor; Kurilla, Gloria, R.N., Keyport High School; Lanerty, Connie; Larson, Paul F., M.D., Senior Vice President for Academic Affairs, UMDNJ; Larson, Scott, M.D., Bayshore Hospital; La Venia, Gary F.; Lautenberg, Frank R., U.S. Senator; Lavelli, Betty, South Amboy First Aid Squad; Lear, Bill, President, N.J. Coalition for Smokers' Rights; Lee, John J.; Leikind, Jane L., Vice President, Strategic Services, Monmouth Medical Center; Leone, Anita, Executive Director, Family Planning Association of New Jersey; Lesko, William, M.D.; Levinson, Steven C., M.S., H.O., President, New Jersey Health Officers Association; Light, Frank B., President, Medical Staff, Rahway Hospital; Lloyd, John K., President, Jersey Shore Medical Center; Lindberg, Curtis, President, VHA of New Jersey; Long, Gwendolyn, NJ Public Policy Research Institute (presented by Lorna Johnson); Longchamp, Leon C., Executive Director, The Ramsey Homestead; Lory, Marc H., Vice President and CEO, UMDNJ-University Hospital, Newark; Lourenco, Ruy, M.D., Dean, UMDNJ Medical School; Lowe, Susan, E.M.T., M.I.C.P., Prehospital Care Giver, Pediatric Unit, Bayshore Hospital; Luongo, Gerald J., Mayor, Township of Washington; Lynch, Diane, Executive Director, LAB IV; Lynch, Sister Patricia, CSJP, President, Holy Name Hospital; Lynn, George F., President, Atlantic City Medical Center; Mackenzie, James, M.D., Chairman, Dept. of Surgery, RWJ Medical School; Madaras, John S., Jr., M.D., Staff Physician, Bayonne Hospital; Magee, Richard, Administrative Director of Special Projects, Burdette Tomlin Memorial Hospital; Malhiot, George D., Esquire; Marchetti, Carl, Chairman, LAB VI, Senior Vice President, Jersey Shore Medical Center; Marcus, Steven M., M.D., Councilor, American Academy of Pediatrics, N.J. Chapter; Maro, Robert J., Sr., M.D., New Jersey Academy of Family Physicians; Maron, Arthur, M.D., President, St. Barnabas Medical Center; Martin, Carol, Executive Director, Bridgeton Area Health Services; Martone, Edward, American Civil Liberties Union of New Jersey; Mathews, Robert T., President, Graduate Health System; Mattel, Stephen F., M.D., President, Medical/Dental Staff of St. Mary's Hospital in Passaic; McConnell, Carol, Public Health Nurse Supervisor, Bergenfield Health Department; McDonald, Denise, MSN, RNC, Assistant Vice President—Maternal Child Health, Memorial Hospital of Burlington County; McKearnd, Kathleen, Director of Community Relations, Bayonne Hospital; McManis, Heather B., Secretary, Salem County Ambulance Association; McNamara, Thomas C., M.D., Medical Director, Mid-Atlantic Stone Center; Meier, Kathleen J.; Melini, Carlo B., M.D., American Academy of Pediatrics, NJ Chapter; Mertz, Paul, Vice President, Hospital Center at Orange; Messina, Rudolph, M.D., Chairman, Pediatrics, Clara Maass Medical Center; Metsch, Jonathan M., Dr. P.H., President, Jersey City Medical Center; Miller, Dennis; Miller, Frank, Board of Directors, Caring Alternatives for the Aged; Miller, Judy, Director of Services, MCOSS Nursing Services; Miller, Pamela T., Esquire, Executive Director, LAB III; Milsten, Richard, M.D., Medical Director, Mid-Atlantic Stone Center; Milton, Gene C., President and CEO, Hackettstown Community Hospital; Miranda, Catherine, Deputy Executive Director, PROCEED, Inc.; Moles, Dan, L.N.H.A., R.N., M.H.A., Administrator, Ashbrook Nursing Home, Mega Care Inc.; Monagle, William J., F.A.C.H.E., President, Somerset Medical Center; Moore, Roger A., M.D., Burlington County Medical Society; Moran, Michael, Coordinator, New Jersey Coalition on Disabilities, Alcoholism and Drug Abuse, Inc.; Morris, Patricia, Center for Hope; Murray, James J., ACSW, Executive Director, Bayshore Youth & Family Services of the Community YMCA; Murray, Richard E., President, Kennedy Memorial Hospitals (supplemented by seventeen letters of support); Narvaez, William, Chairman, Hispanics for Fair Representation; New Jersey Dietetic Association, Inc. (letters submitted from fifty-two members); New Jersey Hospital Association (with assessment prepared by McManis Associates, Inc.); New Jersey State Nurses Association; Newkirk, Alan W., Clerk, Upper Pittsgrove Township; Noon, Joseph, Director of Planning, Bergen Pines County Hospital; Noonan, Cathleen Modesta, Chairwoman, Health Advisory Council, Township of Belleville; Norz, Bernadette, Corporate Director of Business Development, Franciscan Health System; Noto, Gloria, Freeholder, County of Cumberland; Nunberg, Helen; O'Leary, John T., Mayor, City of South Amboy (supplemented by 671 petition signatures); Obzansky, John J., President, Towne Laboratories, Inc.; Olejnik, Marilyn, C.F.O., St. Mary's Hospital; Ortiz, Thomas, M.D., Board Member, LAB III; Osterlund, Betty, Central Monmouth Smokers Rights Association; Oths, Richard P., President, Morristown Memorial Hospital; Packer, Mark E., Executive Director, Appel Farm Arts and Music Center; Pascuiti, James M., Vice President for Professional Services, Children's Specialized Hospital; Patmas,

Michael A., M.D.; Patschke, Timothy, Ph.D., Chairman, LAB II; Paul, Carol, Vice President, Morristown Memorial Hospital; Payne, Dennis; Peck, Christina, R.N., Kennedy Memorial Hospitals; Pearson, Ronald G., General Counsel, Time, Inc.; Pennisi, Lee, Director of Marketing, Senior Care Center, American Senior Care; Perkel, Dave; Perry, Constance S., Township Clerk/Administrator, Township of Pittsgrove; Perry, Maria; Persichilli, Judith, Executive Vice President, St. Peter's Hospital; Perweiler, Elyse A., Chairperson, LTC Overview Panel; Peters, Pat; Pettingell, Margaret, M.Ed., C.H.E., Director of Nutrition Education, Dairy Council; Peterson, Patricia, Executive Vice President, COO, St. Mary's Hospital; Pignatelli, Robert; Pino, Robert, M.D.; Pirolli, Augustine R., President, Kennedy Health Care Foundation; Porter, Margery N., Program Director, Glanbeigh Health Sources; Potter, Thomas E., M.D., Chairman, Department of Pediatrics, Seton Hall University School of Graduate Medical Education; Powles, Mary Ann; Pownall, Douglas R., L.N.H.A., Administrator, United Methodist Homes of New Jersey; Poysse, Leo F., Vice President/Corporate Development, Newcomb Medical Center; Quigley, Hugh A., President, St. Mary's Hospital; Rapkin, Richard H., M.D., Medical Director, Children's Hospital of New Jersey; Rash, Edna; Ratliff, Robin, Vice President for Planning, Hackensack Medical Center; Rayvid, Pamela, Director of Planning, Dover General Hospital and Medical Center; Regional Perinatal Centers of New Jersey; Reihl, Patricia A., President, Association of Alcoholism and Drug Addiction Halfway Houses of New Jersey; Reilly, Phyllis, M.A., CADC, Director, University of Medicine & Dentistry of New Jersey; Revicky, Bernadette, Administrator, Hunterdon Convalescent Center; Rider, Charles F., DDS; Rider, Mary Margaret; Riener, Carol Ray, Vice President, Palmyra Board of Education; Rigtrup, Edward, M.D., Director of Pediatrics, Mountainside Hospital; Rivera, Aurelio, Program Director, La Casa de Don Pedro, Inc.; Rizzi, Kenneth, Assistant Health Administrator, City of Englewood Department of Health; Robinson, Frederick, President, Advisory Council, Salem County Office on Aging; Robinson, Norman, Jr., Chairman of Board, Four Seasons Campgrounds, Inc.; Rondum, Ritamarie G., Member, AARP; Rosa, Ulrich J., President & CEO, Franciscan Health System (presented by Bernadette Norz); Rubin, Marvin J., DPM, President, New Jersey Public Health Association; Rushnak, Michael J., M.D.; Sachs, Gregory R., M.D., Treasurer, LAB III; Sadowski, Charlotte; Samilson, Lori A., Esquire; Samuel, Ellen, Executive Director, Planned Parenthood League of Middlesex County; Santoro, Tom, Associate Administrator, Pascack Valley Hospital; Saxton, H. James, United States Representative, 13th District; Schwartz, Mark G., M.D.; Scheib, Garry L., President, Rancocas Hospital; Schepps, Toby, Smokers' Rights Association; Schermer, Robert, Executive Director, LAB I; Schiffner, Wayne C., President, Dover General Hospital and Medical Center; Schiro, Kathleen, Councilwoman of Wallington, Senatorial Aide to Senator John Scott; Schmidt, Richard D., President, Elmer IGA; Schneider, Marvin, the First Class at Bayshore; Schoenberg, Robert, Director, St. Barnabas Seniorhealth (presented by Gary Walker); Schnuriger, Barbara; Schuber, William Pat, Bergen County Executive; Scott, John, State Senator, 36th District; Seracusano, Frank (presented by Buckalew, Jan.); Sherber, Joseph, President and CEO, Kimball Medical Center; Shields, Gary; Simcox, Freda R.; Sisto, Donna; Skrika, Margaret; Slade, John, M.D.; Smith, Bradford S., State Senator, 7th District, (supplemented by 1,609 petition signatures in support of Zurbrugg Riverside Hospital); Smith, Warren F., NOCIRC of New Jersey; Smolenski, Benjamin, Orthopedic Surgeon at Riverside Hospital; Sniffen, Michael J., President & CEO, Overlook Hospital; Snyder, Nancy, Co-Chair, Northern Ocean Smokers' Rights Alliance; Sonatore, Gail, Shelter Program Director, Women's Center of Monmouth County; Sorgento, Theresa; Sosa, Jose F., Assemblyman, 7th District; Sprott, Kendell, Dr., Associate Medical Director, Children's Hospital; Squires, Richard E., County Executive, Atlantic County; Stager, Diana, Assistant Vice President for Planning, NJHA; Stanton, Jan B., M.S., R.D., Executive Director, Dairy Council, Inc.; Staples, Beth, Councilwoman, Borough of Westwood; Stedman, Peggy, Lactation Consultant, WIC, Camden; Sullivan P.; Surpin, Jo, Interim Staff, LAB V; Szymanski, Eve, Dr.; Tadzynski, Leslie, Dr., Pediatrician at Kennedy Memorial Hospitals; Tamborlane, Theodosia A., P.C., for Raritan Radiology, MRI of Central Jersey, and Magnetic Imaging Associates of Monmouth County, P.C.; Terrill, Thomas E., Ph.D., Executive Vice President, University Health Systems of New Jersey; Tettleman, Edward, Director, Legal and Regulatory Affairs, New Jersey Department of Human Services; Thigpen-Rodd, Rosalind, M.H.A., Director, Office of Minority Health, New Jersey Department of Health; Tillyer, Herbert K., Monsignor, Chancellor, Roman Catholic Diocese of Paterson; Titelbaum, Jules A.,

M.D., Director, The Children's Center at The Beth; Tolbert, Thelma N., RN, MSN, President, NJ Association of Public Health Nurse Administrators, Inc.; Township Committee of the Township of Upper Deerfield; Trainor, Peter, Caring Alternatives for the Aged; Tremble, Lee; Troutman, Adewale, Committee for the State of Black Health; Underland, Ann, Care for Aged; Vandervalk, Charlotte, Assemblywoman, 39th District (presented by Beth Staples); Vanore, Frank, M.D., Director of Pediatrics, St. Mary's Hospital, Hoboken; Veloric, Michael, Vice President of Geriatric Medical Centers, Inc.; Viswanathan, Uma, M.D., Chief, Pediatrics, Rahway Hospital; Vork, Anna; Wagner, David, Senior Vice-President, St. Barnabas Medical Center; Waldron, William H., III, Executive Director, Southern N.J. Hospital Council; Walker, Leslie, Secretary, LAB III; Wargacki, Walter G., Mayor, Borough of Wallington; Weatherly, Bruce, Chairperson, Southern Jersey Concerned Citizens on Ethics; Weisfeld, Neil E., Director of Education, Research, & Regulatory Affairs, Medical Society of NJ; Wesley, Herman L.; Westwood Board of Health; Wheeler, Alan G., Deputy Director, Department of Human Services, Division of Medical Assistance, State of New Jersey; Whelan, Charles A., M.D., President, Medical Staff, The Mountainside Hospital; Wilpert, Frank, Administrator, Sussex County Department of Health & Public Safety; Wisda, John, Administrator, Elmer Community Hospital (supplemented by 537 letters of support); Wirta, Wayne, Executive Director, New Jersey Council on Alcoholism and Drug Abuse, Inc.; Women's Center of Monmouth County; Wright, Joyce; Yankus, Wayne, M.D., Councilor, The American Academy of Pediatrics/NJ Chapter; Yoder, John, President, Rahway Hospital (supplemented by seventy-three petition letters); Ycre, Louis R., Jr., Chairperson, LAB II, President, Pascack Valley Hospital; Zane, Raymond J., State Senator, 3rd District; Zastocki, Deborah, Chilton Memorial Hospital.

General Comments. State Health Plan Process and Content

COMMENTS: Many commenters recommended approval of the State Health Plan.

A few commenters supported the process of developing the State Health Plan and described it as a catalyst which has generated public debate over the kind of health care system New Jersey desires in the twenty-first century. The Department was commended for including a wide range of providers in the development of the proposals. A criticism of the Department of Health over the past decade has been the lack of an overall plan to guide the formulation of regulatory policy. These commenters contend that the development of a State Health Plan overcomes this significant problem. Rather than focus attention on providers who are "winners" or "losers" in this plan, these commenters believe that the public's attention should center on whether the plan will improve the health of the citizens of New Jersey. One commenter states that the plan has the potential to help government, providers and consumers set priorities that will result in better health. The plan is an excellent beginning.

Many of the commenters objected to what they perceived as top-down central planning used to develop the State Health Plan and contended that the process did not allow for sufficient time for input from consumers and providers. Some commenters raised concerns that the Plan may become cumbersome, counterproductive and may interfere with future plans of local authorities. Though the State Health Plan is a good idea in theory, they think there should have been more consultation with hospital administrators.

One commenter stated that the public hearings held by the Health Care Administration Board (HCAB) were the only opportunity that providers and consumers had to impact the development of the Plan.

Commenters were critical that Local Advisory Boards (LABs) did not have full participation. One commenter suggested that separate task forces be implemented to assist the LABs in determining what different interest groups want.

Several commenters recommended that implementation of the Plan should be delayed to allow for further refinement of the proposals. One commenter suggested that the draft plan be refined during the coming year using the LAB as the forum for input, using the current draft as a discussion guide. Without refinement, concern was expressed that the Plan may restrict new and imaginative approaches to health care delivery.

One hospital commenter expressed skepticism about the rulemaking process in general saying that it is the experience of hospitals that little if any material changes are ever made.

RESPONSE: The Department concurs with those who support adoption of the Plan.

The Department appreciates the support for the State Health Plan and the planning process and agrees that the Plan should be approved. Input from the public not only has been beneficial to the Plan, but has also been educational to the Department in terms of how best to reach the public. Although many commenters perceived the planning process as exclusionary, in reality the development of these rules has been more inclusive than any other endeavor undertaken by the Department. The process is described for the record below:

The State Health Plan was developed over a period of more than seven months during which intense public scrutiny and discussion has occurred across the State. It included formal public input to the State Health Planning Board (SHPB) as well as the HCAB, and informal input in the form of numerous newspaper articles and editorials, legislative action and televised debates. It was the subject of a televised Assembly Appropriations hearing.

The SHPB held five public hearings in various locations around the State and an additional 12 public meetings in its consideration of the State Health Plan. Hundreds of organizations and individuals have testified and thousands of pieces of mail have been received and carefully reviewed. As a result of this public input, major changes were made to the original drafts of the plan.

In addition to SHPB activity, the Department of Health staff discussed the proposals with several official advisory groups such as the Commissioner's Parent and Child Advisory Council, the Commissioner's Cardiac Services Advisory Council, and the Governor's Council on Alcoholism and Drug Abuse. Several meetings have been held with the Medical Society of New Jersey, the New Jersey Hospital Association Council on Planning, the New Jersey Nurses Association, the New Jersey Family Planning Association and other professional organizations. Department staff formed three long-term care advisory groups that include 60 people from various areas of expertise. They are currently working on issues related to the long-term care proposals. Another advisory group of 30 additions experts are working on proposals from that chapter.

The Department worked with the public and the industry on a hospital-by-hospital basis for the six institutions recommended for transition from acute care to other needed health services and offered to meet with the 15 hospitals slated for closure of pediatric units. That work has included town meetings, meetings with legislators, hospital officials and physicians, and site visits. All but one hospital agreed to participate in these ongoing planning sessions.

The LABs all had voting representation on the SHPB. Many held hearings in their areas. At the February 27, 1992 meeting of the SHPB, all of the six LAB representatives were present; five voted to send the plan on to the HCAB, one abstained. The SHPB also added a provision to the proposed rules which requires that the LABs present their recommended revisions to the plan to the SHPB no more than four months after final adoption of the plan. The Board made it clear that the LABs should continue to make ongoing recommendations on how the plan should be changed.

On March 12, 1992 the Department proposed, and the HCAB endorsed, an extended 60-day public comment period on the proposed rules. This formal process for accepting public comment included public hearings, an extraordinary action for the HCAB. The HCAB held six public hearings, one in each LAB region. At those hearings 250 consumers and providers testified. Each LAB also testified in time specifically reserved for them. The six hearings held by the HCAB added to the five SHPB hearings equals 11 public hearings held during a six and one-half month period. Following these hearings, Kevin Halpern, Chairperson of the HCAB, specified five key areas for further discussions with and possible rule amendment by the Department: closing pediatric units; regionalizing pediatric services; measuring "quality of care"; converting acute care services; and giving preference to core teaching hospitals in the distribution of new technologies. Department consideration of these matters is set forth in this summary. The hearings record may be reviewed by contacting Margaret Payne, Department of Health, Office of Boards and Councils, CN 360, Trenton, NJ 08625.

New Jersey has functioned without a health plan for the past 10 years. The negative effects of this are clear: the State has a system of care in which many are denied access until they are severely ill; the State has too many of some services such as MRIs and too few of others such as immunizations for childhood diseases; the number of people without health insurance grows larger every year; and those with health insurance find their coverage eroding and a larger proportion of income consumed by paying for health care services through larger deductibles, co-payments and stop-loss thresholds. Further delays will only serve to exacerbate these negative effects.

The Department sees the Plan first and foremost as a document for the State's citizens. From the outset, an underlying principle has been that the plan is flexible and dynamic. The State Health Planning Board formally endorsed that principle by including the provision in the proposed rules to begin the review process four months after final adoption. The plan is not a rigidly prescriptive document. Rather it is a long range vision of where to head. It is a five to 10 year planning document. As with any strategic plan, many mid-course changes will be necessary to achieve long range goals.

The dozens of changes made to the draft proposals by the State Health Planning Board in response to public comment demonstrate that the planning process is flexible. The administrative procedure process does work. Changes are frequently made to a rule at final adoption. Every major proposal of Statewide scope has experienced revision after initial publication. The recommendations contained herein are a direct result of the public process. Furthermore, these rules have an explicit requirement that a revision process begin within months of final adoption.

COMMENTS: The intent of the proposed rules to provide a systematic planning process is strongly supported by many of the commenters. A participatory approach inherent in the mission of the Local Advisory Boards is lauded.

New Jersey Public Policy Research Institute and the Committee on the State of Black Health requested the Department to require the LABs to have African-American consumer and community representation that is at least proportional to the population of the LAB region. They further urged the Department to require the LABs to effectively solicit African-American input on issues such as hospital bed reductions, closings, mergers, service reductions and major capital renovation projects.

RESPONSE: The Department agrees that although only a few months old, the LAB network has established a firm foundation for regional health planning. The Department will support the LABs to accomplish regional needs assessments, identify problems, and make recommendations for building areas resources to address these needs.

In response to the comment about African-American representation in regional health planning, it should be noted that the LAB Request for Applications specified that the board membership be representative of the demographics of the population of the region. It is a condition of funding that this representation be maintained. Persons concerned about the representation of a board should discuss it with the LAB staff to determine how representation can be improved. Further, the LABs are currently seeking community participants for committees and task forces. Anyone interested in participating should contact the LAB in his or her region.

COMMENTS: Several commenters stated that physicians need to be involved in solving the health care crisis and that government needs to listen to physicians.

RESPONSE: The Department agrees with these commenters. Indeed, physicians have played an important role in the Plan's development. They were among the most involved of the professional groups, Subchapter 4, Maternal and Child Health, was largely based on the Perinatal Technical Advisory Group convened in 1989. This group included many physicians. In the early stages of development, Subchapter 8, Addictions, had direct input from many physicians specializing in addiction medicine and Subchapter 9, Cardiovascular Diseases, was reviewed by the Commissioner's Cardiac Services Committee. Input was also sought from the Parent and Child Health Advisory Committee. These standing advisory committees have physicians participants.

Dozens of physicians provided testimony at 11 public hearings and in written form. Four meetings were held with the Medical Society of New Jersey which also submitted two sets of formal comments. Meetings were held with representatives from the New Jersey Chapter of the American Academy of Pediatrics and the New Jersey Pediatric Society. Many physicians participated in discussions held by the Department about specific hospital recommendations. Two State Health Planning Board members are physicians, and 13 sit on Local Advisory Boards. One Health Care Administration Board member is a physician.

Physician input was extremely valuable in refining the proposals. Many of the changes made by the State Health Planning Board and in the final rules were the result of physician input. The Department of Health acknowledges the crucial role played by the physicians in this State in refining Phase I of the Plan and is encouraged by the level of involvement already demonstrated in developing Phase II of the Plan.

COMMENTS: Several commenters stated that the State Health Plan adds bureaucracy and more government. Some called for the Plan to more clearly state the need for collaborative efforts among the Depart-

ments of Labor, Law and Public Safety, Education, Human Services and Health to address the health and well-being of New Jersey residents.

The American Academy of Pediatrics specifically recommended improving the level of Medicaid reimbursement to 80 to 90 percent and incorporating other programs such as the WIC program.

RESPONSE: The plan does not add layers of government, but rather provides for coordination of the many components of government involved on the financing and provision of health care services. Too often agencies of government operate in isolation or even opposition. The Department agrees that interagency collaboration is necessary. Such collaboration is called for in over 50 of these rules throughout the Plan. This collaboration among existing agencies is the key to avoiding the creation of new bureaucracies.

The suggestions of the American Academy of Pediatrics were contained in the proposal. Their support of these rules is appreciated.

COMMENTS: Many commenters voiced strong support of regionalization and its potential positive impact on containing costs, removing access barriers and improving quality of care.

A few commenters stated the belief that the Plan will not accomplish its own goals and will only limit access and increase costs to the residents of New Jersey. Some said that regionalization will result in inaccessibility and it will concentrate services in the high cost tertiary hospitals rather than low cost community hospitals. Family physicians were cited as low utilizers of expensive care resulting in quality health outcomes. Some commenters contend that community-based family health centers have a psychosocial benefit.

The Hospital Association stated that only public disenchantment will be fostered through this Plan. While the Plan recommends cuts in certain services and the expansion of others, it does not allow for the new services to substantiate themselves. They do not prove their need, yet other programs are sacrificed for them. Therefore, the public remains suspect of the changes.

Further, a representative of the Medical Center at Princeton stated that the hospital should be in its own planning area rather than combined with either Trenton or New Brunswick. The health needs of Princeton are different than the health needs of Trenton and the Medical Center should be allowed to develop services that meet the needs of its patient population.

Also, counties like Bergen and Hudson should not be paired together because the grouping of a very affluent community with one that is not does not benefit either community.

RESPONSE: Regionalization results in many system benefits. In obstetrics, trauma care and other areas, the value of regionalization has been proven. The quality of care has improved, access has been increased through referral and coordination of services, and the true costs linked to value have decreased.

The Plan is fostering a robust public debate on the future of health care in New Jersey. There are few "cuts" called for in the Plan. The Plan instead calls for moderation of excessive and expensive growth in the specific areas. The new services called for are either proven effective, or to be tried on a demonstration and evaluation basis.

The health care problems of New Jersey cannot be solved by institutions continuing to operate in isolation. The Medical Center of Princeton is a major health care provider in Mercer County serving the needs of many beyond the boundaries of Princeton. Similarly, many residents of Princeton seek care in other areas of the State, and even outside of the State. Cooperation among providers is essential to ensure that resources are distributed in the most effective and efficient ways over the next decade.

COMMENTS: Several commenters stated that to keep markets competitive, regulation should be kept at a minimum and regulations such as those in Subchapter 14, specifically some in the pediatric component, should be abandoned.

A few commenters requested proof of economic cost-benefit analysis. Several commenters called for better use of existing services rather than creating expensive duplication of services.

Another commenter related concern that the State Health Plan is a cost-containment strategy which may be moving towards rationing health care much like the Oregon Plan because of its dependence on savings and innovative funding.

One commenter suggested that the Department should obtain an 800 number and launch a media campaign to gain public support and bring all the players to the table to develop solutions to our health care crisis.

RESPONSE: The use of unfettered markets to provide health care is controversial. There is legitimate concern that such a system will be

best for those who can pay, not for those who cannot. There is a growing body of evidence that competition in U.S. health care markets adds rather than contains costs. The specifics in the hospital inpatient subchapter are designed to give New Jerseyans measures of accountability. Without these, the plan would become vague and it would be impossible to measure progress towards certain goals.

Wherever possible, the Plan discusses the economic problems of the State's current health care delivery system. For instance, the addictions and hospital inpatient subchapters discuss the costs of the current system of care in detail, and give specific goals for change. These estimates will continue to be developed by the Department as part of implementation plans. Should any recommendation be determined to be too costly or not beneficial to implement, the plan will be revised.

The Plan is based on the fundamental assumption that an Oregon "rationing" plan is inappropriate and premature for New Jersey. Rather, the emphasis of the New Jersey Plan is to assure that needed services are provided efficiently and economically before denying people access to these same services on the basis of extreme cost.

The Department will look closely at the recommendation of a toll-free telephone number. The LABs and the SHPB are seen as the vehicles for bringing these people to the table. Already, some of the LABs are working on developing public surveys and establishing task forces and committees for grass roots participation.

COMMENTS: Several commenters supported the Plan's proposed effort to direct resources toward the underserved, those in most need of health care, in areas where physicians are scarce. The State medical schools are currently working on strategies to influence and encourage the graduates of residency training programs to enter practice in underserved areas of the State. The New Jersey Chapter of the American Academy of Pediatrics stated that community health centers should be open 24 hours a day, seven days a week. Many commenters advocated a greater role for family practitioners.

Many individuals endorsed a shift of emphasis from acute care to preventive care. More governmental resources should be reserved for the prevention of disease, thereby reducing the dependence on relief and maintenance of acute illness. Individuals often resort to the emergency room for medical care, whereas, if they had basic health care such as immunizations, more severe illnesses could be prevented. One person stated that in the case of Latinos, this is doubly true. Another individual echoed these remarks for African-American communities.

RESPONSE: The Plan is based on the premise that access to primary health care needs to be improved if the health of New Jerseyans is to be improved. The Department agrees that community health centers must expand their hours to serve the uninsured, who are generally employed or dependents of persons who are employed. This expansion has been a condition of the funding of our State's federally qualified health centers from the Health Care Cost Reduction Fund established by P.L. 1991, c.187.

An endorsement of the Plan and community-based health facilities is appreciated. The Department applauds the New Jersey medical schools' efforts to expand the primary care provider base in communities. Increasing the number of residents who can access primary care is paramount. This is expressed in the objective at N.J.A.C. 8:100-1.1(b)1i. In addition, several subchapters contain specific recommendations for preventive activities. The next phase of the Plan will contain an entire subchapter on preventive and primary care. By focusing on "ambulatory care sensitive" conditions, the Department has tried to qualify the resultant cost of delayed or absent preventive and primary care.

COMMENTS: Several hospitals in the northern regions of the State expressed the concern that the Plan presents a bias toward UMDNJ over other health care facilities and presented the necessity of teaching hospitals not affiliated with UMDNJ. In addition, they presented the notion that if the policy were to limit institutions from pursuing other educational opportunities outside of the UMDNJ offerings, the residents of New Jersey will be adversely affected by reduced quality of care.

RESPONSE: The Department concurs that the Plan's focus should be on developing the best system of care, regardless of specific teaching affiliations. Much of the perception of favoritism was engendered by a proposed provision in N.J.A.C. 8:100-15.1(a)3 which has been deleted.

COMMENTS: Several commenters stated that a continuum of care incorporating preventive, primary, secondary, tertiary, and aftercare alternatives should be implemented. They concurred that the demographic make-up of the State should be taken into account in planning efforts.

RESPONSE: The Department concurs. With the completion of the Plan, a vision of a continuum of care, from birth to old age, will be in place. The Plan also emphasizes the changes in the State's ethnic and age composition.

COMMENTS: A number of commenters who identified themselves as smokers stated that the Department of Health should not be wasting its time in regulating the rights of smokers. Rather, they believe that the Department should focus their attention on more important subjects including the accessibility of mammograms and other preventive medical tests, halting the spread of AIDS, and distributing simple immunizations.

RESPONSE: Smoking is a major contributor to death and disease in New Jersey. However, due to the efforts of the public and private sectors over the past 30 years, the number of New Jerseyans who smoke, and who suffer heart disease, has dropped dramatically. It is important to extend this known health benefit to all segments of the population. Other health concerns are not being ignored as these commenters allege. The other suggestions are contained in subchapters of the Plan.

Subchapter 1. Introduction

N.J.A.C. 8:100-1.1 Purpose

COMMENTS: Numerous commenters agreed with goals of prevention and obtaining value for health care spending. *Healthy New Jersey 2000* (the goals and objectives of which are contained in this section of the rules) is a step in the right direction.

A number of commenters remarked that the plan should be adopted in one rather than two phases. The following reasons were offered: (1) subchapters on Maternal and Child Health and Hospital Inpatient Services cannot be created without consideration of preventive and primary care, AIDS, cancer, diabetes and mental health; (2) it is difficult to get a comprehensive picture of the health care system of the future; and (3) phase II should provide the ability to integrate all components of the Plan in sufficient detail to assure that health care issues are addressed in a coordinated and complementary fashion.

Other commenters stated that the Plan focuses on six specific areas, not overall State health care. They contended that even in the six areas it does not present a concrete *modus operandi* for achieving the goals it outlines and fails to consider the actual needs of the population.

Several commenters indicated that quality of care should be the focus of the plan since high quality care can be less expensive. They agreed that quality assurance in all settings (hospitals and community providers) is essential.

In addition to the objective proposed for reducing unintended pregnancy in adolescents, commenters requested the addition of an objective to reduce the incidence of unintended pregnancy for all women.

Three commenters asked that more specifics be incorporated into the rule regarding the breastfeeding objective, such as increasing hospital success rates by five percent each year and tracking those success rates.

One commenter raised concern about racial disparity in health targets for women and children.

The Medical Society requested an addition to the rule which would form two special task forces: one to examine administrative costs and another to empower consumers.

RESPONSE: The Department is pleased that the underpinnings of the comprehensive health plan received such strong support.

Some commenters may have overlooked Subchapter 1. The goals and objectives of the entire Plan are presented and objectives for all subchapters are contained within this section of the rule. Phase II of the Plan will be consistent with these overall goals and specific objectives. In addition, every subchapter discusses issues relevant to other chapters. For example, Subchapter 4, Maternal and Child Health, has references to primary and preventive care.

The State Health Plan is the most comprehensive and detailed review of New Jersey health care to date. It is divided into discrete subchapters to make it a concrete document designed to serve decision making. Throughout, population-based needs assessments are used wherever possible. The Plan is designed to meet the needs of people, not providers.

Promoting quality health care services is an explicit purpose of the State Health Plan stated at N.J.A.C. 8:100-1.1(a)5. In addition, each subsequent subchapter addresses quality of care. For example, Subchapter 4 identifies total quality improvement as one of the functions of the Maternal and Child Health Consortia. This will mean quality review and improvement in every provider setting. Subchapter 8 outlines a system of care for addictions that is based on patient need rather than patient insurance status which should directly enhance quality of care. Subchapter 9 requests a Statewide review of quality and appropriateness

of cardiac procedures. Subchapter 14 begins to address quality of care in pediatric inpatient services by starting the process of regionalization of services. Subchapter 15 reinforces standards of care for all transplant centers in order to ensure quality of care. One final example is in Subchapter 16 where many of the rules support quality of life for frail elderly and disabled New Jerseyans in addition to quality of care in the long-term care services they need. Objectives have been added at N.J.A.C. 8:100-1.1(b)12 to improve the health status for racial and ethnic minority populations and paragraph (b)12 recodified as (b)13. These objectives were drawn from information gathered over time by the Office of Minority Health, from contract with various representative groups.

Although baseline data is not available, the Department agrees that an objective to reduce unintended pregnancy within the general population of women should be added to the rule in N.J.A.C. 8:100-1.1(b). The objective of a one-third increase by 1995 was derived from the Alan Guttmacher Institute (AGI), the national clearinghouse for family planning information.

The objective for breastfeeding as written in the rule focuses on a realistic outcome measure for providers. Maternal and child health consortia may design strategies locally in conjunction with Department of Health consultants. Such service strategies are not referenced anywhere else in the rule; therefore, no change is recommended regarding these comments.

The targets set for different racial and ethnic groups are based on *Healthy New Jersey 2000* and are meant to be realistic and attainable over the course of the decade. The Department does not condone gaps in health status between racial and ethnic groups and will continue to work into the next century to close these gaps.

The Medical Society's suggestions have merit. There are a number of issues the Department will consider as the State Health Plan evolves. The issues raised by the Medical Society will receive priority consideration. No change is made in the rule.

So they would correspond to the goals and objectives set forth in *Healthy New Jersey 2000*, as was explained in the proposal Summary and in this section, changes have been made to the objectives at N.J.A.C. 8:100-1.1(b)3iv and 10ii.

N.J.A.C. 8:100-1.2 Scope

COMMENTS: Senator Corman expressed hope that the Department of Health would aim to refine the State Health Plan to make it a viable document that the Legislature can support.

Jersey Coast Health Planning Council anticipates being able to make additional revisions to the plan four months after adoption is specified in this rule.

It was recommended that the LABs be given six to 12 months instead of four to evaluate phase I of the plan.

RESPONSE: The Department is committed to refining the State Health Plan. Future refinement of the plan is ensured at N.J.A.C. 8:100-1.2(b) which states that the plan is to be a dynamic document and defines the role of the LABs in recommending changes within four months after adoption and at least annually thereafter in response to local health needs. This rule has been amended to allow the LABs six months to evaluate each subchapter and recommend revisions to the SHPB.

N.J.A.C. 8:100-1.3 Definitions

COMMENTS: One commenter stated that the definition of alternate family care should identify the parties to the contract. Several family planning providers suggested a definition for reproductive health is needed.

RESPONSE: The "alternate family care" definition has been revised as recommended. A definition of "reproductive health services" has been added to this section.

In revising Subchapters 4 and 14, the Department determined that the acronyms "LDRP," "NIRA," and "PICU" should be defined in this section.

Questions and Answers from the Public Hearings

Below is a summary of questions asked by Health Care Administration Board members of those who testified at the six public hearings, and the responses provided.

Q: Would you characterize the recommendation from LAV VI to approve the State Health Plan as having a strong sense of unanimity?

A: Yes.

Q: The speaker stated that Medicare had administrative overhead of 60 percent. This statistic was challenged. Department of Health staff were requested to verify this statistic.

A: The speaker stated that this statistic is widely reported in medical journals. Department staff reported that the percent of national health expenditures spent on administration is six percent, three quarters of which is for private insurance (Staff report that administrative costs for Medicare and Medicaid are 2.1 percent and 5.1 percent, respectively. Source: National Health Expenditures, Health Care Financing Review).

Q: (To representative of Essex County Medical Society) Does the Medical Society support any of the State Health Plan?

A: We are in support of a health plan. But the people who are actively involved with taking care of patients are not the ones being asked for their input. The state is asking people such as administrators and academic physicians, not those on the front line.

Subchapter 4. Maternal and Child Health Services

COMMENTS: General

Many commenters expressed support for the maternal and child health subchapter of the State Health Plan. They acknowledged the span of years over which it was developed and the degree to which public input was incorporated into revisions. The McManis Report for the New Jersey Hospital Association stated that the specificity of the Department's recommendations regarding reimbursement changes provided unequivocal evidence of the Department's intent to channel resources to community-based providers.

The Office of the Public Advocate stated that the subchapter did not go far enough in addressing underlying social and economic problems, such as boarder babies, HIV/AIDS, and homeless women and children.

Several family planning providers requested that the definition of reproductive health be broadened to include more than pregnancy-related concerns. They also identified that regional planning for accessible abortion services is not recognized within the chapter.

RESPONSE: General

The Department appreciates the comments supporting the maternal and child health subchapter of the Plan.

The Department recognizes the need to equalize health care and appreciates the support. 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 targets set in goals and objectives are based on *Healthy New Jersey 2000* and are meant to be realistic and attainable with interventions such as those in the proposed State Health Plan. The consortia model begins by addressing health issues on a local level. Consortia membership, although specified in the rule as including mostly health providers, does not preclude membership of other interested groups such as schools and job training programs. Such membership is encouraged by the Department in the consumer category. Real impact on the issues affecting maternal and child health care, such as homelessness of families and the problems of boarder babies, can only be made with comprehensive local input and holistic planning efforts.

For the commenter who raised concern about the inadequate coverage of issues pertaining to HIV/AIDS, N.J.A.C. 8:100-7 will specifically address this area including its impact on women and children.

The Department concurs that "reproductive health" cited at N.J.A.C. 8:100-4.6(d) should be broadly defined to include health care related to fertility issues and should be added to the definitions section at N.J.A.C. 8:100-1.3. Also, agencies providing reproductive health services will be added to the consortia membership in N.J.A.C. 8:100-4.4(a). Further development of women's health issues and service needs will be addressed in Subchapter 2, Prevention, Primary and Ambulatory Care Services. The Department recognizes the significant contribution of family planning providers in New Jersey to women's health and looks forward to working with this group in the development of Subchapter 2.

N.J.A.C. 8:100-4.1 General recommendations

COMMENT: Specific language was offered to include reproductive health in the Department's General Recommendations.

RESPONSE: N.J.A.C. 8:100-4.1(a)1 is amended to include reproductive health.

N.J.A.C. 8:100-4.2 Regionalization

COMMENTS: The New Jersey Hospital Association asserted that the enforced approach to regionalization prescribed in this segment fails to acknowledge or accommodate market forces. One hospital supported the concept of consortia but stated that institutional planning should be

driven by an institution's strategic plan, not by an outside consortia. This commenter added that as consortia evolve, cooperative efforts will be realized.

RESPONSE: Nationally, the benefits of regionalization are clearly documented. In the 1990 Perinatal Technical Advisory Committee (PTAC) report, New Jersey recommitted itself to the concept of regionalization by regulation. Although regions have clear criteria as defined in the rule, providers have choices regarding their regional affiliations. Criteria for designation of individual hospitals are based on the documentation of existing referral and transport patterns, which does acknowledge existing market forces. In addition, the current seven Robert Wood Johnson Foundation funded perinatal consortia are the basis for establishing the Maternal and Child Health Consortia. Most of these consortia were based in hospitals and were well aware of their institution's strategic plan concerning maternal and child health care. However, now with the responsibilities of the consortia expanding to include prevention and primary care, it would not be appropriate for them to remain hospital-based. The consortia as not-for-profit, independent agencies will focus more on the needs of mothers and children than on strategic plans of hospitals. In addition, due to restraint-of-trade issues, consortia may not remain hospital-based. There will be no change recommended as a result of these comments.

N.J.A.C. 8:100-4.3 Regional designation

COMMENTS: Three hospitals noted that the designation of Maternal and Child Health Consortia is an entirely new bureaucracy which will only serve to add cost to the system. One of the commenters strongly supported the concepts of regionalization but commented that detail is lacking in the definition of a maternal and child health region and in the conflict resolution process. This commenter also expressed concern that a not-for-profit corporation would decide how a hospital would function. In addition, there was criticism regarding the requirements for a regional perinatal center that must be met at the time of certificate of need application. This was seen as inequitable since children's hospitals are allowed to phase-in.

Five commenters strongly supported the continued strengthening and development of the Consortium along the lines of the Robert Wood Johnson model.

One local advisory board expressed concern that \$4.4 million in funding would promote a proliferation of consortia and that the Department would feel pressured to share MCH block grant funds with each consortia. Also, this commenter requested clarification of the relationship between the maternal and child consortia and the local advisory boards and how two consortia within Essex and Union counties would relate to one another.

One hospital noted that specifying the years to use in trend data would eventually outdate the rule.

RESPONSE: Currently, seven perinatal consortia are funded by Robert Wood Johnson foundation as a result of a grant given to New Jersey in 1988 to formalize the system of perinatal regionalization initiated in 1981. This structure has had a direct impact on improving rates of infant mortality and prenatal care accessed in the first trimester. Data on maternal and infant transfers from 1989 birth certificates clearly document that 88 percent of maternal transfers and 91 percent of neonatal transfers in-State are appropriately made to regional perinatal centers. There is much evidence nationally to support the concept of regionalization in improving infant outcomes.

Due to restraint of trade issues, the Department cannot "grandfather" the current seven Robert Wood Johnson funded consortia. However, the rule provides criteria regarding the definition of a region, for example, the deliveries, 100 very low birthweight infants, geographic accessibility, and a documented history of transport and referrals. Despite the funding, this definition will limit the total number of consortia able to form. The funding will be provided through hospital rates, not through MCH block grants. MCH block grant funds will still be utilized for direct service. The role of the Maternal and Child Health Consortia will be to make recommendations regarding the funding for local programs.

The Consortia will not decide how a hospital functions. Hospitals will apply for their designation based on their capacity to meet the requirements delineated in the perinatal planning rules and the region's needs regarding intensive and intermediate care. This regional planning process should take place in the arena of the consortia. An application for designation will be made by the individual hospital and batched by the consortia. These will then be submitted to local advisory boards in accordance with the new certificate of need process and then sent to

the Department, once approved by the local advisory boards. The Department will seek SHPB approval of these designations as part of the Maternal and Child Health Consortia Certificate of Need approval process. Following initial designation, there is flexibility regarding future changes in the designation process based on regional need.

The flexibility allowed in Subchapter 14 for a phase-in period is only for the number of beds in facilities (renovation/construction), not quality of care or clinical criteria such as that required for designation of perinatal centers which includes staffing and task capability. Specific criteria for perinatal designation have been developed by experts and tested over a number of years, and are available to appropriately make these determinations. Such criteria are not yet available for pediatric planning and therefore cannot be required at this time. They will be developed by a pediatric clinical advisory committee to be convened by the Department. All of these details, including a conflict resolution process, are appropriately described in the proposed revised perinatal planning rules, N.J.A.C. 8:33C, published June 1, 1992 (see 24 N.J.R. 2005(a)). The conflict resolution process has several steps at the local consortia level with ultimate decision-making resting with the Department.

The consortia will result in a net savings to the system. When regionalization was first initiated in 1981, all of the hospitals functioning as regional centers in New Jersey were approved for rate increases due to increased regional responsibilities except for hospitals in the New Jersey Southern Perinatal Cooperative. The Cooperative received funding for the activities of both Cooper Medical Center and Our Lady of Lourdes Medical Center in an amount equivalent to a rate increase of one regional center in other regions Statewide. Funding the consortia regionally avoids duplication within the region and resolves the issue of restraint of trade for certificate of need.

Funding the Consortia through the hospital rates was first explored by the Perinatal Technical Advisory Committee and recommended as a more stable funding base than legislation could procure. The actual average rate increase to fund the proposed Maternal and Child Health Consortia will be less than .1 percent. The \$4.4 million estimated annually to fund the consortia for perinatal and now pediatric activities could potentially save much more. In 1989, over \$85 million was spent on neonatal intensive care alone (without the additional cost estimate of long term disability) and over \$42 million was spent in preventable pediatric admissions (17,000) statewide. To save \$4.4 million or "break even", either 63 preterm deliveries would have to be prevented or 1,781 ambulatory care sensitive pediatric admissions prevented or some combination of both. Outcome objectives set in *Healthy New Jersey 2000* and in this rule would far surpass either of these indicators.

Consortia serving adjoining areas will function independently, although certain service agencies may be shared. The Plan anticipates cooperation among the Consortia and its members.

References to data issues are duly noted and N.J.A.C. 8:100-4.3(a) and 4.6(c)2 will be changed accordingly.

N.J.A.C. 8:100-4.3(d) was added upon adoption to set forth the sequence for designation of facilities as Community or Regional Pediatric Centers, to include the promulgation of pediatric planning rules, to replace N.J.A.C. 8:100-14.11(c) through (e) and 14.19(a).

N.J.A.C. 8:100-4.4 Maternal and Child Health Consortia

COMMENTS: One commenter expressed concern regarding the impact of the consortia on decision-making for funding for categorical services. Another commenter felt strongly that the consortia must be a function of strong community involvement and that they need a stronger say in the allocation of resources and funding.

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 status from a prevention perspective.

Commenters remarked that medical societies and social services agencies should be represented on all of the consortia.

RESPONSE: The structure of the consortia membership and its governing board as specified in the rule clearly outlines equal membership on each board (one vote per member), and includes one-third each consumer, hospital and nonhospital provider configuration. The consortia will make recommendations for funding to the Department.

The Department agrees that certified community health nurses can bring the appropriate prevention perspective to the consortia. N.J.A.C. 8:100-4.4(b) has been amended to include community health nursing as an appropriate certification for R.N.s on the consortia Boards of Direc-

tors. In addition, at the suggestion of the HCAB, consortia board membership of 18 to 21 members has been established as a minimum, rather than a limit, to allow for maximum community participation in the board.

This rule does not preclude medical societies or human services agencies from membership. This comment will be considered further as part of the process for the proposed revised perinatal planning rules N.J.A.C. 8:33(c) published in the New Jersey Register on June 1, 1992 (see 24 N.J.R. 2005(a)) which contains a much more detailed list of consortia members.

N.J.A.C. 8:100-4.5 Functions of Maternal and Child Health Consortia

COMMENTS: Several family planning agencies urged that the Plan recognize that it may not be necessary for all providers to directly offer all services on-site. They further stated that it may be costly and duplicative to do so. In addition, they urged the recognition of family planning agencies as primary care providers for women.

RESPONSE: The Plan's intent is to link services and improve accessibility for women and children currently receiving health care services in a fragmented fashion. The benefits of "one-stop shopping" are clearly documented though not always available. Primary care-givers must also be prepared to address acute care needs. Traditionally, family planning agencies have deferred to other providers for their clients' acute care and thus do not meet the strict definition of primary care providers. Primary care includes more than obstetrical/gynecological needs although in private practice these providers are frequently the primary care-givers. However, family planning services are recognized as an entry point for many women not able to access full primary care services.

It was not intended to **require** that all family planning providers become primary care providers. However, the structure of the consortia model does require that planning for all services be coordinated and that inter-agency linkages be established. The intent of the Plan is to provide services based on a local needs assessment. Following the determination of needs, existing resources should be evaluated to identify appropriate providers for expanded services and increased reimbursement rather than creating a new network of providers. It was intended to recognize family planning providers as a valuable resource pool for provision of services to women. Family planning agencies should be given priority consideration for funding of primary care services to women. N.J.A.C. 8:100-4.5(b)-(d), 4.6(d), and expansion of 4.8(h) of the rule have been revised to add clarity.

N.J.A.C. 8:100-4.6 System of care

COMMENTS: Perinatal

Comment was received regarding the criteria for a regional perinatal center, indicating confusion regarding the definition of maternal referrals and transports, and the management of 40 very low birth weight infants. Specific language was offered.

RESPONSE: Perinatal

The rule is based on the criteria developed by the Perinatal Technical Advisory Committee (PTAC). The criteria offered by the commenter was much more restrictive than that proposed. As it was not the commenter's intention to have more restrictive criteria, no change has been made to this rule.

COMMENTS: School Based Adolescent Reproductive Health

Several commenters urged the Plan to address the problem of adolescent pregnancy by encouraging the delay of initiation of sexual intercourse, and encouraging the availability of contraceptive services. They suggested that this could be accomplished by requiring formal documentation of linkages between school based youth services and family planning agencies.

One family planning provider offered specific language to require that family planning services be routinely available in schools.

RESPONSE: School Based Adolescent Reproductive Health

The rule states that adolescents should have access to information about contraception and family planning services (N.J.A.C. 8:100-4.6(d)). In addition, the rule specifies coordination between the Department of Health and the Departments of Education and Human Services regarding adolescent health care, including information about reproductive health which may require linkage with local family planning agencies (N.J.A.C. 8:100-4.7(e)3 and (f)3). School based youth services are under the authority of the Department of Human Services, not the department of Health, which clearly impacts on the Department of Health's ability to require formal linkages with family planning agencies. School systems are under the authority of the Department of Education. The Depart-

ment can not mandate services within schools. There is a recommendation for the Department to coordinate education programs for pregnant adolescents in N.J.A.C. 8:100-4.8(f)3. Language will be added to include family planning services.

COMMENTS: Pediatric

The American Academy of Pediatrics/New Jersey Chapter supported the recommendation in the rule regarding immunization follow-up for children, and also encouraged the Department to consider providing vaccine to private providers. Also, the Robert Wood Johnson Immunization project was referenced as a model.

Comment was also received from Children's Specialized Hospital in Mountainside that the needs of chronically ill children with disabilities in various levels of inpatient and outpatient care, specifically pediatric rehabilitative needs, were not adequately addressed.

Many providers and agencies offered comments concerning the regionalization of pediatric care and supported the overall concept but not the Plan's proposal for closure of pediatric units based on occupancy alone. Comments suggest additional criteria such as: Services to the community, same day surgery occupancy, existing relationships to other hospitals and providers, relationship with children's hospitals, specifics on specialty and subspecialty care, geographic accessibility, and additional quality of care issues (staffing, equipment, professional education and training). Comment was also received regarding the quality of care in currently licensed pediatric serving bed units. There are application sequence inconsistencies between Subchapters 4 and 14. Specific language changes were offered.

Children's Hospital of New Jersey stated that because of the projected number of consortia, it may be burdensome for children's hospitals to be represented on each consortia. Therefore, there should be a smaller number of consortia, that is: two or three established around a specialized children's hospital.

Further, the plan encourages the proliferation of pediatric intensive care units (PICU) and tertiary services. The criteria, as currently written, seem to upgrade regional pediatric centers into mini-children's hospitals. This may lead to increased costs unnecessarily. Pediatric subspecialists should be available in a regional pediatric center and especially for regionalizing pediatric intensive care. The numbers of needed PICU beds is smaller, however, and is estimated at 56 to 68. There are currently 62 such beds. This means that the need for regional pediatric centers is for a maximum of six. The Department should consider convening a "Pediatric Technical Advisory Committee" to review all of these issues.

Concern was expressed over payment for children's hospitals consultative services. One commenter does not want the American Academy of Pediatrics criteria enforced as minimal criteria for reimbursement. In N.J.A.C. 8:100-4.6(f) change "shall" to "should" in line one. Also, to assure that N.J.A.C. 8:100-4.6(g) is not intended for private physician offices.

One hospital commented that although the Plan addresses the integration of pediatrics into the maternal and child health consortia, the recently released "maternal and child health regulations" do not do so.

More attention should be placed on hospital based clinics and emergency room care as an integral part of community-based linkages.

RESPONSE: Pediatric

The rule implies that the Department of Health will seek input external to State government in promulgating pediatric planning rules which will incorporate many of the issues raised above, but is not expressly clear in this regard. The Department agrees that such input should be explicit in these rules. This subchapter has been amended to separately describe perinatal and pediatric systems of care at N.J.A.C. 8:100-4.6 and 4.7, respectively, convening a pediatric clinical advisory committee to examine the pediatric system Statewide, including all of the commenter's concerns and pediatric rehabilitation needs, and making recommendations to be utilized in developing pediatric planning regulations need to be added. The use of criteria recommended by the commenters should be incorporated into the language of the rule. N.J.A.C. 8:100-4.2(b), 4.3(b) and 4.6 will be modified to accommodate these changes. A new section will be added. Pediatric rehabilitation will be addressed by this committee but will also be included in Subchapter 17.

Comments regarding the number of PICU beds are duly noted and will be addressed in N.J.A.C. 8:100-14.

The commenter's reference to "maternal and child health regulations" concerns the revised perinatal planning rules published separately in the New Jersey Register June 1, 1992. These were never intended to address pediatric regionalization. They do, however, incorporate pediatric providers into the structure of the Maternal and Child Health Consortia

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as a first step. The next step will be to plan for the development of pediatric planning regulations which will involve convening a pediatric clinical advisory committee as specified above.

While the Department agrees that in many instances, hospital-based services are the single provider of care to both very rural and urban areas, the emphasis of this plan is on prevention and lower cost services at community based sites.

The Department feels that American Academy of Pediatrics criteria should be universally utilized. However, N.J.A.C. 8:100-4.6(f) does not link these criteria to reimbursement. N.J.A.C. 8:100-4.6(g) does not refer to physician office practices.

Regional activities for tertiary services in New Jersey have traditionally required professional outreach, education and consultation by subspecialists. This has always been part of the justification for their increased rates.

Due to budget and staff restrictions, the Department is unable to provide private practitioners with vaccine biologicals. Providers should note that where this has been implemented, administrative burdens have been overwhelming for physicians. This is due to the federal documentation requirements for each vaccine dose. The Robert Wood Johnson immunization model (along with other programs such as WIC and AFDC combined immunization sites being implemented by the Department) are noteworthy and once evaluated will be replicated as appropriate Statewide. There will be no changes to the rule as a result of these comments.

COMMENTS: Public Health Nursing

Many comments supported all of the proposals involving the use of public health nurses and other community models.

RESPONSE: Public Health Nursing

The Department appreciates this support.

N.J.A.C. 8:100-4.7 (recodified as 4.8) Policy changes/restructuring

COMMENTS: Support was received for on-site registration for Medicaid. The Department of Human Services requested that N.J.A.C. 8:100-4.7(c) be amended to include social services agencies.

Comment was received that school nurses are best utilized as education coordinators and screeners of health problems. Support was given for the section on school nurses but added that physicians should also be referenced. Further, the New Jersey State School Nurses Association endorsed the need for the delivery of primary health care to all children identified in the Plan. The Association emphasized that procedures are already in place expanding the role of the school nurse and school nurse practitioner as primary care providers and agreed that certified school nurses are frequently underused due to misinterpretation of their role. The Association stated its belief that certified school nurses are the appropriate health providers in the school setting and will be happy to work with the Department to assure continuity of care.

One commenter suggested that the Department utilize the Office of Minority Health in designing media strategies. One hospital did not feel it a worthwhile endeavor to change public perceptions of the importance of early and adequate prenatal care and pediatric care. This commenter further stated that the answer lies in communities banding together as a team including families, churches, schools, etc. In N.J.A.C. 8:100-4.7(g), it was recommended by the Medical Society of New Jersey that the word "launch" be changed to "prepare or propose."

A specific recommendation was made by the Office of the Public Advocate for universal lead screening for children. The Public Advocate also asked the Department to require physicians and local health departments to screen children.

RESPONSE: The Department appreciates the support for on-site Medicaid registration. N.J.A.C. 8:100-4.7(c) only applies to those agencies under the auspices, either by regulation or funding, of the Department of Health.

The Department agrees that school nurses have been valuable in providing school based health education programs and health appraisals. However, in many school districts there is a lack of coordination with the primary care system both public and private. Immunizations deficits are frequently not followed up by school nurses to assure that students were able to access services. N.J.A.C. 8:100-4.6(e) requires that the Department work with the Department of Education to assure that school nurses link with primary care providers (which include private physicians) and provide additional services where appropriate, for example, immunizing children under standing orders of physicians and in accordance with all applicable regulations and standards of care. There will be no changes to the rule recommended by the Department based

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on this comment. The Department appreciates the New Jersey State School Nurses Association's support and looks forward to a partnership with certified school nurses in delivering primary health care services to children.

The Department appreciates the input regarding the use of the Office of Minority Health with a media campaign. Public education through the mass media is only one strategy of many. The Department agrees completely with the concept that current issues in health care require a multi-faceted approach. The consortia are not precluded from including schools, churches and job training personnel in their membership, and are actually encouraged to do so.

The Department appreciates the input from the Medical Society of New Jersey. A language change substituting "propose" for "launch" in N.J.A.C. 8:100-4.7(g) has been made.

N.J.A.C. 8:100-4.8(a)2v reiterates that local health departments comply with Chapter 13 of the State Sanitary Code (N.J.A.C. 8:51) on lead which incorporates many of the recommendations of the Office of Public Advocate.

The Department does not regulate private physician practice. Also, adopted N.J.A.C. 8:100-4.9(j) recommends a certification for lead testing for a home sale in New Jersey.

At N.J.A.C. 8:100-4.8(e), the Department has added what subjects will be considered in the development of pediatric planning rules, to replace the definite standards contained in proposed N.J.A.C. 8:100-14.15, 14.16 and 14.17, so that more appropriate requirements can be developed.

N.J.A.C. 8:100-4.8 (recodified as 4.9) Reimbursement and cost containment

COMMENTS: General

One local health department supports this entire section of the rule.

RESPONSE: General

The Department appreciates the comment which supports this section of the rule.

COMMENTS: Medicaid Reimbursement and Insurance Issues

Six commenters supported the rule which recommends an increase in Medicaid reimbursement for private physicians to 80 percent of reasonable cost. Other comment was received suggesting that HealthStart reimbursement be expanded to cover acute care visits.

In contrast, the Department of Human Services (DHS) opposed the Plan's recommendations in N.J.A.C. 8:100-4.8(b)1 and gave the following reasons: (1) there is no appropriation to cover Medicaid expansion; (2) the cost implications for cost-based reimbursement to certain facilities has serious cost implications; and (3) the DHS thinks it is inappropriate for the Department of Health to suggest what increases should be recommended for Medicaid rates. Alternate language offered to amend the proposed rule is "The Department of Human Services will work with the Department of Health to examine and discuss issues involving Medicaid, including services and reimbursement."

The Department of Human Services requested that they be involved in planning health insurance strategies.

RESPONSE: Medicaid Reimbursement and Insurance Issues

The Department appreciates the comment which supports an increase in Medicaid reimbursement for private practitioners.

The Department respects the Department of Human Services position on Medicaid reimbursement. The Department is aware of the cost implications involved with this rule and is also aware that the DHS has put forth numerous requests to increase reimbursement levels for physician services. The Department's intent is to support DHS to accomplish this.

The comment on HealthStart is duly noted and will be incorporated into N.J.A.C. 8:100-4.9(b).

Currently the rule includes only the Departments of Health and Insurance. The Department appreciates DHS' request to participate in addressing insurance issues. Language will be added to N.J.A.C. 8:100-4.9(c) to include the Department of Human Services.

COMMENTS: Funding Community-Based Programs

Three commenters expressed support for the restoration of public health priority funding to \$6 million. One commenter indicated that this is legislative prerogative.

Several commenters including the Health Officers Association preferred no restrictions placed as conditions of the increase in funding level. Additionally, other programs should not have to compete at the local level for these services with maternal and child health services.

Three commenters expressed concern regarding the potential for disruption of services due to the substitution of hospital rates for MCH

grant funding of hospital based maternal and child health care, and that legislation may be required to implement this.

RESPONSE: Funding Community-Based Programs

The Department's intent is for an increase in public health priority funds to be utilized most appropriately (based on needs) at the local level, without restriction. This broadens the recommendation beyond maternal and child health services which should then be deferred to N.J.A.C. 8:100-2 and deleted from this chapter.

Removal of MCH grants funds from hospital-based services actually took effect on January 1, 1992 without any disruption in service. Legislation was not required. The funding for these programs was rolled into the rates. There will be no change recommended regarding this comment.

COMMENTS: Nursing Incentive Reimbursement Award (NIRA)

The Medical Society of New Jersey comments that the Department should "forget about" using NIRA for public health nurses or as a "cover to expand nurse practitioner programs." This involves "regulatory approval to use hospital reimbursement to support political lobbying" and they question its legality. This entire reference should be deleted.

One commenter strongly supports the use of NIRA funding as referenced in the rule.

RESPONSE: NIRA

NIRA funding was established to combat the nursing shortage and is not contingent on hospital based activities. This would be an effective use of this funding. Public health nursing activities have been demonstrated to improve infant outcomes and reduce mortality in maternal and child health as well as other areas. This is no different than funding physician education or primary care initiatives. There will be no changes recommended to the rule as a result of this comment.

COMMENTS: Consortia Funding

One hospital was concerned that this funding would be inadequate. Region III LAB stated that the consortia will probably have more money to plan for an MCH region than the Region III Local Advisory Board will have for their planning responsibilities. As a result, local advisory boards and MCH consortia should be encouraged to share facilities and/or services in order to build habits of cooperation and make planning dollars go farther.

Comment was received from the Medical Society of New Jersey that legislation may be required to fund the consortia through the hospital rates.

RESPONSE: Consortia Funding

The \$4.4 million allocated Statewide to fund the consortia is based on obstetric, neonatal and pediatric admissions which total more than 400,000 admissions. Consortia will be funded through the rates based on the number of regional deliveries. While planning is a large responsibility for the consortia initially, implementation is also an important component. Other activities include coordinating transport systems, total quality improvement program, outreach and education, funding recommendations, etc. The consortia and the LABs are encouraged to cooperate in mutual planning activities. Legislation is not required to implement this increase to the hospital rates. There will be no changes recommended as a result of this comment.

COMMENTS: Inpatient Reimbursement Issues

Hospitals expressed concern regarding reimbursement disincentives for inappropriate pediatric care delivered in an emergency room. One commenter supported this proposal regarding perinatal and neonatal care.

Support was given for the provision of the rule which proposes to change the current reimbursement system to pay for back transport of infants. The commenter questioned what the mechanism would be.

RESPONSE: Inpatient Reimbursement Issues

The Department's position is that many children are not receiving appropriate primary care. Frequently, these children are seen by hospitals who may not direct or follow-up on children's primary and preventive care needs. The interest of the rule is to appropriately move hospitals in the direction of focusing on and coordinating preventive care.

Comment is duly noted but there will be no changes recommended to the rule as a result of these comments. The Department appreciates the support.

The Department appreciates the support for neonatal back transport reimbursement. Comments are duly noted and will be addressed in reimbursement regulations.

N.J.A.C. 8:100-4.9 (recodified at 4.10) Manpower

COMMENTS: Five commenters supported the rule where recommendations would enhance the pool of certified nurse midwives and nurse practitioners.

The Medical Society of New Jersey suggested deleting N.J.A.C. 8:100-4.9(b) since recent legislation began to initiate this process of physician assistant and nurse practitioner practice.

The American Academy of Pediatrics/ New Jersey Chapter commented that the use of mid-level practitioners as possible substitutes for physicians, as suggested in the Plan, is a dangerous concept because it allows for two standards of care. This commenter stated that mid-level practitioners should be utilized but under the supervision of responsible physicians.

The Medical Society and the American Academy of Pediatrics/New Jersey Chapter offered support for the section of the rule on tort reform.

Other commenters suggested that initiatives to attract physicians to high need areas need to be developed. The use of health enterprise zones was offered by the New Jersey Public Policy Research Institute and the Committee for the State of Black Health.

RESPONSE: The Department appreciates the comment which supports the section of the rule on mid-level practitioners. Although recent legislation has initiated the process of licensing physician assistants and nurse practitioners, the Boards of Medical Examiners and Nursing must still develop licensing rules. The rule calls for the use of mid-level practitioners as a valid and effective resource especially in areas of physician shortages which includes both urban and rural locations. N.J.A.C. 8:100-4.9(b) already specifies that the practice of mid-level practitioners should be "under the direction of a physician." No changes are made to this section of the rule as a result of these comments.

The Department appreciates the support for tort reform.

The comments on health enterprise zones are duly noted and will be addressed in N.J.A.C. 8:100-2 and 3, Prevention, Primary and Ambulatory Care Services and Health Personnel Supply, respectively.

N.J.A.C. 8:100-4.10 (recodified as 4.11) Total Quality Improvement Program

COMMENTS: Commenters supported a total quality improvement program on the condition that regulations and negative sanctions not be imposed by the Department. Specific language was offered.

The Medical Society of New Jersey stated that N.J.A.C. 8:100-4.10(b) represents a perversion of the concept of continuous quality improvement in order to expand regulatory controls. The content of the hospital medical record is a question of hospital licensure. This may also generate administrative costs and consume health care resources. This section should be deleted. In contrast, another commenter asserted that standards for clinical practice and adherence to acuity of care assignments are needed to implement the State Health Plan. This commenter stated that quality assurance and utilization review should be implemented preferably by an "expert panel" convened at the Department of Health level.

The Medical Society also urged that the sale of tobacco products in retail pharmacies be discouraged or eliminated.

RESPONSE: The commenters are referred to the proposed revised perinatal planning rules at N.J.A.C. 8:33C that address a total quality improvement program in detail. This proposed chapter specifies that each consortia must design a program and establish a committee which reviews perinatal and pediatric statistics and pathology. There are no outcome sanctions or further regulations. The primary intent of this program is to implement fetal and infant death review, and identify barriers to prenatal and pediatric primary care in a local, confidential peer review fashion in accordance with N.J.A.C. 8:43G-4.1(a)21, licensing standards for confidentiality of patient records. Currently, the Department conducts such a review of maternal mortality in conjunction with the Medical Society of New Jersey. Because the total numbers of maternal deaths statewide are smaller than those of infant or fetal origin, such a review can be managed at the State level. In addition, the primary purpose of such a review is to educate providers, identify barriers, and improve the local delivery system. There will be no changes to the rule as a result of this comment.

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. Consortia may choose to purchase these forms for records in bulk thus providing savings for their locally practicing physicians. 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. Minor language changes will be made to N.J.A.C. 8:100-4.10(b) to clarify that the Department does not regulate delivery privileges.

The Department has also added a provision to discourage the sale of tobacco products in retail pharmacies, since retail pharmacies are purveyors of health care products, which is not an appropriate setting in which to sell cigarettes.

Questions and Answers from the Public Hearings

Below is a summary of questions asked by Health Care Administration Board members of those who testified at the six public hearings, and the responses provided.

Q: Would the scope of services provided by family planning agencies be better represented by inclusion in the primary care chapter of the Plan than in the maternal and child health chapter?

A: They need to be in both chapters. However the primary care chapter is in the next phase of development. Until Planned Parenthood of Monmouth County and Family Planning Program of Ocean County know how family planning agencies will be represented in the forthcoming chapter, they are not willing to support the maternal and child health proposals.

Q: (To a hospital administrator) Will we see the day when the MCH Consortia will be funded through state tax revenues?

A: The level of funding will be minimal if the level of state requirements are kept to a minimum. It should not take much funding. We are not trying to increase taxes, however.

Subchapter 8. Addictions

N.J.A.C. 8:100-8.1 Purposes

COMMENTS: The majority of the commenters praised and wholeheartedly supported the Addictions Subchapter of the State Health Plan. Several commenters specifically addressed the all addictions model, described it as innovative and constructive, and gave it hearty endorsements. Another stated that implementation of this chapter will put New Jersey in the national forefront in impacting the human and economic cost of addiction.

Also, professionals, providers, and planners alike approved the definition of addiction as more inclusive than alcoholism and drug addiction.

A few commenters supported the subchapter but qualified their responses. Several raised concerns related to the need to identify adequate funding sources to accomplish the objectives. One strongly supported the purpose and thrust but added that technical problems required solutions. Another stated that the plan was thoughtful and accurate with the exception that it was biased against inpatient detox, a treatment that was identified as a medical necessity, especially in urban areas. Two others added that the evidence supported the shift to prevention, detection, and outpatient treatment. This was qualified with the comment, "While there is 'much to be commended' in this chapter, too many recommendations are without priority, sequence, and funding."

The New Jersey State Nurse's Association supported the all addictions model, screening, and triage to care based on severity of illness instead of insurance coverage, and suggested that nurses are uniquely qualified to perform screening. The Association included that the subchapter is consistent with the "Nursing Agenda for Health Care Reform," a document based on *Healthy People 2000*.

A representative for the disabled who are addicted requested that the unique needs of this population be addressed throughout the subchapter. Consistent with the thrust of the chapter, this commenter suggested that a philosophy of prevention, intervention and treatment of addictions and codependency for the disabled population be adopted. Wording that would include a statement of this philosophy and assure compliance with State and Federal anti-discrimination laws were specified.

Two commenters stated that alcohol and drug dependence should be given priority in planning and service delivery over other addictions. One of the reasons cited included that although the disease of addiction is one illness, there are disparities in the results of addictive processes. Another given was that all addictions are not the same and providers cannot do any more. Two providers felt that until the existing health care system was revised to serve more people, expansion of services to include other addictions is unlikely.

Some commenters were extremely critical, especially smokers who did not believe that smoking is an addiction like an addiction to drugs. Commenters suggested that these proposals should be abandoned because 1) They set up more bureaucracy and intrude on smoker's rights; 2) Jefferson and Washington smoked; 3) Aids, cancer, toxic chemicals,

and unemployment are more suitable areas for government intrusion; and 4) "People who don't want to stop bad habits can't be helped."

The Public Advocate agreed with the thrust of the subchapter. Two issues recommended for inclusion to enhance the subchapter's content were (1) that more addiction treatment is needed for pregnant women and women with children, especially longer term care than one to three weeks; and (2) that attention to the special needs of dually diagnosed patients and discrimination between systems for mental illness and addiction treatment should be addressed.

RESPONSE: The Department appreciates and is encouraged by the hearty support for the Addictions Subchapter.

For those who raised concerns about financing, this critical issue is being addressed through demonstration projects and by seeking to have enacted legislative initiatives to raise taxes on alcohol and tobacco. Commenters are referred to N.J.A.C. 8:100-8.9 and 8.10 for further discussion of financing mechanisms.

The Department acknowledges the implied bias against inpatient hospital detoxification. Adoption of patient placement criteria proposed in Subchapter 8 will authorize acute medical detoxification according to specific measures of medical necessity. This will correct for the occasional practice of inappropriate patient placement while directing those in medical need of inpatient detox services to hospital settings.

The Plan does not seek to direct scarce alcohol and drug resources to nicotine, gambling and food addiction. The reforms proposed will be applied first among persons with alcohol and drug problems. The Plan encourages attention to co-morbidity and the frequent occurrence of substituting another addiction for the substance or behavior that is the target of treatment. Such awareness enhances treatment effectiveness and decreases costs.

It is acknowledged that many treatment settings are severely overtaxed and cannot do any more. More seriously ill persons in ever greater numbers are overwhelming some settings. The patient placement criteria will more evenly distribute patients.

Pregnant women, women with children, and dually diagnosed persons have been recognized as target populations with unique needs, especially for improved access to more kinds of treatment. The dually diagnosed will be discussed in the Mental Health Chapter as well.

The Department is pleased to have the support of the New Jersey State Nurses Association and looks forward to the partnership of the organization and its members in implementing addictions services recommended in Subchapter 8.

The Department agrees that the needs of the physically, developmentally, and mentally disabled were not specifically addressed. Exclusion of underserved populations is not intended or desired. Language has been added throughout Subchapter 8 where appropriate, to include these groups and the appropriate agencies involved in service provision.

Smoking is a symptom of nicotine dependence. Through research, evidence has been accumulated that nicotine harms not only smokers but also persons who inhale secondary smoke. Addiction to nicotine is far more costly in terms of lives and health dollars than all other addictions combined. This area yields to public health interventions and is appropriate to the State Health Plan. Therefore, no changes to the Plan to remove smoking as an addiction have been made.

N.J.A.C. 8:100-8.2 Prevention

COMMENTS: As with the subchapter overall, the majority of those who commented on issues related to prevention supported the content proposed. Glenbeigh Health Sources welcomed and supported the proposal for sugar and caffeine free addiction treatment centers. They reported having treated over 2,000 food addicted persons in the last five years, many from New Jersey. The treatment philosophy and program used by the facility is a traditional Hazelden chemical dependency, 12-step model applied to food addiction. This Hospital has been sugar and caffeine free for several years and has reported many health benefits to staff and patients. In contrast, the Dairy Council expressed a special interest in food addictions, but stated that sugar is a natural part of many foods and should not be considered addictive, nor obesity an addiction.

One commenter pointed out that no use of tobacco should be the standard for pregnant women.

Smoker's Rights Alliance commenters supported smoking and non-smoking sections in restaurants and designated smoking areas in other public places and the workplace. However, the Plan was termed a "coercive social agenda" and smoking areas were recommended for patients and employees at hospitals.

Two commenters believed that 18-year-olds should be able to smoke and drink. Other commenters concerned with protecting smokers' rights

complained that tobacco taxes were already high. They rejected mandates to provide services; believed that smoking was harmless to people's health; viewed uniform screening and mandatory treatment as infringements on individual rights; and indicated that limited resources would be spent on useless, intrusive, and wasteful endeavors. The A.C.L.U. advised that the State may limit advertising of alcohol and tobacco on State property, but it is a violation of free speech to limit it on private property. Another commenter opposed school based education on smoking or drinking on the belief that this is a parental responsibility.

Similarly, the licensed beverage industry raised concerns about restrictions on advertising promotions and recommended tax increases to pay for prevention and treatment. As a result of the last alcohol beverage tax increase, one commenter reported that 770 (11 percent) of licensed retail outlets went out of business and that 4,000 persons were put on unemployment or welfare. Rather than labels or taxes, he asserted that education is the answer to alcohol abuse.

The V.H.A. supported reducing rates of morbidity and mortality due to the use and abuse of tobacco, alcohol and other drugs, especially in communities using the V.H.A. program, Stay Healthy USA. Other supporters of prevention activities added that the application of the education and screening initiatives in criminal justice settings and circumstances needs more attention.

Supporters of tax increases for substance abuse prevention activities stated that proposed pricing policies will help the tobacco and alcohol industries to achieve their goal of discouraging minors from using these substances. They justified this support by documenting that the percentage of retail price for cigarettes used for taxes fell from 50 percent in 1954 to 25 percent in 1989 and indicated that it is time for an increase.

Commenters supporting data gathering and reporting in prevention stated that it would allow traditional public health approaches to be applied in the addiction area, including the use of birth, death and emergency room data.

Three groups offered to take responsibility for implementation of various aspects of the Addictions Subchapter. The first group, the Governor's Council Prevention Committee, offered to oversee implementation of this section with staff assistance from the Department of Health. A network of subcommittees is envisioned with stages of the lifecycle as the organizing principle for allocating tasks. A second group, the 19 local Councils on Alcoholism and Drug Abuse, volunteered to manage the media campaigns and the dissemination of public information. This group issued almost 500 press releases and 5,000 public service announcements in 1991; and generated over 300 radio and TV appearances, almost 500 newspaper articles, and 23 local press and legislative events, all on addictions. The Councils identified themselves as the experts in this field and asserted that their network should be the primary method used to implement these objectives, as no other group in addictions has had more experience to bring to the task. The third group, the NJSNA, offered nurses to assist with the media campaigns, screening, and in-service training to implement the prevention goals.

The New Jersey Council on Alcoholism and Drug Abuse commented that some persons in active addiction cannot be expected to make very informed choices. They stated that follow-up must include person to person contact and emphasized that phone interviews, alone, even including a significant other, were not sufficient for program evaluation decisions.

RESPONSE: Food addiction is a relative newcomer to the field of addiction, but the evidence in favor of a physical as well as psychological addictive process is persuasive. Withdrawal from caffeine is characterized by headache and from sugar by flu-like symptoms. Both involve thought disorder and irritability. Education about the special vulnerability of chemically sensitive persons to these addictions is necessary and healthful. Availability of alternative foods and beverages makes sense in addiction treatment settings, and the Department has amended N.J.A.C. 8:100-4.11 to provide this alternative.

The body of knowledge demonstrating the harmful effects of smoking on health is incontrovertible. The evidence of the addictive nature of the use of nicotine is plentiful and unambiguous. Persons who are addicted to nicotine, have a right to be treated with respect and afforded treatment for psychoactive substance abuse/nicotine dependence. There is widespread agreement among health professionals that smoking prevention and treatment for nicotine dependence are two of the most promising public health tools available to save lives and health care dollars.

The Department agrees that smoking is an important health issue for pregnant women, and has added pregnant women to N.J.A.C. 8:100-4.11(a) and 8.2 to reflect the commenter's concerns.

Local campaigns to achieve these objectives are consistent with the plan and to be commended. The Department looks forward to the partnership with the groups that have graciously offered to assist with implementation of prevention activities. Wording to this effect has been incorporated in the proposed rule at N.J.A.C. 8:100-8.2(b)3.

The 21 year old drinking age saved thousands of lives in the last eight years. Raising the smoking age to 19 removes legal sale from high school aged youth. Tobacco taxes are being raised throughout the nation as a public health measure.

Raising prices does result in decreased sales and consumption, injury, disability and death. States which use only state stores to sell alcoholic beverages have the lowest per capita consumption and least health damage. There is strong evidence that the fewer the retail outlets the better for the public's health.

The Department acknowledges that data gathering and reporting in prevention enables the use of a public health approach to be applied to the addiction area. N.J.A.C. 8:100-8.2(c)7 has been added to include that the proposed reporting system will allow for the consolidation of related birth, death, and emergency department data, and Department interaction with reporting entities to assist in proper provision of data.

The criminal justice system is an appropriate setting for screening for addiction. The Department of Health is pleased to share screening recommendations with the Department of Corrections, Administrative Office of the Courts, and the Department of Law and Public Safety.

The Department agrees with and accepts the comment that severely ill, addicted persons may be too impaired to make informed choices and should be directed to treatment. The rule has been modified at N.J.A.C. 8:100-8.6(a)4 to allow for this situation.

N.J.A.C. 8:100-8.3 Uniform addiction screening

COMMENTS: Most commenters, including the American Civil Liberties Union, supported screening. One commenter looked forward to the day when addiction screening would become as commonplace as taking a blood pressure. There is a difference of opinion as to whether screening should be broadly directed to persons seeking health care, or directed to those with a history of addiction or addiction caused illnesses. Almost all felt that follow up and treatment accessibility were essential to goal attainment. Some felt concern about screening in the absence of universal access to treatment.

The Network of Councils on Alcoholism and Drug Abuse offered to provide implementation assistance in training, information and referral, including case management. The Councils aggregately referred 25,000 persons in 1991 and are particularly suited to this work. Because councils do not provide and are not affiliated with treatment, they are free of bias and conflict of interest. It was also noted that use of objective standards will help managed care abuses to be adjudicated fairly.

The Nurses' Association and Trenton State College offered to join the providers of training for screening.

One commenter felt that the Department should clarify the civil liberties aspects of addiction screening if the procedure is to be mandatory. This commenter commended the comprehensive approach, especially payment for service on basis of severity of illness. It was suggested that outcome results of various treatment modalities be disseminated to providers and planners.

One commenter suggested that screening measures should be developed, rather than a uniform tool, which is not flexible enough. This commenter felt that screening should be a recommended professional standard, not a rule.

Another commenter noted the high density of race tracks and casinos in one region and supported services for all addictions, especially screening for compulsive gambling.

Several commenters expressed the concern that screening while being seen for another health problem was a violation of the right to perform a legal act and exercise a personal choice by smoking.

New Jersey Psychiatric Association (NJPA) stated that the Plan does not address dual diagnoses or co-morbidity in which major psychiatric disorders are intermingled with the disease of addiction. NJPA offers to assist in the design of such plans in the future. The absence of residential rehabilitation facilities for addicted persons without concurrent psychiatric disorders results in chaos and misuse of psychiatric services by these clients.

Unique concerns of disabled and mentally ill persons were called to the attention of the Department by several commenters. Disabled persons' groups, and persons with psychiatric disabilities, should be part of the planning process to assure that their needs are considered in the provision of services.

RESPONSES: The Department thanks supporters of screening for their advice, support and offers to provide training locations (which have been added to N.J.A.C. 8:100-8.4). The rule has been revised to promote screening, rather than the use of a specific screening tool. Measures and a protocol will be developed and recommended. Instead of all medical contacts, only appropriate medical contacts will be subject to the screening mandate. Screening will be alert to special needs of disabled and mentally ill persons, as commenters recommended.

The Mental Health subchapter of the State Health Plan will contain additional recommendations regarding identification and treatment of persons with the dual diagnoses of psychiatric disorder and addiction. The Department of Health is working with NJPA in the development of the Mental Health Subchapter.

Screening will identify persons at risk, many of whom will require treatment. Access to residential treatment for the uninsured is problematic. Outpatient and self help services are available and are effective for the majority of addicted persons. A small proportion of persons are able to recover following a medical warning, even in the absence of treatment.

Screening for addiction is not a value judgement, it is a health education, prevention, and intervention opportunity. Treating a child for recurrent asthma or ear infections and failing to ask whether anyone in the household uses tobacco is not providing adequate health care to that child. As one expert put it "treating for cirrhosis and not discussing drinking should be construed as malpractice." Screening is an information process and a health education opportunity. Participation in treatment is always voluntary. The planners and providers will have access to treatment outcome results as they become available.

Civil liberties aspects of the administration of screening for addiction will be a consideration of the work group that established the screening measures and protocol. Outcome findings will be disseminated as requested.

N.J.A.C. 8:100-8.4 Diagnostic criteria and treatment placement

COMMENTS: There were few comments on this section of the Plan. UMDNJ offered to assist in addictions training and to participate on the expert panel to select criteria for treatment placement. UMDNJ supports a modified American Society of Addiction Medicine Model to meet New Jersey's needs and two different entities within the University are willing to become part of a working group to develop and apply this concept. Another commenter asked that the special needs of the disabled and mentally ill be considered.

One commenter pointed out that the Department's role is to monitor and support, rather than to "ensure" in service training about this new initiative. The Nurses Association and Trenton State College were noted as additional providers of medical education and participants in these goals. Uniform patient records are desirable, but should be coordinated with other similar efforts.

The Department was asked to make corrections to the name of the New Jersey Council on Alcoholism and Drug Abuse, to avoid confusion of this agency with the Governor's Council on Alcoholism and Drug Abuse. Other agencies should also be permitted to participate in training.

NJPA comments that while the disease of bulimia has many characteristics and a family history consistent with the disease of addiction, it also has ties to the biogenetic aspects of Affective Disorder. Also, Anorexia Nervosa does not lend itself to the treatment modality effective in dealing with the addictive disorders. NJPA applauds the Plan's recognition of co-dependence as an illness.

RESPONSE: Supporters of developing patient placement criteria using the ASAM standards as a guide are thanked. The Department is pleased to modify the process for establishing patient placement criteria to ensure that special needs of disabled and mentally ill persons are taken into consideration. The cooperation and willingness of other health care groups to participate is acknowledged and programs will be supported and monitored, rather than "ensured." The rules have been modified to reflect this.

As a practical matter, the criteria will first be developed and applied in the areas of alcohol and drug addiction in the demonstration project. Inclusion of anorexia and bulimia in the addiction subchapter is not intended to minimize the psychiatric aspects of these illnesses. Both

disorders have been shown to respond to addiction treatment. Regardless of the treatment modality, bulimia is more responsive than anorexia.

A correction has been made at N.J.A.C. 8:100-8.4(c) to clarify that the New Jersey Council on Alcoholism and Drug Abuse, Inc., is the agency referred to, and to include other accredited providers of training services. The Department believes that community input is very important in this area.

N.J.A.C. 8:100-8.5 Establish appropriate levels of care

COMMENTS: There is general agreement with the concept of re-ordering addiction treatment licenses to be consistent with ASAM levels, although it is recognized as a large undertaking.

One commenter asked for clarification to specify that ambulatory medical care will not be included in revised licensing standards and Certificate of Need requirements for "all" addiction treatment. It was also this commenter's opinion that requiring Board certification in addictions is impractical because of a shortage of personnel.

The Association of Halfway Houses supported revising licensure standards as described in N.J.A.C. 8:100-8.5(a) and requested that halfway houses be regulated by the Department of Health instead of the Department of Community Affairs. The Association submitted a position paper reviewing statutory authority which permits this.

One commenter stated that it is a mistake to certify rather than license outpatient drug and alcohol addiction facilities. To deny licensure would relegate outpatient centers to less than equal status with the residential treatment facilities.

There are not enough treatment centers and there is no formula for the number of inpatient and outpatient clinics needed per region or per population. More slots and new modalities (for example, acupuncture) are needed, and a better tie into primary health care.

The mental health screening agencies and the Department of Human Services indicated that access to detox beds was problematic and requested a study and the development of a bed need methodology.

One commenter expressed concern that the Plan ignores clients in the criminal justice system. Another commenter described the need for treatment placement for women with children, in-patient care for the uninsured, and aggressive ambulatory care for AIDS patients to prevent inpatient care.

Another commenter asked the question whether HMO's can be required to use the same patient placement standard as the rest of the health care delivery system, or is special legislation required.

New Jersey State Nurses Association recommends coordination of outpatient with home health agencies and schools. Non-hospital based providers should be recognized for their experience and used, especially given the new 450 plan to close State psychiatric hospitals.

RESPONSE: The Department acknowledges those who are supportive of reordering addiction treatment settings and modalities and welcomes the assistance of all who offered to work on this project. All mainstream addiction treatment settings and modalities will be included in the levels of care. Private practice medicine or ambulatory medical care will not be licensed and the rule has been revised to clarify this. The American Society of Addiction Medicine criteria will be modified into the New Jersey licensing criteria to include halfway houses, therapeutic communities, methadone maintenance providers, and other alcohol and drug treatment providers.

The Department agrees that access to detox holding beds is an issue for mental health screening centers. A provision has been added at N.J.A.C. 8:100-8.5(c) to promote the study and development of a bed need methodology for detox beds at mental health screening centers.

The Department will consult with appropriate agency staff regarding the request that halfway houses be regulated by the Department of Health. There is no immediate plan to assume such regulation.

Two separate kinds of outpatient options are identified by ASAM: those offering more than nine hours of care per week and those offering less than nine hours per week. The Department will study whether outpatient and halfway house programs should be licensed or certified to ensure a standard of care for this level of residential treatment.

The Department is concerned about service to currently underserved populations, such as pregnant women, teenagers, and incarcerated persons. The waiver process outlined in N.J.A.C. 8:33-5.1 may be utilized for applications to provide services to such underserved populations, or any group which lacks access to existing beds.

Although there are fewer than one hundred ASAM certified physicians in New Jersey today, four years is expected to be long enough to meet the objective. In March, 1993, a Certificate of Added Qualifications in

Addiction Psychiatry (CAQ) examination will be offered by the American Board of Psychiatry and Neurology. This will constitute a comparable additional acceptable credential.

N.J.A.C. 8:100-8.6 Match patients with appropriate levels of care

COMMENTS: Commenters felt that the ASAM criteria and levels will work in New Jersey and not be difficult to adapt to include all treatment modalities. Provider and professional associations can be relied upon to adapt the model to present practice and unique services.

Most commenters expressed concern that an uncompensated care funding mechanism, perhaps financed by increased alcohol and tobacco taxes, is needed to establish access to all modalities of care in the addictions.

Two commenters noted that the Plan does not address the issue of the existing waiting lists for treatment and does not adequately address special populations such as HIV/clients and disabled people who are addicted and in need of comprehensive treatment. Another commenter noted that follow-up treatment should include face-to-face contact at least annually, for reliability, and that choices should be offered based upon the person's general medical and/or psychological condition.

RESPONSE: The rules reflect concern about absence of treatment access for the uninsured, and treatment placement based on ability to pay, (rather than severity of illness). These are the priority areas for reform if New Jersey is to attain Year 2000 targets. Rules have been amended to incorporate clarifications regarding the degree of disability and addictions encounters by the health care worker with the patient.

AIDS and HIV infection will be addressed in a separate subchapter of the State Health Plan. The interaction between injuries and addictions will be amplified in the subchapters on injuries and comprehensive rehabilitation. In order to assist readers to locate material of special interest, these sections will be cross referenced with subchapter 8 as appropriate.

N.J.A.C. 8:100-8.7 Expand outpatient treatment capacity

COMMENTS: Expanding out-patient care and establishing access were fairly universally praised. One commenter said that expanding out-patient care and affording access to the uninsured are worthy goals without methods.

NJPA suggests freestanding psychiatric hospitals and clinics be allowed funding from uncompensated care to secure their financial viability and access for the uninsured. NJPA is especially concerned about indigent Mentally Ill Chemical Abusers (MICA) clients.

RESPONSE: Most agree that out-patient care is appropriate to the needs of early and middle stage addicted persons and that freestanding treatment programs for addiction are less costly alternatives to hospital based care. These settings will be investigated as part of the demonstration to implement the treatment placement methodology. This same theme applies in mental health and will be addressed in that chapter. Indigent MICA clients will not be excluded from the demonstration.

N.J.A.C. 8:100-8.9 Cost containment

COMMENTS: Many commenters hailed payment appropriate to degree of impairment and intensity of care needed as forward thinking. One commenter reported that payers are now attempting this in the absence of sound clinical guidelines. The Medical Society of New Jersey commented that paying for care based on severity of illness rather than insurance coverage is "tantamount to abolishing private health insurance coverage . . . It is illegal, impractical, and unnecessary," including the caution that there are more parties to reimbursement reform than the Department of Health.

Commenters expressed concern about the funding mechanisms and reimbursement policy to enact the Plan, specifically, the manner in which long-term treatment beds will be funded. It was noted that many treatment programs are either unable to admit Medicaid eligible, indigent or MICA clients or are unable to provide a full range of services due to inadequate reimbursement levels.

RESPONSE: Establishing a degree of disability necessary for admission to a level of care is not uncommon. Nursing home placement, for example, demands a certifiable level of disability. This is legal, practical and necessary. The ASAM criteria were developed in cooperation with the National Association of Treatment Providers and has widespread credibility in the addictions field as setting standards for medical necessity for admission to four distinct levels of care. New Jersey experts will adapt these to be more inclusive of primary addiction treatment settings and modalities in New Jersey.

The inadequacy of Medicaid reimbursement for addictions is acknowledged. In two other states, Medicaid payment for addiction will be contingent upon use of the ASAM criteria. New Jersey will be in a good position to negotiate similar Medicaid reimbursement once the New Jersey criteria and treatment levels are adopted.

Long-term residential treatment beds will not be excluded from reimbursement in the demonstration project, and are far less costly than hospital and freestanding residential care, but they are not appropriate to medically or psychiatrically disabled addicted persons. MICA patients who are in remission and stable are sometimes appropriate for long term residential treatment.

A funding mechanism is needed to implement the patient placement criteria among persons who are uninsured. Alcohol and tobacco taxes have been proposed. A demonstration will show cost savings if implemented in one area. No one disagrees that more oversight over patient placement will save health care dollars. The challenge is to provide clinically appropriate oversight.

N.J.A.C. 8:100-8.10 Administration

COMMENTS: Comments to this section addressed coordination of planning with funding across several political jurisdictions, municipal, county, LAB, and State. The Professional Advisory Committee to the Department, and other groups, offered to assist in this process. The New Jersey Association of County Alcoholism and Drug Abuse Coordinators (NJACADAC) commends the Department for a comprehensive and productive Plan, especially as it relates to tobacco and to managed care. The Local Advisory Councils on Alcoholism and Drug Abuse (LACADAs) should have an expanded role in planning as related to expenditure of funds by the Division of Alcoholism, Drug Abuse and Addiction Services. Recommended changes have been incorporated in the rule.

One commenter felt that the Department should reconsider the proposal to authorize the LACADAs to assist the Local Advisory Boards in their review of Certificate of Need applications, but gave no reason for this.

Several commenters agreed that local zoning board and neighborhood opposition to siting facilities has to be overcome by whatever means is appropriate because treatment capacity cannot expand without it. This required no change in the rule.

One commenter cautioned that need methodologies should be developed for services for each of the addictions.

Three commenters supported modifying Trust Fund eligibility to aid compulsive gamblers. It was reported that at one program, patients in treatment for compulsive gambling, while still employed, had indebtedness in the \$40,000 to \$100,000 range, with a few in the millions of dollars. Of the last 200 persons treated, not one qualified for Trust Fund assistance. Even family members usually had \$1,000 in a retirement account, so were ineligible for aid. Professional help is denied to families who could benefit.

Another commenter provided a summary of findings from a 1990 study of compulsive gamblers with co-morbidity of alcohol and drug abuse. Those gamblers studied with incomes under \$15,000 gambled over \$11,000 per year and those with incomes of \$15,000 to \$35,000 gambled an average of almost \$17,000 per year (80 percent of persons served). Amounts of gambling debt being paid back ranged from \$10.00 to \$500.00/week. Three out of four gamblers were employed. Some felt that gambling addiction was primary over alcohol addiction, but were grateful for mandatory alcohol treatment coverage, which allowed for gambling treatment. This population is financially impoverished, deserving of assistance, and at risk of suicide.

The Medical Society supports increasing alcohol and tobacco taxes to pay for uncompensated care but opposes earmarking part of these funds for disease specific causes. The Medical Society opposes aiding compulsive gamblers, in treatment for addiction, in attaining eligibility for uncompensated care funding of addiction treatment (by subtracting payments for gambling debt from monthly income). The Medical Society opposes, as an unworthy question, studying hiring recovering addicted persons in contract agencies. The Society also feels that the rules contain too many calls for legislation.

The New Jersey Licensed Beverage Association opposes raising taxes on alcohol and tobacco. Funding the addictions chapter at the expense of the manufacturers and retailers is unfair. Comparing these products to illegal drugs is mistaken. The alcohol industry trains servers to decline service to intoxicated patrons. It does its fair share and should not be put out of business.

Several private citizens and the Smokers' Rights Coalition oppose raising taxes on alcohol and tobacco. Smokers already contribute 300 million dollars annually to the General Fund. Smoking and drinking are individual rights. Prohibition did not work.

There was some sentiment among smokers' rights commenters that non-smokers should not get incentives. Employers who offer smoking and weight reduction classes should not get tax credits. The plan will be another "runny egg law." High health costs are not because of alcohol and nicotine. These legal products already generate taxes that are not used properly. Lincoln said that alcohol is not a bad thing—overuse of it is.

One commenter warned that increases in excise taxes on alcohol and tobacco should be applied on a percentage of price basis. Otherwise, inflation erodes the price effect of the tax. A mathematical formula has been derived to estimate the actual number of fewer deaths from alcohol related causes for each percentage point of increased price/tax. Another commenter reported that each penny of cigarette tax would have generated \$8 million dollars in 1989. This is less than the amount of tax generated from sales to minors each year.

RESPONSE: The rule has been amended to include, as time frames and statutory authority permits, LACADAs in the dissemination process for funding announcements calls for demonstration projects, training opportunities and other communications from the Department, to make more explicit their roles and responsibilities in the process. This is consistent with the stated purpose of the Local Advisory Committee on Alcoholism and Drug Abuse.

The Department appreciates support and constructive revisions received on this part of the plan. Rules were amended to accept the offer of the Professional Advisory Committee and other groups to recommend ways to coordinate planning and funding streams better. Mental Health Boards are authorized to review and comment on CN applications in their area, pursuant to current CN rules, and the amendment is consistent with this practice. There is no justification for omitting the input of Local Advisory Committees on Alcoholism and Drug Abuse (LACADAs) from review and comment on CN applications.

Much comment was received about the proposed tax increases as valid public health policy. No changes were made to the rule. Earmarking taxes on alcohol and tobacco for prevention, treatment and enforcement activities has produced good results. In California, smoking prevalence declined at least five to seven percent after a price hike and media campaign. The decline was almost 30 percent among teenagers. In Canada, the declines were even greater.

Since 11 percent of drinkers consume 67 percent of alcohol sold, problem drinkers can be perceived as contributing to their future care. Raising taxes saves lives whether it is earmarked or not, by decreasing sales and use. Dedicating funds for prevention and treatment has produced good results.

In New Jersey, alcohol beverage taxes were raised in 1983 with a portion earmarked for counties for prevention and treatment. Fifteen percent of alcohol treatment provided is purchased for indigent and uninsured county residents. A portion was earmarked for increased enforcement of intoxicated driving statutes. This program is so successful, it is touted as a national model and drinking and driving deaths are among the lowest in the U.S.

Because of the major system reform under consideration with respect to health care financing for the uninsured, no changes will be proposed in determining eligibility for the uncompensated care reimbursement system at this time. Therefore, the Department has not adopted the proposed language at N.J.A.C. 8:100-8.10(g), but will consider such issues in the development of new eligibility standards.

Development of need methodologies for each addiction is an implicit future task. The agenda set forth thus far is sufficiently ambitious that this set of data collection and analysis jobs can be postponed.

Questions and Answers from the Public Hearings

Below is a summary of questions asked by Health Care Administration Board members of those who testified at the six public hearings, and the responses provided.

Q. (To a witness who objected to government interference with a smoker's right to smoke) Are you opposed to smoke-free buildings so that non-smoking employees would not be exposed to smoke? Are you aware of the tens of millions of dollars that could be saved if we had no smoking-related illnesses?

A: Yes. As long as there are separate facilities. As a manager, this witness did not note any difference between smokers and non-smokers in sick leave.

Q: Did you receive an honorarium for your testimony?

A: No.

Subchapter 9. Cardiovascular Disease (CVD) Services

N.J.A.C. 8:100-9.1 Prevention of Smoking Initiation and Treatment for Nicotine Dependence Policies

COMMENTS: The Medical Society of New Jersey commented that at N.J.A.C. 8:100-9.1(a)2 the role of the Department of Education should be acknowledged for their role in establishing school curricula. The Medical Society also supported the concept of increasing tobacco taxation, but the first priority of those funds should be the Health Care Trust Fund.

Several commenters stated that the proposed task force on smoking law enforcement should include broader-based representation, including the Commission on Smoking OR Health and the profession of medicine.

The New Jersey Hospital Association, in a report prepared by McManis Associates, Inc., supported the inclusion of higher health insurance rates for smokers. They also suggested using these higher rates to provide insurance coverage for smoking cessation services. Cardiovascular health promotion initiatives are a positive addition to the plan.

Dr. Slade noted that this section echoes elements of the addictions subchapter, stating that the charge to the proposed task force is too narrow to be useful. Legislative action is needed to significantly reduce underage access. Dr. Slade suggested that the task force should be charged with preparing revised legislation. He also voiced his support regarding the availability of treatment for nicotine dependence at N.J.A.C. 8:100-9.1(b)2, suggesting that hospitals be required to provide services for nicotine dependence to inpatients as required in the addictions subchapter at N.J.A.C. 8:100-8.2(g)2.

RESPONSE: The Department acknowledges that the State Department of Education would be necessarily involved in developing smoking prevention initiatives in the health education school curricula. Specific reference is made to the need for cooperation between departments at N.J.A.C. 8:100-9.2(a)2.

The Medical Society suggested to earmark tobacco tax revenues for the health care trust fund is an excellent one and should be considered when the debate over the trust fund goes forward. The Department does not rule out the inclusion of other representatives and interests on the smoking law enforcement task force.

The appropriateness of the use of higher insurance premiums paid by smokers for providing smoking cessation coverage requires more detailed evaluation and coordination of a number of departments of State government. Further study of the implications of such a policy need to be explored.

The Department does not believe that the task force that is to be convened at N.J.A.C. 8:100-9.1(a)3 will be precluded from assisting in the preparation of additional legislation. The task force will include broad representation from appropriate professional groups.

N.J.A.C. 8:100-9.2 Cardiovascular Health Promotion Policy

COMMENTS: The Camden County Division of Health supported the section on Cardiovascular Health Promotion Policy, with particular emphasis on population-wide cardiovascular health promotion media campaigns. Under subsection (c), they recommend that community based as well as outpatient nutrition services be provided.

The New Jersey Public Policy Research Institute and the Committee for the State of Black Health raised concerns regarding racial disparities in CVD morbidity and mortality statistics and pressed for increased awareness and sensitivity for cultural influences that hinder healthy CVD behaviors among minority populations.

St. Elizabeth Hospital stated its support for the emphasis on prevention and health promotion and pledged to work closely with the LAB in the development of cardiac outreach education and prevention programs.

The New Jersey State Nurses Association (NJSNA) stated that the emphasis on public service announcements must be intertwined with one-to-one screening, health promotion, and disease prevention activities. The NJSNA noted that the nursing profession can play a pivotal role in identifying risk factors and developing plans of care.

A member of the New Jersey Dietetic Association, Inc. supported the plan and suggested that a registered dietician or qualified nutrition

professional should be appointed to the Cardiac Services Committee. This commenter also suggested that several professional groups should be included in the discussions with the Department of Agriculture regarding nutrition incentives in CVD health promotion programs.

RESPONSE: The Department acknowledges the value of providing community-based nutrition services. Support for these services is addressed at N.J.A.C. 8:100-9.2(a)7.

The Department views this subchapter as one that is strongly supportive of health promotion and disease prevention activities as evidenced by the recommendations contained in this section.

The CVD subchapter has clearly delineated the racial disparities that exist in the incidence and treatment of the disease and calls for increased surveillance of the issue. The increased support of the myocardial infarction data acquisition system (MIDAS) recommended at N.J.A.C. 8:100-9.3(c), for example, will serve to monitor Statewide treatment variation for all myocardial infarction patients.

Recommendations for nutrition representation on specific health promotion and disease prevention committees is appreciated. Membership on the committee is not specified in this rule. Nutritionists will be considered when the committee is formed.

N.J.A.C. 8:100-9.3 Acute Care Cardiac Services and Resource Allocation Policy

COMMENTS: Community Medical Center expressed support for the inclusion of the LAB's plan in the need for regionalized services such as cardiac diagnostic and surgical services. This hospital is concerned that the only open heart surgery operating room located within the boundaries of LAB VI is not centrally located and creates access problems. Jersey Coast Health Planning Council, Inc., voiced similar concerns regarding what it viewed as a maldistribution of services in the State. The concentration of services in the northern counties does not account for population shifts. These services need to develop within its region.

The Department of Human Services (DHS) supported limitation of cardiac service expansion, particularly cardiac surgery services. The presence of sufficient capacity and the availability of alternative medical treatments support such a policy. The commenter suggests that profitability of invasive cardiac services may be overriding the use of other clinical options. DHS suggested that, based on past local decisions, the State should have more control in the area and not rely too heavily on regionalized plans.

Monmouth Medical Center recommended that all New Jersey teaching facilities be allowed to have cardiac catheterization capability before neighboring facilities are permitted to expand and prior to delivery of such services at non-teaching facilities. MMC also noted that they are the only major teaching facility in the State without this service and that costs incurred for the transport of patients to alternative sites for cardiac catheterization are considerable.

One commenter offered support for the objectives of the plan and the emphasis on prevention, early detection and reversal of heart disease. Regarding the distribution of cardiac surgery programs, he stated that services for cardiac patients for northern New Jersey should not be centralized in Newark. There is an overriding fear on the part of patients and their families regarding their safety in a city environment. Patients should receive needed care expeditiously and near their homes so that proper support can be provided easily. Atlantic Health Systems has tried to create a regional program and alternative for cardiac care with sites at Morristown Memorial and Overlook Hospitals.

Another commenter remarked that both cardiac catheterization and cardiac surgical programs in the State have available capacity. The addition of new centers would not make new services available, but would shift the site of services away from inner city hospitals to the wealthier suburban facilities. Residents of the inner city would be hurt the most.

The Medical Society of New Jersey suggested changing the wording of the first sentence at N.J.A.C. 8:100-9.3(b) to read, "Future certificates of need to expand the availability of cardiac services in the state..." in order to avoid confusion about whether or not this rule encompasses certificates of need for new programs.

St. Elizabeth Hospital recognized the State's position regarding the establishment of new cardiac surgery programs and anticipated focusing its attention on outreach programs to the indigent populations in their service area. By doing so, the hospital feels that it will further enhance their need for cardiac surgery services.

Atlantic Health Systems, Inc. (AHS) submitted voluminous material related to a hearing held in July, 1991 to contest the denial of a certificate

of need to expand its regional adult cardiac surgery program to a second AHS hospital site. AHS stated that this material (that is, public hearing transcript, hearing exhibits, post trial brief) demonstrates the great need to expand the AHS program which is not reflected in the current text of the proposed rule. AHS urges that the plan be amended to reflect the need for this expansion.

RESPONSE: The Department of Health has historically supported local input in the process of establishing Statewide policies for regionalized services. In order to provide appropriate access to a regionalized service to residents residing within specific boundaries, it is important to note that the CVD subchapter emphasizes that cardiac resources extend beyond the boundaries of a municipality, county or even local advisory board (LAB) area. Consideration of future need for regionalized cardiac services must account for existing referral patterns that transcend municipal, county and state boundaries and the impact of proposed new services on existing providers who are dependent on established referral patterns to maintain the quality and efficiency of their respective programs.

Cardiac surgical services in northern New Jersey are not centralized in Newark. As the commenter noted, Morristown Memorial Hospital is the site of a cardiac surgery center. Additionally, there are four other centers in northern New Jersey (in Bergen and Passaic counties) which are not located in Newark.

The Department concurs with the statements regarding the presence of considerable unused cardiac service capacity throughout the State.

The wording of N.J.A.C. 8:100-9.3(b) is clear and applies to all services. The Department respectfully disagrees with Atlantic Health Systems' (AHS) representations that there is a need for additional cardiac surgery resources in the State. Rather, the Department agrees with the findings of the SHPB that there are sufficient cardiac surgery resources located within the State, including the service area being served by AHS hospitals, to meet the needs of the residents of those areas. Approval of additional sites would be counter to the State's regionalization efforts and would violate the principles of the Health Care Cost Reduction Act.

The Department notes that expansion of existing services is more cost-effective than is the initiation of new services. There is no indication that provision of cardiac catheterization services in a teaching hospital is superior to such services provided in non-teaching hospitals. Additionally, the Department notes that there are sufficient cardiac catheterization resources throughout the State, and that additional resources are not needed at this time. Therefore, the charges requested by Monmouth Medical Center have not been made.

Questions and Answers from the Public Hearings

Below is a summary of questions asked by Health Care Administration Board members of those who testified at the six public hearings, and the responses provided.

Q. Is a hospital without cardiac catheterization unable to train residents in internal medicine?

A. It is not a requirement now, but is expected that in-house catheterization will become a requirement. Rotating residents to other facilities for this training will add to the cost of health care.

Subchapter 14. Hospital Inpatient Services

Comments about general issues clustered around two main ideas: (A) the measures and data used to derive recommendations, and (B) access and cost savings. The comments are grouped below.

COMMENTS: Measures and Data Accuracy

Several commenters expressed concern with the overreliance on occupancy rates as a measure of hospital efficiency and the need for inclusion of cost and quality indicators as criteria for review of certificates of need. Many expressed concern over the accuracy of the data reported in the Hospital Inpatient narrative. Many commenters were critical of data discrepancies. A few hospitals questioned the preference for hospitals with over 200 beds. Factors recommended for consideration include the difference between licensed and maintained beds; recently approved but not yet implemented Certificate of Need applications; the use of UB-82 vs. SHARE data; the inconsistencies among hospitals in defining patient populations such as pediatrics; other important factors (AIDS, managed care, increase in geriatric patients, recapture of outmigration); the need to maintain approved residency programs; clinic care to the poor and indigent; and the use of 1991 data.

The New Jersey Hospital Association presented the findings of the review of this subchapter by their consultant, McManis Associates, Inc. Some of their criticisms were that it defined need only in terms of capacity and defined capacity only in terms of beds. They suggested that

need should be determined by demand, using population-based methods and that quantifiable measures of clinical outcomes should be used to assess effectiveness.

The Medical Society asserted that the need for critical care beds in the State is a serious problem and should be addressed.

A number of commenters strongly suggested that same day patients, in particular pediatric same day surgical patients, be included in evaluating the hospital's occupancy statistics.

RESPONSE: Measures and Data Accuracy

It is incorrect that occupancy rates alone were used as a measure of hospital efficiency. In addition to occupancy rates, population projections and need for physical plant enhancements were factored into the hospital inpatient need methodologies as well. The Plan includes detailed, county-by-county discussions of population trends. The Plan also used clinical outcomes data, particularly in the area of maternal and infant health. There is, however, agreement that additional clinical outcomes data should be developed. The Department has already begun these efforts, especially in the area of cardiac catheterization and surgery. None of the commenters provide an alternative methodology that refutes the basic findings of the plan—that New Jersey hospitals have excess capacity of at least 2,000 beds.

Text has been added to the subchapter in an effort to clarify that those hospitals currently within the two-year timeframe provided by N.J.A.C. 8:43I for the achievement of full capacity may continue to work toward that capacity.

Commenters who questioned the preference given to larger hospitals are referred to the Hospital Inpatient narrative. Here a full rationale for giving priority to larger hospitals is provided.

With respect to data discrepancies, the concerns expressed about use of SHARE data and other data sources are unfounded. The Department clearly indicated that hospital-generated statistics submitted on B-2 forms to the Center for Health Statistics are the source of facility planning data. Based upon public comment, the Department reevaluated SHARE Actual Reports and billing data from the UB-82 system and found that there were only a few hospitals with significant discrepancies between the data sources. The discrepancies, by and large, were due to inconsistencies in data reported to the Department by hospitals, and not to recording or reporting errors by the Department. In general, hospitals were unable to explain their reporting inconsistencies. Two reasons identified for the discrepancies between UB-82 and B-2 data are that (1) there are differences in defining the age range of pediatric patients; and (2) all pediatric admissions billed were not necessarily admitted to pediatric units. In general, there are clinically appropriate admissions of pediatric-aged patients to other adult inpatient service units. As the Plan measures need for a discrete inpatient pediatric service, these admissions are not relevant to the inquiry. The Department also has evaluated any specific data which hospitals supplied subsequent to initial publication. The Department held meetings with several hospitals and as a result resolved several data discrepancies and clarified other issues. Some data corrections lead to amended recommendations about specific hospitals.

The shortage of critical care beds is an issue, and was addressed in the Hospital Inpatient narrative which serves as the basis of this rule. Additional critical care beds are not precluded herein and will be further addressed in the forthcoming subchapter on injury.

It should be noted that same day services do not constitute an admission or a patient day and that the retention of a discrete pediatric inpatient unit is not needed for recovery of an SDS patient, including those of pediatric age.

COMMENTS: Access and Cost Savings

Several commenters stated that excess beds are not the cause of rising health care costs. Questions were also raised regarding whether the closure or consolidation of selected pediatric and maternity units, and the apparent planned reduction of acute care beds in general, would produce significant cost savings. It was suggested that unoccupied beds allow hospitals to flex its staffing according to demand.

One commenter spoke about the Plan's effect on geriatric patients, particularly with regard to the reduction of acute care beds and the effect on access. He asserted that with fewer beds available, more people will have to be sent to inner-city hospitals, where the technology and beds will be concentrated, but where older people would not always want to go.

Many commenters asserted that the elimination of pediatric and maternity units may drive primary care physicians out of the community.

RESPONSE: Access and Cost Savings

Physical plant issues in addition to occupancy rates were examined in making these recommendations. Many of the hospitals for whom downsizing or transition was recommended were in need of major physical plant overhauls. Cost savings are most likely to accrue when replacement of an unneeded physical plant is avoided. The replacement cost of a hospital bed is estimated to be \$225,000. With an annual budget of \$225 million through 1994, the system cannot afford to invest in unneeded facilities.

Downsizing of acute care capacity should not result in access problems. The Plan does not call for converting or eliminating **used** beds. Instead, it calls for conversion of a fraction of the State's **unused** bed capacity. This will not impede access. Rather, it may increase access to more needed community services. To address concerns raised about access for geriatric patients, facilities recommended for transition are located in areas where other hospitals are in close proximity.

Current trends indicate that the need for pediatric inpatient services will continue to decline. The majority of pediatric services are provided in physicians' offices or clinics. Services available through a regionalized system of care would enhance a pediatrician's local practice by creating better access to state of the art inpatient pediatric care when it is needed. The same is true for obstetricians and obstetrical services as has been documented since the inception of perinatal regionalization in the 1970's.

COMMENTS: Other General

Two commenters presented local area planning efforts aimed at addressing the delivery of coordinated pediatric services. The Southern New Jersey Hospital Council stated that it has decided to participate in the Task Force Committee to Develop an Agenda for the Delivery of Pediatrics in Southern New Jersey. As described, the aim of this task force is to develop a workable plan for the provision of pediatric services in southern New Jersey. The Children's Center, a cooperative venture between Newark Beth Israel Medical Center and Elizabeth General Medical Center, was offered as a model of integrated tertiary care for children.

The Medical Society of New Jersey contended that negotiations between the Department and individual hospitals about pediatric bed closures would undermine health planning efforts.

The New Jersey State Nurses Association (NJSNA) supported the plan to reevaluate bed need and occupancy rates. NJSNA and many others stated that preventive care will alleviate the burden seen in emergency rooms.

The American Academy of Pediatrics and numerous pediatricians expressed great concern about the Plan's proposal to allow "swing beds" in adult units for pediatric admissions.

Many commenters stated that Subchapter 14 is difficult to follow. In order to access recommendations for a specific hospital, one has to refer to three different sections of the rule. The commenters also pointed out the need to better integrate the pediatric section with the Maternal Child Health Subchapter of the Plan. The Children's Hospital specifically commented that nine to 11 pediatric centers referenced in the Plan result in 56 to 60 PICU beds being needed. There are currently 62 such beds. This means that the need for regional pediatric centers is for a maximum of six. The Department should consider convening a "Pediatric Technical Advisory Committee" to review this issue.

The New Jersey Public Policy Research Institute and the Committee on the State of Black Health identified a need for the Department to include input from the African-American community in the implementation of the State Health Plan including the transitioning of hospitals, bed reductions, etc.

RESPONSE: Other General

It should be re-emphasized that the Department supports the efforts of the State's hospitals and doctors to create primary care networks, which can be key parts of larger, integrated structures. The Department also supports voluntary regional planning efforts such as that for pediatrics in Southern New Jersey. It looks forward to the results of these efforts.

The sessions held with hospitals were examples of the public process at its best. Through this process, planning information relevant to all hospitals around the State was identified. Certificate of need changes to licensed bed capacity are noted within the narrative State Health Plan.

The Department agrees that expansion of preventive and primary care will address a broad range of problems in the health care system.

No recommendations for "swing beds" are contained in the final rule. The practice of operating such units should be reviewed by the pediatric clinical advisory committee.

The recommendations to better organize this subchapter and integrate the pediatric proposals in this subchapter with Subchapter 4, Maternal and Child Health were well taken. The final version of the rules is organized so that all recommendations pertaining to a specific LAB, county or hospital are contained within one section of the rules. These recommendations can be found in adopted N.J.A.C. 8:100-14.13. In addition, subchapters 4 and 14 have been amended to provide consistent language and cross references. The original recommendation called for the designation of nine to 11 Regional Pediatric Centers (RPC's), each with six PICU beds. The final rule is silent on the number of RPC's. The number and distribution of PICU beds will be considered by the Pediatric Clinical Advisory Committee as recommended by the commenters.

The Department is very interested in the involvement of the African-American community in the implementation of the goals and objectives of the Plan. Input will be sought at the Local Advisory Board level. This has been addressed in greater detail in this notice's discussion under Subchapter 1, General Comments.

N.J.A.C. 8:100-14.1 General recommendations

COMMENTS: One commenter recommended that N.J.A.C. 8:100-14.1(a)3 be amended to include priority for projects addressing community services and expansion or renovation.

The Medical Society stated that the "general recommendations" really are goals and should be labeled as such. They also stated that quality of care should be addressed in the SHP's narrative chapters and proposed regulations.

Some commenters recommended removing the names of the targeted hospitals and services from the Plan, and either allowing existing market forces to achieve the same planning goals or replacing those sections with general recommendations relative to each Local Advisory Board. Two commenters asserted that identifying specific institutions by name or by "process of elimination" had the effect of awarding Certificates of Need without a certificate of need process.

RESPONSE: Restriction to "community services" might pose problems for an institution trying to meet a regional or Statewide need. The language is amended at N.J.A.C. 8:100-14.1(a)2 and 3 to clarify the meaning of the rule.

N.J.A.C. 8:100-14.1 is intended to present purpose which includes goals and objectives and scope of this subchapter. Definitions for all chapters are contained in N.J.A.C. 8:100-1.3; however, each subchapter begins with statements. No change is recommended.

The Department agrees that quality of care measures need to be developed and used in future planning efforts. To strengthen the Department's commitment to further quality of care, N.J.A.C. 8:100-14.1(a)5 was added, which directs the Department to research quality and develop quality of care indicators.

The level of specificity in the Plan (by hospital name) is intended to provide the LAB's and consortia with policy guidance on the areas in which their planning activities should be focused. Market forces are not always sufficient to achieve planning goals because health care is not a perfect market. Left to market forces, health care services may well diminish in the areas of greatest need.

Similarly, the naming of a facility is not the same as awarding a CN but rather a means of guiding the planning and designation processes of the LABs and consortia. Each of these recommendations must be fulfilled by a hospital's filing of a CN and meeting all review criteria. For clarification, it should be noted that N.J.A.C. 8:100-14.15 through 14.17 in which specific service levels for pediatric hospitals were described, have been deleted from the chapter as adopted and will be reintroduced in pediatric planning rules following the deliberations of the Pediatric Clinical Advisory Committee described in Subchapter 4.

N.J.A.C. 8:100-14.2 Hospital efficiency targets and objectives

COMMENTS: The Medical Society proposed adding a new subsection which states: "Target occupancy rates presented in this subchapter shall be reasonably and flexibly applied."

A few commenters asserted that the State Health Plan emphasizes hospital occupancy and does not give sufficient weight to factors such as length-of-stay and severity of illness. It was recommended that N.J.A.C. 8:100-14.2(e) be amended to reflect that the Department and LAB study will address the average length of stay for acute care services "based on the services provided and the demographics of the LAB area." It was also recommended that a new subsection (g) be added, stating that "The Department and LABs will study the hospitals' number and

proportion of same day patients and diversion statistics and utilize such statistics in decisions relating to hospital expansion."

The Department of Human Services stated full support of target occupancy rates as a means of establishing efficiency expectations.

RESPONSE: Target occupancy rates are Statewide planning goals which are not intended for strict application to specific hospital certificate of need applications. Certificate of need planning regulations allow for case by case flexibility. Obstetrical and gynecological unit occupancy targets are recodified from N.J.A.C. 8:100-14.12(a) as 14.2(b).

The Department expects LABs to include local demographics and resources in any analysis of length of stay. The issues of same day patients and diversion are presently evaluated in the context of hospital certificate of need projects dealing with acute care and critical care beds and services. The Department and LABs will undertake further study as to how they should affect capital decisions. The Department contends that simple numbers and proportions of same day patients are inappropriate for the basis of capital decisions. Clarifications to language at 14.2(g) were made to focus study of areas with high ambulatory care sensitive (ACS) admission rates.

The Department of Health acknowledges the support of the Department of Human Services.

N.J.A.C. 8:100-14.3 Statewide bed need

COMMENTS: The Medical Society recommended that N.J.A.C. 8:100-14.3(a) be softened or deleted, as the stating of a Statewide bed excess number is not a suitable regulation.

Another commenter stated that N.J.A.C. 8:100-14.3(b) should be amended to permit, in the event of a conflict in the meaning, the Commissioner to decide which rules should be applied in order "to promote the orderly development of effective health care services." The Medical Society preferred that this rule be deleted.

RESPONSE: In the 1991 Health Care Cost Reduction Act, P.L.1991, c.187, it was mandated that the State Health Plan be placed in regulation. This excess bed number is a central finding of the Plan, and thus notation in the rule is both appropriate and needed. Amendments to subsection (a) were made to clarify that paragraph (a)1 applies to a Statewide total of all acute care beds, while paragraph (a)2 is added to provide the excess of medical/surgical beds that is a subset of the Statewide total, along with the need for 300 ICU/CCU beds Statewide in paragraph (a)6. This subsection is adopted in a consolidation of these figures from other rules. This provides the reader with a basis for arriving at the Statewide total which was contained in the methodology approved by the State Health Planning Board.

The Department views the State Health Plan as the basis for other companion rules. A central tenet is that a plan, not a technical rule, should drive the orderly development of services. The Department will work to eliminate any potential conflicts in meaning.

N.J.A.C. 8:100-14.4 Decertification of unused beds

COMMENTS: The Medical Society commented that neither the Commissioner nor the Governor should have the sole discretion to close hospitals. Rather, the LABs and the SHPB should be involved and the Department should be required to conduct discussions with the hospital before taking action.

The Department of Human Services strongly supported the reduction of unused beds.

RESPONSE: The removal of unused beds from a hospital's license is not only mandated by the Health Care Cost Reduction Act, but also is an action presently authorized for beds deemed abandoned. Although not mandated specifically by the statute, the rule includes a notice and hearing procedure which will assure adequate discussion with hospitals. It should be noted, however, the cited rule does not address closure, which must be accomplished through Certificate of Need (CN). The commenter is referred to N.J.A.C. 8:33C, at 24 N.J.R. 2005(a), and N.J.A.C. 8:33H, at 24 N.J.R. 2014(a), proposed as new rules in the June 1, 1992 New Jersey Register, defining the CN Application and Review Process in which the LABs, SHPB, and the Department are involved.

The Department of Health acknowledges the comment from the Department of Human Services.

The language of this rule has been changed to substitute "removal of unused beds from a hospital's license" for "decertification of unused beds."

N.J.A.C. 8:100-14.5 Prioritization of hospital capital expenditure limits under Chapter 187

COMMENTS: The Medical Society commented that the effects of prioritization are unclear, and offer no opportunity to approve non-priority projects. They suggested that there should be a formula to indicate the weight given to priority projects. Regarding N.J.A.C. 8:100-14.5(a)3, they asserted that the SHPB and LABs should be included in the determination of whether a project is essential to reach the goals of the State Health Plan.

Two hospital representatives objected to the target occupancy rates. One asserted that an average occupancy rate of 85 percent yields little admitting flexibility. The hospital also objected to requiring occupancy rates in excess of 90 percent in all services in order to exhibit priority community need. Both hospitals and another commenter suggested that occupancy rates be applied to the service area in question rather than all services. One commenter recommended that N.J.A.C. 8:100-14.5(a) be amended to lower occupancy thresholds to 85 percent and that the need assessment to be conducted for beds be based upon the hospital service area rather than the county. Further, the addition of a new criterion was requested: "The hospital is able to meet established occupancy, average length of stay, quality, and cost effectiveness indicators in relation to hospital activity levels and its service area demographics." It was also urged that the Department review under affordability criteria the hospitals' cost effectiveness compared to other competing applicants and/or area providers, and its equity contribution.

RESPONSE: By its nature, a limit on capital spending requires a prioritization method. This section outlines a clear, understandable method that is linked to the rest of the Plan. The open, public certificate of need process in which the SHPB and LABs are key participants, will be the major forum where prioritization decisions will be made. While not proposing specific weighting and scoring priorities, the Department does clarify the rule to give more priority to applicants who meet multiple criteria and to address fiscal feasibility criteria.

The use of a target occupancy rate of 85 percent for medical-surgical beds is based upon a careful assessment of current utilization trends, existing and historical occupancy rate requirements and goals, and the ability of larger institutions to achieve this level of occupancy without significantly affecting the ability to provide access to inpatient beds.

The term "service area" is not defined and could lead to endless debate and discussion over definition. The Department wishes to study various operational definitions of "cost-effectiveness" and "quality" indicators before mandating their use by rule propagation.

The recommended change limiting review to services encompassed in the CN submission will significantly increase the number of projects meeting this particular prioritization criterion, rendering it less meaningful. In addition, the Department wants to encourage hospitals to reallocate slack resources before adding new ones. No change was made to the rule.

N.J.A.C. 8:100-14.6 Nondiscrimination

COMMENTS: One commenter recommended changes to N.J.A.C. 8:100-14.6 to limit certificate of need application for discrimination in admissions or patient care only, and that the prohibition be lifted when the discrimination is remedied.

The Medical Society stated that the second sentence of this subsection should be deleted, as it is both over-inclusive and under-inclusive.

The Department of Human Services requested that this rule be amended to encourage hospitals to provide sufficient outpatient services.

RESPONSE: In a complex institutional setting, discrimination can be manifested in many ways beyond admission and patient care practices. The Department agrees with the addition allowing submission of certificates of need after the discrimination is remedied, and the rule has been so amended.

The second sentence is appropriately inclusive of the sanctions that the State Health Planning Board and the Department believe should be imposed for violations of civil rights statutes. No change is made.

The issue of outpatient services will be addressed in the forthcoming subchapter 2.

N.J.A.C. 8:100-14.7 Criteria for assessing need for a hospital

COMMENTS: The Medical Society recommended that the SHPB convene LABs and other key organizations in an effort to define criteria that will better assure that needed projects will be approved, and that unnecessary projects will be rejected. They assert that this subsection, as it exists, represents a top-down approach to planning.

One hospital representative stated that the Acute Care Plan understates the need to reduce the number of hospitals. They also noted that there are many aspects of acute care services not yet addressed by the Plan such as the extent to which licensing and reimbursement rules will be revised to encourage the development of services outside the walls of the hospital and guidelines for expanding surgical suites both for inpatients and outpatients.

Regarding the geographic isolation criteria at N.J.A.C. 8:100-14.7(e)1, one commenter stated that consideration should be given to the time required to travel, rural vs. urban areas, types of roads traveled, and the availability of public transportation. Other suggestions included that the service area be defined as that within which the hospital gets 60 percent of its patients; and that the criteria be changed to reflect whether or not a hospital is the primary care leader in its service area and whether or not there is another hospital in its service area.

One commenter recommended several technical changes to this section as well as adding a criteria for overall hospital activity levels, and granting "high" community need status to certain projects. In addition, it was recommended that the hospital's costs of providing care under its DRG charges be reviewed competitively with other hospitals in the same county or counties.

RESPONSE: This section represents enhancements to existing policy reflected in existing certificate of need rules. The proposed language evolved following months of discussions at the State Health Planning Board, at the LABs, and with various industry members and associations. This section is also reflected in proposed N.J.A.C. 8:33 now under review. The objection to "top-down" planning is noted, but the rules are established for the purpose of setting criteria for local health planning bodies as well as the State Health Planning Board to apply in reviewing Certificate of Need applications. Constructive suggestions for future modification by the Medical Society are welcomed.

Based upon the magnitude of the Statewide excess of beds (2,175 total), the advent of minimally invasive surgery and the current uncertainty surrounding the hospital rate-setting system, it is likely that further downsizing of the acute care hospital system will occur over the next 10 years. In some counties and LAB areas, specific mechanisms to accommodate the need to downsize were not clearly apparent, and thus, further study by LAB's is recommended (for example, Mercer County). As this State decides how the health care system of the future should look, licensing and reimbursement modifications will be necessary.

Hospitals are without question moving away from the historical model of solely providing inpatient services and are today offering highly sophisticated and technical services on an outpatient, same day, or home health care model. In the next phase of the Plan, a subchapter will be proposed covering surgery and dialysis services. In the adopted chapter, "Subchapter 16. Surgery and Dialysis (Reserved)" has been added and the subchapter on long-term care recodified from N.J.A.C. 8:100-16 to N.J.A.C. 8:100-18.

The Department agrees that it is appropriate for both the public and private sectors to analyze and compare costs across institutions. However, such comparisons need to include such factors as patient severity and socioeconomic characteristics, and validated outcome measures.

Refinement of criteria, such as accessibility, quality of care, reimbursement, for assessing need for a hospital will be ongoing as knowledge is gained through the new certificate of need process involving the LABs and the SHPB. Given a recent Federal court decision (*United Wire, Metal and Machine Health and Welfare Reform, et al. v. Morristown Memorial Hospital, et al.*, Civil Action No. 90-26 39 (D.N.J. May 27, 1992)) which throws into question the validity of core provisions of the current hospital reimbursement system, the State Health Planning Board should keep abreast of hospital financial status and possible changes in the reimbursement system resulting from this court decision or subsequent legal proceedings. Should a change in the reimbursement system financially endanger needed hospitals, the criteria for evaluating CN applications may need to be reexamined. No changes are made to the rule at this time.

In order to conform to existing non-discrimination laws and policies, the Department has changed the references to "persons with AIDS" in N.J.A.C. 8:100-4.7(e)1 and (e)1iii to "persons with diseases or disabilities that may engender personal, institutional or political discrimination (for example, AIDS)."

N.J.A.C. 8:100-14.9 (recodified as 14.8) Limitations on hospitals and areas with excess bed capacity

COMMENTS: One commenter recommended that exceptions be granted for projects for expansion of beds or services when a hospital meets the review criteria of N.J.A.C. 8:100-14.7.

The Medical Society recommended that N.J.A.C. 8:100-14.9 be deleted and that the responsibility for planning and making recommendations to the State Health Planning Board (SHPB) regarding excess beds should rest with the LABs.

UMDNJ commented that the Plan does not identify needed and/or desired alternative uses nor does it sufficiently address financial incentives for conversion.

RESPONSE: The wording of these proposed rules is designed to effect a decrease in excess capacity in a sound and flexible fashion. The exceptions language is designed to maintain an open and objective CN process.

Creation of the State Health Plan, which includes a calculation of bed need, rests clearly with the LABs and State Health Planning Board. The Commissioner's decisions are bound by the findings contained in that Plan.

The Hospital Inpatient narrative of the State Health Plan from which these rules are derived, calls for conversion of unneeded acute care capacity to alternative uses and describes several incentives to do so. As those uses are dependent upon both Statewide and area need for alternative health care services, a process of working with community planning bodies and appropriate state agencies is required before a statement is made concerning which alternative uses are appropriate. For example, conversion to mental health services requires an understanding of the need methodologies now under development in the Mental Health chapter of the State Health Plan, endorsement of the New Jersey Division of Mental Health and Hospitals, and identification of need by the affected County Mental Health Boards. Alternative services also have differing reimbursement systems and the individual institution will need to undertake financial feasibility studies before a plan can be put forth for public review.

N.J.A.C. 8:100-14.10 County specific recommendations for medical/surgical and total hospital services

COMMENTS: General

UMDNJ applauded the Department of Health for not proposing to eliminate over-bedding by relying upon broad-based bed reductions at each hospital throughout the State. It agreed that this approach would serve only to reduce the total number of beds licensed in the system without achieving a redirection of the health care delivery system or a reduction in health care costs. UMDNJ cautions, however, that the Department's Plan may be too ambitious and that providers must be afforded an opportunity to correct or supplement the information the Department used for its decision-making.

UMDNJ also stated that the Department's proposed reconciliation of licensed to operational beds should be completed on a Statewide basis prior to finalizing the bed reduction plan.

The Medical Society of New Jersey commented that given the aging of the population, advances in medical technology, increased morbidity associated with the AIDS epidemic, and increasing social problems, the demand or need for hospital services will probably not decline as much as projected. There should be more emphasis placed on financial incentives and on promoting hospital efficiency, and less emphasis on mandated bed closures. There should be an assurance in the Plan that more than the identified six hospital closures will not be forced unless the demand for hospital services declines substantially. Local Advisory Boards and hospitals could encourage mergers, and the Hospital Rate Setting Commission would create disincentives for inefficient hospitals to remain open. The need for emergency services and critical care beds will increase with an aging population. Several areas of the State will be especially compromised. A task force on critical care needs should be established. Special attention should be paid to the needs of less densely populated areas and to the needs of pediatric patients and their families.

The Medical Society also offered the suggestion that this section should be changed by replacing the word "must" wherever it appears, with "should."

The Department of Human Services stated that the Division of Mental Health and Hospitals should be directly involved when converting a facility with psychiatric services.

RESPONSE: General

As previously stated, proposed N.J.A.C. 8:100-4.10 has been deleted upon adoption and its provisions recodified as part of N.J.A.C. 8:100-4.13.

The Department acknowledges UMDNJ's support of the approach taken to effect downsizing of the acute care system Statewide, and agrees that careful and open analysis of recommendations by affected providers and communities is necessary and has been initiated since release of the first Hospital Inpatient narrative on January 15, 1992.

The first phase of the reconciliation of licensed bed capacity has been conducted and the process will be completed before initiation of the certificate of need cycle for new hospital services. Based upon initial evaluation, differences are not of significant enough variation to warrant delay or any substantive revisions to this rule.

The Department acknowledges the Medical Society comments about future need for hospital services but notes that there is an absence of any factual analysis in support of their conclusions. In the Hospital Inpatient narrative, the Department reviewed the impact of AIDS, aging of the population, and managed care, among other factors, and noted that specific modifications to the bed need methodology on a statewide basis were not warranted. On an aggregate basis, all trends affecting use of inpatient beds are reflected in overall admission and patient day data, and the relatively minor shifts in statewide utilization over recent years confirm this. In addition, where AIDS or other like factors are particularly significant (for example, Essex County), the State Health Plan calls for hospitals and LABs to address unique considerations in bed need studies or individual CN's. The Department has found that there is a need Statewide for additional critical care capacity and that expansion of emergency room services has not been precluded by these rules. Both will be addressed in more detail in the Injury chapter now under development.

The Department agrees with the Medical Society's language change in the recommendations concerning the six hospitals slated to transition from acute care to other needed services. Given the uncertainty surrounding the Chapter 83 reimbursement system as a result of a recent district court decision (*United Wire*), the Department acknowledges the need to remain flexible. For the transition recommendations regarding these six hospitals, language has been changed from "must" to "should." This change is made to clarify the recommendatory nature of those provisions in N.J.A.C. 8:100-14.10 pertaining to these six hospitals, as expressed in the proposal Summary and understood by interested parties. Elsewhere throughout this subchapter, the word "shall" has been substituted for the word "must."

Language has been added at N.J.A.C. 8:100-14.13(d) which describes transition teams involving all parties including other State agencies.

Language has been added at N.J.A.C. 8:100-14.13(e) indicating the Department's responsibility to report the impact of changes resulting from the *United Wire* decision.

COMMENTS: Specific Hospital Recommendations

Many individuals presented both oral and written testimony in support of St. Mary's Hospital in Passaic. Some discussed the need to maintain a Catholic hospital in the area. Convenient access for senior citizens, the need to keep the emergency room open, the potential impact on Passaic General and Beth Israel, the quality of the physical plant and the patient care, its fiscal health and the potential loss of jobs were some of the issues raised. Hospital representatives provided utilization and financial data disputing that presented in the Plan.

Representatives from the Jersey Hills Health Alliance, a cooperative venture between Hackettstown Community Hospital and Dover General Hospital and Medical Center, asked that the recommendations in the Plan reflect the joint efforts between the two hospitals already underway. Further, Hackettstown Community Hospital objected to the provisions of N.J.A.C. 8:100-14.10(b)4ii, wherein no certificates of need may be submitted by the hospital until the LAB conducts an area wide bed need study. The hospital expressed concern that strict interpretation of this rule may prohibit them from receiving designation as a Community Perinatal Center. They asked that the provision be deleted from the Plan.

Bergen Pines County Hospital requests that the Plan's call for a feasibility study to see if the hospital's medical/surgical service should be closed should be cancelled. Closure of the medical/surgical service would mean closure of the hospital's emergency room and clinics, representing a loss of service to certain underserved populations. The Bergen County Executive expressed dismay that a decision concerning the long-term mission and structure of the Bergen County's hospital could be made without the benefit of an open dialogue with hospital administration.

A commenter on behalf of Montclair Community Hospital stated that it deserves to continue as an acute care hospital. It is financially viable and needed by the community. Closing small hospitals will not necessarily reduce hospital costs.

The Medical Center at Princeton requested that its service area be treated as a distinct district rather than as part of Mercer County as a whole. The Medical Center does not believe it should be obligated to work with the other hospitals in Mercer County to solve the "excess capacity" issue as its medical/surgical units have been operating at capacity for the past year or more.

Senator Corman commented that the recommendation to eliminate all acute care beds at South Amboy Hospital is not supported by the data cited in the Plan. Data indicated that the surplus of acute care beds in Middlesex County is very slight and there is a shortage projected by 1995. The Senator also commented that the community desperately needs the services of the emergency room at South Amboy, and closure of the hospital would constitute a danger to the health and safety of the residents of Sayreville and South Amboy. Further, the location of the hospital in South Amboy makes it physically unsuited to be turned into a mental hospital, as it is in a densely populated residential area with no grounds for patient recreation.

Many commenters submitted oral and written testimony on behalf of South Amboy Hospital. It was noted that when founded 75 years ago, the original purpose of South Amboy Hospital was to care for the medical needs of the community and its neighbors. Other hospitals' emergency rooms are usually overcrowded, and the residential composition of the neighborhood does not provide an adequate environment for psychiatric patients. In 1991 there were 12,000 emergency room visits and 5,576 admissions. Frequently, the major hospitals in the area are on divert, resulting in people being held in the emergency room for several days. Many First Aid Squads use this hospital, and critically ill and injured patients do not do well being transported long distances. If acute care services are taken away, people will die needlessly. The hospital is aggressively recruiting new physicians and has up-to-date technology. South Amboy Memorial Hospital should remain a viable health care provider offering a solid continuum of care.

Objections were presented to the proposal to discontinue the provision of acute care services at Zurbrugg Memorial Hospital at Riverside. Concern was also expressed regarding the lack of a public hearing prior to making the recommendation. It was stated that Zurbrugg turns away acute care and emergency patients, not because of a lack of beds, but because of a lack of sufficient staffing in ICU and CCU. This situation, in turn, keeps admissions low, occupancy rates low and produces a less favorable profit picture. Should Zurbrugg be closed, the concern was raised that residents in some areas may not reach an emergency care facility in less than 20 or 30 minutes. Municipal EMS squads questioned who would pay for added transportation costs to the next nearest hospital. For those not needing an ambulance, there is no convenient public transportation, especially for the elderly, to either Rancocas Valley or Memorial Hospital. The Plan does not address "peak periods" of utilization, such as occurs during a flu epidemic. Plans to consider converting Zurbrugg to an AIDS treatment facility are ludicrous; the number of AIDS patients in Burlington County is insignificant.

A representative of Graduate Health Systems, the corporate manager of Zurbrugg stated that the management fees paid by the Riverside Division are reasonable for the range of services provided. He further stated that the claim that lack of staff is responsible for low utilization rates is not true.

A commenter noted that the Plan does not recognize the high occupancy of the medical/surgical and ICU/CCU beds at the Voorhees Division of West Jersey Health System. Expansion of these bed categories may be warranted.

Many individuals gave testimony in support of Elmer Community Hospital. It was requested that the recommendation for the LAB to study the need for the hospital be removed from the Plan. The language of the recommendation predisposes an outcome that would possibly affect the future of Elmer Community Hospital. Hospital representatives submitted data and community letters in support of the need to continue Elmer as an acute care hospital.

RESPONSES: Specific Hospital Recommendations

The hospital-specific recommendations are recodified to N.J.A.C. 8:100-14.13 in order to consolidate all rules related to specific institutions in single section.

The Department acknowledges the concerns expressed by hospital and community representatives about the potential impact of the recommen-

dation to phase out St. Mary's Hospital. These will be strongly considered in efforts to develop a Plan to develop alternative services in the area, and the Department will work closely with the hospital, its community, and the LAB in developing this Plan.

The Department is aware of the affiliation between Hackettstown Hospital and Dover General and notes that there is no relevant section of the rule to state this fact. However, the Plan will be amended to broaden the LAB study to all acute care services, recognizing the inter-relationship between these two facilities.

The Plan calls only for a study of Bergen Pines role in acute care, and does not reflect any pre-determined decision. The future of Bergen Pines Hospital has been the subject of many discussions between the Department and the hospital's administration and will clearly remain such a subject in the future.

Low utilization and the hazardous financial status of Montclair Community Hospital have been issues of concern to the Department and the State Health Planning Board. The Department has revised the rule to enable Montclair to continue discussions with area hospitals concerning joint programs. A report is to be submitted to the LAB within six months as stated at N.J.A.C. 8:100-14.13(b)3i(5).

The Medical Center of Princeton has forged various cooperative relationships with other acute care hospitals in Mercer County that have an overall effect on planning for downsizing of this region's excess bed capacity. In addition, while the Department acknowledges that medical/surgical occupancy exceeds target occupancies, admissions declined between 1990 and 1991, and patient days remained stable, indicating that length of stay rose. During 1991, there were low utilization rates in obstetrics and pediatrics at the Medical Center. All of these factors along with the overlapping of market areas on a regional basis indicate that there should be LAB evaluation prior to significant investment in replacement of a physical plant by any Mercer County hospital.

The State Health Plan recommends that South Amboy Hospital develop a transition plan to phase out of acute care and provide alternative services. It also suggests that exploration of joint ventures or merger with other area hospitals take place. There is a need identified to maintain valuable mental health services already provided at South Amboy, but the Plan does not identify this as the only option. In reflection of continued downward trends in acute care admissions at the hospital, this transition tied into affiliation with an area hospital will allow continued availability of services in this community. This also permits distribution of acute care services at sites where there is sufficient volume for providers to maintain skill levels necessary to assure quality of care for patients with a wide variety of illnesses. With any alternative, maintenance of emergency and ambulatory care services will be afforded serious consideration.

The Department has noted that the financial status and low utilization rates of Zurbrugg-Riverside Division has been an issue of some concern. Issues of staffing are the responsibility of the hospital's management. There are no references in the Plan to converting Zurbrugg to an "AIDS treatment facility" or to long-term care uses. The Department has met with the hospital's community, doctors and administration. It hopes to work toward a solution that best serves the needs of the community. Transportation issues will need to be addressed in the transition plan.

In reference to West Jersey Hospital's comments, the Department refers the hospital to pages 72-73 of the Hospital Inpatient narrative in which the "relatively well utilized" services of the hospital were discussed. This document served as the basis for the rules contained in Subchapter 14.

The Department is looking closely at the recommendations concerning Elmer Community Hospital. The data in support of need for acute care services will be analyzed. This recommendation was designed to initiate a long-term study of the best acute care configuration for Salem County and was not intended to pre-determine the outcome of the study. The wording of this rule, now found at N.J.A.C. 8:100-14.13(b)5v(1), has been amended to remove specific reference to this hospital alone.

N.J.A.C. 8:100-14.11 (recodified as 14.9) Obstetric and pediatric services—Maternal and Child Health Consortia

COMMENTS: The Medical Society stated that N.J.A.C. 8:100-14.11(d) should be deleted. Another commenter suggested, regarding N.J.A.C. 8:100-14.11(f)iv, that consideration to maintain OB/GYN units cannot be made solely on the basis of occupancy. Rather, geographic isolation and community needs should equally come into play. Such consideration should be documented in advance of any recommendation to close a unit.

Hackensack Medical Center noted a correction to the inventory of Level III bassinets given in the Inpatient Obstetric Services section of the Plan. The Medical Center has five neonatal intensive care bassinets, and 10 intermediate neonatal care bassinets.

Jersey Coast Health Planning Council, Inc. commented that it supports the concept of regionalizing perinatal services but opposes the idea of closing pediatric units at Kimball Medical Center and CentraState.

RESPONSE: N.J.A.C. 8:100-14.11(a)-(e) have been superseded upon adoption by N.J.A.C. 8:100-4.3(d), which sets forth the sequence for designation of facilities as community or regional pediatric centers, to include the promulgation of pediatric planning rules. The Department has assessed geographic isolation and community needs issues and has recommended further study by LAB's in areas where this is of concern.

The Department notes that the comments by Hackensack Hospital are addressed in the Hospital Inpatient narrative and not the rule. However, the Department's records indicate Hackensack was designated as a Level II facility which is not approved for Level III bassinets.

Prior to proposal of the State Health Plan as a rule, the State Health Planning Board amended the Plan to permit Kimball Medical Center and CentraState Medical Center to maintain pediatric units.

N.J.A.C. 8:100-14.12 Inpatient obstetric and gynecological (OB/GYN) services

COMMENTS: UMDNJ suggested the Department use a more sophisticated bed forecasting model for areas such as obstetrics. The commenter does not believe the formula used by the Department is adequate for services which are subject to significant random variation.

The Medical Society commented regarding N.J.A.C. 8:100-14.12(a), that there must be protective language to assure that targets are applied reasonably and flexibly. The Society further stated that findings of excess beds (N.J.A.C. 8:100-14.12(b)), do not belong in regulations.

RESPONSE: The methodology utilized for obstetrical bed need depends to a large extent on birth rates and trends in average length of stay. The Plan provides for a range of alternative use rates and further calls for the consortia to develop area specific need assessment for hospitals in each region. The Department will work towards providing additional factors for consideration as well as a common data base during this process.

Various companion rules, including the CN policy manual, allow for such flexibility. The finding of excess beds is a key part of the State Health Plan which, by law, is to be placed in a regulation.

N.J.A.C. 8:100-14.12 has been deleted as a separate rule; subsection (a) has been recodified as N.J.A.C. 8:100-14.2(b), and subsection (b)'s projection as N.J.A.C. 8:100-14.3(a)3.

N.J.A.C. 8:100-14.13 Local area need

COMMENTS: Two commenters recommended that this section be deleted from this chapter and placed either within the context of the Maternal Child Health Services chapter or in general recommendations specific to each LAB.

Hackettstown Community Hospital raised objections to the recommendation to consolidate the two Warren County OB/GYN programs at one site. Warren and Hackettstown Community Hospitals are nearly 20 miles apart and share virtually no parts of their service area. The recommendation is largely arbitrary and should be deleted until further study indicates otherwise.

Objections were raised to the Plan's recommendation to downsize or eliminate the OB/GYN units at Bayonne Hospital, St. Mary Hospital in Hoboken, and Washington Township Division of Kennedy Memorial Hospitals.

A representative of Medical Center of Ocean County gave testimony in opposition to the Plan's proposal to reduce the OB/GYN bed capacity at the hospital. He asserted that such a reduction would run counter to their modernization/renovation certificate of need which gave the Medical Center approval to relocate obstetric services from Point Pleasant to Brick Hospital. These services were allowed under the certificate of need to achieve minimum occupancy within a period of two years following completion of the project.

Several individuals supported the maintenance of obstetrical services at the Washington Township Division of Kennedy Memorial Hospitals. One representative stated that the recommendation to reduce the number of OB/GYN beds at the Washington Township Division would pose a serious threat to the integrity of graduate medical education programs and to the delivery of health care services to the rural and suburban poor in the area. It was emphasized that this hospital is just

completing a renovation which was allowed under the certificate of need to achieve minimum occupancy within a specified period following completion of the project.

West Jersey Health System pointed out that the Plan does not recognize the need within their Voorhees Division for additional OB/GYN beds. They stated that occupancy of the 50 licensed OB/GYN beds at the Voorhees Division has remained at the 90 percent level.

The Medical Society recommended that the rule be amended to require only that the Maternal and Child Health Consortium review the recommendations of the Department regarding individual hospitals that have been identified as having OB bed excesses.

A representative of Kimball Hospital commented that the concept of reducing beds to cut costs is erroneous because there is not a guarantee that a hospital which absorbs beds or services is any more efficient than the hospital losing them. If the State analyzed the data, it might be adding [obstetric] beds to Kimball, not trying to eliminate them. This representative cited Kimball's maternity clinics which have grown in volume from over 1,799 visits four years ago to nearly 3,500 last year and asserted that these statistics supported maintaining the current level of 24 beds. He also noted that the true measure of hospital efficiency and profitability is not occupancy rates, but how well length of stay is managed and how efficiently resources are used. The key management tool is the DRG system; it is the efficient manager's best friend. To improve the system, however, it is necessary to shift to Statewide DRG averages and thus eliminate that portion of the reimbursement system that is peculiar to each hospital. This would automatically reduce costs; those hospitals above the averages would quickly be forced into efficiency so they would not lose money.

RESPONSE: It is fundamental to regional health planning under this Plan that LABs, rather than Consortia, review any bed excesses. The comments pertaining to the organization of the rule were helpful. This subchapter has been revised to better integrate with Subchapter 4, Maternal and Child Health and to provide a more user-friendly format. This proposed section is now incorporated into a new N.J.A.C. 8:100-14.13. The Department has evaluated the above public comment as well as integrated further findings on utilization trends and the impact of the proposed rule on access to obstetrical care services.

New N.J.A.C. 8:100-14.13(b)iv is amended to no longer require consolidations of OB/GYN programs at Hackettstown and Warren Hospitals.

New N.J.A.C. 8:100-14.13(b)2ii(1) and (7) retain the language to eliminate or reduce OB/GYN beds at Bayonne and St. Mary, as no additional data was submitted to support a change in the rule.

Text has been added at N.J.A.C. 8:100-14.13(b)2ii(5), 3(i)7, 5iv(1) and 6iv(3) to clarify that those hospitals currently within the two-year time-frame provided by N.J.A.C. 8:431 for the achievement of full capacity may continue to work toward that capacity.

The Hospital Inpatient narrative cites the West Jersey occupancy levels and this rule does not preclude the hospital from applying for additional OB beds if criteria for bed expansion are met within appropriate planning regulations.

The Department acknowledges the point of view concerning the importance of efficiency and profitability measures for hospitals, but cannot accept the recommendations to use these exclusively, which essentially would reduce health care planning to a free-market approach. The public and State interest in maintaining a health care system that is of high quality, affordable cost, and full accessibility requires that many of the aspects of public utility regulation be applied.

N.J.A.C. 8:100-14.14 Designation of pediatric services

COMMENTS: The Children's Hospital of New Jersey/United Hospitals commented that the Plan encourages a proliferation of pediatric tertiary services to a large number of Regional Pediatric Centers. These centers should not become "mini-children's hospitals" with the full range of capabilities of a children's hospital. It was suggested that hospitals which do not have the array of services to become a Regional Pediatric Center could be named "Centers of Excellence" in recognition of their singularly strong programs in specific areas (for example, burns, oncology).

The Children's Hospital also suggested that the process by which an institution receives full accreditation for a pediatric residency program is a better way of determining whether an institution should be designated as a regional pediatric center or a children's hospital. Further, the hospital offered the opinion that Pediatric Intensive Care Units (PICU) should exist only at children's hospitals and a limited number of regional pediatric centers.

A commenter charged that with minor wording changes, the study of pediatric services which had been privately commissioned by UMDNJ, had made its way into the Plan. This includes recommendations regarding the "need" for three children's hospitals.

UMDNJ agreed with the Department's determination that there is a need for three tertiary "regional pediatric centers," and remarked on the similarity between the proposed pediatric system identified in the State Health Plan and that recommended in a UMDNJ study which assessed the need for tertiary level regional pediatric centers in New Jersey. The commenter noted however that its plan analyzed all hospital admissions of children age 17 and under and did not call for the closure of any existing pediatric services.

Cooper Hospital/University Medical Center wished to emphasize that their designation as the Southern New Jersey Regional Children's Hospital need not force the closure or reduction of any pediatric unit in South Jersey.

The Medical Society commented that this provision appears to prohibit hospitals from providing any services to children outside the three-level designation process. A hospital could find itself in a bind between violating this regulation and committing malpractice. It is unclear as to who has authority for designation.

A few commenters stated that the designation process sometimes sets up a "Catch-22" situation, whereby a hospital which is designated as a regional pediatric referral center does not participate with any HMO's. In this situation a patient might not be covered for necessary medical care, even though they are insured (through an HMO).

Elizabeth General Medical Center (EGMC) commented that the Perinatal Technical Advisory Committee's recommendations to expand regionalization to incorporate perinatal with pediatric primary care services are an important step toward improving maternal and child outcomes. EGMC challenges the Department to evaluate all current funding sources for maternal and child health programs to determine duplications, streamline State funding, and identify and fund successful agencies. EGMC recommends that the Department and maternal and child health consortia evaluate the success and appropriateness of hospital-based programs before assuming that alternative settings are the solution to problems of access that may not exist or that may be solved by changes made within the current delivery system.

The Southern New Jersey Hospital Council commented that the closure of some hospital pediatric units and/or pediatric services may deny access to those pediatric patients in need. The Council requested the opportunity to develop an alternative approach to regional distribution of total care to pediatric patients for southern New Jersey. The Council assures the Department that Local Advisory Board(s) V and VI would be involved in the effort.

RESPONSE: The excellent points raised formally by The Children's Hospitals and informally by many others has caused the Department to agree to slow down the process for pediatric regionalization in order to allow for additional clinical input. In amendments contained in Subchapter 4, Maternal and Child Health, the Department calls for the convening of a pediatric clinical advisory group to help develop pediatric planning rules. The planning rules will clearly delineate the services (including PICU) to be provided.

The classification of Centers for Excellence has been used by hospitals in marketing specialized services, but is not especially appropriate for official designation purposes by the Department. However, the suggestion to consider recognition of hospitals with singular programs is one that can be considered during the planning process described above.

The Department was aware that UMDNJ had commissioned a study of pediatric services. Some of the Department's conclusions are similar to those in the UMDNJ study and some are vastly different.

The Department agrees that the proposed phase-out of pediatric inpatient services at some hospitals was not linked to the legislative designation of two children's hospitals in New Jersey.

The Department believes that the Medical Society's fears are unfounded. As in other regionalization systems, physicians will be expected to treat patients in the most appropriate clinical settings for the benefit of the patient. Referrals should be made to facilities identified in regional plans as having clinical expertise in various services and levels of care.

Referral agreements will need to be reflected in future HMO contract negotiations. The Department of Health believes that HMOs are equally committed to providing the best possible care for children.

The Department acknowledges Elizabeth General's support of the enhanced role of MCHC's in both perinatal and pediatric care and will

encourage the Consortia to conduct the types of analyses that are suggested.

N.J.A.C. 8:100-14.15 Specialty acute care children's hospitals

COMMENTS: Several commenters expressed concern that the Plan calls for the development of two to three Children's Hospitals without justification, giving the UMDNJ core teaching hospitals preference. It was felt that this would cause high, undue capital cost without need justification. Current utilization of "super-specialty" services such as pediatric cardiac surgery would indicate that there is not a need for significant increases in these services. Concern was expressed that in order to build these children's hospitals, the Department is recommending closure of Pediatric Units throughout the State. This would prevent the growth and development of community pediatric services. All have agreed that primary care is a priority, therefore capital funding decisions should follow accordingly. Consolidation of subspecialists at three sites would effectively close residencies anywhere else. Furthermore, there are other hospitals which may already meet the criteria for designation as a children's hospital.

Representatives from St. Peter's Medical School, Robert Wood Johnson University Hospital and UMDNJ/Robert Wood Johnson Medical School spoke in support of the development of a third children's hospital located in New Brunswick. UMDNJ recommends that the language in the Plan be revised to reflect "designation" rather than consideration of a children's hospital in New Brunswick.

Further, it was recommended that since the legislature and Commissioner designated Cooper Medical Center as a Children's Hospital during a moratorium and without public documentation of an evaluation of regional need, geographic access, and other need criteria subject to a public process, to which all other projects are subject, the capital costs associated with that project should be funded outside of the \$225 million cap.

One commenter stated that the Plan does not recognize by inclusion or reference the next level of services (that is, Comprehensive Pediatric Rehabilitation) which are available. This commenter noted that the "rehabilitation and communication evaluation and treatment services" addressed in this section of the Plan are already available in a licensed Comprehensive Pediatric Rehabilitation Hospital. He argued that the 120 Comprehensive Pediatric Rehabilitation beds in the New Jersey Rehabilitation Plan and the related out-patient comprehensive rehabilitation services must be included in the State Health Plan.

It was recommended that N.J.A.C. 8:100-14.15(a) through (f) be deleted. It should be the responsibility of the LAB's and the public process at the local level to determine what services and programs are most appropriate for specific institutions in each region, and to identify these institutions through the certificate of need process.

It was noted that at N.J.A.C. 8:100-14.15(f) it is stated that a facility not designated as a children's hospital may not provide specialty acute care children's services. Concern was raised that this clearly creates exemptions from the certificate of need process.

Comments were received that the two to three year ban on pediatric cardiac surgery certificates of need is too specific.

The Children's Hospital of New Jersey commented that the list of exclusive services to be provided by children's hospitals is far too short. The list of services restricted to children's hospitals should be expanded to include: major pediatric urologic surgery; major pediatric gastrointestinal surgery; major pediatric bone surgery; pediatric immunodeficiency care; major pediatric trauma care; major pediatric neurologic disease care; major pediatric gastrointestinal disease care; major pediatric metabolic and endocrine disease care; major pediatric cancer care; major pediatric renal disease care including hemodialysis; major pediatric ophthalmologic and otolaryngologic care; major pediatric reconstructive surgery; and pediatric intensive care.

Jersey City Medical Center recommended that the Plan clarify that the Specialty Acute Care Children's Hospital must share the availability of core sub-specialty services on a pro-rata basis.

RESPONSE: The Plan notes the legislative designation of two children's hospitals and calls for a study to determine the need for a third. The total scope and costs associated with these projects is not known. The Department will seek to insure that these develop as part of, and not contrary to, a coherent system of children's care. It is not clear how the costs associated with any children's hospital could be excepted from the legally imposed capital cap. The Department will closely review the need for pediatric cardiac surgery and other subspecialties as the structure of children's services evolve.

The Department appreciates that a specialty acute care hospital should offer a comprehensive list of pediatric subspecialty services, most of which should only be available at these centers. There is a need to conduct a more detailed review of this issue using the expertise of a special pediatric clinical task force. Therefore, the Department has revised the rule to delete specific clinical requirements for both specialty acute care and regional pediatric centers until such time that the pediatric clinical advisory group can be appointed and their work completed. Adopted N.J.A.C. 8:100-14.10 prohibits initiation of specified subspecialty services until the Commissioner has called for such applications in accordance with N.J.A.C. 8:33.

Comprehensive pediatric rehabilitation services will be addressed in Phase 2 of the State Health Plan. These will be contained in subchapter 17, Comprehensive Rehabilitation to be proposed in 1993.

N.J.A.C. 8:100-14.15 has been deleted and revised as new N.J.A.C. 8:100-14.10. Many of the concerns expressed about the proposal are addressed in the final rule where specific service configurations have been deleted. A pediatric clinical advisory group will be convened to develop such guidelines and pediatric planning rules will be proposed at a later date.

N.J.A.C. 8:100-14.16 Regional pediatric centers

COMMENTS: Englewood Hospital commented that it is inconsistent to recommend Hackensack Medical Center as a regional pediatric center without requiring that they provide regional coordinative responsibilities. Englewood and Valley Hospitals, which also provide an array of pediatric sub-specialties, stated their belief that they should be given an equal opportunity to compete for this designation.

University Health System of New Jersey expressed its support for the designation of Hackensack Medical Center and Atlantic City Medical Center—City Division as Regional Pediatric Centers.

RESPONSE: Regional Pediatric Centers are to have regional responsibilities under the proposed rules based upon written agreements between these hospitals and community and specialty acute care hospitals, in accordance with the regional plan devised by the Maternal and Child Health Consortia (MCHC). The State Health Plan permits Hackensack and other hospitals who are identified to apply for Regional Pediatric Designation; it does not assure approval, as this presumes the support of the MCHC, LAB and the Commissioner. Pediatric planning regulations must first be devised and adopted, which will contain much more specific criteria than currently contained in the State Health Plan. Based upon current assessment of utilization and services at Hackensack, it is the Department's assessment that it is best situated at this time to qualify for regional designation in its area. No change is made to the rule.

The Department acknowledges the support of University Health Systems for specific recommendations.

The hospital-specific recommendations are recodified to N.J.A.C. 8:100-14.13 in order to consolidate all rules related to specific institutions in a single section.

N.J.A.C. 8:100-14.17 Community Pediatric Centers

COMMENTS: The Medical Society stated that the pediatric designation system will dampen primary care recruitment, training and practice throughout the State adding that pediatricians are not the only providers of pediatric care; family physicians can, and should, care for children. They suggested that the designation process should await the development and review of the primary care chapter of the State Health Plan and asserted that the sole authority to make designations is improperly left with the administration (see N.J.A.C. 8:100-14.17(a)).

Pascack Valley Hospital asked that N.J.A.C. 8:100-14.17 be amended so that hospitals with at least 1,000 births, and preferably more than 1,250 births, be given priority for a Pediatric service. Also, they suggested that the designation as a Community Pediatric Center should include consideration of the relationship of a hospital's emergency room to the primary care network in the area. At N.J.A.C. 8:100-14.17(b)1i, it was recommended that hospitals with greater than 20 pediatric beds be allowed to reduce this number in order to meet target occupancy rates.

RESPONSE: A high quality system of pediatrics can only help such recruitment. The Medical Society correctly states that many providers, including family practitioners, care for children. The Department agrees that all sorts of primary care providers need development and encouragement. The Department appreciates the help of the Medical Society in developing the forthcoming primary care subchapter.

The Department acknowledges the comment from Pascack Valley and concurs that the suggestions be considered by the task force to be

convened for development of pediatric planning regulations as well as by MCHC's.

N.J.A.C. 8:100-14.18 Pediatric bed need

COMMENTS: Commenters suggested that closure of pediatric units or bed reductions should be based upon an evaluation of occupancy (including same day surgery), services provided by the institution to the pediatric community, existing referral patterns, and geographic and transportation access factors. It was recommended that the Department rely on UB-82 data rather than the SHARE data when measuring inpatient pediatric utilization. It was suggested that the latter data source was less reliable.

One commenter asserted that since the publication of the list of pediatric closures, there has been a change in referral patterns to increase volume at units proposed for closure. This activity is skewing utilization rates of historically better utilized area hospitals to historically under-utilized facilities.

The Medical Society again stated the opinion that findings of bed need do not belong in regulations.

Several commenters stated that since pediatric admission patterns have strong seasonal peaks and troughs, a more conservative occupancy target of 65 percent to 70 percent is advisable.

RESPONSE: These factors have been taken into account by the State Health Planning Board and the Department. Geographic access was a key consideration of the State Health Planning Board when it greatly modified the pediatric recommendations. While it is reviewing UB-82 data, such data addresses admissions of children to any part of a hospital. The Plan's recommendations are aimed at pediatric inpatient visits.

The Department is not considering 1992 data for purposes of this rule as it has not been edited to date and it reflects only one quarter of utilization—subsequent to issuance of the State Health Plan. Therefore, precipitous changes in utilization will not impact on the recommendations.

In response to the last two comments in this section, the finding of bed need is an integral part of the State Health Plan which is a regulation by law. Also, the Department believes that seasonal variations are addressed adequately by the use of a 75 percent occupancy rate.

N.J.A.C. 8:100-14.19 Maternal and Child Health Consortia—pediatric designations

COMMENTS: Numerous comments were received regarding the recommended closures and downsizing of certain inpatient pediatric units. Comments were received regarding pediatric units at the following specific hospitals: Bayshore Community Hospital, Bridgeton Division of South Jersey Hospital System, Clara Maass Medical Center, Helene Fuld Medical Center, Meadowlands Hospital, Mountainside Hospital, Pascack Valley Hospital, Rahway Hospital, Rancocas Hospital, St. Francis-Jersey City, St. Mary's Hospital in Hoboken, Stratford Division of Kennedy Memorial Hospitals; Underwood Hospital. All of the comments received were in opposition to the proposed closures and/or downsizing of pediatric bed units. Various interests were expressed, including: the need to maintain family practice residencies, the rotation of medical students through pediatric units and clinics, the need to maintain emergency rooms and intensive care beds, the ability of community hospitals to more appropriately care for the less-serious acute illnesses, convenience for family members (especially in poor neighborhoods) and the need to have nearby support systems for patients.

In the case of St. Mary's, it was stated that a pediatrics unit was critical to the hospital's Family Practice Residency Program, and that the unit provided access to local residents. Regarding the pediatric unit at Bayonne, the argument was made that the city of Bayonne is geographically isolated and the closure of this unit would create access problems for its community.

Atlantic City Medical Center stated that the Department should have included utilization statistics for 1991 in preparing its recommendations, and comments that if this had been done, the Center's 14 percent increase in pediatric admissions for 1991 would have been reflected.

Numerous statements were made regarding the need to maintain pediatric units in order to support the training of Family Practice physicians, of which there is a great need in this State.

Regarding N.J.A.C. 8:100-14.19(a), it was suggested by the Medical Society that the Public Health Council of the Medical Society of New Jersey, or another voluntary panel of experts, could offer its services to issue a report, in a uniform format, on each challenged proposal following a review of data and arguments.

RESPONSE: The hospital-specific recommendations are recodified to N.J.A.C. 8:100-14.13 in order to consolidate all rules related to specific institutions in a single section.

Based upon analysis of these public comments as well as supplemental information received from the affected hospitals and communities, the following changes to specific pediatric designation recommendations are made or will be proposed as amendments to this rule in the near future. The proposed recommendations for the elimination of pediatric units at Pascack Valley, St. Francis, St. Mary's, Clara Maas, Rahway, Helene Fuld, Rancocas, Kennedy-Stratford Division, South Jersey-Bridgeton Division and Underwood Memorial were not adopted.

N.J.A.C. 8:100-14.13(b)2i(6) will be proposed to permit Pascack Valley Hospital to apply for designation as a community pediatric center following reduction of bed capacity from 24 to 14.

N.J.A.C. 8:100-14.13(b)2ii(5) is amended permitting Meadowlands Hospital, as an alternative to closure, to consolidate the pediatric service at a single site with another area hospital. In addition, language recommending a bed increase for OB/GYN services is amended to clarify the implied requirement that occupancy thresholds of the Hospital Policy Manual must be met as a prerequisite.

N.J.A.C. 8:100-14.13(b)2ii(6) and (7) will be proposed to permit a consolidation of the two services of St. Francis Medical Center and St. Mary's Hospital, part of the Franciscan Health Care System at a single site and designation of a single program as a community pediatric center.

N.J.A.C. 8:100-14.13(b)3i(1) will be amended to permit Clara Maass Medical Center to reduce bed capacity or consolidate its service with an area hospital at one site, and apply for designation as a Community Pediatric Center.

N.J.A.C. 8:100-14.13(b)i(12) is amended to clarify that United Hospitals is implementing an approved Certificate of Need for a children's hospital.

N.J.A.C. 8:100-14.13(b)3ii(4) will be amended to permit Rahway Hospital to apply for community pediatric center designation following a reduction of licensed bed capacity from 24 to 17 beds.

N.J.A.C. 8:100-14.13(b)4 is amended to require the LAB to broaden its study of acute care services at Mercer County hospitals to include recommendations for designation and distribution of pediatric and OB/GYN bed capacity. The specific recommendations to eliminate the pediatric unit at Helene Fuld and to reduce, eliminate, or consolidate obstetrical services at St. Francis Medical Center and Helene Fuld are not adopted, but amendments will be proposed to reflect the need for further local study of the issue. The LAB study must result in a recommendation to consolidate pediatric and OB/GYN services between the two hospitals.

N.J.A.C. 8:100-14.13(b)5i(2) will be proposed to allow Zurbrugg Memorial Hospital Rancocas Division to reduce its pediatric unit from 20 to 10 beds.

N.J.A.C. 8:100-14.13(b)5ii(2), with respect to Kennedy Memorial Hospitals-Stratford, will be proposed to reflect a reduction of its licensed pediatric unit from 20 to 10 beds.

N.J.A.C. 8:100-14.13(b)5iii(4) will be amended to permit the South Jersey Hospital System, Bridgeton Division to apply for community pediatric center designation following a reduction of its capacity from 24 to 10 beds.

N.J.A.C. 8:100-14.13(b)5iv(2) will be amended to permit Underwood Memorial Hospital to apply for community pediatric center designation following a reduction of its capacity from 28 to 10 beds.

The Department met with representatives of Atlantic City Medical Center to clarify discrepancies claimed in reported data and has resolved this issue.

Questions and Answers from the Public Hearings

Below is a summary of questions asked by Health Care Administration Board members of those who testified at the six public hearings, and the responses provided.

Q: What is the percentage of uncompensated care at Kimball Medical Center?

A: The speaker did not know, and DOH staff were asked to provide this information for the HCAB.

Q: Does Kimball Medical Center have a strategic business plan to address changes in technology and changes in community demographics?

A: The hospital is developing such a plan.

Q: What is the nearest hospital to Bayshore Community Hospital? How far away is it from the Shelter Program of the Women's Center at Monmouth County?

A: Riverview Medical Center is the nearest hospital. The distance was not known, however the speaker estimated that the cab fare would be about five times the fare to Bayshore Hospital.

Q: Does the shelter have a primary care agreement with the hospital to do preventive care or to treat illnesses before they become acute? What does the Shelter do for out-patient evaluation of a sick baby or child during the day?

A: One shelter representative responded that with a DYFS referral, the hospital will do a medical evaluation primarily for communicable diseases. There is no ongoing well-child care arrangement with the hospital. Episodic care is provided by pediatricians who are affiliated with the hospital.

The other shelter reported that they call on local pediatricians for primary care and rely on the hospital for acute care needs.

Q: Noting that occupancy rates at the Bayshore pediatric unit are low but there are many emergency room and outpatient visits, what does the hospital need over the next 10 years to take care of children?

A: The speaker disputes that occupancy rates are low stating that the 23 swing bed unit is 50 percent or more. Pediatrics is not a "heavy admission service" with antibiotics now available. The hospital is planning a pediatric urgent care walk-in center which will result in some admissions.

Q: (To the Director of Emergency Medicine) Who stabilizes children before transfer?

A: Either the emergency physician or the pediatrician on call depending on how unstable the child is. Most of the time it is the emergency physician, often with a telephone consultation with a pediatrician.

Q: (To pediatric nurse coordinator) What is the coverage in the pediatric unit over night? If there is a problem, who do you call? Is there a house physician, an emergency physician or do you call the pediatrician at home?

A: It depends on the circumstances. If the problem needs immediate attention, the house physician would be called. The pediatrician could be called at home.

Q: (To social services director) The data presented show 3,000 outpatient pediatric visits and 6,000 emergency room pediatric visits. Is there a pediatric clinic? Who staffs the clinic? How often is it scheduled? Are some of the emergency room visits for primary care? Where do Medicaid patients go when they need care?

A: The clinic is scheduled once a week for a couple of hours. It depends on the number of patients that come in. Some people seek primary care in the ER because they have no other place to go. Unless we change the whole health care system, people who lack a private physician will continue to seek care in the emergency room. The speaker doesn't think a state health plan will change that.

Q: The hearing officer urged Bayshore and other hospitals to submit the portion of their strategic plans that pertain to pediatrics so that the HCAB can gain an understanding of the institution's capabilities and plans for the future.

A: No response given.

Q: Does the Medical Center at Princeton recognize any problems with the health care system? Is a separatist approach the way they have addressed the problems?

A: Princeton does recognize problems with the current health care system.

Q: Is there evidence that teaching hospitals are more expensive than non-teaching hospitals?

A: One speaker stated that she believes that teaching hospitals are more expensive because of overhead and the additional services that are needed. Another speaker stated that she had no data to support or refute the statement.

Q: What is the operating budget and uncompensated care amount for the Medical Center at Princeton?

A: The operating budget is \$80 million and uncompensated care is \$2 million. \$6 million is contributed to the uncompensated care fund. It was reported by the speaker that the hospital takes care of all the indigent population in the service area.

Q: There has been some concern that small hospitals have economic difficulty keeping up with technology. Has South Amboy tried to affiliate with another hospital? What is the population of the hospital's service area?

A: That is something for the Board of Governors of South Amboy to explore to help it achieve its full potential. The hospital serves Sayreville with a population of 45 to 55 hundred and a large portion of Old Bridge with a population of about five thousand.

Q: What will South Amboy's financial situation be in 1993 when the settlement dollars are all paid?

A: The hospital projects a positive bottom line through 1992 and invites the board and LAB to contact the hospital for specific five-year financial projections.

Q: What is the origin of patients who use South Amboy's emergency room?

A: They come from South Amboy, Sayreville and Old Bridge and also some of the smaller surrounding towns. This data will be provided by the hospital for the Board to consider.

Q: To several hospitals with pediatric units recommended for closure, the Board asked whether they had met with the Department of Health to reconcile data issues and provide other relevant information about their delivery of pediatric services.

A: All hospitals responded that they had participated in meetings with the Department.

Q: Of representatives of RWJ Medical Center and St. Peter's Medical Center, the Board asked how many children are transferred to other facilities.

A: Very few pediatric patients, only about five, are transferred. Pediatric patients are not transferred to either Cooper or New York.

Q: How would a children's hospital without walls solve the shortage of pediatric beds that were described by representatives from RWJMC and St. Peter's without a new building?

A: Designation would enable them to apply for certificates of need to expand bed capacity.

Q: (To the Medical Director of the Children's Hospital of New Jersey) In his testimony, this witness recommended a maximum of six regional pediatric centers. How was the number derived? Is centralization rather than regionalization being proposed?

A: Based on experience from another larger state which has no intermediate regional centers but six children's hospitals, the state of New Jersey would not be able to support 14 hospitals with regionalized pediatric services (11 regional pediatric centers and three children's hospitals). With New Jersey's good transportation routes, six regional centers are adequate. To have 13 to 15 children's facilities each capable of doing everything is extremely wasteful of resources. Further, some of the Plan requirements for each of these facilities are impossible to fulfill at this time. One example is the requirement for a pediatric radiologist of whom there are fewer than 14 available in New Jersey now and unlikely to be available in the near future. Without all essential services in one location, the ability to deliver appropriate, efficient, cost effective, high quality comprehensive care to children with multiple problems can not be achieved.

To deliver cost effective, high quality pediatric care, services must be strategically located at a couple of locations, the essence of regionalization. However, a leap should not be made from perinatal/neonatal regionalization to pediatric regionalization without adequate study.

Q: (To a community hospital with a pediatric unit), how do pediatric services at community hospitals reconcile with The Children's Hospital's view of centralization of pediatric care? Why does a community hospital have so many subspecialists? If these services are centralized, wouldn't the community hospital be placed at a disadvantage?

A: At the community hospital, specialty care is referred to a regional center for complicated or problematic cases. At other times, these subspecialists come to the community hospital when needed to provide consultative services. Subspecialists serve as consultants to the community hospital but their main practices are at tertiary care centers.

Q: What is the average daily census in the pediatric unit at Saint Francis Hospital in Jersey City? Why has it increased? Does the hospital run a pediatric clinic?

A: On this day of the hearing there are 13 children. An increase of 50 percent over 1990 levels has been accomplished because more pediatricians have been admitting to the hospital. The hospital has a specialty clinic for overweight children. Otherwise, the emergency room is used as the clinic for primary care.

Q: Is there an OB clinic at Bayonne Hospital and how many obstetrical patients are seen there? How many births occur at the hospital and how much GYN surgery is done?

A: There is a HealthStart Program serving 125 mothers annually. There were 506 births in 1991. GYN surgery is done at the hospital but the amount of was unknown.

Q: (To a public health nurse from Bergenfield Health Department), clarify the key points of your testimony.

A: Community providers have a key role to provide in regionalized services. Non-hospital services such as child health conferences should remain in the community rather than be moved into hospital settings.

Q: What are the main concerns that the county has about Bergen Pines and the proposed State Health Plan? Is the county involved with the LAB? Is it the county's position that acute care services should be maintained at Bergen Pines at the present level?

A: The county did not have input in the recommendations put forth in the Plan and is concerned about how these recommendations will impact the county. In the long range plans for Bergen Pines, acute care is an integral part. The greater concern is that the county have input in any decisions that are made about the facility.

Q: How many pediatric beds does Meadowlands have; what is the daily census; and do they have outpatient services? What is the level of uncompensated care? What is the volume in the emergency room?

A: There are 26 licensed pediatric beds with a daily census ranging from seven to 14. In addition there are same day surgery cases. Because of space limitations, outpatient services are provided in conjunction with the emergency department with follow up visits in pediatricians' offices. It is estimated that there are around 2,300 pediatric visits to the emergency room annually. Of these, about 15 percent are admitted. The hospital serves a number of poor people with the level of uncompensated care being 14 to 15 percent. This hospital met with the Department and provided this and other information to staff.

Q: Would you go out of the area if your child was seriously ill and needed specialized care?

A: I would follow my doctor's advice.

Q: (To a pediatrician from Rahway Hospital) How many pediatric visits are there in the emergency room?

A: About 3,000 per year. We do not have a clinic, but we have 24 hour coverage by pediatricians. Every patient who does not have a pediatrician is referred to one of the attending pediatricians regardless of insurance status.

Q: (To a pediatrician from Clara Maass) Did you discuss data issues with the Department of Health? With these corrections, would the recommendation to close the unit change? Where have the additional admissions come from?

A: We have met with the Department. We think that with the data corrections, Clara Maass no longer meets the criteria for closure of the unit. We should also not be required to participate in the county bed need study. Additional admissions are coming from all over the area.

Q: (To a pediatrician from the Children's Hospital) Should all children be sent to the Children's Hospital? How many regional pediatric centers do we need in New Jersey?

A: No. There should be three levels of inpatient care for children. There should be a coordinated plan for patient management including triage, stabilization and transfer. The plan calls for nine to 11. That is too many, and may have a negative impact on care.

Q: (To Senator Smith) Is Zurbrugg Hospital attempting to recruit staff to reverse the low occupancy attributed to insufficient staff?

A: The hospital administrators have a plan to increase occupancy which involves an HMO. They have communicated this plan to the Department of Health. Copies will be provided to the HCAB.

Q: (To the medical staff from Zurbrugg Hospital) Senator Smith identified that there were staff shortages in critical areas. Your testimony indicated that you had no difficulty in obtaining highly trained, high quality staff. Please clarify.

A: The hospital has no difficulty obtaining medical staff. There were nursing shortages in the 12-bed ICU and CCU which prompted diverting patients to other facilities. Staffing availability decisions were made by Graduate Hospital at the corporate level.

Q: Did Rancocas Hospital meet with the Department regarding the pediatric unit?

A: Yes.

Q: (To a staff member from Kennedy Stratford). With the exception of the City of Camden, do any other pediatric units exist in the vicinity of Kennedy Stratford? Have you participated in any meetings or discussions with the Department about bed allocation? If so, has there been an agreement reached?

A: No there are no other units in the vicinity. Yes, Kennedy Stratford participated in one session with the Department. The discussion has been to downsize the unit to 10 beds but no agreement has been reached.

Q: (A question asked to a neonatologist). Are you in favor of regionalizing newborn care?

A: I am 100 percent for regionalization of newborn care but think that certain higher level technologies can be used successfully at the community level. Many mothers can be cared for in community centers.

Q: (To the president of the American Academy of Pediatrics in New Jersey). What percentage of your membership sees Medicaid patients? Is the resource-based relative value scale (RBRVS) a reasonable fee schedule?

A: Twenty-five percent see Medicaid patients. Yes RBRVS is reasonable.

Q: (To the NJ Hospital Association) Your testimony said that some recommendations in the State Health Plan would devastate a community. Can you give an example?

A: Washington Township would feel devastated by the loss of their obstetrical unit and the residents of Belleville are concerned about losing their pediatric unit.

Q: (To a hospital administrator with a pediatric unit that is to remain operational) Would travelling an extra 12 minutes to the next available pediatric unit put lives in danger?

A: These concerns have been engendered by newspaper reports that if a child were injured next door to a hospital without a pediatric unit that they would not be able to receive care. In reality, these children would have access to emergency care and be stabilized and transferred if necessary. Also, people are not aware of advances in pediatric medicine. Today children can receive medical care without having to stay overnight in a hospital.

Q: (To an administrator at South Jersey Hospital System) Are you saying that without a pediatric unit at the hospital the pediatricians in your area will move elsewhere?

A: It is hard to recruit pediatricians to South Jersey. They need to have access to the full range of services. They are not going to come to an area in which they have to travel 15 or 20 minutes to serve the children.

Q: (To a representative from the community health center in Bridgeton) How many pediatric admissions does the center supply to the hospital?

A: Four hundred a year.

Q: (To a pediatrician who works at the health center and has a private practice in the same area) How many children are admitted on behalf of the health center? They just stated about 400 were admitted. What types of diagnoses are common for children who are admitted?

A: The health center was probably referring to patient days, not admissions. Admission would be closer to 80-100 children per year. The hospital administrator concurred. The Pediatrician stated that he admitted about two children a week. Common diagnoses are seizure disorders, acute gastroenteritis, dehydration.

Q: (This question was asked of several witnesses) Were you aware of the public hearings held by the State Health Planning Board?

A: Some witnesses were aware and had testified. Others were aware, but had not testified. Still others were unaware that public hearings had been held.

Subchapter 15. High Technology Services

COMMENTS: One commenter supported the extension of Certificate of Need regulation to physicians so that the proliferation of expensive equipment can develop in a planned environment.

A radiologist objected as an owner of an MRI unit, to his need to obtain a Certificate of Need whereas "other non-radiologists are not required a Certificate of Need for any imaging modality, i.e., x-ray, ultrasound, CT and MRI as well as Positron Emission." This radiologist stated that overutilization of radiologic procedures can be contained through amendatory language that restricts ownership of radiographic equipment to that totally owned by radiologists or equipment located within the physical plant of accredited hospitals. An additional provision proposed by this commenter would eliminate the possibility of any investor-owned laboratory or facility and exclude any provision for grandfathering such facilities. As a result of these proposed amendments, the commenter feels, the practice of radiology would be put back in the hands of the radiologist.

The Department of Human Services supported limiting the establishment of high-cost technology where sufficient capacity exists.

The Radiological Society of New Jersey wrote that the Department of Health should support legislative measures to prohibit the practice of self-referral of patients by physicians who derive financial benefit from the health care services to which they refer.

The Medical Society of New Jersey called the subchapter "extremely disturbing," particularly with regard to the plan's recommendations for

regulatory control. The Society made several comments and suggestions: (1) the plan should provide a "benefit-cost" analysis of all proposed new regulatory programs; (2) the emphasis on the cost of high-technology in the plan is disproportionate to its actual impact on hospital costs; and (3) the Department should be required to provide a plan for performing the various regulatory tasks proposed in the chapter.

A hospital commented that the moratorium on the development of high technology services in the State was undertaken without a serious look at the issues that are now negatively impacting volume at existing "high technology" services.

The New Jersey Hospital Association provided comment based upon a report completed by McManis Associates, Inc. Among the major points included in this report, apart from the preferential treatment of the core hospitals of the state medical school issue addressed below, is the questionable definition of high technology in the Plan. The consultants asked whether the Department means high cost technology, experimental technology, or proven technology? The NJHA report also states that the plan does not accurately address supply; the plan incorrectly equates capacity with need. In addition, the plan does not structure the payment system to reward efficient and effective providers of high-technology services.

The New Jersey State Nurses Association (NJSNA) suggests that a set of criteria and an RFP process should be established prior to the consideration of new technology pilot projects. NJSNA emphasizes that geographic and financial factors should guide access considerations "in order to best serve vulnerable populations."

The New Jersey Public Policy Research Institute and the Committee for the State of Black Health raised concern that a Statewide policy of not adding high technology resources fails to address the lack of access that currently exists for minority and poor population groups. The commenter also states that the Plan does not go far enough in ensuring appropriate levels of education about organ and tissue donation and transplantation issues among the African-American population.

The Region One LAB expressed concern that the proposed recommendations would result in an inequitable distribution of advanced technological services that would require residents in rural portions of the State to travel inordinate distances for services that could be provided more efficiently and effectively in community hospitals.

RESPONSE: A growing body of research demonstrates that the dispersion of costly technology without planning is the single issue most responsible for increased health care costs during the last decade.

The Department is in accord with the Radiological Society regarding support of legislative efforts to prohibit the practice of self-referral and may support such a legislative initiative provided the legislation, if proposed, is appropriately drafted. The Health Care Cost Reduction Act (P.L. 1991, c. 187) does require disclosure of a referring physician's financial interest to patients, with some exceptions. The Plan includes a recommendation at N.J.A.C. 8:100-15.2(c) that calls for an appropriateness review of physician and non-physician investor MRI services in recognition of the potential abuse that is present due to self-referral.

The Department also agrees with the commenter regarding the extension of certificate of need authority to physicians in certain instances, as permitted under the provisions of the Health Care Cost Reduction Act (P.L. 1991, c. 187).

The Department does not agree with the radiologist's view that investor-owned radiologic equipment is exempt from certificate of need review.

The high technology subchapter essentially focuses on health care services of relatively recent origin that have had a significant impact on the cost and quality of health care service delivery. The subchapter acknowledged the fact that high technology exists throughout the health care delivery system, and therefore focused its attention largely on those services identified by the Prospective Payment Assessment Commission (PROPAC) as influencing the future cost of health care. The subchapter is also careful to cite specific technologies that are included in other subchapters of the State Health Plan in an effort to avoid duplication.

The subchapter assesses need separately for each technology, and does not necessarily equate underused capacity with an absence of need. For example, the underutilization of transplantation services may be attributed to a number of factors including, but not limited to, the availability of donated organs or insurance coverage policies. The presence of 80 MRI units in the State, for example, exceeds by a considerable margin New Jersey's current need methodology as well as any other need methodology appearing in the literature. The need for kidney lithotripsy had been established during the demonstration process that introduced

the technology to the State in 1987. That demonstration was extended to a third site in order to assure sufficient resources in the event that the incidence rate of kidney stones reached the highest possible level (two cases per thousand). That level of incidence has not materialized and the statewide data gives no indication that it will in the distant future. The chapter also acknowledges that need for transplantation services and PET scanning should be examined by panels of clinical and planning experts.

The radiologist's suggestion for amendments to the rules is unnecessary because, regardless of ownership, there are sufficient resources in the State of New Jersey.

As far as the subchapter's emphasis on State regulatory activity of new technology is concerned, the recommendations do not propose any more regulation than currently exists in New Jersey. In fact, by deregulating CT services one can argue that it is less regulatory toward the health care facility portion of the industry. As far as extending regulatory activity to providers who have been excluded in the past, the subchapter implements the legislative changes contained in the Health Care Cost Reduction Act.

The need to establish Statewide high technology dissemination policy that ensures equal access by all New Jersey residents appears throughout this section of the Plan. The recommendations contained in the subchapter regarding transplantation services clearly emphasize the need to improve organ donation. N.J.A.C. 8:100-15.4(f) states that "all New Jersey residents . . . shall be ensured access to a qualified transplant center without regard to ability to pay, race, or any other nonmedical factors." It should also be emphasized that while New Jersey's organ donation rates are low for all population groups, minority access to transplanted organs at New Jersey transplant centers is well above national figures.

The concern over inequitable distribution of technological services expressed by the LAB commenter and the NJSNA is shared by the Department.

Geographic distribution of emerging technology has always been and will continue to be a key element in the State's resource allocation policies. A technology that has already been shown to be more "effectively and efficiently provided in community hospitals" as proposed by the LAB, is a technology that by definition has advanced well beyond the introductory stage. In short, it is a technology that would have advanced to the point where the question would focus on the need to regionalize the service at all.

The Department is required to provide an Economic Impact statement with every proposed rulemaking, in accordance with N.J.S.A. 52:14B-1 et seq., the Administrative Procedure Act, and N.J.A.C. 1:30, Agency Rulemaking. It is inappropriate and unnecessary to include such a requirement in N.J.A.C. 8:100. The Department is obligated to consider all factors affecting health care cost, including the cost of high technology equipment. The Department considers the inclusion of a plan of implementation of rules as overregulatory, and would prefer to consult with the regulated community regarding the appropriate implementation of the rules.

COMMENTS: Concern was expressed that the plan does not place a high value on maintaining and developing leading-edge technology within New Jersey, and that not enough was being done to discourage out-migration to New York and Philadelphia.

One commenter noted that through the granting of preference (in disseminating new technologies) to UMDNJ-affiliated programs the plan would increase out-of-state referrals by limiting patient and physician options.

RESPONSE: There is a general misconception that New York and Philadelphia provide numerous services and technologies that are available in New Jersey. In fact, few such services and technologies that are available in these neighboring out-of-state hospitals are unavailable in New Jersey. The misconception is fueled by the recognition that thousands of New Jersey residents seek their care in New York City and Philadelphia health care institutions. This outmigration, which has decreased in recent years, is caused by numerous factors. Such factors as patient preference, physician referral practices which are often shaped by physician allegiance to his or her training site, proximity to the worksite, and perceptions about the quality of New Jersey services appear to contribute to outmigration far more than the unavailability of a service or technology within New Jersey.

The Department has supported the introduction of services and technologies in the State whenever sufficient need has been demonstrated. The high technology subchapter calls for a thorough evaluation of the

need for several specific types of services that currently are unavailable in New Jersey. The availability of these services will be closely examined by clinical and planning experts to determine whether there is sufficient need to provide these services in-state. The cost of providing these services in New Jersey must be weighed against the need to provide these services and the capacity to provide them in sufficient volume to ensure quality.

It should also be emphasized that the few services unavailable in New Jersey are not present in a large number of other states because of the limited need. With this fact in mind, New Jersey's close proximity to New York City and Philadelphia medical research and teaching institutions can be viewed in a positive light. As a result of the State's geographic location, New Jersey residents are afforded health care choices that are second to none.

N.J.A.C. 8:100-15.1 High technology process development

COMMENTS: The University of Medicine and Dentistry of New Jersey (UMDNJ) agreed with the recommendation to establish a core clinical advisory group on new technology assessment. However, they felt that this group should not focus on the distribution of existing modalities but, rather, no looking to the future and anticipating new breakthroughs.

The medical school disagreed with bringing in out-of-State experts to serve on the advisory group and offered that UMDNJ can provide from with its school many clinicians and scientists whose input would be extremely valuable. There was also opposition expressed to an implicit assumption that not all state-of-the-art treatment modalities need to be available within New Jersey, since access to services for the State's middle class, poor, and minority residents would be seriously compromised.

The Radiological Society of New Jersey (RSNJ) stated that a representative of the RSNJ should have a permanent position on the core clinical advisory committee, since a major component of new high technology equipment has been diagnostic imaging.

Princeton Public Affairs Group stated that the core clinical advisory group should focus on utilization and not availability and that there should be representation from payers, providers, health care economists, legislators, and regulatory staff.

RESPONSE: Evaluation of health care technology must not only consider the emergence of new technology, but the necessity to contain the cost of technologies that no longer represent state-of-the-art clinical practice. It is essential to monitor the clinical applications of existing technology in order to determine the need to continue or discontinue regulatory activity for the modality. Clinical input into all of these technology-related issues will be sought by the Department in an effort to keep pace with technological change. Requests by specific professional groups such as the RSNJ for permanent representation on the core clinical advisory group are premature.

The Department is well aware of the clinical and research expertise that is available within the State's medical school and anticipates utilizing that expertise, as it has in the past, in being responsive to the technological needs of the health care system and the residents of the state. However, out-of-state expertise will also be sought to encourage objectivity. Representation on the core clinical advisory group will be broadly based in order to provide the Department with informed public policy recommendations.

The Department is concerned about the issue of equal access to state-of-the-art health care services, has historically championed this issue throughout all of its regulatory activities, and will continue to do so.

COMMENTS: Support by University-affiliated commenters was given for the granting of preference to major teaching hospitals of the University of Medicine and Dentistry of New Jersey (UMDNJ) in the development and/or receipt of new technologies. Support for this position was made by Dean Edelman in terms of providing quality of care, enabling the aggregation of a critical mass of technology, medical education and physician training, the development of academic health centers, and the support of research. Dean Humphrey stated that medical academicians would be more likely to be objective in assessing new technologies and less likely to be influenced by personal financial gain.

The President of the Medical School, Stanley S. Bergen, Jr., M.D., suggested that the current language referring to "core" teaching hospitals is changed to read "major teaching affiliated" hospitals of the University of Medicine and Dentistry of New Jersey. This sentiment was echoed by a number of commenters, including representatives of hospitals comprising the University Health System of New Jersey. Dr. Bergen subsequently proposed the deletion of the existing paragraph at N.J.A.C.

8:100-15.1(a)3 and the substitution of language stating that the clinical advisory group will utilize the expertise of UMDNJ in the evaluation of new technology.

A number of hospitals objected to the granting of preference to the core teaching hospitals and/or major teaching affiliates of UMDNJ in the dissemination of new technologies. Mr. Bornstein, of Newark Beth Israel Medical Center, was concerned with the implications that the proposed preferential treatment would have on future recruitment of physicians at non-affiliated teaching hospitals. An inner-city hospital's ability to attract suburban-based physicians, it was noted, is largely dependent on its tertiary care and high technology services. St. Joseph's noted the hardships that would be faced by inner city patients in seeking transportation to new technology at core hospitals. One of the reasons stated for opposition to the current language was that a policy of concentrating technology and services in the teaching hospitals represented the most expensive arena for medical care. Another commenter stated that hospitals should be allowed to compete for new services and equipment based on their qualifications and their communities' needs. It was also noted that other hospitals, while not considered core teaching hospitals or major affiliates of UMDNJ, were affiliated with other medical schools. Their provision of medical education would be negatively impacted if the core teaching hospitals and/or major teaching affiliates of UMDNJ received preference in acquiring new technologies.

Other hospitals, commenting in opposition to the preference issue, emphasized the possibility of technological breakthroughs that would be more appropriate in ambulatory settings that would perhaps favor community rather than tertiary care placement of technology. The NJHA stated in the absence of a comprehensive vision of the role of the state medical school, awarding priority for high technology to the core teaching hospitals lacked justification within the Plan. The LAB Region One stated that preference to the core teaching hospitals of the medical school was appropriate for the initial demonstration phase of technology assessment, but provision should be made for subsequent dissemination to the community hospitals.

Atlantic Health Systems, Inc., stated that the preferential language was an example of "how the plan ignores what is happening to health care delivery in other states."

The Mid-Atlantic Stone Center, citing its own role in the initiation of Extra Corporeal Shock Wave Lithotripsy services in New Jersey, joined opponents of the existing language regarding preference to the core teaching hospitals and urged its removal.

RESPONSE: The intent of the proposed language was to ensure optimal dissemination of state-of-the-art diagnostic and treatment services by explicitly assuring the role of the clinical campuses of the State's medical school in the resource allocation process. There was no intention to imply that the role of medical education in the State was the sole province of the "core teaching hospitals." Many fine hospitals in the State provide excellent teaching opportunities for residents and fellows that are not affiliated with the State's medical school. To insure equal access to high technology opportunities among all hospitals in the state, N.J.A.C. 8:100-15.1(a)3 has been deleted in the final rule.

N.J.A.C. 8:100-15.2 Magnetic Resonance Imaging (MRI) Services and Resource Allocation Policy

COMMENTS: The Radiological Society of New Jersey made three recommendations with regard to the regulation of MRI services. The Department should not restrict MRI services in New Jersey that do not have certificate of need approval from Medicare and Medicaid certification and reimbursement. The Department should not impose a licensure requirement on all existing MRI services in New Jersey. A certificate of need application should not be required to be submitted by all existing MRI services in New Jersey seeking to replace their MRI equipment, regardless of whether the MRI has certificate of need approval.

The University of Medicine and Dentistry of New Jersey and The New Jersey Hospital Association believe that MRI, like CT, should be deregulated.

An attorney representing several MRI providers in the State recommended the deletion of N.J.A.C. 8:100-15.2 because it overreaches the legislative intent of the Health Care Cost Reduction Act (HCCRA). The requirement that MRI services be required to submit a certificate of need for equipment replacement, it was argued, is tremendously onerous, unfair, inequitable, and contrary to the grandfathering provisions of the HCCRA.

Princeton Public Affairs Group (representing General Electric) stated that the intent of the legislation was to focus attention on new equipment and not on replacement equipment. If that had been their intent, the legislature would have included specific language to that effect. This same commenter suggested that any DOH review of MRI utilization should include whether the technology used is considered appropriate by the (insurance) carrier, the physician, and the patient.

One hospital commenter took issue with the imposition of a moratorium on new MRI programs and stated that more MRI units should be located in hospitals. This commenter provided a position paper on MRI services which opposed the emphasis on ambulatory MRI settings.

RESPONSE: The first two comments from the Radiological Society regarding MRI services were directed at elements that were not included in the final recommendations that were published in the New Jersey Register and are no longer at issue.

The requirement for a certificate of need application prior to the replacement of MRI equipment by all existing MRI providers is required by the Health Care Cost Reduction Act. All regulated health care services are subject to the same type of requirement.

It is the Department's view that it is premature to consider the deregulation of MRI services, since the clinical applications for this modality have not been completely determined.

The Department views the existence of at least 80 MRI units as far more MRI resources than are needed by the residents of the State, because the capacity of the equipment greatly exceeds the number of patients who currently require such services, based on available utilization data. The provision of MRI services remains a predominantly outpatient service.

Data available to the Department indicate that the vast majority of MRI services provided in New Jersey (75 percent) are being provided on an ambulatory basis. There has been little evidence that inpatient access to MRI services has been a problem in this State.

N.J.A.C. 8:100-15.3 Computerized Tomography (CT) Services and Resource Allocation Policy

COMMENTS: Three commenters supported the deregulation of CT scanner services, with appropriate reimbursement.

RESPONSE: The Department's view is that CT is being appropriately reimbursed and that the widespread clinical utility of CT permits the deregulation of this service.

N.J.A.C. 8:100-15.4 Transplantation Services and Resource Allocation Policy

COMMENTS: Commenters representing the medical school felt that the problem of organ procurement in this State is not due to a lack of donors, but rather, a lack of high quality transplant centers. There is a need for a responsible, progressive transplantation policy in New Jersey. Further, it was expressed that new Certificates of Need for transplantation programs should be given to the core teaching hospitals of UMDNJ.

One commenter stated that, except for kidney transplantation, a short moratorium on transplantation is appropriate. Regarding bone marrow transplantation, one commenter noted that the best interests of the citizens of the State would not be served by a continued moratorium of these services.

Several commenters felt that there were barriers to the provision of renal transplantation in New Jersey. It was noted that the subchapter's constrictor of transplantation services was in contradiction to the Cardiovascular Disease chapter's recognition of renal transplantation as the most cost effective treatment of end-stage renal disease.

There was general support, with one exception, for the formation of a transplantation task force. The dissenting opinion from the Sharing Network, stated that there already existed a task force in New Jersey as well as an advisory council on organ transplantation and that the formation of a new one would waste valuable time. Concerns were expressed regarding the over-reliance on out-of-State experts balanced against the need to safeguard against conflicts of interest. It was suggested that the task force not only address the obvious and "known" major causes of end-stage renal disease (ESRD), such as diabetes and hypertension, but also AIDS and drug abuse as contributing factors in the increasing rate of ESRD in urban areas.

One commenter noted that potential transplant recipients in New Jersey will be at a marked disadvantage if they have to rely on neighboring states which give lower priority to those who live farther away from

the transplant centers. The cost of going to another state for a transplant is high and may result in discrimination against those who are less able to afford such costs.

The NJHA consultant report agreed that organ transplantation is not a single state issue and the State should look to shared resources in adjacent states. They also commented that the issue of unlimited access to health care has not been adequately addressed. The State must begin to address a balance between: the enormous costs of single procedures for individuals; the increased near-term costs of funding prevention; and the limited public resources for health care services.

One transplant physician suggested amendments at N.J.A.C. 8:100-15.4(c) that would provide for consideration of new transplant programs under the "strictest of scrutiny." This language would be intended to avoid indefinite delays in establishing new programs that would place such potential new programs at a competitive disadvantage with new programs in neighboring states. Alternative language is also suggested by this commenter at N.J.A.C. 8:100-15.4(g) recommending State exploration of "alternative methods of providing appropriate medical care to these individuals on a case by case basis." The commenter closes with the hope that the State avert a situation that has occurred in Illinois, where deregulation of transplant services has resulted in multiple transplant sites performing small numbers of transplants with Federal designation of one heart transplant program being rescinded because of poor survival statistics.

Hackensack Medical Center proposed that the Department consider a competitive demonstration process for bone marrow transplant services, with all centers meeting quality and volume standards at the end of the demonstration permitted to continue providing services. Such a process, it is argued, would have the added benefit of incorporating physician preference.

RESPONSE: It must be emphasized that one of the principal barriers to the initiation of new or additional transplantation programs in New Jersey is the relatively low organ donation rate in the State. The addition of transplant programs without a concerted effort to improve statewide organ procurement will only result in the performance of fewer numbers of transplant procedures at a greater number of sites. With New Jersey transplant programs already functioning well below capacity levels, the end result would be greater costs to the system and the possible diminution in overall quality performance levels because transplant surgeons will be unable to perform sufficient procedures to maintain surgical skills. Testimony from the single heart transplant program in the State, for example, indicated that twice as many heart transplants could be performed if sufficient organs were available.

There is also a misperception that the transplantation section of the subchapter calls for the constriction of transplantation in New Jersey. One emphasis of the transplantation section of the plan is to support the existing transplantation programs in the state and to call attention to the need to improve the state's organ procurement process. The subchapter also calls for an overall assessment of future transplant service needs in the State.

The Department has established many clinical advisory bodies in the past to provide technical assistance in the development of Statewide policy. Often these groups have included out-of-State expertise in order to encourage objectivity. An appropriate level of in-State expertise will also be present on the proposed transplantation task force; however, the need to include outside experts for objectivity purposes precluded the use of existing committees alone. This task force should consider the issues of access, shared resources and evaluation in its deliberations.

The suggestion of a competitive demonstration process that would permit any potential bone marrow transplant provider to initiate the service and subsequently evaluate each program at the conclusion of the process not only invites further proliferation, but abrogates the Department's responsibilities in assuring patient safety and quality care.

N.J.A.C. 8:100-15.5 Extracorporeal Shock Wave Kidney and Biliary Lithotripsy (ESWL and ESWBL) Services and Resource Allocation Policy

COMMENTS: The New Jersey Hospital Association commented that the ESWL need methodology does not reflect any unique demographic characteristics of New Jersey. Even under the proposed methodology, the expected number of cases can exceed the current calculated capacity. The plan equates ESWL with ESWBL and addresses them together; these services are not the same.

UMDNJ concurred with statements in the Plan which stated that, at the present time, the need for extra-corporeal lithotripsy services in the

State has been satisfied. The requirement to have free-standing facilities obtain Certificates of Need will eliminate potential duplication of lithotripsy services.

RESPONSE: It was not the intent to equate ESWL and ESWBL. The two have been linked in the past because of the capability of some lithotripsy equipment to perform treatment for both kidney and biliary stones. For a brief period of time during the development and evaluation of ESWBL equipment, consideration was given by the Department to an expansion of lithotripsy sites due to the potential need for biliary (gallstone) lithotripsy treatment. However, the introduction and rapid clinical acceptance of laparoscopic cholecystectomy, combined with difficulties surrounding ESWBL (for example, complication rates, success rates), has virtually eliminated the need for ESWBL.

The potential need for kidney lithotripsy beyond the present capabilities of the existing three providers is exceedingly remote. This range of possible kidney lithotripsy patients is based on a "worst case scenario" of two cases per thousand that has not been the experience in New Jersey. ESWL data indicate that kidney lithotripsy treatment levels peaked in 1989 (3,299 cases) and have declined by more than 10 (10.3) percent in the past two years. The Department is therefore confident that there is sufficient ESWL capacity well into the future.

N.J.A.C. 8:100-15.6 Interim Statewide Policies—Mobile High Technology Health Care Services

COMMENTS: One hospital encouraged the Department to develop policies which facilitate the use of mobile high technology services as a cost effective way of increasing service accessibility. Jersey Coast Health Planning Council, Inc. (LAB Region VI) indicated that it would be examining the feasibility of mobile versus fixed services in its region because of geography.

RESPONSE: While the Department will be examining this issue in the future, it will do so on a technology by technology basis. Caution is particularly necessary in dealing with high technology services that involve invasive procedures, because of the need to carefully evaluate the quality of service implications that may arise in providing the service in a mobile rather than a fixed setting.

N.J.A.C. 8:100-15.7 Positron Emission Tomography (PET) Scanning Services and Resource Allocation Policy

COMMENTS: UMDNJ commented that, historically, New Jersey has trailed other states in the development of new imaging modalities such as CT, MRI, and PET scanning. The "core clinical advisory group" should define the mechanism for evaluating emerging technologies, including PET and other imaging modalities, within New Jersey's academic health centers.

The NJHA agreed with the plan's proposal to have the core clinical advisory group develop demonstration parameters for PET scanning within the next year.

RESPONSE: It is the Department's intention to work with the core clinical advisory group, once it is established, to define the evaluative mechanisms for future emerging technologies.

Questions and Answers from the Public Hearings

Below is a summary of questions asked by Health Care Administration Board members of those who testified at the six public hearings, and the responses provided.

Q: What is the one transplant program in the State that has national recognition?

A: The adult liver transplantation program at UMDNJ was cited by one speaker.

Q: Has the University ever been turned down for any other transplant programs?

A: Yes. Kidney and bone marrow programs were denied. University Hospital is the only university affiliate with a transplantation program.

Q: Would the University advocate relocating transplantation programs from other sites to the University hospitals?

A: No. If they are successful and meet the criteria, they should continue.

Q: (To University Hospital representative) Please define "University affiliated hospitals" and "High Technology."

A: Hospitals with residency programs integrated with UMDNJ are considered affiliated hospitals. It is important for the people of New Jersey to understand that when reimbursement dollars go to hospitals affiliated with medical schools from other states, New Jersey residents

are supporting out-of-state medical education. High technology is hard to define. It means a new technique. The State defines it as something to be regulated.

Q: (To the representative of University Health Systems) Do you agree with a previous testimony that called for restricting transplantation to University-based hospitals?

A: Transplantation should not necessarily be restricted to University-based hospitals. UMDNJ has teaching affiliations with over 67 hospitals in the state. There should be a collaborative effort to determine the best allocation, and the University and the Department of Health should be included in that partnership.

Q: (To representative of the Radiological Society) You object to physicians having to get a Certificate of Need for replacement of an MRI. How do you rationalize that hospitals should get a CN for replacement, but not physicians?

A: Hospitals and physicians do not have to be on a level playing field. However, hospitals should not have to get a CN for replacement MRI either. There are several sites out there that have first generation MRIs and are not able to compete with more advanced equipment. They need to upgrade that equipment and should not have to get a CN to do so. The problem is that the proposed CN rules say that no new CNs can be granted within a 30 minute drive of one another. That is somewhat arbitrary.

Q: The plan proposes that core teaching hospitals of UMDNJ be given preference in the acquisition of new technologies. How will hospitals not affiliated with UMDNJ get high technology equipment and expertise?

A: The citizens of the State have invested a great deal in our health services universities and these institutions should be assured first access to new technologies, including transplantation. Affiliates of other teaching institutions should also be able to acquire new technologies if there is a need. Teaching institutions have an obligation to share those technologies with other institutions.

Q: (To the dean of the New Jersey Medical School and a representative of University Hospital) If preference were given to UMDNJ, how would other teaching hospitals get access to high technology resources and services that are required to maintain their teaching programs? Do those teaching hospitals gain access to this technology by becoming affiliated with UMDNJ?

A: Yes. UMDNJ Medical School would like to have more teaching hospitals affiliated. In some form or another, interaction between the hospitals and the medical school is important. The medical school should reach out to those hospitals. When a needs assessment determines that more than one unit is needed in the state, those should be in an affiliated facility. We are not advocating a monopoly on high tech services. Those decisions should be made by the planning process, not the university. This type of needs assessment has been tried in some other states. It was clarified that there are three medical schools in New Jersey.

Q: (To an administrator of a community hospital) What is your view on preference to core teaching hospitals?

A: This witness does not want UMDNJ dictating allocation of high tech services. This hospital wants the latitude to make their own decisions about the services to be provided in the community.

Q: (To representative of UMDNJ) UMDNJ is now advocating that high tech services be allocated to its teaching affiliates, not just the four core hospitals. How would hospitals affiliated with teaching institutions other than UMDNJ gain access to these technologies. Is UMDNJ still advocating Certificate of Need for high tech services? Who appoints the clinical advisory group for high technology?

A: The clinical advisory group recommended in the plan would be responsible for the dissemination of technology. This group could be responsible for deployment. The Commissioner of Health would appoint the advisory group.

Subchapter 16. Long Term Care

N.J.A.C. 8:100-16.1 Purpose

COMMENTS: Many commenters concurred that most people would prefer to receive long term care in their homes and community. They support the expansion of home and community based care as a high priority. The long term care plan addresses issues in a positive manner and provides choices to suit the individual needs of older adults. This subchapter was characterized by some as carefully conceived, well worded and reflecting a degree of involvement by people in the field. Further,

it appropriately suggested the use of diverse advisory committees to assist in its implementation. Adoption of this subchapter is recommended.

One commenter expressed reservations that Oregon's plan will work in New Jersey given the differences between the two states. This commenter recommended that a yearly evaluation should be made of the new plan's elements and revisions should be implemented as necessary.

A few commenters called for an evaluation of the current utilization and effectiveness of the alternatives to nursing homes. They believe that the results of this assessment should be conveyed to consumers and providers in this region prior to the implementation of new services in New Jersey. The source and availability of funds should be specifically identified prior to implementation.

One commenter stated that to meet the challenge of the future regarding the quality of life of the institutionalized elderly in New Jersey, a plan needs to be implemented that mandates education and research on aging. Nursing Homes of today are very different from those of the past and will continue to change as their patients become sicker and older. The nursing home should be used in addition to the classroom experience by students training to care for the elderly. New models of nursing practice should be developed and tested to fit the needs of the long term care industry.

One commenter criticized the long-term care implementation deadlines as unrealistic, especially those that involve developing new options, such as alternate family care. Planners, providers and consumers need enough time to receive comprehensive education on long-term care options before careful planning can be executed.

One commenter requested that titles of Department of Health staff responsible for implementing various aspects of the subchapter be identified.

RESPONSE: The Department gratefully acknowledges the many commenters who support N.J.A.C. 8:100-16.

In response to the commenter who is concerned about the Oregon plan, it is noted that the precursor document to Subchapter 16, "Long-Term Care at the Crossroads," described Oregon's noteworthy success in developing several innovative alternatives to nursing home care. The recommendations contained in N.J.A.C. 8:100-16 are intended to foster reforms in New Jersey's long-term care system which are uniquely appropriate for this State. No attempt is made to replicate Oregon's programs in New Jersey; however, the Department has made an effort to learn from other states' successes. In addition to Oregon, the Department has examined the experiences of Massachusetts, Florida, Minnesota, New York, and a number of other states.

A large body of professional literature and research exists to document the effectiveness as well as limitations of alternatives to nursing homes. The new alternatives which are to be developed in New Jersey will be specifically designed and targeted to the needs of people who require longterm care. It is expected that Medicaid reimbursement will be available to fund these services for people who are financially and medically eligible.

The Department agrees that education and research on aging and disabilities is important. Three two-day conferences have been organized by the Department of Health to begin the process of educating health service providers, consumers, governmental, planning, and funding agencies throughout the State regarding new and existing care options and long-term care planning, for the purpose of assuring more effective provision of services. Over 300 individuals are scheduled to attend.

The Department, in collaboration with the Long-Term Care Overview Panel (which includes health service providers, consumers, governmental, planning, and funding agencies), has developed a transition plan and time table to assure that there will be adequate time for the development of new services. The time table allows two years (1992-1993) for planning and a period of three or more years (1994-1997) for the gradual, incremental initiation of various long-term care options and services.

The Department of Health acknowledges the importance of accountability in accomplishing the many provisions set forth in subchapter 16; however, identification of staff more appropriately belongs in a work plan than in the body of this rule.

COMMENTS: Two commenters identified that only one sentence is devoted to long-term care for AIDS patients in subchapter 16. Because it is likely that this problem will intensify as more life prolonging drugs and treatment regimens become available, the commenters assert that this issue must be decisively addressed.

RESPONSE: In the next phase of the State Health Plan, subchapter 7 will be devoted to addressing AIDS and HIV and the continuum of care for persons with this illness.

COMMENTS: The Long-Term Care Overview Panel offered a technical language change. N.J.A.C. 8:100-16.10(a) should be moved up to the "Purpose" section, N.J.A.C. 8:100-16.1. Throughout the subchapter, reference should consistently be made to cooperative efforts by the three departments of State government that have a major role in long-term care: the Departments of Health, Human Services, and Community Affairs.

RESPONSE: N.J.A.C. 8:100-16.10(a) has been moved to N.J.A.C. 18:100-18.1(b), Purpose. The Department agrees that the cooperative efforts of the Departments of Health, Human Services, and Community Affairs should be noted throughout the subchapter, and has done so on adoption.

N.J.A.C. 8:100-16.2 Support services for family caregivers

COMMENTS: One commenter stated that programs such as Respite and Caregiver Education should be expanded and strengthened. Another asserted that in N.J.A.C. 8:100-16.2(a), the long explanation about family caregiving should be removed unless similar explanations are added to the other sections.

Two comments were received regarding insurance issues. One challenged the language in N.J.A.C. 8:100-16.2(a)4i regarding life insurance conversion options stating that it raises the specter of the assignment of life insurance benefits to the final caregiver. The Long-Term Care Overview Panel recommended that long-term care insurance be identified as a financing source for long-term care in N.J.A.C. 8:100-16.2(a)4i.

RESPONSE: The Department acknowledges the commenter's support for N.J.A.C. 8:100-16.2 regarding services for family caregivers. Families have a cornerstone role in the provision of long-term care. The Department maintains that it is appropriate to acknowledge this through the description in N.J.A.C. 8:100-16.2(a).

Regarding the life insurance conversion concern, the intent of the rule is to provide examples of programs to be explored by the Department and the Legislature to expand private approaches to financing long-term care. Life insurance conversion options are mentioned as one example. This refers to the use of one's life insurance benefit prior to death for the purpose of paying for the person's long-term care expenses. The Department agrees that long-term care insurance is an important financing mechanism. A paragraph has been added at N.J.A.C. 8:100-16.10(a) to highlight the importance of insurance as a protection against the catastrophic costs of long-term care.

N.J.A.C. 8:100-16.3 Adult day care services

COMMENTS: The Overview Panel recommended that the language at N.J.A.C. 8:100-16.3(a) be changed so that the Departments of Health, Human Services, and Community Affairs will review rather than develop payment rates for day care and encourage their uniformity. Also, in recognition that day care centers may not be a suitable alternative for those with high levels of impairment, it is recommended that N.J.A.C. 8:100-16.3(b) be modified to delete the reference to day care as an alternative to nursing home placement. Another commenter suggested that in N.J.A.C. 8:100-16.3(b), the phrase "adequate reimbursement must be provided" does not belong in regulations, for there is no way to enforce "must."

RESPONSE: The Department has amended N.J.A.C. 8:100-16.3(a) on adoption to allow for preliminary work to be done prior to the development of payment rates, since such development would be premature at this time. Since the Department cannot guarantee payment for day care, which is provided by Medicaid, the word "must" has been replaced with the word "shall." The Department agrees with the commenter and has deleted the reference to day care as an alternative to nursing home placement.

N.J.A.C. 8:100-16.4 In-home care services

COMMENTS: The Overview Panel recommended that the language at N.J.A.C. 8:100-16.4(d) be changed so that the Departments of Health, Human Services, and Community Affairs will review rather than develop payment rates for home health care and encourage their uniformity.

New Jersey State Nurses Association expressed support for the extension of NIRA grants into home health and the development of legislation which will allow for greater protection of seniors in the community. The Medical Society of New Jersey cautioned that legislation is not the only means by which to prevent elder abuse, and other plans besides legislation should also be considered. In fact, the difficulty of implementing and enforcing existing legislation may contribute to the problem.

RESPONSE: The language changes suggested by the Overview Panel have been made at N.J.A.C. 8:100-16.4(d). The Department acknowledges NJSNA's support of N.J.A.C. 8:100-16.4(b) and (f). The rule has been amended to indicate that NIRA refers to Nursing Incentive Reimbursement Awards.

The Department agrees that elder abuse may be addressed through initiatives other than legislation. However, the potential value of legislation for this purpose cannot be dismissed. The language of N.J.A.C. 8:100-16.4(f) has been modified to reflect a broader concept of support for various types of initiatives aimed at preventing abuse.

N.J.A.C. 8:100-16.5 Assessment, screening, and targeting of long-term care services

COMMENTS: One commenter expressed concern that N.J.A.C. 8:100-16.5 recommends the expansion of the Geriatric Assessment Program to all 21 counties, but there are plans to cease funding current programs. Continued funding of these programs was supported. Another commenter stated that Geriatric Assessment Programs should be increased and made easily accessible.

The Overview Panel recommended that to ensure that those in need will be targeted to receive long-term care services as well as information about all available options, N.J.A.C. 8:100-16.5(b) should be amended to require pre-admission screening for Medicaid and private paying patients and all others, regardless of payment source. Legislation will be needed to accomplish this. Also, N.J.A.C. 8:100-16.5(c) should be deleted, since Prioritization criteria for Community Care Program for the Elderly and Disabled (CCPED) slots for home and community-based services are not applicable with respect to the program; since all CCPED patients are required to be nursing-home-eligible and have, therefore, been previously screened. Furthermore, N.J.A.C. 8:100-16.5(d) regarding health care professionals' continuing education should be broadened to include disability issues. Throughout the subchapter, reference should be made to those who are disabled, as well as the elderly who are in need of long-term care.

One commenter stated that the State's plan to put responsibility for placement decisions in the hands of the Pre-admission Screening Unit creates a duplication of function. County Offices on Aging already perform this function. Duplicating this function would only lengthen and complicate the placement process.

RESPONSE: The Department acknowledges the commenter's support for Geriatric Assessment Programs. The Department of Health's budget request for FY 1993 would maintain funding of the current Geriatric Assessment Programs.

The Department agrees with the comments of the Overview Panel, and language changes suggested by the Overview Panel have been made at N.J.A.C. 8:100-16.5(b) through (d). Long term care may be needed by persons of all ages, not just the elderly.

The Department of Health seeks to build upon the existing system of pre-admission and to make this accessible to all. Currently, pre-admission screening is performed through the Department of Human Services for Medicaid-eligible patients and those who will become Medicaid-eligible within 180 days. The screening entails a thorough review of the individual's needs and preferences for care, their support systems, and other resources. For the most part, non-Medicaid patients do not have access to a comparable screening at the time they seek admission to nursing homes.

N.J.A.C. 8:100-16.6 Nutritional services

COMMENTS: Two commenters stated that programs for home-delivered meals for the elderly should be expanded and out-patient nutrition services should be available to senior citizens.

The Medical Society of New Jersey recommended change at N.J.A.C. 8:100-16.6(b). They asserted that hospitals cannot be forced to provide outpatient nutrition services and suggested alternative wording "... should promote action by hospitals to provide ..."

Several commenters expressed support for the expansion of nutritional services as called for in N.J.A.C. 8:100-16.6 and suggested that long-term care facilities can provide nutritional services for non-institutionalized elderly, in addition to those people they currently serve. It was suggested that reference to hospitals as providers of these services should be deleted and "health care facilities" should be substituted.

RESPONSE: The Department of Health acknowledges the commenters' support for N.J.A.C. 8:100-16.6.

The other recommended amendments have been incorporated in the adopted rule.

N.J.A.C. 8:100-16.7 Mental health services

COMMENTS: The wording in N.J.A.C. 8:100-16.7(b) should be changed regarding health care workers' training to care for people with behavior "problems". Reference to "managing" behavior "disorders" should be deleted.

RESPONSE: The comment is duly noted and the suggested language has been inserted in the rule. The Department agrees that the suggested language contains more neutral terminology.

N.J.A.C. 8:100-16.8 Transportation services

COMMENT: One commenter recommended that medical day care programs should be required to provide transportation service.

RESPONSE: Transportation is a requirement of licensure for medical day care (adult day health care) programs.

N.J.A.C. 8:100-16.9 recodified as 18.9) Housing options for the frail elderly and disabled

COMMENTS: Many commenters stated that due to the foreseen growth of housing needs for the elderly, assistance for housing modifications, household repairs and chore service should be provided so that the chronically ill (many of whom are elderly or disabled) can stay at home. In recognition of the preference of the elderly and disabled to remain in their homes, it was suggested that N.J.A.C. 8:100-16.9(a) be amended to indicate that the State departments will "develop and fund" housing adaptations.

Several commenters recommended that in N.J.A.C. 8:100-16.9(b), "long-term" should replace the word "home" in "home care services" because home equity should not be limited only to home care services; this should be available to cover all long term care options.

One commenter stated his belief that, in N.J.A.C. 8:100-16.9, both subsections (a) and (b) are beyond the scope of Department of Health responsibility. There are many public and private agencies dealing with housing options. The government is not the best authority to deal with these issues.

RESPONSE: The changes suggested in N.J.A.C. 8:100-16.9(a) and (b) have been made in the final rule.

The Department of Health applauds private agencies that are able to develop and fund programs for housing repairs and adaptations. The provisions in N.J.A.C. 8:100-16.9 suggest that the Department will support such initiatives aimed at the very important goal of maintaining frail elderly and disabled persons in their own homes.

N.J.A.C. 8:100-16.10 Improved information and coordination of services

COMMENTS: One commenter stated that the central information source is an excellent idea.

The Medical Society expressed two concerns in this section. First, they applauded the idea of local directories of long term care service options described at N.J.A.C. 8:100-16.10(b). However, they stated that the LABs will require more funding if they are to run such directories. Second, they suggested that it may be helpful to have communication experts review all proposals such as the one suggested at N.J.A.C. 8:100-16.10(c) and (d) and coordinate an affordable package of recommendations. They assert the media and public service campaigns are expensive.

Many commenters asserted that elder care services should be consolidated into one State department and one county agency should be designated to coordinate all information, referral and case management of long term care.

(The Long Term Care plan does not address centralizing a continuum of services under one roof).

RESPONSE: The Department gratefully acknowledges the commenter's support of 16.10(b).

It is the Department of Health's intent, in collaboration with the Departments of Human Services and Community Affairs, to offer substantial technical assistance as needed by the Local Advisory Boards in order to develop long-term care information sources in each county.

The Department welcomes any advice from communication experts concerning this or any other media campaign.

It is outside the authority of the Department of Health to recognize services and functions which are within the domain of other State agencies. Instead, this subchapter calls for very close working relationships between the Departments of Health, Human Services, and Community Affairs.

N.J.A.C. 8:100-16.11 Care options for the nursing home eligible population

Most of the comments received regarding this section of the rule center around three issues: (A) eligibility and availability; (B) nursing home bed supply and substitution; and (C) cost and payment. The comments are grouped below.

COMMENTS: Eligibility and Availability

Several commenters asserted that community long-term care access should be opened to patients who do not medically qualify for nursing home placement, but who may be unable to live independently. In consideration that all long-term care options may not be equally interchangeable in all cases, N.J.A.C. 8:100-16.11(a) should be amended to replace "nursing home eligible" with "in need of long-term care."

The Overview Panel recommended that all counties, regardless of whether they have a long-term care placement need, should be given the opportunity to develop the long-term care alternative options (excluding nursing home beds). By June 30, 1993, the Departments of Health and Human Services should devise a formula to make these options available in counties where no new long-term care placements are required in accordance with N.J.A.C. 8:10-16.11(c).

One commenter stated that the language of the Long Term Care section 18 usually focuses on the Medicaid eligibility population. In so doing, it does not adequately address the needs of middle income families that do not qualify for Medicaid, but do not have assets for private financing.

Another commenter expressed concern that there is no mention of the obligation for long-term care facilities to serve Medicaid-eligible and low income persons.

RESPONSE: Eligibility and Availability

The comments have been duly noted, and the substitute language has been inserted at N.J.A.C. 8:100-16.11(a) and a new subsection (f) has been added to address the Overview Panel's concerns.

The services described in N.J.A.C. 8:100-16.11 will be accessible to middle income families as well as the Medicaid population. The proposed alternatives such as alternate family care, adult day health care, and assisted living, should benefit the middle income population because each is expected to be more affordable than nursing home care.

Subchapter 16 is not intended to supplant N.J.A.C. 8:33H, the Certificate of Need Policy Manual for Long-Term Care. Certificate of Need requirements for Medicaid occupancy in nursing homes are contained in the latter Manual.

COMMENT: Nursing Home Bed Supply and Substituting Other Options for Nursing Home Placement

The Division of Medical Assistance and Health Services, Department of Human Services, stated that all care options presented in subchapter 16 should be substitutable for nursing facility placement. Any proposal to change N.J.A.C. 8:100-16.11(a) to indicate that the options are not substitutable will negate the State's ability to control expansion of the nursing facility bed supply. However, adult day health care is not a straight substitute, and the vast majority of people in day care centers do not meet the nursing facility eligibility requirements. The Department of Health draft certificate of need regulations (N.J.A.C. 8:33H) suggest a 4:1 ratio of adult day health care slots to nursing facility placements. This ratio should be higher, such as 5:1 or 6:1.

Representatives of Caring Alternatives for the Aged stated that the proposed long term care plan "favors institutionalization" by treating the six long term care options as mutually exclusive of each other. It is necessary to define long term care slots more effectively. For example, CCPED provides funds for people who are in adult day health care programs. These are both long term care slots. There is much confusion, as a result over the relationship of CCPED, adult day health care and residential options. Adult day health care should be uncoupled from the residential needs methodology. Subchapter 16 defines the formula which projects long-term care need, but it does not make allowances for out-of-county placements in nursing homes for counties that have an excess of long term care placements. By June 1993, an exception formula will be developed to allow the development of long-term care alternatives in counties with a projected surplus of placements, but that will be too late. It should be included in the plan now, prior to approval of subchapter 16 in order to address the unmet need for adult day health care expeditiously.

Several commenters expressed the opinion that any certificate of need for nursing home beds that is rescinded should be reallocated to a new applicant in order to maintain the approved numbers of nursing home beds.

One commenter noted that, while the State Health Plan formula says Essex County is overbedded, the commenter receives numerous calls from people unable to find space in a quality nursing home.

Several commenters stated that the needs for nursing home beds will grow despite the need for alternative housing arrangements. A goal and component of determining need within the plan should be to assure an adequate supply of nursing home beds and alternatives to eliminate the use of high cost inpatient care for long term care eligible persons.

One commenter offered that the LABs should be given the flexibility to allocate nursing home beds in its area if occupancy exceeds 95 percent and/or if other options are unavailable in its area.

Several commenters objected to a perceived 10-year moratorium on long term care beds unless it can be demonstrated that alternative placements can be developed at a sufficiently rapid rate. They further stated that restraint in bringing on nursing home beds must not result in placement of persons needing services in inappropriate facilities, such as acute care hospitals.

The Plan highlights consumers' preference for home care, but then mandates the development of facility-based programs such as assisted living.

RESPONSE: Nursing Home Bed Supply and Substituting Other Options for Nursing Home Placement

Under the Plan, the nursing home bed supply will be controlled, as will the supply of all alternative options. The Department of Health agrees that adult day health care (ADHC) slots may not substitute on a one-for-one basis. Accordingly, N.J.A.C. 8:100-16.11(a)4 is amended to show that four ADHC slots will count as one long-term care placement of any other type. The Department of Health would welcome data provided by the Department of Human Services or other sources to support the recommendation that five, six or any other number of adult day health care slots should be approved in exchange for one long-term care placement of any other type. Until data are available, the 4:1 ratio will be used.

Until the proposal of the State Health Plan, the Department of Health did not have a method for determining the need for adult day health care services. As a result, a large number of programs received approval with little regard to need; now most counties have an abundance of day care slots, and underutilized programs exist in many areas. A number of new day care programs received certificate of need approval in recent years and these will become operational in the near future. In regard to the "exception formula," this has not yet been developed. With the consideration of the Department's Long-Term Care Overview Panel, it was determined to be reasonable that the formula could be developed by the June 30, 1993 deadline. Subsequent to that date, there will be potential opportunities to expand alternative programs such as adult day health care in every county throughout the state. However, such expansion will be based upon county-level decision-making regarding local need for the service. The long-range benefits of this new "community empowerment" planning process, as described in N.J.A.C. 8:100-16.11(d), are expected to far outweigh the short-term inconvenience that a small number of providers may experience in not being able to expand their services in counties where there is a projected excess of long-term care placements.

When a certificate of need is "rescinded" (that is, terminated), the long-term care placement need will be adjusted and revised to reflect this change. In general, the reduction in beds through such a termination would result in a proportionate increase in the need for additional long-term care placements.

According to the need formula in N.J.A.C. 8:100-16.11, Essex County is projected to have a small excess of long-term care placements by the year 1997. The county has within its inventory 420 certificate of need-approved new long-term care beds which are due to be constructed and licensed in the next several years. These additional beds should adequately accommodate the needs of Essex County residents.

The Plan does not propose a moratorium on nursing home beds. The need formula in N.J.A.C. 8:100-16.11 calls for the certificate of need approval of up to 1,300 additional nursing home beds for applications received in 1992. Certificate of need applications should be filed by October 1 for these beds.

The problem of patients backed up in acute care hospital beds while awaiting nursing home placement has gradually eased over the past decade; nonetheless, a substantial number of individuals do continue to inappropriately occupy costly hospital beds for lengthy stays. Department of Health studies of hospital back-up reveal that the problem exists not so much because there is a shortage of nursing home beds, but rather

because of financial/Medicaid eligibility issues. In some cases, patients must wait for a number of weeks while their Medicaid application for nursing home reimbursement is being processed.

The transition plan described in N.J.A.C. 8:100-16.11(b) should allow a sufficient amount of time to assure that the various options will be available when and to the extent that they are needed. Because it takes on average five years to implement/ license new nursing home beds from the time they are approved, the commenter's recommendation that LABs should be able to approve additional nursing home beds if utilization exceeds 95 percent is not a realistic, short-term solution to a problem of high occupancy rates.

Decisions about whether to develop home care and/or facility-based options will be made by each county's newly created long-term care committee. Facility-based options such as assisted living are needed for the substantial segment of the long-term care population that has no family caregiving support system to make home care a viable option.

COMMENTS: Cost and Payment

One commenter stated that the controlled growth of nursing home bed supply is a positive step because it takes time to develop new services. He asserted that there must be adequate reimbursement for each alternative long term option in order to ensure availability of these options.

The New Jersey Hospital Association stated that not all paradoxes are resolved in the State Health Plan. For example, alternatives to nursing homes are underutilized but actions to reverse this are not proposed.

Also, the cost savings calculations are not realistic. For instance, although the plan indicates that a cause of the underutilization of alternative long term care settings is payment levels, it does not figure in payment increases in calculating the cost savings. It even reduces payment rates for new programs in some cases. (For example, the Oregon Adult Foster Care program pays providers 2/3 of the Medicaid nursing home rate per month, but New Jersey proposes paying half the nursing home rate for alternate family care).

Another commenter stated that the plan needs to address whether the successful implementation of alternatives to nursing homes will encourage families that currently care for elderly people in their homes to utilize these alternatives. If so, will this increase costs?

One commenter stated that alternatives such as assisted living and alternate family care will only be available to private paying patients; the indigent population will have few options.

Another commenter recommended that strategies to address long-term care financing reflect the capability of economically disadvantaged and middle-income African Americans to afford long-term care expenses.

RESPONSES: Cost and Payment

Indigent persons would have their care paid by Medicaid.

It is expected that Medicaid reimbursement will be available to medically and financially eligible persons for each of the proposed long-term care options, including assisted living and alternative family care. Affordability and insurance for long-term care are matters that must be addressed for all low and middle-income elderly and disabled citizens, including economically disadvantaged and middle-income African-Americans. A new provision, N.J.A.C. 8:100-18.10(a), has been added regarding long-term care insurance.

The precursor document to Subchapter 16, "Long-Term Care at the Crossroads," cited residential health care facilities as an example of an underutilized alternative with low payment levels. Subchapter 16 proposes to remedy this problem by allowing these facilities to upgrade to "comprehensive personal care homes" in certain circumstances. Unlike residential health care, comprehensive personal care homes would be eligible for Medicaid reimbursement. The Medicaid payment rate for this and other alternatives such as alternate family care has not yet been determined. The Departments of Health and Human Services are working together to develop realistic cost projections for the alternatives.

It is expected that there will be increased costs when attractive and greatly needed alternatives initially become available. A "woodwork effect" is anticipated, whereby a number of people (including caregiving families) who do not currently use existing services will seek to use the new services. In the long-term, a Statewide cost savings should result, as less expensive alternatives come to substitute for more costly options such as nursing home care. The Departments of Health, Human Services, and Treasury are working together to realistically project these costs.

COMMENTS: Other

The New Jersey State Nurses Association (NJSNA) stated that placing determination of the mix of long-term care services at the local level

is consistent with "Nursing's National Agenda for Health Care Reform." Nursing representation on County Long-Term Care Committees is considered critical.

Another commenter called for the State to adopt a "Nurse Delegation Act."

The Medical Society of New Jersey commented on N.J.A.C. 8:100-16.11(b) stating that nursing home care and regulation should be addressed in a systematic way. The following areas are suggested as worthy of attention: case management, including oversight to ensure continuity of care for patients transferred between nursing homes and hospitals; education, training and prestige of nursing home staff and use of modern management techniques; and alternatives in nursing home regulation, such as incentives for very high-quality care and relief from specific documentation and staffing requirements.

RESPONSE: Other

The NJSNA's support for N.J.A.C. 8:100-16.11(d) is acknowledged. County Long-Term Care Committees will be appointed by the Local Advisory Boards, and each Committee will include representation by health care providers such as nurses.

The Department is consulting with the State Board of Nursing to determine whether a Nurse Delegation Act is necessary.

The merits of the Medical Society's suggestions are duly noted.

N.J.A.C. 8:100-16.12 Alternate Family Care

COMMENTS: The existing foster care system for children has had problems recruiting and training foster parents and ongoing monitoring of foster homes has been difficult. Foster homes for the elderly may present many of the same problems and also may inadvertently discriminate against people with dementia. Furthermore, the advisory language concerning alternative caregiving is not strong enough to ensure its actual implementation.

RESPONSE: The Department of Health, in collaboration with the policy work group, is moving ahead to assure the implementation of a high quality alternate family care program by developing guidelines to address issues such as training and monitoring of families and patient selection criteria. It is anticipated that a number of persons with dementia will be candidates for alternate family care; however, each match will have to be individually tailored, taking into consideration the needs of the patient and the resources and capabilities of the family caregiver.

COMMENTS: The issue of abuse or neglect of patients by providers of alternative care is a serious concern and must be adequately addressed. The feasibility of this alternative must be determined with respect to issues such as caregivers' ability to deliver appropriate care in light of progressive medical deterioration and dependency of the patient.

RESPONSE: Protection against abuse is a priority issue for the Department in developing and promoting alternate family care (AFC). The Department's Policy Work Group for AFC includes representation by a number of agencies concerned with abuse prevention, including Adult Protective Services, the Ombudsman for the Institutionalized Elderly, and the Public Guardian.

COMMENTS: Regarding N.J.A.C. 8:100-16.12: local involvement in decisions will be important in developing alternate family care. Allowing counties to participate in the allocation of long term care placements is important and a positive step.

RESPONSE: The commenter's support for N.J.A.C. 8:100-16.12 in conjunction with N.J.A.C. 8:100-16.11(d) is acknowledged.

COMMENT: The word "institutionalization" should be removed from the end of N.J.A.C. 8:100-16.12(a), and replaced with the word "care." This change should be made throughout the document wherever it appears, as such language is inappropriate and offensive to nursing home providers and patients.

RESPONSE: The comment is duly noted, and the rule has been changed accordingly.

N.J.A.C. 8:100-16.13 Assisted living residences

No comments were received.

N.J.A.C. 8:100-16.14 Residential health care and similar facilities

COMMENTS: Division of Medical Assistance and Health Services, Department of Human Services, suggested that the section heading of N.J.A.C. 8:100-16.14 should be changed; "similar facilities" refers to Class C Boarding Homes. In N.J.A.C. 8:100-16.14(a), "should" should be changed to "shall" to indicate the strong degree of commitment the Division of Medical Assistance and Health Services has to infusing personal care services into the current residential health care network

in order to allow residents to age in place. In N.J.A.C. 8:100-16.14(c), the phrase "very similar indistinguishable levels of care" is superfluous and somewhat argumentative.

One commenter stated that nursing homes containing residential health care beds should be permitted to convert these slots to nursing home beds. Past experience has indicated that residential health care beds in nursing homes are often difficult to maintain in an institutional setting. The commenter suggests that any residential health care facility that wishes to upgrade to the higher level as outlined in the proposed plan, shall be allowed to do so. Furthermore, those residential health care facilities that do not choose to upgrade should remain in the Department of Health as a second level of residential health care facility and should not be forced to move to the Department of Community Affairs. A move to the Department of Community Affairs would eliminate the current consistency in licensing and regulation.

The New Jersey State Nurses Association noted that change in residential health care facilities is contingent upon adjustment in the SSI subsidy. The appropriateness of RHC facilities as long-term care placements must be considered in light of the current profile of residents: a mix of the elderly, homeless, and de-institutionalized mentally ill.

RESPONSE: The suggestions of DMAHS are duly noted and the rule has been changed accordingly.

In counties where there is a long-term care placement need, facilities licensed for residential health care beds may potentially propose to convert to either comprehensive personal care or nursing home beds. However, the new long-term care planning process calls for county-level committees to make the decision about how many of their needed placements should be allocated to each of the long-term care options. To allow all residential health care facilities attached to nursing homes to convert their beds to nursing home beds would violate the integrity of this "local empowerment" planning process. There is no plan at this time to force remaining residential health care facilities to be licensed by the Department of Community Affairs. However, the Department of Health does have a long-range interest in eliminating duplicative levels of care and oversight functions.

Facilities which are most likely to convert from residential health care to comprehensive personal care homes (CPCH) are those which are underutilized, with many empty beds. For existing occupants of facilities which convert to CPCH, there will be the new possibility of "aging in place", so that relocation in order to receive a higher level of care would generally not be necessary. Presumably, facilities will benefit financially from the fact that CPCH would be reimbursed by Medicaid for health and personal care services provided to medically and financially eligible residents.

N.J.A.C. 8:100-16.15 Continuing care retirement communities

COMMENT: The New Jersey Association of Health Care Facilities recommended a change in N.J.A.C. 8:100-16.15(a) in the second sentence, insert the word "option" after "long term care" and before "bed," to recognize other options (that is, assisted living bed, etc.).

RESPONSE: The comment is duly noted, and the language in N.J.A.C. 8:100-16.15(a) has been changed to acknowledge that fact that nursing home beds, assisted living units, and comprehensive personal care beds will, for the most part, be interchangeable and should be treated accordingly in proposals to develop continuing care retirement communities.

N.J.A.C. 8:100-16.16 Specialized long-term care services

COMMENTS: One commenter stated that there is some confusion over limits of specialized care. The commenter believes that specialized care can sometimes be provided in a non-nursing home setting, but this issue is not addressed in the plan. The Department of Health should convene a panel of experts to consider who can benefit from specialized long term care in a non-nursing home setting. The commenter recommends that the specialized long-term care model provision be amended to include one non-nursing home model in each LAB.

RESPONSE: N.J.A.C. 8:100-16.16 does not make any reference to the provision of specialized long-term care in any particular setting such as a nursing home. The commenter's recommendation is understood as supporting N.J.A.C. 8:100-16.16(b).

On its initiative, the Department has deleted the requirement at N.J.A.C. 8:100-16.16(c) that counties identify and address the service needs of area residents requiring specialized care because the needs of such residents may be more efficiently and effectively addressed by the LABs, whose goals include the coordination of planning efforts to address the needs of area residents.

N.J.A.C. 8:100-16.17 Alzheimer's Disease and related dementias

COMMENTS: The Division of Medical Assistance and Health Services, Department of Human Services, requested that the section heading of N.J.A.C. 8:100-16.17 be changed to include "other behavior problems."

RESPONSE: The comment is duly noted and the change made.

N.J.A.C. 8:100-16.18 Comprehensive rehabilitation

COMMENTS: Many commenters objected to the inclusion of Comprehensive Rehabilitation as a minor section of subchapter 16 (N.J.A.C. 8:100-16.18). They asserted that it should be included as a freestanding chapter in the proposed plan. The reasons for this belief are: Comprehensive rehabilitation is a hospital based intensive level of care which is very different from nursing home care. A distinction must be made between comprehensive rehabilitation and nursing homes to educate the community about differing levels and types of care available to them. Some commenters suggested a special advisory committee be organized for future policy and planning decisions regarding comprehensive rehabilitation services if this distinction cannot be made under Phase I or Phase II timeframes.

One commenter stated that comprehensive pediatric rehabilitation is not addressed.

The New Jersey Hospital Association noted that the assumption that comprehensive rehabilitation is **only** an inpatient hospital service is inappropriate. There is a move toward greater ambulatory treatment for rehabilitative services. The role of rehabilitation in relation to the need for other health services is not addressed (for example, rehabilitation may determine the ability to place a person outside of a nursing home).

RESPONSE: It is the Department's intent to develop a separate subchapter for comprehensive rehabilitation when the State Health Plan is amended in 1993. The final rule has been recodified with Subchapter 17, Comprehensive Rehabilitation (Reserved) inserted and Subchapter 16, Long Term Care recodified as Subchapter 18, Long Term Care. The new Subchapter 16 has been reserved for Surgery and Dialysis Services.

Pediatric rehabilitation is currently addressed in N.J.A.C. 8:33M, the Policy Manual for Comprehensive Rehabilitation. It is the Department's intent to include pediatric rehabilitation in the subchapter for comprehensive rehabilitation when the Plan is amended in 1993.

By definition, a comprehensive rehabilitation hospital must provide both inpatient and a wide range of outpatient services. However, the Department acknowledges the commenter's point that there are many other non-hospital-related providers of rehabilitation.

Questions and Answers from the Public Hearings

Below is a summary of questions asked by Health Care Administration Board members of those who testified at the six public hearings, and the responses provided.

Q: Are the number of pediatric rehabilitation beds currently allocated (mostly in the northern part of the State) adequate to serve the entire State?

A: It is an adequate number. It is the understanding of the speaker that an additional 30 beds are to be constructed in the Camden-Burlington area.

Q: Do children come from fairly great distances to Children's Specialized Hospital?

A: Yes. Previously, there were two pediatric rehabilitation hospitals in the state. When Children's Seashore House moved from Atlantic City to Philadelphia, the State made a decision to have three rehabilitation regions: north, central and south. The north has adequate beds; 30 beds recently opened in Ocean County will serve the central part of the State, and the other 30 beds will serve the southern part of the State.

Q: (To DOH staff) Can rehabilitation services be separated from the long-term care chapter of the plan?

A: The State Health Planning Board made a commitment to undertake that next year. The current rules were developed by a task force and are satisfactory to the providers. There is no pressing need to change it at this time.

Q: (To a medical day care provider in Atlantic County) There have been a number of medical day care centers that have closed in Atlantic County. Is the speaker aware of their reasons for closure?

A: It was a marketing problem rather than need in the community. People were not aware of the services provided in medical day care.

Q: In Oregon, are there significant numbers of placements of Alzheimer's patients in in-home or foster family caregiving situations?

A: To date in the 11 year old Oregon system of placements, there are few for Alzheimer's patients though initially there were none. The

point of the comment made was to say that long term care or continuing care placements should be available for all who need them and discriminate against none. With fine tuning, it appears that in Oregon these services will be available to everyone in need of them.

Q: Are ventilator dependent patients and persons who are difficult to manage among those who may be appropriate for non-nursing home placement?

A: Patients should be placed only after determining their needs and identifying the most appropriate and cost-effective care settings. The commenter suggested that an expert panel should be constituted to examine these issues and make these decisions.

Q: Should people who take care of dependent persons in non-nursing home settings be reimbursed for those services even if the services are delivered in a home?

A: One commenter responded that reimbursement for people who care for dependent persons in non-nursing home settings should be considered as a possibility, even if the service is delivered in a home setting.

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 100 STATE HEALTH PLAN

SUBCHAPTER 1. INTRODUCTION**8:100-1.1 Purpose**

(a) The purpose of this chapter is to establish a plan that will satisfy the mandate of P.L. 1991, c.187 and support the public policy of the State in promoting health and high quality health care at a reasonable cost for all the citizens of the State. The State Health Planning Board, established by Section 33 of P.L. 1991, c.187 as the planning advisory board within the Department of Health is required to "prepare and revise annually, a State Health Plan. The State Health Plan shall identify unmet health needs in an area by service and location and it shall serve as the basis upon which all certificate of need applications shall be approved. The plan shall be effective beginning January 1, 1992. (P.L. 1991, c.187 s.34). Specifically, the purpose of this chapter is to:

1. Identify unmet health care needs by service and location;
2. Establish a process for evaluating health care needs and services in six regional health planning areas;
3. Establish guidelines for making health planning decisions;
4. Contain the costs of providing health care;
5. Promote quality health care services;
6. Increase appropriate access for the residents of the State to preventive, primary, acute and sub-acute health care services;
7. Provide a comprehensive, population-based planning guide to health care; and
8. Establish policies for the rational use of health care resources in the State of New Jersey. One of the goals of these policies will be to reach the health targets established in *Healthy New Jersey 2000: A Public Health Agenda for the 1990's*, as well as other supporting health objectives identified below.

(b) The following goals and objectives will serve to guide subsequent policies and rules of the Department of Health (targets are set for attainment by the year 2000 unless otherwise specified).

1. Increase access to preventive and primary care:
 - i. Reduce the proportion of the population under age 65 with no health insurance coverage from 11.7 percent of the total population, 16.0 percent of African Americans and 25.0 percent of persons of Hispanic origin to 3.0 percent for all groups (1989 baseline);
 - ii. Reduce from 7.7 percent to 2.0 percent the proportion of the population without health insurance coverage who are under age 65 and employed or a spouse or dependent of an employed person (1989 baseline);
 - iii. Increase the percentage of residents who have a source of primary care from 84.4 percent of the total population and 84.2 percent of the African American population to 98.0 percent (1986 baseline);

iv. Decrease years of potential life lost per 100,000 population under 65 years of age from 5,778.7 years to 5,200.0 years (1988 baseline);

v. Increase life expectancy for *[White]* *white* babies at birth from 75.9 years to 77.9 years (1988 baseline);

vi. Increase life expectancy for minority babies at birth from 71.8 years to 75.0 years (1988 baseline); and

vii. Reduce by 20.0 percent (26,000 admissions) the number of hospital admissions for ambulatory care sensitive diagnoses, such as pediatric otitis media, pneumonia, bronchitis and asthma, respiratory infections, gastroenteritis, cellulitis, and diabetes (1989 baseline).

2. Improve infant, child health, and maternal outcomes:

i. Reduce total infant mortality from 9.8 to 7.0 infant deaths per 1,000 live at births (1988 baseline);

ii. Reduce African American infant mortality from 19.5 to 11.0 infant deaths per 1,000 live births (1988 baseline);

iii. Reduce the percentage of infants weighing less than 2500 grams at birth from 6.8 percent to 5.0 percent of all births and from 13.6 percent to 9.0 percent of African American births (1988 baseline);

(1) By 1995, increase the number of high-risk pregnant women in appropriate prenatal management, including referral and transport to tertiary centers where indicated (baseline not available);

(2) By 1995, insure that hospitals provide care to mothers and infants based on their approved capabilities (baseline not available);

(3) Increase the percentage of all women receiving prenatal care in the first trimester from 73.1 percent for all births and 57.1 percent of African American births to 90.0 percent of all births (1988 baseline);

(4) By 1995, implement universal access to prenatal care, including comprehensive risk assessment;

(5) By 1995, insure appropriate referral and followup for all pregnant women seen in emergency rooms without a primary care provider (baseline not available); and

(6) Increase the proportion of eligible pregnant women served by Women, Infants, and Children (WIC) from 45.7 percent to 100.0 percent (1991 baseline);

iv. By 1995, increase by 33 1/3 percent or 36,630, the number of women served by the publicly funded family planning agencies who are at risk of unintended pregnancy and in need of free or subsidized family planning services (1990 baseline 110,000);

***[iv.]*v.* Reduce maternal deaths from 24.5 per 100,000 of all live births and 76.2 in the African American population to 5.0 per 100,000 live births (1986-1989 baseline);**

***[v.]*vi.* Increase abstinence during pregnancy from as follows:**

(1) Alcohol to 95 percent (no baseline);

(2) Tobacco from 86.6 percent (1989 baseline) to 90 percent; and

(3) Cocaine, heroin, marijuana or methamphetamines by 20 percent (no baseline);

***[vi.]*vii.* Reduce the annual incidence of measles (rubeola) from 405 cases to zero (1988 baseline);**

(1) Measles (rubeola) immunization levels in two-year-old children will be 90 percent (baseline not available);

***[vii.]*viii.* Immunization levels for H. influenzae type b started at two months will be 80 percent (baseline not available);**

***[viii.]*ix.* Reduce the prevalence of blood-lead levels exceeding 15 mcg/dl in children aged nine months through five years to 14,000 (baseline not available) and those exceeding 25 mcg/dl from 1,500 to zero (1988 baseline);**

(1) By 1995, 100.0 percent of children at high risk and 75.0 percent of all children will be screened for lead poisoning and receive appropriate environmental and medical management (baseline not available);

***[ix.]*x.* Reduce by 20.0 percent (26,000 admissions) the number of hospital admissions for children aged zero to four due to ambulatory care sensitive diagnoses, such as pediatric otitis media, pneumonia, bronchitis and asthma, respiratory infections, gastroenteritis, cellulitis, and diabetes (1989 baseline);**

(1) 75.0 percent of families will have a community-based pediatric primary care provider (baseline not available);

(2) By 1995, all children seen in emergency rooms without a primary care provider will be referred and followed up for primary care (baseline not available); and

(3) 100.0 percent of maternity hospitals and prenatal care clinics will provide active programs of education and support for women to breastfeed (baseline not available);

***[x.]*xi.* Reduce the proportion of children six through 18 with dental caries to 35 percent or less (baseline not available);**

(1) Increase the proportion of people served by community water systems providing optimal levels of fluoride from 19 percent to 62 percent (1990 baseline, estimated; excludes population whose water source is well water and water systems serving fewer than 6,000).

***[xi.]*xii.* Reduce the incidence of iron deficiency among children one through two to under 10 percent and to five percent among children three to four (no baseline); and**

***[xii.]*xiii.* Control the increase in the incidence of AIDS per 100,000 population in children zero to nine years of age so that it only doubles from 4.4 to 8.8 (1988 baseline);**

3. Reduce the incidence of adolescent pregnancy and improve adolescent health:

i. Decrease the prevalence of cigarette smoking among high school students from 41.2 percent to 20.0 percent (1989 baseline);

ii. Reduce the number of births per 1,000 females aged 15 to 19 years of age:

(1) To all women from a rate of 37.5 to 25.7 (1988 baseline); and

(2) To minority women from a rate of 78.9 to 55.8 per 1,000 (1988 baseline);

iii. Reduce the number of births per 1,000 females aged 10 to 14 years of age:

(1) To all women from a rate of 1.0 to 0.7 per 1,000 (1988 baseline); and

(2) To minority women aged 10 to 14 from 2.8 to 2.0 per 1,000 (1988 baseline);

iv. Ninety percent of sexually active high school students shall ***[have used]* *use* contraception during *[their most recent]* intercourse and 60 percent will use barrier methods (baseline not available);**

v. The proportion of adolescent females receiving family planning services will increase from 35.7 percent to 50 percent of adolescent females in need of such services (1987 baseline); and

vi. Adolescents who have engaged in sexual intercourse shall be no greater than 15 percent for tenth grade girls and boys, and 40 percent for 12th grade girls and boys (baseline not available);

4. Prevent and control injuries:

i. Reduce the rate per 100,000 population of deaths caused by motor vehicle crashes from 12.7 deaths to 11.4 in the total population (age-adjusted rates), from 25.8 to 23.0 for youth aged 15 to 24 and from 24.6 to 20.0 for people aged 70 and over (1988 baseline);

ii. Increase the use of seat belts by persons 18 and over "always" or "nearly always" when driving or riding in a car to 75.0 percent (baseline not available);

iii. Decrease the rate per 100,000 population of deaths due to falls and fall-related injuries from 13.0 to 12.0 for people age 65 to 84 years and from 117.7 to 105.0 for people age 85 years and over (1988 baseline);

iv. Decrease homicide deaths for minority males aged 15 to 44 from 48.9 to 39.0 per 100,000 population and from 9.2 to 7.0 per 100,000 population for minority females aged 15 to 44 (1988 baseline);

v. Reduce suicides per 100,000 population from 9.3 to 7.5 for youth aged 15 to 24 and reduce suicides for white men aged 65 and over to 39.2 per 100,000 (1988 baseline for youth, not available for white men aged 65 and over); and

vi. Decrease hospitalizations for nonfatal head and spinal cord injuries per 100,000 population by 15.0 percent (baseline not available);

5. Prevent and reduce the incidence of vaccine-preventable and other infectious diseases:

i. Reduce the annual incidence of measles (rubeola) from 405 cases to zero (1988 baseline);

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- ii. Reduce the annual incidence per 100,000 population of active TB from 10.3 to 4.4 in the total population and from 32.7 to 13.5 in the minority population (1988 baseline);
 - iii. Reduce the annual incidence of lyme disease (with rash) from 550 total cases to 275 cases (1988 baseline);
 - iv. Increase information levels for measles (rubeola) in children by age two to 90.0 percent (baseline not available);
 - v. Increase H. influenzae type b immunization levels started at two months to 80.0 percent (baseline not available);
 - vi. Increase hepatitis B immunization levels in pregnant women and infants to 100.0 percent (baseline not available);
 - vii. Increase hepatitis B immunization levels among intravenous drug users served in publicly-funded clinics from zero to 90.0 percent (1988 baseline);
 - viii. Increase hepatitis B immunization levels among gay men served in publicly-funded clinics from zero to 90.0 percent (1988 baseline);
 - ix. Increase the number of publicly-funded addiction treatment centers which screen HIV-positive clients for tuberculosis to 95.0 percent (baseline not available); and
 - x. Increase the number of all other publicly-funded clinics which screen HIV-positive clients for tuberculosis from zero to 75.0 percent (1988 baseline);
6. Prevent and reduce the incidence of STDs:
 - i. Reduce the incidence per 100,000 of primary and secondary syphilis from 14.2 to 10.0 for the total population and from 68.5 to 65.0 for the minority population (1988 baseline);
 - ii. Reduce the cases per 100,000 live births of congenital syphilis from 64.3 to 30.0 in the total population and from 259.2 to 100.0 in the minority population (1990 baseline);
 - iii. Reduce the incidence per 100,000 total population of gonorrhea from 212.7 to 175.0 (1988 baseline);
 - iv. Reduce the incidence of chlamydia trachomatis infections to 170.0 per 100,000 population (baseline not available);
 - v. Increase the number of publicly-funded clinics which offer provider referral service to patients with bacterial STD from 25.0 percent to 50.0 percent (1988 baseline); and
 - vi. Increase the number of publicly-funded clinics providing STD services to 100.0 percent of all prisons/detention centers (baseline not available) and from zero to 50.0 percent of all other publicly-funded clinics (1988 baseline);
 7. Prevent and control AIDS and HIV infection:
 - i. Reduce the transmission rate of HIV/AIDS so that the incidence rate per 100,000 population is not greater than:
 - (1) 8.8 for the pediatric population zero to nine years of age;
 - (2) 79.2 for white males 25 to 44 years of age;
 - (3) 868.2 for minority males 25 to 44 years of age; and
 - (4) 150.0 for minority females 15 to 44 years of age;
 - ii. Reduce deaths due to HIV/AIDS in the total population from 15.1 to 12.1 per 100,000 population (age-adjusted rates) and for 25 to 44 year olds from 37.6 to 30.1 per 100,000 population (*[1991]* *1988* baseline);
 - iii. 60 percent of sexually active high school students will use barrier contraception at their most recent intercourse (baseline not available);
 - iv. 75 percent of primary care and mental health care providers shall provide age-appropriate counseling on the prevention of HIV infection (baseline not available); and
 - v. Publicly-funded clinics that provide counseling and testing services to HIV-infected individuals shall be increased:
 - (1) From zero to 40 percent *[at]* *of* alcohol treatment centers (1991 baseline); and
 - (2) From a range of 16 to 95 percent to 100 percent *[at]* *of* all other publicly-funded clinics (1991 baseline);
 8. Reduce the rates of morbidity and mortality due to addictions:
 - i. Reduce the prevalence of cigarette smoking among individuals age 20 and over from 24.5 percent to 15.0 percent and among high school students from 41.2 percent to 20.0 percent (1989 baseline);
 - ii. Increase the proportion of women who abstain from tobacco use during pregnancy from 86.6 percent to 90.0 percent (1989 baseline);

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- iii. Increase the proportion of women who abstain from alcohol use during pregnancy to 95.0 percent (baseline not available);
 - iv. Increase by 20.0 percent the proportion of women who abstain during pregnancy from use of cocaine, heroin, marijuana or methamphetamines (baseline not available);
 - v. Decrease the percentage of high school sophomores, juniors and seniors who have used the following substances in the past 30 days: alcohol from 49.6 percent to 37.0 percent, marijuana from 11.8 percent to 9.0 percent and cocaine from 2.2 percent to 1.6 percent (1989 baseline);
 - vi. Decrease by 10.0 percent the proportion of persons 18 years of age and older who consumed five or more alcoholic drinks per occasion, one or more times during the past month (baseline not available);
 - vii. Decrease deaths per 100,000 due to alcohol-related motor vehicle crashes for the total population from 4.0 to 3.5, and for youth aged 15-24 from 5.9 to 5.0 (1988 baseline);
 - viii. Decrease deaths per 100,000 population from cirrhosis for the total population from 10.3 to 6.8 (age-adjusted rates) and for minority males from 20.8 to 12.3 (age-adjusted rates, 1988 baseline);
 - ix. Decrease drug-related deaths per 100,000 population from 8.3 to 6.6 (age-adjusted rates, 1988 baseline);
 - x. Of clients in treatment, decrease the average time between first use and treatment by 20.0 percent for alcohol treatment (baseline not available) and from 9.3 years to 7.5 years for other drug treatment (1988 baseline);
 - xi. Increase the percentage of publicly-funded clinics providing addiction screening services from a range among types of clinics of zero to 27 percent to 100 percent of all types of publicly-funded clinics (1988 baseline);
 - xii. Increase the proportion of persons addicted to alcohol and/or drugs who are treated in residential or outpatient programs annually from 9.0 percent to 20.0 percent (1990 baseline); and
 - xiii. Reduce the prevalence of obesity from 24 percent in men and 27 percent in women aged 20 through 74 to no more than 20 percent, and from 15 percent to 10 percent in adolescents aged 12 through 19 (1976-80 baseline);
9. Increase efforts to prevent, detect and control cardiovascular and other vascular diseases:
 - i. Reduce deaths per 100,000 population due to coronary heart disease:
 - (1) From 142.9 to 107.2 for the total population (age-adjusted rates, 1988 baseline);
 - (2) From 133.1 to 99.8 for the minority population (age-adjusted rates, 1988 baseline);
 - (3) From 206.2 to 154.7 for the total population aged 45-64 (1988 baseline); and
 - (4) From 214.8 to 161.1 for the minority population aged 45-64 (1988 baseline);
 - ii. Decrease deaths per 100,000 population due to cerebrovascular diseases:
 - (1) From 27.0 to 20.8 for the total population (age-adjusted rates, 1988 baseline);
 - (2) From 39.5 to 32.0 for the minority population (age-adjusted rates, 1988 baseline);
 - (3) From 32.6 to 22.8 for the total population aged 45-64, (1988 baseline);
 - (4) From 64.2 to 44.9 for the minority population aged 45-64 (1988 baseline); and
 - (5) From 354.7 to 283.8 for the total population aged 65 and over (1988 baseline);
 - iii. Reduce the rate of end-stage renal disease as a complication of diabetes from 1.9 to 1.8 per 1000 diabetics (1988 baseline) and decrease end-stage renal disease as a complication of diabetes for African Americans by 10.0 percent (baseline not available);
 - iv. Increase by 10 percent the proportion of persons 18 and over who participate in physical activity for at least 30 minutes three or more times per week (baseline not available);
 - v. Increase to 90 percent the proportion of people aged 18 and over who have had their blood pressure checked by a health

professional within the past two years and can state whether their blood pressure was normal or high (baseline not available); and

vi. Increase by 15 percent the proportion of people 18 and over who have had their blood cholesterol checked by a health professional within the past five years (baseline not available);

10. Increase efforts to prevent, detect and control cancer:

i. Decrease breast cancer deaths per 100,000 women:

(1) From 25.2 to 22.7 for all women (age-adjusted rates, 1988 baseline);

(2) From 80.6 to 72.5 for women aged 50-64 (1988 baseline); and

(3) From 144.7 to 130.2 for women aged 65 and over (1988 baseline);

ii. Increase *[by]* *to* 60.0 percent the number of women aged 40 and over who received an annual clinical breast examination and a mammogram (baseline not available);

iii. Reduce the rate of deaths due to lung cancer per 100,000 population to a rate of no more than:

(1) 41.3 for the total population (age-adjusted rates, 1988 baseline); and

(2) 64.8 for minority males (age-adjusted rates, 1988 baseline);

iv. Reduce the prevalence of cigarette smoking among individuals:

(1) Age 20 and over from 24.5 percent to 15 percent (1989 baseline); and

(2) Among high school students from 41.2 percent to 20.0 percent (1989 baseline);

v. Reduce colorectal cancer deaths per 100,000 population from 16.9 to 15.5 (age-adjusted, 1988 baseline);

vi. Increase to five the average daily servings of fruits and vegetables (including legumes) consumed by people aged 18 and over (baseline not available);

vii. Decrease death rates per 100,000 women from cervical cancer:

(1) From 2.7 to 1.3 for all women (age-adjusted rates, 1988 baseline);

(2) From 5.3 to 2.6 for minority women (age-adjusted rates, 1988 baseline); and

(3) From 6.3 to 3.2 for women aged 65 and over (1988 baseline); and

viii. Increase the number of women (with uterine cervix) who have had a Pap smear in the past two years to 85.0 percent for all women, 80.0 percent for minority women and 70.0 percent for women aged 65 and over (baseline not available);

11. Reduce morbidity and mortality related to occupational and environmental hazards:

i. Reduce work-related injury deaths per 100,000 for full-time, male construction workers from 15.0 to 10.0 (1983-1989 baseline);

ii. Reduce the number of workers with occupational exposure causing blood lead concentrations >25 mcg/dl of whole blood from 1,248 to zero (1988 baseline);

iii. Reduce the number of workers with exposures leading to hospitalizations for acute occupational lung diseases from 164 to 82 (1988 baseline);

iv. Increase the number of sites evaluated for potential human exposure pathways to hazardous waste from 100 to 350 (1988 baseline);

v. Reduce the prevalence of blood-lead levels exceeding 15 mcg/dl in children aged nine months through five years to 14,000 (baseline not available) and those exceeding 25 mcg/dl from 1,500 to 0 (1988 baseline);

vi. Increase from 76.0 percent to 100.0 percent the amount of asbestos either properly maintained or removed in school buildings with asbestos management plans submitted and approved by the Department of Health (1988 baseline); and

vii. Increase the proportion of people served by community water systems providing optimal levels of fluoride from 19 percent to 62 percent (1990 baseline, estimated; excludes population whose water source is well water and water systems serving fewer than 6,000); and

***12. Improve the health status and quality of life for race/ethnic minority populations:**

i. Improve the availability of, and accessibility to, culturally and linguistically sensitive comprehensive medical, dental and mental

health care services for race/ethnic minority populations. (Baseline data not available; targets will be set pursuant to the completion of the Final Report on Minority Health by the end of 1992.)

ii. Improve financing for health care services to low income minority populations, that is, affordable services, available insurance coverage and reasonable reimbursement to providers. (Baseline data not available; targets will be set pursuant to the completion of the Final Report on Minority Health by the end of 1992.)

iii. Improve needs assessment, recruitment, retention and training strategies to increase the number of minority physicians and health care providers serving the minority community. (Baseline data not available; targets will be set pursuant to the completion of the Final Report on Minority Health by the end of 1992.)

iv. Organize and develop a Statewide minority health network by improving communications, cooperation, and collaboration with minority community based organizations and other health and human service providers. (Targets will be set pursuant to the completion of the Final Report on Minority Health by the end of 1992.)*

*[12.]*13* Improve the health and quality of life for people with chronic functional impairments:

i. Increase the span of healthy, independent life for all New Jerseyans (no baseline available);

ii. Minimize the limiting effects of chronic conditions and help individuals to maintain their highest level of functioning (no baseline available);

iii. Support and encourage the endeavors of the predominant providers of long-term care: family (no baseline available);

iv. Provide access to an array of affordable long-term care options so that individuals can receive care in the least restrictive setting appropriate to their needs and preferences;

v. Improve access to care for special long-term care patient populations; and

vi. Increase the options available to persons who are eligible for nursing home care so that the number of people accessing these options increases from five percent to 23 percent of the eligible population (1990 baseline).

8:100-1.2 Scope

(a) This chapter establishes comprehensive goals and objectives for future certificate of need, licensure, reimbursement and public health rules to be promulgated by the Department of Health governing health care facilities as defined by the Health Care Facility Planning Act (P.L. 1971, c.136) and health care services. It also provides policies and guidelines for future grant making by the Department of Health and directs the Department to work with sister agencies *[to include]* ***including***, but not ***[be]*** limited to, the Departments of Human Services, Education, Insurance, and Community Affairs to address issues of mutual concern.

(b) The State Health Plan is a dynamic document that should change with the health needs of the people in the State. To that end, it is the role of each LAB:

1. To evaluate each new subchapter as it relates to the specific health care needs and resources of the region, and ***[report]*** ***recommend*** to the State Health Planning Board revisions ***[that are]*** ***it deems*** necessary ***[in response]*** ***to respond*** to local health needs. ***[This report]*** ***The recommendations*** will be completed ***[within four months of adoption of the subchapter and will initiate the first revision]*** ***by January 20, 1993***; and

2. To provide recommendations at least annually for changes to the plan in response to local health needs.

8:100-1.3 Definitions

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

"ACS" means ambulatory care sensitive conditions, which are hospital admissions that usually could have been avoided with appropriate primary care.

"Acute care hospital" means all short-term general hospitals governed by the Chapter 83 rate setting system.

"ALOS" means the average length of stay in a hospital.

"Alternate family care" means a contractual arrangement ***between a patient, alternate caregiving family, and a sponsoring agency*** whereby no more than two individuals in need of long-term care receive room, board, and care in the private residence of a nonrelated family that has been trained to provide the necessary caregiving.

"ASAM" means American Society of Addiction Medicine.

"Commissioner" means the Commissioner, New Jersey Department of Health.

"Community Care Program for the Elderly and Disabled" or "CCPED" means a Medicaid-funded, Federally waived program offering case managed home and community-based care to persons who meet specific eligibility criteria.

"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.

"CN" means certificate of need.

"CT" means computerized tomography.

"CVD" means cardiovascular disease which is diseases of the heart and blood vessels, including coronary heart disease and cerebrovascular disease (stroke).

"Department" means Department of Health.

"ESWBL" means ***[electracorporeal]* *extra corporeal*** shock wave biliary lithotripsy.

"ESWL" means ***[electracorporeal]* *extra corporeal*** shock wave lithotripsy.

"ICU/CCU" means intensive care and critical care hospital units.

"LAB" means local advisory board, a regional health planning agency established by P.L. 1991, c.187 sec. 35 and designated by the Commissioner of Health.

"LDRP" means labor, delivery, recovery and postpartum obstetric units.*

"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” 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 placement" means a unit of service provided to an individual who is nursing home-eligible. The unit of service may be a bed, for example, a nursing home bed, or a slot, for example, a Community Care Program for the Elderly and Disabled slot.

"M/S" means medical/surgical hospital units.

"Maternal and Child Health 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.

"Maternal and Child Health Consortia" means the perinatal and pediatric providers of the maternal and child health region which agree to associate and establish a nonprofit corporation consistent with the Internal Revenue Code under Title 26 of the United States Code Service, Section 501(c)(3).

"MRI" means magnetic resonance imaging.

"NIRA" means Nursing Incentive Reimbursement Awards.*

"Nursing home" means a facility that is licensed by the Department of Health for long-term care beds.

"OB/GYN" means obstetric/gynecological hospital units.

"PET" means positron emission tomography.

"PICU" means Pediatric Intensive Care Unit.*

"Provider" means an institution or individual actively delivering health care services, including, but not limited to, hospitals, physicians, nurses, clinics, local health departments and community health centers.

"Regionalization" means the planning and coordination of services for the best use of financial and medical resources such as staffing, equipment, facilities, education, and expertise to support appropriate, quality health care to a specific population.

"Reproductive health services" means all of the health services related to issues of fertility which include, but are not limited to: preconceptional care, perinatal care, family planning services, sterilization, prevention and treatment of sexually transmitted diseases, abortion services, adoption options counseling, infertility counseling and education and information on all of the above.*

SUBCHAPTER 2. PREVENTION, PRIMARY AND AMBULATORY CARE SERVICES (RESERVED)

SUBCHAPTER 3. HEALTH PERSONNEL SUPPLY (RESERVED)

SUBCHAPTER 4. MATERNAL AND CHILD HEALTH SERVICES

8:100-4.1 General recommendations

(a) The Department shall:

1. Develop a regionalized system of maternal and child health care that emphasizes community-based preventive ***and primary care, including reproductive,*** prenatal and pediatric ***[primary care]*** services, with particular attention to the appropriate linkage of outpatient to regional inpatient providers.

2. Establish a comprehensive health care system which is accessible, affordable and acceptable to women of reproductive age, infants, children, and adolescents including those with special needs, between the ages of 1 and 18.

3. Develop a regionalized system of total quality improvement, using outcome-oriented objectives including peer review, and monitor and enforce programs through licensure standards, certificate of need ***[regulations]* *rules***, and grant requirements.

8:100-4.2 Regionalization

(a) The Department shall ***[designate]* *establish*** an Office of Regionalized ***Maternal and Child Health*** Services in the Department to:

1. Coordinate the regional system both locally and between State agencies;

2. Monitor the Maternal and Child Health Consortia;

3. Evaluate the Maternal and Child Health Consortia using performance criteria based on outcome objectives; and

4. Develop letters of agreement with each Maternal and Child Health Consortia for funding through the rates.

(b) The Department of Health shall revise perinatal planning ***[regulations]* *rules,*** N.J.A.C. 8:33C,* and initiate the development of pediatric ***[regulations.]* *rules.** **The Commissioner of Health shall convene a pediatric clinical advisory committee to make recommendations regarding the development of pediatric rules. This committee shall include, but not be limited to: representation from the private pediatric provider community for both hospital and community-based services (medical and nursing), the American Academy of Pediatrics (New Jersey Chapter), the New Jersey Pediatric Society, the Parental Child Health Advisory Committee to the Department of Health, the Pediatric Subcommittee of the New Jersey Emergency Medical Services Council, the March of Dimes, the Governor's Committee on Children's Services Planning, the Maternal and Child Health Consortia, the local advisory boards, local health departments, community health centers, the University of Medicine and Dentistry of New Jersey, the New Jersey State Nurses Association, the New Jersey Public Health Nurse Administrators Association, the Medical Society of New Jersey, the New Jersey Hospital Association, and consumers. This committee will be**

staffed by the Office of Regionalized Maternal and Child Health Services and consultants external to the State.

(c) The pediatric clinical advisory committee shall make recommendations for the development of pediatric planning rules for a system for pediatric primary and inpatient care with attention to quality of care issues and will also make recommendations for the development of adjunct licensing rules as appropriate.*

8:100-4.3 Regional designation

(a) The Department of Health shall designate Maternal and Child Health Regions, Consortia, and regional perinatal centers based on *[1988, 1989, and 1990 data]* ***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***, and only for approved services in existence at the time of application for certificate of need in accordance with N.J.A.C. 8:33C. A maternal and child health service region shall have:

1. A minimum of 10,000 live births or 100 very low-birthweight neonates (in no case may the number of deliveries be below 8,000 women);

2. At least one facility meeting the qualifications of and functioning as a regional perinatal center and a regional pediatric center (although regions may have more than one of each); and

3. A geographically rational and cohesive network of services with documentation of accessibility to patients and a three year documented history of referral and transport patterns.

(b) Regionalization shall link inpatient with outpatient services.

(c) For perinatal designation, a Certificate of Need application shall be filed in accordance with N.J.A.C. 8:33C-1.19 et seq. ***and N.J.A.C. 8:33.*** [through all affected local advisory boards. Pediatric applications shall be filed in accordance with Certificate of Need rules to be developed by the Department of Health.]*

1. Funding ***for the consortia*** will proceed once the certificate of need application has been filed and fulfills all components specified in N.J.A.C. 8:33C-1.19 et seq.

2. In order to provide perinatal ***[or pediatric]*** services, facilities shall ***join and*** participate in ***[regionalization]*** ***a maternal and child health consortium*** and apply for the appropriate designation through their Maternal and Child Health Consortia in accordance with the certificate of need process specified above.

3. Changes in certificate of need regarding unit size or capital expenditures by facilities following initial designation shall be endorsed by the consortia and affected local advisory boards. Changes in certificate of need regarding designation status shall be submitted by the Maternal and Child Health Consortia.

(d) For pediatric designation, pediatric applications shall be filed in accordance with the pediatric planning rules to be developed by the Department as specified in N.J.A.C. 8:100-4.2, and the certificate of need process in N.J.A.C. 8:33. The designation process shall take place in the following sequence:

1. Certificates of need for renovation, construction, or downsizing of pediatric units shall be accepted and processed in accordance with the recommendations in N.J.A.C. 8:100-14 by local advisory boards with support from the consortia. Applications for designation shall not be accepted until pediatric planning rules are adopted.

2. A pediatric clinical advisory committee shall be convened by the Department as specified in N.J.A.C. 8:100-4.2.

3. Pediatric planning rules shall be proposed utilizing the recommendations of the pediatric clinical advisory committee.

4. In order to provide new or continuing pediatric services, facilities shall join and participate as members of a maternal and child health consortium. Pediatric applications shall be submitted through their Maternal and Child Health Consortia and all affected LABs and the Department.

5. Applications for certificate of need regarding unit size or capital expenditures by facilities following initial designation shall be endorsed by the consortia and affected local advisory boards. Changes in certificate of need regarding designation status shall be submitted by the Maternal and Child Health Consortia.*

((c))***(e)*** Regionalized services shall take into account existing referral patterns, which may not be consistent with regional health

planning boundaries. Maternal and Child Health Regions need not be in accordance with ***[these]*** ***regional health planning*** boundaries; however, care at regional centers must be geographically accessible to patients living within the regions.

8:100-4.4 Maternal and Child Health Consortia

(a) Services in each Maternal and Child Health Region shall be coordinated by a Regional Maternal Child Health Consortium, a private, nonprofit agency organized under IRSC 501(C)(3). This consortium shall be a central service facility licensed by the Department of Health and funded through hospital reimbursement and available ***[state]*** ***State*** funding. General membership in the Consortia shall include a balance of agencies with interests in ***[both]*** **pediatric***, ***[and]*** **perinatal** ***and reproductive health*** issues. Membership shall include all hospitals with maternity, newborn, and/or pediatric services, local health departments, local advisory boards, community health centers, Healthy Mothers/Healthy Babies Coalitions, WIC agencies, family planning agencies, all licensed ambulatory care facilities which provide prenatal or pediatric care, County Human Services Advisory Committees, and any other voluntary, professional or local/county governmental agencies concerned with maternal and child health services.

(b) The Board of Directors of each consortium shall be nominated from and voted upon by the general membership. The general membership shall also vote on the bylaws. The Board shall consist of ***a minimum of*** 18-21 members, one-third of which are hospital providers, one-third are nonhospital providers, and one-third are consumers. Each member agency or hospital is entitled to one vote in either the general membership or the Board. The Board shall also have one each licensed and currently practicing pediatrician and obstetrician, a licensed and currently practicing registered nurse with a certification in ***either*** maternal and child health nursing ***or in community health nursing*** and one health officer.

(c) The 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.

8:100-4.5 Functions of Maternal and Child Health Consortia

(a) Maternal and Child Health Consortia shall:

1. Assess local needs (including service capacity, accessibility, and cultural sensitivity);
2. Develop regional perinatal and pediatric plans;
3. Develop family-centered primary care services as needed;
4. Develop patient tracking systems;
5. Collect and share data with regional providers;
6. Provide total quality improvement;
7. Offer professional education;
8. Coordinate maternal, neonatal and pediatric transport systems;
9. Resolve conflicts;
10. Submit Certificate of Need applications for ***[both]*** facilities and the region;
11. Coordinate outreach and education programs; and
12. Make recommendations to the Department of Health for funding local services.

(b) In addition to (a) above, Maternal and Child Consortia will assess the need to consolidate or expand services provided in the currently funded categorical programs of local health departments, prenatal clinics, and family planning agencies. These ***[services should be expanded]*** ***agencies should be encouraged, through new funding sources, to expand their scope of care*** to provide community-based, accessible primary care to women and children ***where such services are indicated***. For example, Maternal and Child Health block grant funds shall be removed from hospital-based services and replaced with funds from the rates. Maternal and Child Health Block grant funds should then be utilized to expand existing family planning clinics to provide child health and prenatal services, and/or to expand existing prenatal care clinics to provide child health and family planning ***where the need exists and in accordance with regional plans. Primary care availability should begin with evaluating the feasibility of expanding existing programs such as family planning agencies and local health departments. In all settings, there should be coordination of referrals and smooth transitions**

between and among services so that moving from family planning to prenatal to pediatric and to postpartum family planning can be easily achieved*.

(c) One alternative for agencies with specific expertise would be to merge service provision in order to consolidate the availability and delivery of care. Satellite services should be available in housing projects and schools as needs are determined by the Maternal and Child Health Consortia in conjunction with the local advisory boards. These services should be linked or co-located with other services such as employment or job training. *[Primary care availability should be increased with expansion of existing categorical programs into broader maternal and child health providers, where such comprehensive services are indicated.]* See also N.J.A.C. 8:100-2, Prevention, Primary and Ambulatory Care Services, for more detail on specific need areas.

(d) Prenatal care ***services*** shall not be funded without concurrent evaluation of the need for family planning and pediatric components ***or linkage with existing agencies providing these services***. Maternal and Child Health Consortia shall make recommendations to the Department of Health regarding funding for local direct care providers. Local advisory boards should work in concert with Maternal and Child Health Consortia when planning for primary care services for women and children.

(e) Hospitals should follow-up all women and children without primary care providers who are seen in emergency rooms.

(f) Local advisory boards and Maternal and Child Health Consortia should jointly evaluate whether the acute care facilities slated for transition may become primary care facilities or residential and outpatient treatment facilities for pregnant addicted women and their children.

8:100-4.6 *[System]* ***Perinatal system*** of care

(a) Hospital-based and community-based care must comply with licensed ambulatory care standards (N.J.A.C. 8:43A), HealthStart standards (N.J.A.C. 10:49-3), and Standards for Obstetrics and Gynecological Services, 6th ed., 1985, published by the American College of Obstetricians and Gynecologists, 600 Maryland Avenue, SW, Suite 300 East, Washington, DC, 20024-2588, incorporated herein by reference. Prenatal care clinics in a region shall accommodate, at a minimum, the number of Medicaid births in a region annually.

(b) Prenatal care shall include, but not be limited to: history, physical exam, laboratory, risk assessment and plan of care. Support services shall include the following:

1. Outreach and education;
2. Case management;
3. WIC, on-site Medicaid eligibility determination;
4. Public health nursing follow-up in the home which can include the utilization of community volunteers or outreach workers supervised by a public health nurse, including the evaluation by the Department of the use of Nursing Incentive Reimbursement Award (NIRA) funds;
5. Patient/family education which is culturally sensitive and includes nutrition (especially breastfeeding), dental health, contraception, parenting skills, growth and development, injury prevention, HIV risk, and addictions;
6. Family risk assessment for abuse and neglect, addictions, and HIV exposure;
7. Consultation routinely available from registered dietitians or nutritionists, geneticists, social workers, other physician and pediatric specialties; and
8. Co-management between regional perinatal facilities and the perinatal provider in the community-based setting.

(c) Access to routine and high-risk inpatient perinatal care shall be improved by designating a network of perinatal facilities linked with community providers. In accordance with requirements specified in perinatal planning *[regulations (* ***rules***, N.J.A.C. 8:33C*)]**, and based on their capability of caring for low-birthweight infants, facilities shall comply with Hospital Licensing Standards, N.J.A.C. 8:43G-22, and shall be designated as one of the following:

1. Community Perinatal Centers shall be licensed facilities providing prenatal care, intrapartum care including delivery of the patient, and postpartum care to women. Community Perinatal Centers should provide a range of high risk neonatal management based on regional needs, in-house staffing and task capability and in accordance with the letter of agreement with their Regional Perinatal Center. Community Perinatal Centers shall each be designated as one of the following:

- i. Community Perinatal Center—Birthing Center (less than 500 deliveries per year, uncomplicated deliveries);
- ii. Community Perinatal Center—Basic (less than 800 deliveries per year, anticipated deliveries of greater than 2499 grams and 36 weeks gestation);
- iii. Community Perinatal Center—Intermediate (anticipated deliveries of greater than 1499 grams and 32 weeks gestation); or
- iv. Community Perinatal Center—Intensive (anticipated deliveries of greater than 999 grams and 28 weeks gestation).

2. Regional Perinatal Centers are licensed facilities able to provide a full range of perinatal services to their patient population and support to their regional affiliates. The Regional Perinatal Center shall document that for *[1990]* ***the most recent year*** or the average of the last three consecutive years of data *[(1988, 1989, 1990)]* ***available, and which is consistently applied in all applications within a region*** more than 80 maternal referrals or transports were accepted and full neonatal management was provided to more than 40 very low birthweight infants (less than 1500 grams). The Regional Perinatal Center shall have a neonatal intensive care unit in-house and a pediatric intensive care unit available either in-house or linked regionally;

3. Letters of agreement between all facilities in a region shall be specific regarding the coordination of services, transports, and referrals. The Regional Perinatal Center shall be able to provide: total management of the high risk maternal patient referred by the Community Perinatal Center, co-management with the attending physician at the Community Perinatal Center or community based setting, and telephone consultation to the attending physician at the community perinatal center; and

4. All facilities shall provide to the consortia and the Department individual patient data for the purpose of a total quality improvement program.

(d) Family planning services shall be routinely available at prenatal clinics and primary care facilities which should include information on the full array of reproductive health options. Adolescents should have information about methods of contraception readily available and, if sexually active, have access to family planning services. Mentoring programs should be initiated and evaluated for effectiveness. Renewed emphasis should be placed on male involvement and responsibility in reproductive health.]

***[d) Family planning information, or referral to services, shall be routinely available at prenatal clinics and primary care facilities.]**

(e) Reproductive health care services shall be routinely available and accessible which should include information on the full array of reproductive health options. Adolescents should have information about methods of contraception readily available and, if sexually active, have access to family planning services. Mentoring programs should be initiated and evaluated for effectiveness. Renewed emphasis should be placed on male involvement and responsibility in reproductive health. Refer to N.J.A.C. 8:100-2, Prevention, Primary and Ambulatory Care Services, for more detail.*

*(e)]***(f) Residential and outpatient services to pregnant addicted women shall include followup after delivery.

***8:100-4.7 Pediatric system of care**

(a) The pediatric system of care shall be evaluated and planning rules developed as specified in N.J.A.C. 8:100-4.2 and 4.3.*

*(f)]***(b)* The *[system]* ***provision*** of comprehensive pediatric care shall be in compliance with standards established by the American Academy of Pediatrics, P.O. Box 1034, Evanston, Illinois, 60204, the Advisory Committee on Immunizations Practices (Centers for Disease Control) and HealthStart N.J.A.C. 10:49-3.1 through 3.20 which are incorporated herein by reference, and include:

1. A strong network of cooperating pediatric providers; and
 2. An infant-tracking system of all newborns in need of primary care. This shall be accomplished through public health nursing home visits done by public health nurses or community volunteers or outreach workers under the supervision of a public health nurse. All nurses making home visits should have received Nursing Child Assessment Training (NCAT). Funding allocation shall be explored by the Department of Health and should include the possibility of utilizing some Nursing Incentive Reimbursement Awards (NIRA) to reduce ambulatory care sensitive admissions, and improve immunization status.

*[(g)]***(c)* Accessible (operating some evenings and weekends), community-based comprehensive preventive and primary care services to all children and adolescents shall include, but *[is]* ***are*** not limited to, well and 24-hour sick care, as well as:

1. Periodic physical examinations, which include dental assessments;
2. Immunizations;
3. Developmental and nutritional assessments with referral if indicated;
4. Screening tests such as lead levels, vision and hearing screening with referral if indicated;
5. Anticipatory guidance, including injury prevention and age-appropriate sex education;
6. Prompt treatment of all medical conditions not requiring immediate hospitalization or referral for secondary or tertiary care;
7. Case management;
8. Adolescent health services which includes assessment for sexual activity, substance abuse, ***and appropriate referral,*** teen male involvement in reproductive health issues, mentoring, and esteem building programs; and
9. Co-management of children with special needs by primary care providers and pediatric specialists.

*[(h)]***(d)* Refer to N.J.A.C. 8:100-2 and 6 on Prevention, Primary and Ambulatory Services and Infectious Diseases, respectively, for more information on strategies to improve primary immunization status in children.

*[(i)]***(e)* Local access to routine inpatient pediatric care shall be assured by a network of efficient and high-quality regional and community pediatric facilities linked with community providers. Facilities shall comply with Hospital Licensing Standards, N.J.A.C. 8:43G-22. Facility designation shall take place, with the development of pediatric planning ***[regulations]* ***rules***** and in accordance with ***specific hospital*** recommendations discussed in N.J.A.C. 8:100-14, Hospital Inpatient Services*. **The process for developing pediatric planning rules shall consider, but not be limited to, the following criteria for inclusion*:**

- *[1. Community Pediatric Centers shall have a dedicated pediatric inpatient unit and shall link with Regional Pediatric Centers and provide primary and preventive health services to children;
2. Regional Pediatric Centers shall have pediatric intensive care units, and in-house or linkage with a neonatal intensive care unit, pediatric residency or 24-hour house staff, pediatric subspecialty physicians, pediatric trauma/prehospital care program, primary and preventive pediatric care, and professional outreach and education program for community pediatric centers and other community-based pediatric providers, including emergency responders; and
3. Specialty Acute Care Children's Hospitals which have been designated for the provision of highly specialized regional neonatal and pediatric care. They shall be available for Statewide consultation. Criteria for designation shall be developed by the Department in pediatric planning rules utilizing the definition of a children's hospital set by the National Association of Children's Hospitals and Related Institutions, Inc. Allocation of resources will be made in accordance with these pediatric planning.*

***1. The requirement that all hospitals with and without licensed pediatric units, admitting pediatric patients must belong to a maternal and child health consortia and a structure for linkage where issues cross regional boundaries.**

2. The configuration of Community Pediatric Centers, Regional Pediatric Centers, and Specialty Acute Care Children's Hospitals and requirements for each as follows:

- i. Minimum staffing requirements for all facilities admitting pediatric patients;
- ii. Minimum occupancy and average daily census for pediatric units based on facility designation;
- iii. Emergency pediatric care including universal adoption of Emergency Department Approved for Pediatrics (EDAP) protocol by all facilities with emergency departments, pediatric training for emergency department staff, triage capabilities, and transport systems;
- iv. Geographic accessibility;
- v. A description of the relationship between hospitals and the primary care system and the provision of primary and preventive care outpatient services;
- vi. Evaluation of the impact on existing residency programs;
- vii. Evaluation of the impact on obstetric and newborn services designated to continue;
- viii. Inpatient specialty and sub-specialty care by type of designated facility;
- ix. Utilization of the National Association for Children's Hospitals and Related Institutions (NACHRI) criteria for determining requirements of Specialty Acute Care Children's Hospitals;
- x. The structure of the relationship between all member facilities in a region via letters of agreement and their linkage to a designated Specialty Acute Care Children's Hospital for consultation;
- xi. Evaluation of the need for requirements which provide or link to specialized ambulatory care programs which includes, but is not limited to: rehabilitation and communication evaluation and treatment, sickle cell/hemoglobinopathies treatment, hemophilia services, and cleft lip/palate craniofacial anomalies services; and
- xii. Evaluation of adolescent health services.*

*[(j)]***(f)* The Department of Health in conjunction with the Dental School (UMDNJ) should assess dental needs Statewide through the use of data gathering such as a study to determine the "decayed, missing, filled and treated" (DMFT) rate.

8:100-[4.7]**4.8* Policy changes/restructuring

(a) The Department of Health shall propose to the Public Health Council to amend Minimum Standards of Performance for Local Boards of Health (N.J.A.C. 8:52) as follows:

1. Special delivery shall reflect a prioritized system of care based on needs assessment, utilization, cost effectiveness, and a total quality improvement program;
2. Service delivery shall be commensurate with the community's needs such as:
 - i. Local health departments who have defined unmet pediatric primary care needs shall provide a comprehensive preventive health program for infants and preschool children. This shall include an appointment system where an initial appointment shall be no longer than 30 days and for children in areas of high immunization needs identified by the Department of Health shall be scheduled for the appropriate immunization within 14 days;
 - ii. Local health departments shall facilitate service delivery to women and children through linkages and referrals to primary care providers and WIC agencies;
 - iii. Local health departments who serve municipalities which exceed key indicators such as infant mortality, adolescent pregnancy, inadequate prenatal care, and poor immunization status shall provide home visits prenatally and postpartally in order to prevent poor birth outcomes and improve the poor parenting skills that can result in abuse and neglect. All nurses making home visits should receive Nursing Child Assessment Training (NCAT);
 - iv. Local health departments shall facilitate service delivery to high risk pregnant women such as pregnant addicted women, incarcerated women, etc.;
 - v. Local health departments shall provide for the prevention and control of lead poisoning in young children in accordance with Chapter 13 of the State Sanitary Code (N.J.A.C. 8:51); and

vi. Local health departments shall provide a strong program of health promotion and prevention linked to the primary care system; and

3. Local health departments shall participate as members of the Maternal and Child Health Consortia.

(b) The Department of Health shall ensure that proposed intermunicipal contracts for local health services are in accordance with the Local Health Services Act, N.J.S.A. 26:3A2-1-20. See N.J.A.C. 8:100-2, Prevention, Primary and Ambulatory Care Services, for further information on local health departments.

(c) The Department of Health shall require that WIC agencies, family planning agencies, community health centers, Healthy Mothers/Healthy Babies Coalitions and other community-based providers of prenatal or pediatric services participate on the Maternal and Child Health Consortia.

(d) The Department of Health shall work to eliminate system barriers:

1. Women, Infants and Children (WIC) shall develop a memorandum of agreement with Local Health Development Services to expedite follow-up of pregnant women and children with primary care needs;

2. HealthStart and Maternal and Child Health Services shall streamline the existing reporting requirements including the Maternity Services Summary Data Report (MSSD), which is overly comprehensive and demands much administrative time. To attract more providers, the recertification process should also be streamlined, with a concentration on the quality of care delivered. The requirement for home follow-up of high-risk patients should be enforced by a performance audit during recertification. The HealthStart *[regulation]* ***rule*** should be evaluated regarding the issue of comprehensive care on the first prenatal visit. Provider staffing standards should be more flexible during the certification process in order to expand the provider base; and

3. The Department of Health should streamline State monitoring procedures to eliminate duplication.

(e) The Department should coordinate with the Department of Education the expansion of the role of school nurses and increase the utilization of mid-level practitioners as important resources of health care for children and adolescents in public schools linked with primary care providers. This can be done through:

1. School-based youth services clinics;

2. Immunization provision on-site;

3. Adolescent health care, including information about reproductive health which may require linkage with local family planning agencies; and

4. Comprehensive follow-up of children deficient in immunizations and ***[EPSDT]* *Early Prevention, Screening, Detection and Treatment (EPSDT)*** referrals by linking with local health departments and/or primary care providers.

(f) The Department of Health, in conjunction with the Department of Human Services, should coordinate the administration of health programs at the State level through:

1. The administration of health programs and coordination with other departments to eliminate duplication of services and oversite and barriers to care; for example, by providing on-site Medicaid eligibility determination;

2. Coordination of services serving the same populations in need; for example, providing immunizations for indigent populations that are served by the Department of Human Services at ***[AFDC]* *Aid for Dependent Children (AFDC)*** and Food Stamp offices;

3. Coordination with the Department of Education to further develop educational programs for pregnant adolescents to encourage them to finish school or obtain occupational/vocational training; ***to encourage them to seek postpartum family planning services***; to provide prevention curricula on HIV/AIDS, sexually transmitted diseases, family life education, substance abuse, and injury; and to assess for mental health needs or substance abuse problems; and

4. Coordination with the Department of Education to facilitate comprehensive plans to address educational, emotional, social, and health needs of children with specialized needs.

(g) The Department of Health shall ***[launch]* *propose**** a Statewide mass media campaign, including prime time television and radio, to change public perceptions of the importance of early and adequate prenatal care and pediatric well child care and to emphasize the importance of adolescent pregnancy prevention.

(h) The Department of Health shall seek changes in the Federal categorical funding process to promote comprehensive care ***[at a single site]* *in accordance with N.J.A.C. 8:100-4.5(b)**** and to ***[serve]* *provide services to**** women beyond reproductive health age.

8:100-***[4.8]**4.9*** Reimbursement and cost containment

(a) Reimbursement rules (N.J.A.C. 8:31B) shall be revised in order to:

1. Fund Regional Maternal and Child Health Consortia through an ***[add-on to]* *inclusion in**** hospital rates that is based on obstetrical, neonatal and pediatric admissions. The initial estimated total cost annually is \$4.4 million. Funding shall be administered by the Department of Health through letters of agreement with each Maternal and Child Health Consortium. Each Consortium will be monitored, evaluated and held accountable to the Department of Health. Regional allocations shall be based on the number of deliveries and other criteria as determined by the Department of Health;

2. Encourage co-management of ambulatory and primary care services between specialists and primary care providers for children with specialized needs;

3. ***[Inappropriate]* *Reimburse inappropriate**** pediatric primary care delivered in emergency rooms ***[shall be reimbursed]*** at a reduced rate;

4. Allow for back transport of stabilized high risk neonates from facilities with intensive care capabilities to the community perinatal centers—basic or intermediate; and

5. Deny hospital inpatient reimbursement for perinatal and neonatal care delivered at hospitals not designated to provide that care excluding emergencies beyond stabilization.

(b) The Department of Health shall coordinate activities with the Department of Human Services to:

1. Revise the Medicaid reimbursement system to:

i. Increase the level of Medicaid (including HealthStart) reimbursement for pediatric primary care providers including pediatricians and family practitioners for both well and acute care to at least 80 percent of reasonable cost;

ii. Reimburse mid-level practitioners (nurse practitioners and physicians' assistants) at a rate commensurate with their practice;

iii. Expand cost-based payment for Medicaid and other payers to include free-standing licensed ambulatory care facilities, local health departments, and other free-standing facilities;

***iv. Expand HealthStart to include increased reimbursement for acute care pediatric visits*;**

[iv.]**v.* Develop a plan for reimbursing Special Child Health Services (SCHS) case management in order to best utilize Federal and State sources of funds, including Medicaid; and

[v.]**vi.* Expand reimbursement to cover the cost of the multidisciplinary approach and the intensity of primary care required by special needs children.

(c) The ***[Department of Health and the Department of Insurance]* *Departments of Health, Insurance and Human Services**** should jointly develop strategies to encourage health insurance companies and plans to cover comprehensive preventive services to women and children including prenatal care, family planning, immunizations, lead screening and preventive dental care and other services such as genetic testing, counseling, and multidisciplinary specialty care.

(d) The Department of Health should eliminate the provision of grant funds to expensive hospital-based primary care services and incorporate such costs into the rates.

(e) Regional perinatal centers should be encouraged to have open staffing arrangements for physicians from community perinatal centers to deliver their high risk patients whenever possible.

(f) The Department of Health should fund programs utilizing minimum performance standards for productivity levels per full-time

equivalent (F.T.E.) ***which*** will be established for providers in publicly-funded clinics, in accordance with standards established by John Snow, Inc. for the Bureau of Health Care Delivery and Assistance, Department of Health and Human Services (DHHS) incorporated herein by reference. For example:

1. Obstetricians—150 to 225 women/year;
2. Certified nurse midwives—90 to 125 women/year;
3. Family practice physicians—75 to 90 prenatal patients per year; and
4. Pediatricians/family practice physicians—4,500 to 6,000 pediatric encounters per year.

[(g)] Public health priority funding should be restored to a total of \$6 million for local health departments whose services are comprehensive and consolidated; for example, that prenatal care, family planning, and pediatric primary care are co-located, community-based, and with satellites where appropriate (housing projects, schools, day care, etc.), or to initiate primary care services in local health departments. As a minimum criteria for funding, Medicaid/HealthStart providership should be required where indicated.]*

[(h)](g)*** The Department of Health shall seek to enact legislative changes necessary to:

1. Designate a fund for revenue generated by local health departments in the provision of Medicaid services;
2. To amend the Public Health Priority Funding Act, N.J.S.A. 26:2F-6.2, to exempt local health departments from the provision of requiring increasing expenditures in order to qualify for the receipt of Public Priority Funds; and
3. Amend N.J.S.A. 40A:45.2 to exclude increases in local health budgets from the current municipal "cap" of 4.5 percent for priority health services.

[(i)](h)*** Local health departments shall obtain reimbursement from the Department of Education for school health services provided in nonpublic schools, in accordance with P.L. 1991, c.226.

[(j)](i)*** The Department of Health shall recommend to the Hospital Rate Setting Commission the utilization of Nursing Incentive Reimbursement Awards (NIRA) to annually fund public health nursing home visiting activities.

[(k)](j)*** The Department of Health should work to initiate legislation requiring home testing for lead by house purchasers. Lead abatement should be funded in environments where children live, using Federal and State housing funds and employing specially trained neighborhood workers.

8:100-*[4.9]**4.10* Manpower

(a) Loan-forgiveness programs for primary care physicians and mid-level practitioners should be expanded on condition of Medicaid participation.

(b) The practice of mid-level practitioners (for example, nurse practitioners and physicians' assistants), and the advanced practice of post-graduate trained nurses under the direction of a physician should be authorized through licensure.

(c) The Department of Health should recommend to the Hospital Rate Setting Commission that Nursing Incentive Reimbursement Awards (NIRA) be utilized to encourage nurses to seek expanded practice through nurse practitioner and certified nurse midwifery programs.

(d) Hospitals with primary care residencies should be reimbursed at a higher rate for primary care, and pro-rated based on the actual number of residents within each program.

(e) The Department of Health should collaborate with the Department of Insurance, the Trial Lawyers Association, and the Medical Society of New Jersey to resolve the issues of prohibitive costs of liability insurance and to seek tort reform.

(f) Hospitals should be encouraged to allow family practice physicians and certified nurse midwives to provide prenatal care and deliver their patients, where they have privileges and where the care is appropriate.

(g) Local health departments should be encouraged to seek providership as HealthStart Support Package providers for maternity services to augment private obstetricians who desire to become HealthStart providers.

(h) See also N.J.A.C. 8:100-3, Health Personnel Supply, for more specific recommendations.

8:100-*[4.10]**4.11* Total Quality Improvement Program

*** (a) Consortia and facilities shall develop a total quality improvement program which assures that:***

[(a)]**1. Local peer review shall include infant and fetal death review.

[(b)]**2. ***[To maintain delivery privileges,]*** ***Facilities shall document that*** all obstetric providers ***[shall be required to document]*** ***utilize*** a comprehensive prenatal risk assessment on all pregnant women.

[(c)]**3. Local audit shall include immunization level analysis in conjunction with local health departments and schools.

[(d)]**4. Monitoring of ambulatory care sensitive admissions shall occur locally be the Maternal and Child Health Consortia and each facility.

SUBCHAPTER 5. INJURIES (RESERVED)

SUBCHAPTER 6. INFECTIOUS DISEASES (RESERVED)

SUBCHAPTER 7. AIDS AND HIV (RESERVED)

SUBCHAPTER 8. ADDICTIONS

8:100-8.1 Purposes

(a) The purposes of this subchapter are to decrease morbidity and mortality due to addictive illnesses by:

1. Preventing the onset of addiction;
2. Screening for addiction;
3. Treating addiction and co-dependence as early as possible in the least costly and least restrictive setting;
4. Providing aftercare and relapse prevention; and
5. Ensuring universal access to care, based on severity of illness.

8:100-8.2 Prevention

(a) The Department of Health shall establish effective prevention programs appropriate to each stage of the life cycle and each aspect of addictive illness using the biopsychosocial (host, social, environment and agent) model to:

1. Reinforce "light use" norms for alcohol, prescription and over the counter drugs, and gambling;
2. Promote norms of "no use" of tobacco, illicit drugs, and alcohol for persons under age 21 ***and pregnant women***;
3. Support policies to control promotion, limit access and raise prices of alcohol and tobacco; and
4. Increase use of fruits, vegetables and complex carbohydrates, and decrease use of sugar, caffeine, refined carbohydrates, and fats, especially among addicted and co-dependent persons.

(b) The Department of Health in cooperation with ***the Prevention Committee of*** the Governor's Council on Alcoholism and Drug Abuse ***through the Statewide Prevention Affiliate Network*** shall:***** ***[Conduct a bi-lingual media campaign to promote education and awareness in the general population, especially targeting vulnerable groups, such as women, youth, minorities, the disabled, and the elderly;]***

1. Conduct a bi-lingual media campaign to promote education and awareness in the general population, especially targeting vulnerable groups, such as women, youth, minorities, the disabled, and the elderly;

[1]**2. Participation in the dissemination of Public Service Announcements prepared by the Partnership for a Drug Free America. Encourage the use of added messages regarding the addictive properties of alcohol and nicotine and discourage their use;

[2]**3. Promotion of media campaigns conducted by other groups to address addictive illnesses, for example, the Chamber of Commerce, March of Dimes, United Way, American Cancer Society*, the Medical Society of New Jersey; the New Jersey Coalition on Disabilities, Alcoholism and Drug Abuse; the New Jersey State Nurses' Association*;

*[3.]**4.* Collaboration with the Governor's Council on Alcoholism and Drug Abuse to support media activities on the part of local Community Alliance planning groups*, the **Statewide Prevention Affiliate Network and*** in cooperation with County Alcoholism and Drug Abuse Authorities and Local Advisory Boards for Health Planning;

*[4.]**5.* Cooperation with the Departments of Education, Human Services, and Labor to establish appropriate prevention initiatives for all addictions for use in schools, workplaces, child care agencies, Headstart, and local human service agencies;

*[5.]**6.* Earmarking a percentage of tobacco and alcohol taxes to counter tobacco and alcohol advertising;

*[6.]**7.* Targeting ***[public information at]* families and significant others of addicted persons *for receipt of public information***;

*[7.]**8.* Providing addiction prevention materials, such as videos and brochures, to primary care providers for use in waiting areas, and for in-service training of staff; and

*[8.]**9.* In cooperation with the Department of Human Services, expansion of school-based youth service programs*, **including special education and teen programs***, currently dealing with adolescent drug, alcohol and mental health issues to include health education, intervention and care for gambling and food addiction; and

10. In cooperation with the Department of Human Services, engage in planning and program development for improving and expanding services for individuals with mental illness and alcohol and drug addiction.

(c) The Department of Health shall establish a reporting system for prevention activities and relate the conduct of prevention programs to measured changes of ***health status***, opinion and behavior. The Department shall:

1. Convene a work group of individuals knowledgeable about information gathered in New Jersey on addiction prevention. This group should include, but not be limited to, the Department of Human Services Office of ***the* Prevention*[.]* *of Mental Retardation and Developmental Disabilities***; the prevention section of the Division of Alcoholism, Drug Abuse and Addiction Services within the Department of Health; the Commission on Smoking or Health; the American Heart Association; Rutgers Center of Alcohol Studies Clearinghouse; the alliance section of the Governor's Council on Alcoholism and Drug Abuse; ***the New Jersey Coalition on Disabilities, Alcoholism and Drug Abuse***; and the Statewide association of the local Councils on Alcoholism and Drug Abuse;

2. Determine uniform taxonomy and identifying missing data elements;

3. Publish an annual report on all prevention activities;

4. Seek and obtain funding from government or private sources, such as the Office of Substance Abuse Prevention of the U.S. Public Health Service*, to establish a survey agency to track changes in public opinion about addiction and changes in high risk behavior;

5. Prepare bi-annual reports to the Legislature and the cabinet on the relationship of prevention efforts to high risk behaviors and public opinions and attitudes on addiction; ***[and]***

6. Cooperate with the Governor's Council on Alcoholism and Drug Abuse to review findings and establish policy*[.]*; and*

7. Enhance the quality, consolidate the collection, and analyze the existing sources of patient data regarding drug, alcohol, and nicotine exposed births, drug and alcohol related deaths and emergency room contacts.

(d) The Department of Health shall seek to ***[enact]* *have enacted*** the legislative changes necessary to restrict advertising and activities promoting the use of alcohol and tobacco, especially those targeted at women, youth and minorities. The Department shall:

1. Support legislation to limit alcohol and tobacco advertising and promotions, especially in urban areas, on college campuses, and in State buildings and facilities, including sporting events conducted on State property;

2. Promote advertising which ties sports and physical exercise to non-smoking, non-drinking behaviors;

3. Eliminate the advertising of alcohol and tobacco products on billboards, in transit vehicles and at point*s* of purchase; and

4. Publicize and strengthen clean indoor air laws, and smoke-free workplaces.

(e) The Department of Health, Office of Health Policy and Research, shall assess the positive and negative impact of triplicate prescription statutes, in states such as New York, which have implemented the additional reporting requirement, for effectiveness in decreasing abuse.

(f) The Department of Health shall seek to ***[enact]* *have enacted*** the legislative and regulatory changes required to:

1. Revise the age of sale law for tobacco from 18 years to 19 years of age in order to stop sales to high school aged youth;

2. Ban automatic or vending machine sales of tobacco products, single cigarette sales, and self service;

3. ***[Ensure that all sales take place only from behind the counter, rather than self serve, through establishment of a means for local enforcement;]* *Establish a means of local enforcement to ensure that all sales take place only from behind the counter rather than self service;***

4. Increase penalties for underage sales. Establish primary enforcement through administrative procedures, such as escalating fines, license suspension, and revocation;

5. Discourage the sale of tobacco in retail pharmacies;

***[5.]**6.* License retailers at the local level to sell tobacco products, and establish specific local roles and responsibilities to educate *these retailers regarding these rules* *[and enforce]*; and**

***[6.]**7.* Use licensing fees to fund this program at the local level.**

(g) The Department of Health shall initiate and support initiatives which expand the number of sites which are smoke-free, such as:

1. Updating existing legislation providing for clean indoor air and smoke free workplaces and schools to reflect new knowledge of medical harm to persons exposed to smoke in their environment;

2. Amending hospital smoking ***[bans]* *ban policies*** to incorporate nicotine dependence treatment by:

i. Working with patients, staff and visitors to assure compliance with the ***smoking* ban** ***[on smoking]*** by establishing education and enforcement ***programs***; and

ii. Mandating that treatment be available for patients and employees;

3. Providing education to businesses and schools about how to establish smoke free environments and why they are important;

4. Assisting the Department of Education in extending school building smoking bans to include school grounds, both when school is in session and when it is not;

5. Proposing a gubernatorial executive order to ban alcohol and tobacco advertising, promotion, sale and sponsorship on State property;

6. Amending licensing rules N.J.A.C. 8:39, 8:42, 8:42A, 8:42B, 8:43, 8:43A, 8:43F and 8:43H to establish smoke-free environments in all licensed health care facilities ***[within three years of adoption of these regulations]* *by July 20, 1995***; and

7. Issuing advisories and ***[provide]* *providing*** training to all Department of Health contractors in preparation for becoming smoke-free ***[within three years of the adoption of these regulations]* *by July 20, 1995***.

(h) The Department of Health shall initiate and support activities directed to sensitizing high risk populations about food addiction, such as amending licensure rules (N.J.A.C. 8:42A, 8:42B, and 8:43A) to promote education about the addictive properties of sugar and caffeine, and to achieve sugar and caffeine free ***[environments]* *alternatives* *[within five years of the adoption of these regulations]* *by July 20, 1994***.

(i) The Department of Health shall publish alcohol and drug addiction, nicotine dependence, gambling and food addiction treatment directories ***in accessible format for disabled persons (that is, Braille, cassette tape)***. The Department shall:

1. Promote communication and referral among addiction providers through establishment of a newsletter, regional information exchanges, and development of interagency referral agreements;

2. Assist the New Jersey Alcoholism and Other Drugs of Abuse Counselor Certification Board in the development and certification of expertise in food, nicotine, and gambling addictions; and

3. Establish cross-training in addictions for counselors, planners, and managers of addictions programs, using new and established training networks.

8:100-8.3 Uniform addiction screening

(a) The Department of Health shall establish and implement utilization of *[a]* uniform addiction screening *[tool]* by:

1. Amending the licensing standards at N.J.A.C. 8:42A, 8:42B, 8:43A, and 8:43G to require *[the use of the tool]* ***screening*** in all licensed health care facilities; and

2. Collaborating with the Departments of Human Services, Education, Labor, Law and Public Safety, *[and]* Corrections ***and State agencies serving the disabled population*** to implement the use of *[this tool]* ***screening*** in their service settings ***[to screen for addiction]***.

(b) Every ***appropriate*** medical contact for ***health care,*** illness or injury should result in an objective, non-judgmental screening and, if needed, referral for diagnosis and treatment. The Department of Health shall:

1. Convene a task force to select and field test a screening ***[instrument within six months following the adoption of these rules]*** ***protocol and measures by January 20, 1993***. The task force should include experts in nicotine, alcohol, drugs, gambling and food addiction*, **co-existing mental disorders, and disabilities***;

2. Develop addiction screening curriculum, films, and training for health care professionals within six months of the adoption of the screening instrument;

3. Implement assessment and referral training for employees of all health care institutions and programs within two years of the completion of the training curriculum;

4. Incorporate ***this screening methodology into*** ongoing continuing education components at the University of Medicine and Dentistry of New Jersey, the New Jersey Hospital Association, the New Jersey Medical Society, the New Jersey Council on Alcoholism and Drug Abuse, and the Academy of Medicine;

5. Establish a reporting system for aggregate reporting of results of implementation of screening for addictions throughout the health care system;

6. Include an addiction screening as part of the 12-hour evaluation process in Intoxicated Driver Resource Centers. Treatment plans should include attention to other addiction problems;

7. In conjunction with the Division of Mental Health and Hospitals of the department of Human Services, provide training to clinicians in community mental health programs and psychiatric hospitals. Sessions should include information about addictions, as well as training in the use of the standardized addiction screening instrument, and when to refer to addiction evaluation professionals to determine the severity of addiction;

8. Cooperate with the Department of Human Services' Division of Mental Health and Hospitals, and the Governor's Council on Alcoholism and Drug Abuse in the development of a comprehensive assessment tool for determining mentally ill chemical abusers for use by both systems;

9. Train student assistance counselors in grades kindergarten through 12 to recognize the symptoms of all addictions and to intervene and refer for treatment students with addictions ***including special education students***. Training should be supported by policy changes by the Department of Education encouraging the expansion of services to addicted students; and

10. In cooperation with the Department of Labor, ***Division of Vocational Rehabilitation and the Department of Human Services, Commission for the Blind and Visually Impaired and Division of the Deaf and Hard of Hearing,*** establish screening for addiction as part of vocational assessment, and establish vocational assessment as part of addiction treatment, as appropriate.

8:100-8.4 Diagnostic criteria and treatment placement

(a) The Department of Health shall establish a review committee to adapt the American Society of Addiction Medicine (ASAM)

criteria for use in New Jersey to establish medical necessity for each level of care ***[within six months of the adoption of these rules]*** ***by January 20, 1993***. The review committee shall:

1. Assess the severity level of people identified by screening to be at risk for addiction; this shall be known as the severity of addiction assessment;

2. Determine the appropriate nature and intensity of treatment, based on addiction severity, treatment history, environment, and other patient characteristics;

3. Promote the use of the least costly and least restrictive setting for treatment; ***[and]***

4. Determine the severity level of co-dependence using a standard for prescribing the level and duration of treatment ***[.]*** ***and***

5. Ensure the appropriateness of the addition severity assessment to the needs of persons with disabilities, and persons with co-existing mental disorders.

(b) The Department of Health shall develop curriculum, films, and training on the use of the New Jersey adaptation of the ASAM criteria for patient placement in level of treatment within six months of adoption of the criteria.

(c) The Department of Health shall support the ***New Jersey* Council on Alcohol and Drug Abuse and Rutgers Center on Alcohol Studies** ***[to implement]*** ***and other accredited providers in the implementation of*** training for credentialled addiction professionals ***[within two years of the adoption of these regulations]*** ***by July 20, 1994***.

(d) The Department of Health shall ***[assure]*** ***monitor and support*** the establishment of ongoing in-service training at the University of Medicine and Dentistry of New Jersey, the New Jersey Hospital Association, the ***Medical Society of*** New Jersey ***[Medical Society]***, Rutgers Center on Alcohol Studies, the New Jersey Council on Alcoholism and Drug Abuse, the Academy of Medicine, ***the New Jersey State Nurses Association, Trenton State College***, and the New Jersey Alcoholism and Other Drugs of Abuse Certification Board.

(e) The Department of Health shall prepare a uniform client record to be used ***in health care settings for screening and placement*** at six month intervals for two years from point of assessment as described in the case management process contained in N.J.A.C. 8:100-8.6(a)3.

8:100-8.5 Establish appropriate levels of care

(a) The Department of Health shall designate a working group to review the ASAM levels of care and revise them to establish a comprehensive system reflecting ***[all]*** ***primary*** New Jersey ***ad-diction*** treatment modalities.

(b) The Department of Health shall revise licensure standards ***and reimbursement rules*** (N.J.A.C. 8:42A, 8:42B, ***[and]*** 8:43A ***and 8:31C***) to:

1. Classify licensed alcohol and drug treatment programs into a single continuum of care, ***to*** include unlicensed out-patient ***and halfway house*** addiction treatment programs;

2. Define a comprehensive addictions treatment system which has varying levels of intensity of care;

3. Promote the development of program components specific to the type and degree of addiction and co-dependence;

4. Recommend changes consistent with New Jersey patient placement criteria ***[within six months of adoption of these regulations]*** ***by January 20, 1993***;

5. Set rates for residential drug treatment and alcohol halfway house treatment programs within one year of adoption of the patient placement criteria; ***[and]***

6. Set rates for outpatient treatment within two years of adoption of the patient placement criteria ***[.]*** ***and***

***7. Monitor compliance of licensed facilities with the Americans with Disabilities Act of 1990 (P.L. 101-336, 42 U.S.C. 794), Section 504 of the Rehabilitation Act of 1973 (P.L. 93-112, 29 U.S.C. 794) and its amendments, and Title X:5-1, N.J.S.A. 10:2-1 et seq.; and**

8. Review unlicensed treatment programs to determine whether a licensing or certification process is appropriate to establish a standard of care.*

(c) The Department of Health shall authorize the issuance of certificates of need for addiction services **[pending]** as described in the addictions chapter of the State Health Plan in accordance with N.J.A.C. 8:33. New certificate of need applications will be accepted for treatment programs targeted at adolescents, and pregnant women.

(d) The Department of Health shall revise licensure standards (N.J.A.C. 8:43G) to require that hospital based addiction services be staffed by a physician who is certified in Addiction Medicine by **[The]* *the* American Society of Addiction Medicine (ASAM) *(or who has a Certificate of Added Qualifications in Addiction Psychiatry from the American Board of Psychiatry and Neurology)*, **[within four years of the adoption of these regulations]* *by July 20, 1996*.**

(e) In cooperation with the Local Advisory Boards, the Department of Health shall designate, in each region, a Comprehensive Addiction Care Center to serve as a model for hospital based addiction prevention, intervention, and treatment, **[within two years of the adoption of these regulations]* *by July 20, 1994*.*

(f) The Department of Health, in cooperation with the Department of Human Services, shall develop a bed need methodology for detoxification/rehabilitation units developed in conjunction with designated mental health screening centers by July 20, 1993.

8:100-8.6 Match patients with appropriate levels of care

(a) Based on the results of the standardized diagnostic criteria including the severity of addiction assessment established in N.J.A.C. 8:100-8.4(a), the Department of Health shall:

1. Determine appropriate treatment placement or level of care needed;
2. Structure a reimbursement system that is contingent upon appropriate patient placement;
3. Establish a case-management process to ensure follow-through with the prescribed treatment plan and the reporting of treatment outcomes at six month intervals for two years **with at least once annual in person contact**; and
4. Develop methods to assist patients to make informed choices about service settings offering the level of care needed, according to the severity of addiction assessment*, *and take into consideration degree of impairment when eliciting participation in treatment choices**.

8:100-8.7 Expand outpatient treatment capacity

The Department of Health shall ensure universal access to less costly outpatient treatment by expanding outpatient treatment capacity, and develop a financing mechanism to guarantee access to the uninsured as described in N.J.A.C. 8:100-8.9.

8:100-8.8 Aftercare and relapse prevention

(a) The Department of Health shall amend licensing standards N.J.A.C. 8:42A, 8:42B, 8:43A, and 8:43G to provide that treatment facilities shall:

1. Utilize a uniform client record;
2. Perform a follow-up assessment using the uniform client record every six months for two years from assessment of addiction severity;
3. Promote the use of self-help programs for aftercare and relapse prevention; and
4. Submit data contained on the uniform client record to the Department of Health upon request.

8:100-8.9 Cost containment

(a) The Department of Health shall emphasize screening activities, outpatient expansion, and care for the uninsured to reduce the high costs associated with inpatient care by:

1. Structuring a reimbursement system that is contingent upon appropriate patient placement;
2. Appointing an implementation task force to review means of paying for universal access to addiction treatment based on severity of illness rather than insurance coverage;
3. Encouraging hospitals to develop lower cost effective addiction treatment programs;

4. Establishing a methodology for assuring addiction screening and assessment for all patients in addiction caused or exacerbated diagnostic-related categories in health care facilities and programs;

5. Establishing interagency referral agreements with facilities providing each of the levels of care for addiction; and

6. Encouraging drug and alcohol testing only as an adjunct to a comprehensive addiction screening and assessment.

(b) The Department of Health shall seek to **[enact]* *have enacted** legislative changes necessary to set aside funds from the New Jersey Health Care Trust Fund (N.J.A.C. 8:31B-4) to support screening and assessment for addiction in earlier stages of illness, and to demonstrate the efficacy and cost savings of these initiatives.

8:100-8.10 Administration

(a) The Department of Health shall promote the siting of new addictions programs by supporting legislation that would pre-empt local zoning ordinances in favor of establishing a Statewide master plan for locating facilities.

(b) The Department of Health shall seek to **[enact legislative changes]* *have enacted legislation** to substantially increase alcoholic beverage and tobacco taxes, based on a percentage of price*. *Earmark***, *which would earmark** the proceeds for addiction prevention and treatment*. *Establish** **and establish** a trust fund to pay for access to treatment for addicted persons and their family members.

(c) The Department of Health shall collaborate with the Department of Insurance to promote **[reimbursement]* *payment** by all payers, including HMOs and PPOs, for all addiction screening and treatment based on severity of illness.

(d) The Department of Health shall develop reliable prevalence estimates for every addiction, which include adjustments for special populations and geographic variations. These estimates should include comorbidity with other addictions**[.]** because of the high rates of cross-prevalence of each addiction with the other addictions.

(e) The Department of Health shall amend the rules governing the certificate of need process (N.J.A.C. 8:33^{*}[.]) **and* 8:33K)* to:

1. Establish a structure and process that ensures an accurate count of all addiction services provided by county and health planning region; and
2. Authorize the Local Advisory Committees on Alcoholism and Drug Abuse (LACADAs) to assist the Local Advisory Boards in their review of Certificate of Need applications for addiction services from their county.

**(f) The Professional Advisory Committee of the Division of Alcoholism, Drug Abuse and Addiction Services and the Governor's Council on Alcoholism and Drug Abuse shall review planning and funding processes to assure consistency between municipal alliance plans, county alcoholism and drug abuse plans, LAB addiction services plans and the State Health Plan as funding determinations are made.*

*(g) Funding announcements, calls for demonstration projects, training opportunities and other communications from the Department will be disseminated through LABs, LACADAs and municipal alliances when timeframes and statutory authority allow.**

[(g) The Department of Health shall amend the charity care eligibility criteria for reimbursement, under the New Jersey Health Care Trust Fund (N.J.A.C. 8:31B-4.40) to allow hospitals to consider repayments of gambling debts as allowable adjustments to income when determining eligibility of compulsive gamblers receiving treatment.]

(h) The Department of Health shall seek to **[enact]* *have** legislation **[necessary]* *enacted** to collect fines imposed by the courts upon admitted compulsive gamblers, bookmakers and others involved in illegal gambling activities. These funds should be placed in a fund to finance treatment and intervention activities for gamblers in the same way Drug Enforcement Demand Reduction (DEDR) money is used to fund drug abuse prevention programs.

(i) The Department shall amend licensing rules (N.J.A.C. 8:42A, 8:42B, and 8:43A) to encourage revision of by-laws and admissions policies of drug and alcohol treatment centers to allow admission and treatment of compulsive gamblers, nicotine dependent and food

addicted persons, and to assure that staff have received specialized training and patients are placed according to severity of addiction.

(j) The Department of Health shall cooperate with the Department of Community Affairs and the Department of Human Services to develop outreach programs for senior citizens with addiction problems. Few senior citizens currently enter treatment, but they account for a sizable portion of casino business. Senior citizens are not often involved with the criminal justice or other systems which frequently result in referrals of younger persons. Programs should be conducted through senior citizens' centers and health care agencies in conjunction with the county Offices on Aging.

(k) The Department of Health shall collaborate with other states which have initiated comprehensive addictions programs. Research findings, new treatment approaches, and prevention strategies should be shared. A combined effort should be made to encourage national planning and funding for these activities.

(l) In cooperation with the Department of Health, the Department of Human Services shall expand Medicaid coverage for addiction treatment services for pregnant addicted women, *[within six months of adoption of these regulations]* ***by January 20, 1993*.**

(m) The Department of Health, Office of Health Policy and Research, shall investigate and report on the advisability of amending rules for government contractors, to require hiring an established percentage of recovering addicted persons as a condition of receipt of contract.

(n) The Department of Health shall collaborate with the Departments of Community Affairs, Labor, and Human Services to increase outreach to disabled persons who are at higher risk of addiction than non-disabled persons, yet are underrepresented in treatment programs.

SUBCHAPTER 9. CARDIOVASCULAR DISEASE (CVD) SERVICES

8:100-9.1 Prevention of Smoking Initiation and Treatment for Nicotine Dependence Policies

(a) Smoking prevention activities and strategies shall be promoted actively by the Department of Health throughout New Jersey. These strategies shall include:

1. Countering the effects of cigarette advertising and promotion by providing public service announcements (PSAs) on the harmful effects of smoking and on the benefits of quitting smoking at any age;

2. Promoting prevention of initiation of smoking programs at the grade-school level by including instruction in the health education curriculum; and

3. Reducing access to tobacco by increasing the cost of cigarettes through an increase in the cigarette tax, with proceeds earmarked for nicotine dependence treatment and education activities, restricting the sale of tobacco to minors, and providing the necessary enforcement of access laws. The Department of Health shall convene a task force comprised of individuals from educational, business, and law enforcement sectors to develop fair, effective methods of enforcing the laws currently in effect.

(b) Nicotine dependence treatment activities and strategies shall be promoted actively by the Department of Health throughout New Jersey. In recognition that cigarette smoking, one of the most preventable causes of cardiovascular disease, is highly addictive, the policy recommendations directed at eliminating tobacco dependence are fully supported. Additional nicotine dependence treatment strategies include:

1. Increasing support for nonsmokers' rights by stiffening clean indoor air regulations and encouraging smoke-free environments through tax breaks to smoke-free employers who provide smoking cessation programs for employees, and providing the necessary enforcement of clean indoor air laws. The Department of Health shall convene a task force comprised of individuals from educational, business, and law enforcement sectors to develop fair, effective methods of enforcing the laws currently in effect;

2. Encouraging a "smoke free" New Jersey by increasing the availability of nicotine dependence treatment programs by providing

insurance coverage for tobacco addiction treatment programs, and encouraging innovative programs targeted to high-risk populations such as pregnant women, minorities, and chemical industrial workers; and

3. Providing economic incentives such as decreased health and life insurance premiums to nonsmokers.

8:100-9.2 Cardiovascular Health Promotion Policy

(a) Cardiovascular health for all New Jersey communities and citizens shall be promoted through the promulgation of public policy by the Department of Health that supports healthy behaviors, creates supportive environments, and empowers individuals to maintain healthy choices in daily living. Specifically, the Department of Health shall:

1. Establish and maintain a Cardiovascular Health Promotion Disease Prevention Subcommittee as an advisory body to the Commissioner of Health through the Commissioner's Cardiac Services Committee, to serve as the mechanism for providing health promotion and disease prevention planning, implementation and evaluation;

2. Collaborate with the Department of Education to *[implement]* ***encourage*** the New Jersey school system *[with]* ***to implement*** policies that integrate cardiovascular health education as part of the health curriculum in grades kindergarten through 12;

3. Collaborate with the Department of Agriculture to implement policies which support the integration of nutrition incentives within cardiovascular health promotion programs;

4. Collaborate with the Department of Environmental Protection and Energy, Division of Parks and Forestry, and the New Jersey Recreation and Parks Association to provide and maintain adequate, safe and accessible facilities for physical activity;

5. Collaborate with the Department of Labor to implement policies supporting cardiovascular health promotion and education in all worksites with 50 or more employees;

6. Coordinate within the appropriate divisions of the Department of Health to implement policies promoting cardiovascular health promotion and disease prevention programs in health care facilities and health departments;

7. Provide for technical assistance encouraging community organizations to carry out health promotion programs which create an environment which supports cardiovascular health;

8. Provide for, coordinate and enhance data sources to monitor the health behaviors and cardiovascular risk factors of New Jersey communities and citizens;

9. Provide for cost-effective, population-wide models that motivate persons and communities to permanently adopt behavior which promotes community and individual cardiovascular health;

10. Collaborate with organizations, and especially with the American Heart Association, to provide cardiovascular health education to health professionals throughout the State, enabling them to counsel and advise their clients and communities on lifestyle changes which support cardiovascular health;

11. Provide for population-wide cardiovascular health promotion media campaigns that stress healthy decisions and behavior regarding cardiovascular risk factors, healthy eating, and physical activity;

12. Provide for scientifically-based information about cardiovascular health for health professionals, communities and consumers;

13. Promote and support policies that ensure the availability of healthy food choices to all citizens, and promote policies and incentives to encourage food industry attention to nutrition in product development and promotion; and

14. Establish incentives for the development of innovative programs that encourage cardiovascular fitness.

(b) Mechanisms or evaluative techniques shall be continually developed and modified by the Department of Health to evaluate existing health promotion/prevention activities conducted in New Jersey, such as the New Jersey State Healthy Heart Programs.

(c) Outpatient nutrition counseling services should be provided through designated referral sources in all acute-care hospitals, in order to maximize the opportunity for cost-effective primary and

secondary CVD prevention and intervention strategies. A sliding fee scale for underserved minority and elderly populations should also be provided.

8:100-9.3 Acute Care Cardiac Services and Resource Allocation Policy

(a) Statewide mechanisms shall be developed to review the quality and appropriateness of the cardiac procedures now performed in New Jersey. Implementation of pre-procedure, patient-risk stratification mechanisms shall be completed and perhaps extended to other aspects of cardiac intervention by the Commissioner's Cardiac Services Committee. The outcomes from these evaluative measures shall be linked to future expansion or contraction of the State's cardiac resources.

(b) Future certificates of need to expand cardiac services shall be contingent on the development of a regionalized plan by the local advisory boards to include, but not be limited to, organized referral patterns, a network of community-based secondary and tertiary, acute care providers, educational programs, and cost containment considerations. Preference should be given to existing programs that have demonstrated quality care through utilization of its cardiac services. Pediatric cardiac services, to be provided by the State's children's hospitals are established in the acute care subchapter (N.J.A.C. 8:100-14).

(c) Increased Department of Health resources should be devoted to the Myocardial Infarction Data Acquisition System (MIDAS), in order to facilitate long-term policy and resource-allocation decision-making. The Department of Health should expand its support for MIDAS to evaluate variations in treatment of hospitalized myocardial infarction patients.

SUBCHAPTER 10. CANCER (RESERVED)

SUBCHAPTER 11. DIABETES (RESERVED)

SUBCHAPTER 12. MENTAL HEALTH (RESERVED)

SUBCHAPTER 13. OCCUPATIONAL AND ENVIRONMENTAL HEALTH (RESERVED)

SUBCHAPTER 14. HOSPITAL INPATIENT SERVICES

8:100-14.1 General **[Recommendations]** ***recommendations***

(a) The Department of Health shall:

1. Assure the appropriate distribution and supply of acute care hospital beds throughout New Jersey to meet the identified health care needs of consumers, assure access to care, and promote quality of care and cost effectiveness;

2. Promote the use of appropriate levels of care, such as primary care^[,] ***and*** preventive ***care***, and care to special populations, including children, the frail elderly, and persons with AIDS;

3. **[Allocate new hospital capital expenditures within the Statewide capital cap by setting]** ***Set*** priorities for approval of needed projects ***in order to allocate new hospital capital expenditures within the Statewide capital cap***; **[and]**

4. Encourage the development of a strong regionalized health care system through coordination and consolidation of institutional and community resources^[,] *******; **and***

***5. Actively address quality of care by:**

i. **Developing uniform quality indicators that are outcome measures;**

ii. **Strengthen and make uniform Utilization Review that is quality driven;**

iii. **Engage in research to determine appropriateness of care; and**

iv. **Develop quality sensitive payment mechanisms.***

8:100-14.2 Hospital efficiency targets and objectives

(a) The target occupancy rate by 1995 for medical-surgical units of hospitals shall be 85 percent.

***(b) Within one year of approval of the Maternal and Child Health Consortia regional designation plan, the target annual OB/GYN occupancy rates, based on licensed beds, shall be determined as follows:**

1. Units with less than 20 licensed beds;

i. LDRP: 55 percent

ii. Postpartum: 65 percent

2. Units with 20 or more licensed beds:

i. LDRP: 65 percent

ii. Postpartum: 75 percent*

(b)**(c) The target occupancy rate by 1995 for all other inpatient services shall be 75 percent occupancy, except where otherwise identified in this rule.

(c)**(d) The Statewide objective for occupancy within the inpatient acute care hospital system is to achieve an occupancy of between 80 and 85 percent.

(d)**(e) Target rates for units located in geographically isolated areas or having unique service area responsibilities shall be developed by the LAB in conjunction with the Department.

(e)**(f) The Department and LABs will study the average length of stay for acute care services and promote appropriate utilization of facilities.

(f)**(g) The Department **[and]** ***in conjunction with the*** LABs will investigate the high rates of ***hospital*** admissions for certain ambulatory care sensitive conditions in ***[areas of]** the State^{*,} and promote actions to reduce ***[them to]** ***rates in areas significantly above*** the Statewide average.

8:100-14.3 Statewide bed need

(a) Using the **[methodology]** ***methodologies*** adopted by the State Health Planning Board ***which are based upon hospital admissions, patient days and length of stay trends***, ***[an overall excess of 2,175 hospital beds is projected for 1995.]*** ***the Department finds the State will have:**

1. An excess of 2,175 licensed acute care beds in 1995;

2. An excess of 1,700 licensed M/S beds in 1995;

3. An excess of 100 licensed obstetric beds in 1995;

4. An excess of 300 licensed pediatric beds in 1994;

5. An excess of 375 licensed beds for other services in 1995; and

6. A need for 300 additional licensed ICU/CCU beds in 1995.*

(b) All certificate of need projects submitted by a hospital shall be reviewed under the provisions of this **[subchapter]** ***chapter*** and also under the requirements of N.J.A.C. 8:43I, the Hospital Policy Manual, or under other planning **[regulations]** ***chapter***, where applicable. In the event of a conflict in the meaning, this **[subchapter]** ***rule*** shall supersede ***all other rules promulgated by the Commissioner of Health***.

8:100-14.4 **[Decertification]** ***Removal*** of unused beds ***from a hospital license***

(a) Pursuant to the Health Care Cost Reduction Act, N.J.S.A. 26:2H-38(d), the Commissioner may amend a facility's license to reduce that facility's licensed bed capacity to reflect actual utilization at the facility. This authority may be exercised if the Commissioner determines that 10 or more licensed beds in the health care facility have not been used for at least the last two succeeding years. For purposes of this rule, ***[retroactive review of hospital utilization may begin on January 1, 1990]** ***review of the hospital's utilization may go back as far as January 1, 1990***.

(b) Notice of the Commissioner's intent to **[decertify]** ***remove unused*** beds from a hospital license will be issued to an affected hospital with a statement of the reasons for the proposed action. The hospital may request an informal hearing with the Department within 30 days of receipt of the notice of intent.

(c) If the Commissioner issues a final decision to **[decertify]** ***remove*** beds ***from a hospital license***, a request for fair hearing submitted within 30 days of receipt of the decision will be granted and conducted in accordance with ***the Administrative Procedure Act,*** N.J.S.A. 52:14B-1 et seq. and 52:14F-1 et seq.^{*,} the Administrative Procedure Act^{*,} and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

8:100-14.5 Prioritization of hospital capital expenditure limits *[under Chapter 187]*

(a) Priority will be assigned to a Certificate of Need proposing a capital expenditure *[in which]* ***where*** the following factors are demonstrated within the application:

1. Community Need: A hospital will be deemed to have exhibited priority community need when it has the following characteristics:

i. Occupancy in excess of 90 percent in all services during the last calendar year preceding the application. Services that are proposed in the application to be closed may be excepted;

ii. The county in which the hospital is located has been determined to have a bed need; and

iii. The county's and hospital's rates of inpatient admission and length of stay have been demonstrated to be appropriate and not likely to decline as a result of changing medical practice or reimbursement policy;

2. Project Need:

i. The project is substantially directed to correcting Life Safety Code A or B level deficiencies, or other conditions posing imminent peril to health and safety of patients and staff; and

ii. The hospital has not implemented a major modernization or construction program in the affected areas of the project for a period in excess of 10 years. In addition, the overall average age of the physical plant exceeds 10 years based on the Department's calculations using generally accepted accounting principles; ***and***

3. Project Goals: The certificate of need application has been submitted in order to address a priority or a specific recommendation that is identified in the State Health Plan, and is determined by the Department to be essential to achieving that goal. These in specific include hospital closure or merger applications that demonstrate significant cost savings to the health care system, or projects implementing ambulatory care initiatives that improve health care delivery patterns and reduce system expenditures; ***[and]**[.]***

[4. Affordability:]* (b)* Projects [meeting]* shall demonstrate at least* one of the [above]* prioritization criteria [shall be assessed for affordability.]* *in (a) above. The strength of the demonstration and the number of prioritization factors demonstrated will be considered in the ranking of the projects. The projects will also be prioritized for affordability. Indicators of affordability are the total project cost, cost per adjusted admission, and the institution's ability to obtain low cost financing. ***[Within the list of all identified priority projects, the Department's assessment of the measures of affordability will be utilized to rank projects.]***

8:100-14.6 Nondiscrimination

All patients must have equal access to treatment for all services available in the hospital system. Any hospital which has been found to violate State or Federal laws prohibiting discrimination on the basis of race, age, religion, national origin, sex, sexual preference, handicap, ability to pay, or diagnosis (including AIDS), is not eligible for submission of a certificate of need for new or expanded services ***until such discrimination is remedied***.

8:100-14.7 Criteria for assessing need for a hospital

***[(a) In assessing whether a hospital has demonstrated community need for purposes of this plan and Certificate of Need review, the criteria in this section shall be used.**

(b)(a)* A hospital [must]* shall* demonstrate that it will be efficiently operated. If the hospital has less than 200 beds and overall occupancy below 75 percent, need for continued operation [must]* shall* be based on area need and/or geographic isolation.**

***[(c)**(b)* A [hospital's]* hospital shall demonstrate* overall financial viability [must be demonstrated,]* based on standard measures of profitability, liquidity and debt structure.**

***[(d) Concerning the]* (c) The* need for capital investment*[:**

1. An)* **shall be demonstrated by an*** assessment of the relative age and condition of a hospital's physical plant*, **which shall*** ***[must]*** indicate that it has maintained a safe and efficient environment for delivering patient care services*.****[; and**

2. If the hospital has demonstrated high community need, then a hospital's obsolete or unsound physical plant must receive priority attention.

(e) The following pertain to the criteria of community need:]*

(d) A hospital shall demonstrate community need.

1. Community need may be demonstrated by the special consideration of unique service provision to a geographically isolated region, ***to* a medically indigent population, or to persons with *[AIDS.]* diseases or disabilities that may engender personal, institutional or political discrimination (for example, AIDS), as defined below:***

i. Geographic isolation as used in this rule refers to the lack of an alternative hospital within 15 miles where at least 40 percent of service area residents use the hospital.

ii. Unique service provision to a medically indigent population can be demonstrated ***[where]* *if* the hospital provides services to a significant medically indigent population [where]* *and* there are no [alternate]* alternative* providers.**

iii. Unique service provision to a disproportionate share of persons with ***[AIDS]* diseases or disabilities that may engender personal, institutional or political discrimination (for example, AIDS)* can be demonstrated [where]* *if* a hospital serves as a clinical [AIDS]* resource center ***for such patients* and [it]* provides a significant level of services to [HIV-positive]* these* individuals in its service area.****

2. Community need may be demonstrated by hospitals providing a needed regionalized tertiary care service. Regionalized tertiary care services include: cardiac surgery (adult and pediatric), trauma, organ transplant and neonatal intensive care.

3. ***[Community need will consider the factor of]* The* quality of care provided by a hospital will be considered in assessing community need*.** Priority will not be given to those facilities which exhibit significant levels of licensure deficiencies, penalty actions, validated consumer complaints, and adverse patient outcomes.

(e) If a hospital has demonstrated high community need, then its projects addressing any obsolete or unsound physical plant will receive priority attention.

8:100-14.9 Limitations on hospitals and areas with excess bed capacity

(a) A hospital ***[which is]* recommended for transition from acute care services is not eligible to submit any certificate of need [application]* applications* except for [those]* projects* associated with its transition from acute care or projects essential to the safety of patients in accordance with the rules of the Department*.** ***[Reimbursement of]* Payment for* capital expenditures for [renovations]* renovation* of physical plant areas not requiring certificate of need approval will be limited. Alternative actions may be taken to effect this recommendation including a merger or consolidation resulting in an equivalent reduction in acute care beds.**

(b) ***[All hospitals in a county which has been designated as having excess beds in 1995 based upon a methodology approved by the State Health Planning Board in a magnitude that exceeds the size of any hospital in the county will not be permitted to submit any certificate of need application for major renovation/construction (in excess of \$10 million) until a plan to implement the required bed reduction has been approved by the LAB and the Department and implementation steps have been initiated. Exceptions for projects that address physical plant conditions demonstrated to have a significant negative impact on patient care outcomes may be granted by the Commissioner.]* If a county's excess bed capacity for 1995, projected in accordance with the methodologies approved by the State Health Planning Board, exceeds the number of beds in any hospital in the county, the LAB in which that county is located shall develop a plan for bed reduction. A LAB plan shall also be developed for counties identified in N.J.A.C. 8:100-14.13 in which significant downsizing may be needed. The plan shall be approved by the State Health Planning Board and the Department before any certificate of need applications for major renovation or construction projects (in excess of \$10 million) will be accepted from hospitals in the county. The Department may require initial implementation of the plan before accepting certificates of need from hospitals in**

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the county. Exceptions may be granted by the Commissioner for projects that address physical plant conditions demonstrated to have a significant negative impact on patient care outcomes, or for areas in which the excess is addressed by this plan through a recommendation for a hospital to transition from acute care.*

(c) The Department of Health will not recommend any special rate adjustment for a hospital which has been designated for phase out of all acute care inpatient services or closure of ***pediatric or obstetrical* services***,* ***[(that is, pediatric and obstetrical)]*** until such a plan has been approved by the ***[hospital(s) board(s)]* *hospital's board*** of trustees and appropriate regulatory agencies.

(d) The Department of Health may initiate a full rate review under N.J.A.C. 8:31B-3.52 for a hospital which has been recommended for phase out of all acute care services in the following circumstances:

1. Patient volume falls below an average daily census of 50, or to a level which ***[results]* *the Department determines will result*** in adverse patient care outcomes or risk to patient safety; and
2. The hospital is financially insolvent.

***[8:100-14.10 County specific recommendations for M/S and total hospital services**

(a) Based upon the criteria contained in N.J.A.C. 8:100-14.3, 14.5, and 14.7, the actions set forth in (b) through (g) below are to be taken by hospitals, Local Advisory Boards, and the Department:

(b) Local Advisory Board I:

1. Morris County:

i. Dover and Chilton must participate in a LAB M/S bed need study to determine whether bed reductions are warranted.

ii. The LAB must complete an areawide acute care bed need study and submit it to the State Health Planning Board and Department of Health.

iii. All other hospitals in Morris County must take steps to achieve target occupancy levels identified in this plan.

2. Passaic County:

i. St. Mary's—Passaic must transition from inpatient acute care services by 1995.

ii. The LAB must complete an areawide acute care bed need study that also addresses the phase-out of St. Mary's and the need to continue the psychiatric inpatient programs currently provided at St. Mary's.

iii. All other hospitals in Passaic County must take steps to achieve target occupancy levels identified in this plan.

3. Sussex County:

i. Newton and Wallkill Valley must participate in an areawide acute care bed need study to determine whether bed reductions are warranted.

ii. The LAB must complete an areawide bed need study and submit it to the State Health Planning Board and Department of Health.

iii. Until the LAB areawide bed need study is approved by the State Health Planning Board and the Department of Health, no certificate of need applications related to inpatient acute care services may be submitted by Newton or Wallkill Valley. An exception may be made only if the Department determines that a serious quality of care issue has occurred which requires immediate attention.

4. Warren County:

i. The LAB must complete an areawide bed need study and submit it to the State Health Planning Board and Department of Health.

ii. Until the LAB areawide bed need study is approved by the State Health Planning Board and the Department of Health, no certificate of need applications related to inpatient acute care services may be submitted by Warren or Hackettstown Hospitals. An exception may be made only if the Department determines a serious quality of care issue has occurred which required immediate attention.

(c) Local Advisory Board II:

1. Bergen County:

i. Bergen Pines County Hospital must participate in a LAB study to determine if inpatient acute care services must remain at this facility.

ii. Kennedy Memorial—Saddlebrook must transition from inpatient acute care services by 1995.

iii. All other hospitals in Bergen County must take steps to achieve target occupancy levels identified in this plan.

2. Hudson County:

i. Greenville Hospital must transition from inpatient acute care services as the Jersey City Medical Center implements its Certificate of Need for a replacement facility.

ii. All other hospitals in Hudson County must take steps to achieve target occupancy levels identified in this plan.

(d) Local Advisory Board III:

1. Essex County:

i. Montclair Hospital must transition from inpatient acute care services by 1995.

ii. Clara Maass Medical Center must participate in a LAB study to determine if further bed reductions are warranted.

iii. St. James and St. Michaels must participate in a LAB study to determine if service consolidations at one site are warranted.

iv. Newark Beth Israel and Irvington General Hospitals must work with the LAB to further consolidate and efficiently distribute acute care services between the two facilities.

v. United Hospitals Medical Center must participate in a LAB study which studies its future role in providing adult acute care services.

vi. All other hospitals in Essex County must take steps to achieve target occupancy levels identified in this plan.

2. Union County:

i. Muhlenberg Hospital must participate in a LAB study to determine if acute care bed reductions are warranted.

ii. All other hospitals in Union County must take steps to achieve target occupancy levels identified in this plan.

iii. Requests for additional ICU/CCU beds may only be approved if the applicant and the LAB clearly demonstrate serious access or quality care problems.

(e) Local Advisory Board IV:

1. Hunterdon County:

i. Hunterdon Medical Center may maintain current bed status.

2. Mercer County:

i. Each hospital in the county must participate in a LAB acute care bed need study.

ii. The LAB plan must include a definite strategy for acute care bed reductions and must consider the option of phasing out one existing acute care facility, through merging two facilities or by other means.

iii. Until the LAB plan and bed need study is approved by the State Health Planning Board and the Department of Health, no certificate of need applications related to inpatient acute care services may be submitted by any hospital in the county. An exception may be made only if the Department determines that a serious quality of care issue has occurred which requires immediate attention.

3. Middlesex County:

i. South Amboy Memorial Hospital must transition from inpatient acute care services by 1995.

ii. Raritan Bay Medical Center must participate in a LAB study to determine whether acute care bed reductions are warranted at its Perth Amboy division.

iii. Raritan Bay Medical Center and South Amboy Memorial Hospital must participate in a LAB study to determine the appropriateness and feasibility of joint ventures, particularly to retain South Amboy's inpatient psychiatric programs in the county.

iv. All other hospitals in Middlesex County must take steps to achieve target occupancy levels identified in this plan.

4. Somerset County:

i. Somerset Medical Center may maintain current bed status.

(f) Local Advisory Board V:

1. Burlington County:

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i. Zurbrugg Memorial Hospital-Riverside Division must transition from inpatient acute care services by 1995.

ii. The LAB must develop a plan to maintain access to the psychiatric and substance abuse services currently being provided by Zurbrugg's Riverside Division.

iii. All hospitals in Burlington County must take steps to achieve target occupancy levels identified in this plan.

2. Camden County:

i. Kennedy Memorial Hospitals must participate in a LAB bed need study to determine if acute care bed reductions are appropriate for its Stratford and Cherry Hill divisions in this county.

ii. All hospitals in Camden County must take steps to achieve target occupancy levels identified in this plan.

3. Cumberland County:

i. Each hospital in the county must participate in a LAB acute care bed need study.

ii. Until the LAB bed need study is approved by the State Health Planning Board and the Department of Health, no certificate of need applications related to inpatient acute care services may be submitted by any hospital in the county. An exception may be made only if the Department determines that a serious quality of care issue has occurred which requires immediate attention.

4. Gloucester County:

i. All hospitals in Gloucester County must take steps to achieve target occupancy levels identified in this plan.

5. Salem County:

i. Elmer Community Hospital must participate in a LAB bed need study to determine if this facility should continue to provide inpatient acute care services.

ii. Until the LAB study is approved by the State Health Planning Board and the Department of Health, Elmer Community Hospital may not submit a certificate of need application related to inpatient acute care services. An exception may be made only if the Department determines that a serious quality of care issue has occurred which requires immediate attention.

(g) Local Advisory Board VI:

1. Atlantic County:

i. All hospitals in the county must participate in an LAB acute care bed need study.

ii. Until the LAB study is approved by the State Health Planning Board and the Department of Health, no certificate of need applications related to inpatient acute care services may be submitted by any hospital in the county. An exception may be made only if the Department determines that a serious quality of care issue has occurred which requires immediate attention.

2. Cape May County:

i. Burdette Tomlin Memorial Hospital must take steps to achieve target occupancy levels identified in this plan.

3. Monmouth County:

i. Monmouth Medical Center must participate in a LAB acute care bed need study to determine if this facility should reduce beds.

ii. All other hospitals in Monmouth County must take steps to achieve target occupancy levels identified in this plan.

4. Ocean County:

i. Southern Ocean County Hospital must participate in a LAB study to determine if financial stability may best be achieved through merger with another hospital.

ii. All other hospitals in Ocean County must take steps to achieve target occupancy levels identified in this plan.]*

8:100-*[14.11]**14.9* Obstetric and pediatric services—Maternal and Child Health Consortia

(a) The Department of Health shall designate a network of regional Maternal and Child Health Consortia as specified in N.J.A.C. 8:100-4.3(a) and (c).

(b) Until such time that the Maternal and Child Health Consortia are designated and operational in a region, the Department will not accept certificate of need applications from hospitals requesting changes in their OB/GYN *[and/] pediatric bed complement. Exceptions may be granted by the Commissioner only where the

applicant and LAB can document that serious access or quality problems will *[accrue]* *occur* absent such certificate of need consideration.

*(c) When the Maternal and Child Health Consortia are established, they shall file certificate of need applications which will be accepted in accordance with the batching cycles established in N.J.A.C. 8:33. The applications shall request the initial perinatal and pediatric designations of each hospital in the region, as well as the initial complement of licensed pediatric and OB/GYN beds and intensive and intermediate care bassinets. Such applications will be reviewed and recommended for approval or denial based on the State Health Plan, these regulations, any other applicable approved planning/certificate of need regulations, and the advice of the Local Advisory Board.

(d) Once the Maternal and Child Health Consortia are established and operational and have recommended and had approved initial perinatal and pediatric designations for each hospital in the region, only the consortia may file an application for a change in an individual hospital designation, not the hospital itself.

(e) Once the Maternal and Child Health Consortia are established and operational, an individual hospital may file a certificate of need application for changes in the number of bassinets or in its OB/GYN and/or pediatric bed complement. Such an application must contain a recommendation for endorsement from the regional Maternal and Child Health Consortia.

(f) Within one year of formation, each Maternal and Child Health Consortium shall develop a perinatal and pediatric regional plan which includes letters of agreement between facilities for regionalized care. The plan shall be developed in cooperation with all appropriate Local Advisory Boards and submitted to these boards, the State Health Planning Board and the Department of Health.

1. Each Maternal and Child Health Consortium regional plan shall consider, but not be limited to, the following:

i. The requirements in N.J.A.C. 8:100-4.3 through 4.6;

ii. Obstetric and pediatric recommendations and criteria contained in these regulations and the State Health Plan;

iii. Geographic accessibility to obstetric and pediatric inpatient services by residents of each region;

iv. Increasing obstetric and pediatric unit size for those hospitals that meet criteria approved in these regulations, the State Health Plan, the Local Advisory Boards, and any other applicable regulations; and

v. Decreasing obstetric and pediatric unit size or closing the service. Closing the OB service shall be considered in those hospitals with less than 1,000 annual deliveries or less than 1,500 annual OB/GYN admissions or less than 60 percent OB/GYN annual occupancy for three consecutive calendar years based on licensed beds. Pediatric unit closures must be considered in those hospitals that fail to meet the utilization criteria described at N.J.A.C. 8:100-14.16(b) or 14.17(b).]*

*(g)**(c)* The Department of Health, the State Health Planning Board, and the Local Advisory Board shall utilize the criteria in *(f)1 above]* *N.J.A.C. 8:100-4.3 through 4.7 and N.J.A.C. 8:33* in reviewing *[any]* certificate of need *[application]* *applications* affecting *[any]* *an* applicant's inpatient OB/GYN or pediatric service.

(d) Pediatric planning rules shall be proposed by the Commissioner with the advice of the pediatric clinical advisory committee as specified in N.J.A.C. 8:100-4.2, 4.3 and 4.7. The Maternal and Child Health Consortia shall submit certificate of need applications for pediatric designation status in accordance with the pediatric planning rules and N.J.A.C. 8:33. Certificate of need applications requesting designation status will be approved by the Commissioner based upon the State Health Plan and the adopted pediatric planning rules. Only hospitals that are appropriately designated through the pediatric designation process shall provide licensed pediatric beds. All hospitals that admit pediatric patients shall participate in the Maternal and Child Health Consortia.

***[8:100-14.12 Inpatient obstetric and gynecological (OB/GYN) services**

(a) Within one year of approval of the Maternal and Child Health Consortia regional designation plan, the target annual OB/GYN occupancy (based on licensed beds) shall be:

- i. Units with less than 20 licensed beds:

LDRP: 55 percent

Postpartum: 65 percent.

- ii. Units with 20 or more licensed beds:

LDRP: 65 percent

Postpartum: 75 percent.

(b) Based upon a methodology approved by the State Health Planning Board, the Department projects that there is an excess of at least 100 licensed obstetric beds by 1995.

8:100-14.13 Local area need

(a) The Maternal and Child Health Consortium must address the following individual hospitals that have been identified as having OB bed excesses or bed need as part of its certificate of need application for designation (arranged by current perinatal region):

1. Northern Consortium (Bergen, Passaic, parts of Morris and Sussex Counties):

- i. St. Mary's (Passaic)—OB/GYN unit closure; and
- ii. Wayne General—OB/GYN unit closure or bed reduction.

2. Essex County Consortium (Essex and part of Union Counties):

- i. St. James and St. Michael's Medical Center—consolidation of OB/GYN services at one site;

- ii. Rahway Hospital—further OB/GYN bed reductions;

- iii. Elizabeth General—OB/GYN bed reduction;

- iv. St. Elizabeth's—reduction of OB/GYN bed capacity;

- v. St. Barnabas Medical Center—OB/GYN bed increase; and

- vi. Newark Beth Israel—OB/GYN bed increase.

3. Hudson County Consortium (Hudson County):

- i. Bayonne Hospital—OB/GYN unit closure or bed decrease;

- ii. St. Mary's (Hoboken)—OB/GYN unit closure or bed decrease; and

- iii. Meadowlands Hospital—OB/GYN bed increase.

4. Northwest Consortium (Morris, Sussex, part of Union Counties):

- i. Dover—OB/GYN bed decrease; and

- ii. Warren and Hackettstown Hospitals—potential consolidation of their OB/GYN programs at one site.

5. Central New Jersey Consortium (Middlesex, Mercer, Hunterdon, Somerset, part of Union Counties):

- i. St. Francis Medical Center—OB/GYN bed reduction, unit closure, or consolidation with Helene Fuld at one site;

- ii. Helene Fuld—OB/GYN bed reduction, unit closure, or consolidation with St. Francis at one site; and

- iii. St. Peter's Medical Center—OB/GYN bed increase.

6. Monmouth/Ocean Consortium (Monmouth and Ocean Counties):

- i. Paul Kimball Medical Center—OB/GYN bed reduction;

- ii. Northern Ocean Medical Center—reduction of OB/GYN bed capacity; and

- iii. Monmouth Medical Center—OB/GYN bed increase.

7. Southern Jersey Perinatal Cooperative (Burlington, Camden, Gloucester, Salem, Cumberland, Cape May and Atlantic Counties):

- i. South Jersey Hospital System (Bridgeton)—OB/GYN bed reduction, unit closure, or consolidation with Newcomb at one site;

- ii. Newcomb Hospital—OB/GYN bed reduction, unit closure, or consolidation with Bridgeton at one site;

- iii. JFK (Washington Division)—OB/GYN bed reduction;

- iv. Shore Memorial Hospital—reduction of OB/GYN bed capacity;

- v. Underwood—reduction of OB/GYN bed capacity;

- vi. Atlantic City (City Division)—OB/GYN bed increase;

- vii. Memorial Hospital of Burlington County—OB/GYN bed increase; and

- viii. Cooper Medical Center—OB/GYN bed increase.

8:100-14.14 Designation of pediatric services

Pediatric services, including additional specialty acute care hospital services, shall only be provided by the appropriate facility as determined by the pediatric designation process. Designations shall be recommended by the Maternal and Child Health Consortia following adoption of pediatric planning rules by the Commissioner.

8:100-14.15 Specialty acute care children's hospitals

(a) The two designated specialty acute care children's hospitals, at United Hospitals/University Hospital in Newark, and Cooper Medical Center in Camden, shall develop plans to become operational.

(b) The Department shall evaluate the need for the development of a third specialty acute care children's hospital, either as a joint program between Robert Wood Johnson and St. Peter's Medical Centers in New Brunswick or elsewhere in the State.

(c) Facilities designated as specialty acute children's hospitals may provide:

- i. Major chest surgery, including pediatric cardiac surgery;

- ii. Pediatric neurosurgery;

- iii. Pediatric solid organ transplants; and

- iv. Pediatric burn care.

(d) An exception to (c) above is made for Deborah Hospital in Burlington County, which maintains an active pediatric cardiac surgery program.

(e) No certificates of need for additional pediatric cardiac surgery sites will be accepted until at least 1994.

(f) A facility not designated as a specialty acute care children's hospital that is not currently approved to perform the services in (c) above may not do so without first obtaining certificate of need approval.

(g) Specialty acute care children's hospital must demonstrate the ability to serve as the core of a regional network to provide and advise on the provision of all clinical pediatric care.

(h) Minimum criteria for designation as a specialty acute care children's hospital shall include:

1. Licensed pediatric beds:

- i. A minimum of 75 beds within five years of designation; and

- ii. The ability to meet all licensing standards for inpatient pediatric beds;

2. A separately identifiable, designated pediatric intensive care unit (PICU) with:

- i. A minimum of PICU 12 beds within two years of designation;

- ii. A minimum of 1000 annual admissions to the PICU within two years of designation;

- iii. A minimum annual occupancy of 75 percent; and

- iv. The ability to meet licensing standards for PICU at N.J.A.C. 8:43G;

3. The provision of the following core services within two years of designation, each with its own full-time staff director:

- i. Neonatal intensive care bassinets and a Regional Perinatal Center or Community Perinatal Center—Intensive designation and demonstrated compliance with applicable perinatal regulations;

- ii. Pediatric critical care;

- iii. Pathology;

- iv. Radiology;

- v. Child life;

- vi. Cardiology;

- vii. Emergency care;

- viii. General pediatrics;

- ix. Surgery;

- x. Anesthesiology; and

- xi. Neurosurgery and neurology;

4. A pediatric residency program that:

- i. Is accredited and affiliated with a university medical school; and

- ii. Has a full time program director;

5. Immediate availability of pediatric trauma/prehospital care program including:

- i. A separate pediatric emergency room;

- ii. Specialized pediatric training for emergency room staff; and

- iii. Leadership and participation in a regionwide referral and transport network;

6. Availability within one year of designation of the following specialized ambulatory care programs, including:

- i. Rehabilitation and communication evaluation and treatment;
- ii. Sickle cell/hemoglobinopathics treatment;
- iii. Hemophilia program and services; and
- iv. Cleft lip/palate craniofacial anomalies services. These may be provided by affiliation with a Regional Pediatric Center(s);

7. Immediate ability to provide primary and preventive care outpatient services;

8. Research capability and programs;

9. Ability to serve as a Statewide pediatric education resource center for both health care professionals and the public;

10. The specialty acute care children's hospital shall have a board structure and administration separate from that of any other health care facility, although it may be affiliated with or subsidiary to an existing board of trustees;

11. The specialty acute care children's hospital shall have an identifiable entrance separate from that of any other health care facility; and

12. The specialty acute care children's hospital shall provide parent/guardian accommodations.

8:100-14.16 Regional pediatric centers

(a) The Department shall designate nine to 11 Regional Pediatric Centers.

(b) Minimum criteria for designation as a Regional Pediatric Center include the following:

1. Licensed pediatric beds:

- i. A minimum of 30 beds within two years of designation;
- ii. A minimum average daily census of 23 within two years of designation;
- iii. A minimum of 1500 annual admissions within two years of designation; and
- iv. The ability to meet all licensing standards for inpatient pediatric beds;

2. A separately identifiable, designated pediatric intensive care unit with:

- i. A minimum of six beds within two years of designation that do not include general pediatric beds;
 - ii. A minimum annual occupancy of 75 percent; and
 - iii. The ability to meet licensing standards;
3. Provision of neonatal intensive care services:

i. Designation as a Regional Perinatal Center or Community Perinatal Center—Intensive; and

ii. Demonstrated compliance with applicable perinatal regulations;

4. A pediatric residency program approved by the Residency Review Committee of the American Council of Graduate Medical Education;

5. The provision of the following core services within two years of designation, in accordance with regional services plan approved by the Maternal and Child Health Consortia:

- i. General pediatrics;
- ii. Pediatric critical care;
- iii. Anesthesiology;
- iv. Neurology;
- v. Otolaryngology;
- vi. Orthopedic;
- vii. Cardiology;
- viii. Psychiatry and/or psychology;
- ix. Radiology; and
- x. Pathology;

6. Immediate availability of a pediatric trauma/prehospital care program, including:

- i. A separate pediatric triage area in an existing emergency room;
 - ii. Specialized pediatric training for emergency room staff; and
 - iii. Participation in a regionwide referral and transport network;
7. Availability within two years of designation of specialized ambulatory care programs. The designated center must provide such programs from among the following:
- i. Rehabilitation and communication evaluation and treatment;

ii. Sickle cell/hemoglobinopathics treatment;

iii. Hemophilia program and services; and

iv. Cleft lip/palate craniofacial anomalies services. These may be provided by affiliation with another Regional Center or Specialized Acute Care Children's Hospital; and

8. Immediate provision of primary and preventive care outpatient services;

8:100-14.17 Community Pediatric Centers

(a) The Department shall designate a minimum of 30, but not more than 40, Community Pediatric Centers.

(b) Criteria for designation as a Community Pediatric Center include, but are not limited to:

1. Licensed pediatric bed criteria:

i. A minimum of 20 beds. This may be waived for facilities determined by the Department to be geographically isolated or offering care to historically underserved populations;

ii. Demonstration that a minimum average daily census of 15 or an annual occupancy of 75 percent for units of 20 beds or more will be achieved within two years of designation; and

iii. Demonstration that a minimum annual occupancy of 60 percent for units of less than 20 beds will be achieved within two years of designation;

2. Written affiliation and transfer/referral agreement with a designated New Jersey Regional Pediatric Center at the time of designation; and

3. Immediate ability to provide primary and preventive care outpatient services.

8:100-14.18 Pediatric bed need

Pediatric bed need shall be in accordance with the methodology approved by the State Health Planning Board. The Department finds an excess of 300 pediatric beds will exist in 1994.

8:100-14.19 Maternal and Child Health Consortia—pediatric designations

(a) Certificate of need applications for the designation of Regional and Community Pediatric Centers, arranged by current perinatal region, may be filed by Maternal and Child Health Consortia as described below. However, based on their determination of regional need, geographic access, access to special populations and quality, the Consortia may recommend the retention of pediatric units that are recommended for elimination.

1. Northern Consortium (Bergen, Passaic, parts of Morris and Sussex Counties):

i. St. Joseph's Medical Center may apply for designation as a Regional Pediatric Center;

ii. Hackensack Medical Center may apply for designation as a Regional Pediatric Center;

iii. Englewood, Holy Name, Valley and Barnert Hospital(s) may apply for designation as Community Pediatric Centers;

iv. Hospitals located in the City of Passaic must participate in a LAB pediatric bed need study to determine which unit will remain as a Community Pediatric Center to best serve the access needs of the area; and

v. Pascack Valley shall eliminate its licensed pediatric unit.

2. Essex County Consortium (Essex and part of Union Counties):

i. Newark Beth Israel and St. Barnabas may apply for designation as Regional Pediatric Centers;

ii. Columbus, Hospital Center at Orange, St. James and St. Michael's may apply for designation as Community Pediatric Centers;

iii. Clara Maass, Mountainside and Rahway Hospital(s) shall eliminate licensed pediatric units; and

iv. Elizabeth General and Muhlenberg may apply for designation as Community Pediatric Centers.

3. Hudson County Consortium (Hudson County):

i. Jersey City Medical Center may apply for designation as a Regional Pediatric Center;

ii. Bayonne and Christ Hospitals may apply for designation as Community Pediatric Centers; and

iii. Meadowlands, St. Mary's and St. Francis Medical Center (Jersey City) shall eliminate licensed pediatric units.

4. Northwest Consortium (Morris, Sussex, Warren, part of Union Counties):

i. Morristown and Overlook Hospital may apply for designation as a joint Regional Pediatric Center;

ii. Newton and Warren Hospitals may apply for designation as a Community Pediatric Center; and

iii. Morris County hospitals must participate in a LAB pediatric bed need study to determine which hospital will be designated as a Community Pediatric Center to best serve the access needs of the area.

5. Central New Jersey Consortium (Middlesex, Mercer, Hunterdon, Somerset, part of Union Counties):

i. Robert Wood Johnson and St. Peter's Medical Centers may apply for designation as a joint Regional Pediatric Center;

ii. Mercer Medical Center may apply for designation as a Regional Pediatric Center;

iii. Hunterdon Medical Center, Somerset Medical Center, JFK-Edison, Raritan Bay, Princeton, and St. Francis may apply for designation as Community Pediatric Centers; and

iv. Helene Fuld shall eliminate its licensed pediatric units.

6. Monmouth/Ocean Counties (Monmouth and Ocean Counties):

i. Jersey Shore and Monmouth Medical Centers may apply for designation as a joint Regional Pediatric Center;

ii. CentraState Medical Center, Riverview Hospital, Community Medical Center, Kimball Medical Center, and Medical Center of Ocean County may apply for designation as Community Pediatric Centers; and

iii. Bayshore shall eliminate its licensed pediatric beds.

7. Southern Jersey Perinatal Cooperative (Burlington, Camden, Gloucester, Salem, Cumberland, Cape May and Atlantic Counties):

i. Atlantic City-City Division may apply for designation as a Regional Pediatric Center;

ii. Memorial Hospital of Burlington County, West Jersey-Eastern Division, Our Lady of Lourdes, Newcomb, Kessler, and Shore may apply for designation as Community Pediatric Centers; and

iii. Atlantic City-Mainland Division, Rancocas Valley, Kennedy-Stratford Division, Bridgeton, and Underwood shall eliminate licensed pediatric units.]*

*8:100-14.10 Specialty acute care children's hospitals

(a) The two designated specialty acute care children's hospitals, at United Hospitals/University Hospital in Newark, and Cooper Medical Center in Camden, shall develop plans to become operational in accordance with the requirements listed in (c) through (f) below.

(b) The Department shall evaluate the need for the development of a third specialty acute care children's hospital, either as a joint program between Robert Wood Johnson Medical Center and St. Peter's Medical Center in New Brunswick or elsewhere in the State.

(c) All specialty acute care children's hospitals shall provide the following bed complement:

1. A minimum of 75 licensed pediatric beds which shall:

i. Operate at 75 percent occupancy within five years of designation; and

ii. Meet all licensing standards for inpatient pediatric beds at N.J.A.C. 8:43G.

2. A minimum of 12 pediatric intensive care unit (PICU) beds which shall:

i. Operate at 75 percent occupancy within two years of designation;

ii. Have a minimum of 1,000 annual admissions within two years of designation;

iii. Exist as a separate, identifiable unit; and

iv. Meet all licensing standards for PICU at N.J.A.C. 8:43G.

3. Neonatal intensive care bassinets with a regional perinatal center or community perinatal center-intensive designation and demonstrated compliance with applicable perinatal rules.

(d) All specialty acute care children's hospitals shall have at a minimum the following educational components:

1. A pediatric residency program with a full time program director, accredited and affiliated with a university medical school;

2. Research capability and programs;

3. The ability to serve as the core of a regional network to provide and advise on the provision of all clinical pediatric care;

4. The ability to serve as a Statewide pediatric education resource center for both health care professionals and the public; and

(e) Within one year of adoption of the pediatric planning rules as described in N.J.A.C. 8:100-14.9(d), all specialty acute care children's hospitals shall provide at a minimum the following services:

1. Pediatric inpatient services;

2. A pediatric trauma and prehospital care program;

3. Specialized ambulatory care programs; and

4. Accessible primary and preventive care.

(f) All specialty acute care children's hospitals shall have written affiliation, transfer, referral and consulting agreements with facilities meeting the requirements of a regional pediatric center.

(g) Until certificate of need applications are requested by the Commissioner in accordance with N.J.A.C. 8:33, no hospital may initiate the following pediatric subspecialty services:

1. Major chest surgery, including pediatric cardiac surgery;

2. Pediatric neurosurgery;

3. Pediatric solid organ transplants; and

4. Pediatric burn care.

8:100-14.11 Regional pediatric centers

(a) The Commissioner shall designate regional pediatric centers in accordance with the pediatric designation process at N.J.A.C. 8:100-14.9(d).

(b) An applicant for designation as a regional pediatric center shall provide the following bed complement:

1. A minimum of 30 licensed pediatric beds which shall:

i. Operate at 75 percent occupancy within two years of designation;

ii. Have a minimum of 1,500 annual admissions within two years of designation; and

iii. Meet all licensing standards for inpatient pediatric beds at N.J.A.C. 8:43G.

2. A minimum of six PICU beds which shall:

i. Operate at 75 percent occupancy within two years of designation;

ii. Exist as a separate, identifiable unit; and

iii. Meet all licensing standards for PICU at N.J.A.C. 8:43G.

3. Neonatal intensive care services with a regional perinatal center or community perinatal center-intensive designation and demonstrated compliance with applicable perinatal rules.

(c) An applicant for designation as a regional pediatric center shall have a pediatric residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME).

(d) In accordance with the pediatric planning rules as described in N.J.A.C. 8:100-14.9(d), an applicant for designation as a regional pediatric center shall provide at a minimum the following services:

1. Pediatric inpatient services, in accordance with regional services plan approved by the Maternal and Child Health Consortia;

2. A pediatric trauma and prehospital care program;

3. Specialized ambulatory care programs; and

4. Accessible primary and preventive care.

(e) An applicant for designation as a regional pediatric center shall have written affiliation, transfer, referral and consulting agreements with facilities meeting the requirements of a specialty acute care children's hospital and community pediatric centers.

8:100-14.12 Community pediatric centers

(a) The Commissioner shall designate community pediatric centers in accordance with the pediatric designation process at N.J.A.C. 8:100-14.9(d).

(b) An applicant for designation as a community pediatric center shall provide the following bed complement:

1. A minimum of 20 licensed pediatric beds which shall operate at 75 percent occupancy within two years of designation and meet all licensing standards for inpatient pediatric beds at N.J.A.C. 8:43G. This may be waived for existing facilities determined by the

Department to be geographically isolated, offering care to historically underserved populations, or demonstrating unique community need.

2. A unit of less than 20 beds as identified in (b)1 above, which shall operate at 60 percent occupancy within two years of designation and meet all licensing standards for inpatient pediatric beds at N.J.A.C. 8:43G.

(c) An applicant for designation as a community pediatric center shall provide accessible primary and preventive care services.

(d) An applicant for designation as a community pediatric center shall have written affiliation, transfer, referral and consulting agreements with facilities meeting the requirements of regional pediatric centers and/or specialty acute care children's hospitals.

8:100-14.13 Specific recommendations

(a) While providing appropriate care, all hospitals shall take steps to achieve target occupancy levels identified in N.J.A.C. 8:100-14.2.

(b) Based upon the criteria contained in N.J.A.C. 8:100-4 and N.J.A.C. 8:100-14.3, 14.5, 14.7 and 14.8, certificate of need applications shall be consistent with the following list of responsibilities and provisions:

1. Local Advisory Board I shall submit to the State Health Planning Board and the Department of Health: a M/S bed need study for each county, an OB/GYN bed need study for Warren County which addresses consolidation of programs at one site, and a pediatric bed need study for Morris County and the city of Passaic. The LAB shall also submit a bed need study that addresses the conversion of St. Mary's and the need to continue the psychiatric inpatient programs currently provided at St. Mary's. The responsibilities of the hospitals in LAB I are listed by county as follows:

i. Morris County:

(1) All Morris County Hospitals shall participate in a LAB pediatric bed need study to determine where licensed pediatric bed reductions are warranted, and which hospital may apply for designation as a community pediatric center to best serve the inpatient needs of the children in the area.

(2) Chilton Memorial Hospital shall participate in a LAB M/S bed need study to determine whether licensed M/S bed reductions are warranted.

(3) Dover General Hospital shall reduce its number of licensed OB/GYN beds and shall participate in a LAB M/S bed study to determine whether licensed M/S bed reductions are warranted.

(4) Morristown Memorial Hospital may apply for designation as a joint regional pediatric center with Overlook Hospital in Union County.

ii. Passaic County:

(1) All hospitals located in the City of Passaic shall participate in a LAB pediatric bed need study to determine which unit may remain and apply for designation as a community pediatric center to best serve the inpatient needs of children in the area.

(2) Barnert Memorial Hospital may apply for designation as a community pediatric center.

(3) St. Joseph's Hospital may apply for designation as a regional pediatric center.

(4) St. Mary's Hospital should transition from inpatient acute care services by 1995.

(5) Wayne General Hospital shall eliminate its licensed OB/GYN unit or reduce its number of licensed OB/GYN beds.

iii. Sussex County:

(1) In addition to meeting the requirements of N.J.A.C. 8:100-14.8(b), the LAB area bed need study shall be approved by the State Health Planning Board and the Department of Health, before certificate of need applications related to inpatient acute care services may be submitted by Newton Memorial Hospital or Wallkill Valley Hospital. An exception may be made if the Department determines that a serious quality of care issue exists which requires immediate attention.

(2) Newton Memorial Hospital shall participate in the LAB M/S bed need study to determine whether M/S bed reductions are

warranted. It may apply for designation as a community pediatric center.

(3) Wallkill Valley Hospital and Health Centers shall participate in the LAB M/S bed need study to determine whether M/S bed reductions are warranted.

iv. Warren County:

(1) In addition to meeting the requirements of N.J.A.C. 8:100-14.8(b), the LAB area bed need study shall be approved by the State Health Planning Board and the Department of Health, before certificate of need applications related to inpatient acute care services may be submitted by Hackettstown Community Hospital or Warren Hospital. An exception may be made if the Department determines a serious quality of care issue exists which requires immediate attention.

(2) (Reserved.)

(3) Warren Hospital may apply for designation as a community pediatric center.

2. Local Advisory Board II shall submit to the State Health Planning Board and the Department of Health a M/S bed need study that addresses the feasibility of maintaining M/S beds at Bergen Pines County Hospital. The responsibilities of the hospitals in LAB II are listed by county as follows:

i. Bergen County:

(1) Bergen Pines County Hospital shall participate in a LAB study to determine if inpatient M/S services should remain at this facility.

(2) Engelwood Hospital may apply for designation as a community pediatric center.

(3) Hackensack Medical Center may apply for designation as a regional pediatric center.

(4) Holy Name Hospital may apply for designation as a community pediatric center.

(5) Saddle Brook Hospital should transition from inpatient acute care services by 1995.

(6) (Reserved.)

(7) Valley Hospital may apply for designation as a community pediatric center.

ii. Hudson County:

(1) Bayonne Hospital shall eliminate its licensed OB/GYN unit or reduce its number of licensed OB/GYN beds. It may apply for designation as a community pediatric center.

(2) Christ Hospital may apply for designation as a community pediatric center.

(3) Greenville Hospital should transition from inpatient acute care services as Jersey City Medical Center implement its certificate of need for a replacement facility.

(4) Jersey City Medical Center may apply for designation as a regional pediatric center.

(5) Meadowlands Hospital Medical Center shall eliminate its licensed pediatric unit or consolidate its licensed pediatric beds at one site with an area hospital. Any consolidation shall include a reduction in the total number of licensed pediatric beds. If pediatric services are consolidated at Meadowlands, it may apply for designation as a community pediatric center following the pediatric bed consolidation. Also, it may apply for an OB/GYN licensed bed increase if occupancy meets the requirements in N.J.A.C. 8:43I.

(6) (Reserved.)

(7) St. Mary Hospital shall eliminate its licensed OB/GYN unit or reduce its number of licensed OB/GYN beds.

3. Local Advisory Board III shall submit to the State Health Planning Board and the Department of Health M/S bed need studies for Essex and Union Counties. The responsibilities of the hospitals in LAB III are listed by county as follows:

i. Essex County:

(1) Clara Maass Medical Center shall participate in a LAB study to determine if further acute care bed reductions are warranted.

(2) Columbus Hospital may apply for designation as a community pediatric center.

(3) Hospital Center at Orange may apply for designation as a community pediatric center.

(4) Irvington General Hospital and Newark Beth Israel Medical Center shall work with the LAB to further consolidate and efficiently distribute acute care services between the two facilities.

(5) Montclair Community Hospital should continue discussions with area hospitals concerning joint programs and provide a written report to the LAB, the State Health Planning Board and the Department of Health by January 20, 1993.

(6) Mountainside Hospital shall eliminate its licensed pediatric unit and work with the LAB and the Department to ensure the hospital maintains adequate M/S capacity.

(7) Newark Beth Israel Medical Center may apply for a licensed OB/GYN bed increase if occupancy meets the requirements in N.J.A.C. 8:43I. Also, it may apply for designation as a regional pediatric center.

(8) St. Barnabas Medical Center may apply for a licensed OB/GYN bed increase if occupancy meets the requirements in N.J.A.C. 8:43I. Also, it may apply for designation as a regional pediatric center.

(9) St. James Hospital and St. Michael's Medical Center shall consolidate OB/GYN services at one site and shall participate in a LAB study to determine if other service consolidations are warranted.

(10) St. James Hospital may apply for designation as a community pediatric center.

(11) St. Michael's Medical Center may apply for designation as a community pediatric center.

(12) United Hospitals Medical Center, which has been designated as a specialty acute care children's hospital, shall participate in a LAB study to determine its future role in providing adult acute care services. It shall implement its approved certificate of need for a specialty acute care children's hospital.

ii. Union County:

(1) Elizabeth General Medical Center shall reduce its number of licensed OB/GYN beds. It may apply for designation as a community pediatric center.

(2) Muhlenberg Regional Medical Center shall participate in a LAB study to determine if M/S bed reductions are warranted. It may apply for designation as a community pediatric center.

(3) Overlook Hospital may apply for designation as a joint regional pediatric center with Morristown Memorial in Morris County.

(4) Rahway Hospital shall reduce its number of licensed OB/GYN beds.

(5) St. Elizabeth's Medical Center shall reduce its number of licensed OB/GYN beds.

4. Local Advisory Board IV shall submit to the State Health Planning Board and the Department of Health M/S bed need studies for Mercer and Middlesex Counties. The LAB shall develop a strategy for acute care bed reductions in Mercer County including consideration of converting one existing facility to another needed service. The LAB shall submit a study recommending a plan to consolidate to one site pediatric and OB/GYN services at Helene Fuld Medical Center and St. Francis Medical Center. Also, it shall submit a study of Raritan Bay Medical Center and South Amboy Memorial Hospital to determine the appropriateness and feasibility of joint ventures, particularly to retain South Amboy's inpatient psychiatric programs in the county as South Amboy transitions from general acute care services. The responsibilities of the hospitals in LAB IV are listed by county as follows:

i. Hunterdon County:

(1) Hunterdon Medical Center may apply for designation as a community pediatric center.

ii. Mercer County:

(1) All Mercer County hospitals shall participate in the LAB M/S bed need study.

(2) In addition to meeting the requirements of N.J.A.C. 8:100-14.8(b), the LAB area bed need study shall be approved by the State Health Planning Board and the Department of Health, before certificate of need applications related to inpatient acute care services may be submitted by any hospital in the county. An exception may be made if the Department determines that a serious quality of care issue exists which requires immediate attention.

(3) and (4) (Reserved.)

(5) Mercer Medical Center may apply for designation as a regional pediatric center.

(6) The Medical Center at Princeton may apply for designation as a community pediatric center.

iii. Middlesex County:

(1) John F. Kennedy Medical Center may apply for designation as a community pediatric center.

(2) Raritan Bay Medical Center shall participate in a LAB study to determine whether M/S bed reductions are warranted at its Perth Amboy division. It may apply for designation as a community pediatric center.

(3) Raritan Bay Medical Center and South Amboy Memorial Hospital shall participate in an LAB study to determine the appropriateness and feasibility of joint ventures, particularly to retain South Amboy's inpatient psychiatric programs in the county.

(4) Robert Wood Johnson University Hospital may apply for designation as a joint regional pediatric center with St. Peter's Medical Center.

(5) St. Peter's Medical Center may apply for an OB/GYN licensed bed increase if occupancy meets the requirements in N.J.A.C. 8:43I. It may apply for designation as a joint regional pediatric center with Robert Wood Johnson University Hospital.

(6) South Amboy Memorial Hospital should transition from inpatient acute care services by 1995.

iv. Somerset County:

(1) Somerset Medical Center may apply for designation as a community pediatric center.

5. Local Advisory Board V shall submit to the State Health Planning Board and the Department of Health M/S bed need studies for Camden, Cumberland and Salem Counties. The LAB shall submit a plan to maintain access to the psychiatric and substance abuse services currently being provided by Zurbrugg's Riverside Division as the hospital transitions from general acute care services. The responsibilities of the hospitals in LAB V are listed by county as follows:

i. Burlington County:

(1) Memorial Hospital of Burlington County may apply for an OB/GYN licensed bed increase if occupancy meets the requirements in N.J.A.C. 8:43I. It may apply for designation as a community pediatric center.

(2) (Reserved.)

(3) Zurbrugg Hospital should transition from inpatient acute care services by 1995.

ii. Camden County:

(1) Cooper Hospital/University Medical Center, which has been designated as a specialty acute care children's hospital, may apply for an OB/GYN licensed bed increase if occupancy meets the requirements in N.J.A.C. 8:43I.

(2) (Reserved.)

(3) Kennedy Memorial Hospitals shall participate in a LAB bed need study to determine if M/S bed reductions are appropriate for its Stratford and Cherry Hill divisions.

(4) Our Lady of Lourdes Medical Center may apply for designation as a community pediatric center.

(5) West Jersey Hospital—Voorhees may apply for designation as a community pediatric center.

iii. Cumberland County:

(1) All Cumberland County hospitals shall participate in a LAB M/S bed need study.

(2) In addition to meeting the requirements of N.J.A.C. 8:100-14.8(b), the LAB area bed need study shall be approved by the State Health Planning Board and the Department of Health, before certificate of need applications related to inpatient acute care services may be submitted by any hospital in the county. An exception may be made if the Department determines that a serious quality of care issue exists which requires immediate attention.

(3) Newcomb Medical Center shall reduce its number of licensed OB/GYN beds, eliminate the unit or consolidate at one site with South Jersey Hospital System (Bridgeton Division). It may apply for designation as a community pediatric center.

(4) South Jersey Hospital System (Bridgeton Division) shall reduce its number of licensed OB/GYN beds, eliminate the unit or consolidate at one site with Newcomb Medical Center.

iv. Gloucester County:

(1) Kennedy Memorial Hospitals (Washington Division) shall implement its approved certificate of need for OB/GYN services and shall reduce its number of licensed OB/GYN beds if the minimum occupancy rate is not achieved.

(2) Underwood-Memorial Hospital shall reduce its number of licensed OB/GYN beds.

v. Salem County:

(1) (Reserved.)

(2) In addition to meeting the requirements of N.J.A.C. 8:100-14.8(b), the LAB area bed need study shall be approved by the State Health Planning Board and the Department of Health, before certificate of need applications related to inpatient acute care services may be submitted by Elmer Community Hospital. An exception may be made if the Department determines that a serious quality of care issue exists which requires immediate attention.

6. Local Advisory Board VI shall submit to the State Health Planning Board and the Department of Health M/S bed need studies for Atlantic, Monmouth and Ocean Counties. The responsibilities of the hospitals in LAB VI are listed by county as follows:

i. Atlantic County:

(1) All Atlantic County hospitals shall participate in an LAB M/S bed need study.

(2) In addition to meeting the requirements of N.J.A.C. 8:100-14.8(b), the LAB area bed need study shall be approved by the State Health Planning Board and the Department of Health, before certificate of need applications related to inpatient acute care services may be submitted by any hospital in the county. An exception may be made if the Department determines that a serious quality of care issue exists which requires immediate attention.

(3) Atlantic City Medical Center (City Division) may apply for an OB/GYN licensed bed increase if occupancy meets the requirements in N.J.A.C. 8:43I. Also, it may apply for designation as a regional pediatric center. The Mainland Division shall eliminate its licensed pediatric unit.

(4) Shore Memorial Hospital shall reduce its number of licensed OB/GYN beds. It may apply for designation as a community pediatric center.

(5) William B. Kessler Memorial Hospital may apply for designation as a community pediatric center.

ii. Cape May County:

(1) There are no recommended changes to the number of beds in Cape May County.

iii. Monmouth County:

(1) Bayshore Community Hospital shall eliminate its licensed pediatric unit.

(2) CentraState Medical Center may apply for designation as a community pediatric center.

(3) Jersey Shore Medical Center may apply for designation as a joint regional pediatric center with Monmouth Medical Center.

(4) Monmouth Medical Center shall participate in the LAB M/S bed need study to determine if this facility should reduce its number of licensed M/S beds. It may apply for an OB/GYN licensed bed increase if occupancy meets the requirements in N.J.A.C. 8:43I. Also, it may apply for designation as a joint regional pediatric center with Jersey Shore Medical Center.

(5) Riverview Medical Center may apply for designation as a community pediatric center.

iv. Ocean County:

(1) Community Medical Center may apply for designation as a community pediatric center.

(2) Paul Kimball Medical Center shall reduce its number of licensed OB/GYN beds. It may apply for designation as a community pediatric center.

(3) Medical Center of Ocean County shall implement its approved certificate of need for OB/GYN services and shall reduce its number of licensed OB/GYN beds if the minimum occupancy

rate is not achieved. The Brick Division may apply for designation as a community pediatric center.

(4) Southern Ocean County Hospital shall participate in a LAB study to determine if financial stability may best be achieved through merger with another hospital.

(c) Based on their determination of regional need, geographic availability of services, access for special populations, and quality of care, the Consortia and the LABs may recommend the retention of units that are recommended for elimination.

(d) The Department, in conjunction with the appropriate LABs, will convene transition teams to work closely with all involved parties including other State agencies to ensure that each transition from an inpatient acute care provider to another level of care is completed in a manner that maintains quality and access and is fair to current hospital patients, physicians and employees.

(e) Prior to proceeding with the implementation of the recommendations contained in this section, the Department of Health shall report to the State Health Planning Board and the Health Care Administration Board at or before their September meetings regarding the impact of changes resulting from the United States District Court decision in *United Wire, Metal and Machine Health and Welfare Reform, et al. v. Morristown Memorial Hospital, et al.*, Civil Action No. 90-2639 (May 27, 1992).*

SUBCHAPTER 15. HIGH TECHNOLOGY SERVICES

8:100-15.1 High technology process development

(a) The Department of Health shall establish an orderly evaluation process for innovative, high-technology health care services and equipment, based on established criteria, that permits the analytical appraisal and initial limited diffusion of innovative equipment and/or services, prior to the further allocation of resources. Mechanisms shall include:

1. Establishment of a core clinical advisory group with representation from, at a minimum, the *[New Jersey]* Medical Society *of New Jersey*, the *[Biomedical Ethics Committee]* *New Jersey Bioethics Commission*, the University of Medicine and Dentistry (UMDNJ), *the Seton Hall University School of Graduate Medical Education*, the New Jersey Hospital Association (NJHA), the New Jersey State Nurses Association (NJSNA), hospital clinical social *[worker]* *workers*, and home health *[professional]* *professionals*, to advise the Department of Health; *and*

2. Development of criteria that will be an elaboration of *[statewide]* *Statewide* demonstration project criteria contained in current certificate of need rules, along with the commitment of sufficient Department of Health resources to permit a meaningful evaluation of demonstration activities*]; and]***.*

*[3. The criteria developed by the core clinical advisory group will give preference for new technology demonstrations to the core teaching hospitals of the State medical school given compliance with all other criteria. These hospitals will assume the responsibility to share access to the technology for patient care, education, and research.]**

8:100-15.2 Magnetic Resonance Imaging (MRI) Services and Resource Allocation Policy

(a) A certificate of need application shall be submitted by all existing MRI services in the State seeking to replace their MRI equipment, regardless of whether the service currently has certificate-of-need approval.

(b) The Department of Health shall continue and expand a utilization and data-monitoring system for MRI services to assist in the evaluation of their Statewide need.

(c) An appropriateness-review study of physician-investor and non-physician-investor MRI facilities shall be undertaken by the Department of Health to determine differential-use rates and variations in practice patterns.

8:100-15.3 Computerized Tomography (CT) Services and Resource Allocation Policy

Computerized Tomography (CT) services shall be deregulated through the repeal of the CT rules (N.J.A.C. 8:33G), because virtual-

ly every acute-care provider in the State now has access to these services either on-site or through a contractual arrangement with a CT vendor.

8:100-15.4 Transplantation Services and Resource Allocation Policy

(a) The Department of Health will strengthen its efforts to support the existing transplant services provided in New Jersey and to seek to improve organ donation and compliance with the State's assured option law.

(b) The Department of Health shall convene a transplantation task force of out-of-State and in-State experts to evaluate future State transplant service needs for both solid organ and bone marrow programs. This evaluative effort will include an examination of organ distribution rules and their impact on the in-State availability of organ transplant services to New Jersey residents. Priority consideration will be given to the review of kidney and bone marrow transplantation policy. The findings of this task force shall be used in future discussions of transplantation services in the State Health Plan.

(c) Consideration of new or expanded solid organ transplantation services shall await the recommendations of the transplantation task force established in (b) above.

(d) A certificate of need shall be required for all bone marrow transplantation services, regardless of type. Consideration of new or expanded bone marrow transplantation services shall await the recommendations of the transplantation task force established in (b) above.

(e) The current regulatory standards for minimum volume, staff credentials and experience, infection control, and quality assurance (see N.J.A.C. 8:33Q) shall be maintained by all existing New Jersey transplant centers, in order to ensure high-quality services.

(f) All New Jersey residents with a demonstrated medical need for nonexperimental transplantation services shall be ensured access to a qualified transplant center without regard to ability to pay, race, or any other non-medical factors.

(g) The Department of Health, with advice from the expert task force established in (b) above, shall develop financing mechanisms to pay for transplantation services performed out-of-state.

8:100-15.5 Extracorporeal Shock Wave Kidney and Biliary Lithotripsy (ESWL and ESWBL) Services and Resource Allocation Policy

(a) Additional kidney and biliary lithotripsy services in New Jersey are not needed at this time. Statewide need for kidney lithotripsy services has been met by the three existing providers and the potential need for biliary lithotripsy devices and services has been virtually eliminated by the widespread acceptance of the laparoscopic surgical procedure for gallstone removal (laparoscopic cholecystectomy).

(b) The Department shall establish a mechanism to monitor the quality and efficacy of care at approved Extracorporeal Shock-Wave Lithotripsy (ESWL) sites. Additional reporting requirements shall be established which include, but are not limited to, procedure failures, stone recurrence, and post-procedure infection data.

(c) The Department shall develop licensing standards for all ESWL sites, as well as for the other free-standing high-technology services discussed in this subchapter.

8:100-15.6 Interim Statewide Policies—Mobile High Technology Health Care Services

(a) The Department of Health shall develop certificate of need and licensing standards for all mobile high technology services, including new technology offered, or proposed to be offered, on a mobile basis. Until such standards are developed and promulgated, all applicants for a certificate of need for a mobile service that has been justified based on geographic isolation shall:

1. Provide documentation from the New Jersey Department of Transportation that the proposed mobile vehicle will be permitted on New Jersey roadways;

2. Describe how current fixed-site licensing requirements (for example, ambulatory care and/or hospital standards) or their equivalents will be maintained by the mobile service, and identify

those that cannot be maintained demonstrating that this loss will not adversely affect quality of care;

3. Submit protocols for recalibration of equipment, including a listing of the equipment that requires recalibration, how often this will be done, and wherever possible, the manufacturer's recalibration recommendations;

4. Specify the infection-control protocols that will be employed for any invasive procedures and document how sterility will be consistently maintained in a mobile vehicle;

5. Submit proposed admission criteria for the mobile service proposed, as well as clinical criteria for exclusion;

6. Specify the protocols for addressing any emergency conditions that a patient may experience during the proposed procedure(s);

7. Submit a written Quality Assurance (QA) Plan that specifies the mechanisms for appropriate follow-up, quality assessments, responsible personnel for QA, etc.;

8. For applications accepted as "demonstration projects," submit an independently developed research protocol for evaluation of the proposed program, including, at a minimum, the data that will be collected and analyzed, frequency of data collection, norms against which the data will be evaluated, criteria for concluding that the demonstration program offers safe, effective, efficient, and affordable care, and the length of time necessary to demonstrate same; and

9. Document that the proposed service will be available to all who would benefit from it regardless of ability to pay.

8:100-15.7 Positron Emission Tomography (PET) Scanning Services and Resource Allocation Policy

The core clinical advisory group, established in N.J.A.C. 8:100-15.1, shall develop demonstration parameters for Positron Emission Tomography (PET) scanning within one year of the effective date of this rule. No certificate of need applications for Positron Emission Tomography scanners will be accepted until the recommendations of this technical committee are adopted by the Health Care Administration Board, either as a separate new (PET) rule or as an amendment to the State Health Plan.

SUBCHAPTER 16. SURGERY and DIALYSIS (RESERVED)

SUBCHAPTER 17. REHABILITATION SERVICES (RESERVED)

SUBCHAPTER *[16.]*18.* LONG TERM CARE

8:100-*[16.1]**18.1* Purpose

(a) The purpose of this subchapter is to foster a diverse but well coordinated array of high quality, affordable long-term care services which are readily accessible to those who need them. In so doing, the Department recognizes the long-term care population's heterogeneity: people's needs and preferences for care vary depending on the nature and degree of their functional impairments, availability of family and social supports, and so forth. The importance of consumer participation in decision-making about which services to use is underscored, along with the necessity of making information, assessment, case management, and referral resources available. The Department acknowledges the fact that most people would prefer to receive long-term care in their own homes; therefore, the expansion of home and community-based care is of the highest priority. As much as possible, long-term care should enable people to "age in place." When relocation cannot be avoided due to increasing debilitation, it should be to a homelike setting that affirms the individual's right to privacy, dignity, and a "normal" lifestyle, to the greatest extent possible.

(b) The Commissioners of the Departments of Health, Human Services, and Community Affairs should develop a memorandum of understanding to facilitate improved coordination of services for the elderly and disabled. A subcabinet level work group should be established by the Commissioners to carry out the intent of the memorandum of understanding.*

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8:100-*[16.2]**18.2* Support services for family caregivers

(a) The Department shall enhance the ability of family caregivers to continue to care for their elderly or disabled relatives. Informal caregivers are a key component in the State's long term care system. Without the care provided by them, the State would be unable to meet the long term care needs of its residents through the existing formal system. It is essential that this valuable component of the long term care system be supported and enhanced through the expansion of community services. The Department of Health shall:

1. Expand respite care programs, such as the Respite Care (DHS) and Dementia Day Care Program (DOH). The Departments of Health and Human Services should investigate approaches that can be taken, including additional appropriations, to expand existing services to support family caregivers.

Department of Health should expand the Caregiver Education and Support Program in the following ways:

- i. Develop a curriculum for employed caregivers;
- ii. Revise the caregiver manual;
- iii. Develop a practicum for caregivers to gain hands-on experience in providing physical care safely; and
- iv. Provide seminars for the facilitators to assist them in remaining current in their knowledge.

3. The Department of Health, in conjunction with the NJ Business and Industry Association, should develop seminars to educate and sensitize employers to the concerns of employees with caregiving responsibilities.

4. The Department of Health should encourage State legislation *[to] *which would*:

- i. Offer tax incentives to private industry to develop new financing sources for long term care, such as employee benefits, life insurance conversion options, *long-term care insurance,* grants, etc.; and
- ii. Allow family caregivers to deduct expenses incurred in caring for an aged or disabled relative, as they are currently able to do for child day care.

8:100-*[16.3]**18.3* Adult day care services

(a) The Department of Health, in conjunction with the Departments of Human Services and Community Affairs, should *[develop uniform]* *review* third party payment rates for adult day health care and adult day care *and encourage uniformity*.

(b) The Department of Health should encourage the development of *[new]* adult day health care centers which target unserved and underserved populations*, particularly those whose level of physical and/or mental impairments would necessitate nursing home placement without community supports*. Adequate reimbursement *[must]* *should* be provided to meet the staffing needs required appropriate to the level of care provided.

(c) The Department of Health, in conjunction with the Departments of Human Services and Community Affairs and the New Jersey Adult Day Care Association, should develop licensing standards for social day care centers and determine the appropriate licensing authority.

(d) The Department of Health, in conjunction with the Departments of Human Services and Community Affairs, should design a common data collection instrument for adult day care centers that would gather information on services provided, costs, volume of care, special populations served, licensure status, and staffing information.

8:100-*[16.4]**18.4* In-home care services

(a) The Department of Health, in conjunction with the Departments of Human Services, Community Affairs, and Law and Public Safety, should design a common data collection instrument for home care services that would gather information on services provided, costs, volume of care, special populations served, licensure status, and staffing information.

(b) The Department of Health should extend NIRA *(Nursing Incentive Reimbursement Awards)* grants to home care providers for programs involving registered nurse education and retention, expanded and innovative roles for home health nurses, and care for special populations.

(c) The Department of Health, in conjunction with the State Board of Nursing and the Department of Higher Education, should

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collaborate to develop a standardized core curriculum for the training of aides that will be complemented with specialized modules for home health, long term care, and hospital care.

(d) The Department of Health, in conjunction with the Departments of Human Services and Community Affairs, should *[encourage the development of uniform]* *review* third party payment rates for comparable home care services *and encourage their uniformity*.

(e) The Department of Health, in conjunction with the home care industry, should establish an advisory committee to investigate the extent of unmet need for home care services and to develop appropriate certificate of need requirements for home health agencies and other recommendations to improve access to high quality in-home care. The advisory committee should complete its deliberations and submit recommendations to the Commissioner of Health by June 30, 1993.

(f) The Department of Health, in conjunction with the Department*s* of Human Services *and Community Affairs*, should support *[the introduction of comprehensive legislation]* *legislative and regulatory initiatives and other programs* to further protect vulnerable adults from abuse and neglect.

(g) The Department of Health should conduct a study to determine the need for additional inpatient hospices and identify appropriate reimbursement mechanisms. Any additional in-patient need may be considered as an alternative use for acute care hospitals transitioning to non-acute facilities.

(h) The Department of Health should pursue legislation requiring all agencies providing home care services to meet minimum licensing standards for areas such as patient services, continuity of care, quality assurance, supervision, training of personnel, etc.

8:100-*[16.5]**18.5* Assessment, screening, and targeting of long-term care services

(a) The Department of Health should expand the current Geriatric Assessment Program to assure access to this service to residents of all 21 counties in the State.

(b) *[Impartial pre-admission screening for long-term care services should be promoted by the Department of Health, to assure that people will receive an appropriate level of long-term care services. This assessment should be available regardless of an individual's payment source and should be offered in conjunction with information about all available, suitable long-term care options.]*
A uniform Statewide pre-admission screening program for nursing home services should be required by the Department of Health, to assure that people will be targeted to receive appropriate long-term care services regardless of their payment source. This preadmission screening should be offered in conjunction with information about all available, suitable long-term care options. The Department of Health should pursue legislation to accomplish this goal.

[(c) To assure that long-term care placements are targeted to those in greatest need, the Departments of Health, Human Services, and Community Affairs should work collaboratively to develop well-defined prioritization criteria which may be applied uniformly throughout the State in determining eligibility for long-term care services. Those with the greatest immediate likelihood of being admitted to a nursing home should receive priority for admission to home and community-based programs such as the Community Care Program for the Elderly and Disabled (CCPED), provided that the person is otherwise eligible for and desirous of the program.]

[(d)](c)* The Department of Health, in conjunction with the Medical Society of New Jersey, New Jersey State Nurses Association, and other professional organizations, should design and offer continuing education on various geriatric *and disability* issues for health care professionals *[to assure expertise in performing client assessments and pre-admission screenings for long-term care services]*.

8:100-*[16.6]**18.6* Nutritional services

(a) The Department of Health should support additional funding for the Department of Community Affairs, Division on Aging, to enable them to expand home-delivered meals for the elderly.

(b) The Department of Health should ***[increase the number of hospitals providing]*** ***promote action by health care facilities to provide*** outpatient nutrition services, with an emphasis on minority and elderly populations.

(c) The Department of Health should mandate that nutrition be a core activity in "Recognized Public Health Activities and Minimum Standards of Performance for Local Boards of Health in New Jersey," and identify an adequate funding base.

(d) A mechanism should be established to enable the public to identify qualified nutrition professionals who meet minimum standards for practice.

8:100-***[16.7]**18.7*** Mental health services

(a) The Departments of Health and Community Affairs should assist the Department of Human Services with an evaluation of the adequacy of community based mental health services in meeting the needs of the elderly ***and disabled***.

(b) The Departments of Health and Community Affairs should assist the Department of Human Services in developing training programs for mental health professionals in gerontology and gerontological psychiatry to enable them to recognize the special needs of gero-psychiatric clients. Conversely, long term care and residential health care providers should be trained ***[on managing]*** ***to care for*** residents who present behavior ***[disorders]*** ***problems***.

(c) The Departments of Health and Community Affairs should assist the Department of Human Services in designing appropriate educational and informational programs for the elderly in order to reduce the stigma associated with mental health treatment and to increase access by elderly ***and disabled*** clients of mental health services.

8:100-***[16.8]**18.8*** Transportation services

The Departments of Health, Community Affairs and Human Services and New Jersey Transit should design a transportation survey to identify existing services, gaps, costs and recommendations for improvements.

8:100-***[16.9]**18.9*** Housing options for the frail elderly and disabled

(a) The Department of Health should assist the Department of Community Affairs in exploring ways ***[in which]*** ***to develop and fund programs for*** housing adaptations/modifications, household repairs, housekeeping*, ***[and]*** chore and yard services ***[can be provided]*** to enable the ***[chronically ill]*** ***frail elderly and disabled*** to live better and keep up their homes.

(b) The Departments of Health and Community Affairs and the New Jersey Housing and Mortgage Finance Agency should explore ways in which the equity in an older person's home can be used to pay for ***[home]*** ***long-term*** care services.

8:100-***[16.10]**18.10*** Improved information and coordination of services

(a) ***[The Commissioners of the Departments of Health, Human Services, and Community Affairs should develop a memorandum of understanding to facilitate improved coordination of services for the elderly and disabled.]*** ***The Department of Health, in collaboration with the Department of Insurance, should promote awareness of long-term care insurance products and should disseminate information to assist consumers in evaluating these products.***

(b) Long-term care consumers should have access to a single information source in each county which will enable them to make educated choices regarding all available care options in their area. To promote access to appropriate levels of care, one agency in each county should be designated by the Department*s* of Health, ***Human Services, and Community Affairs*** in consultation with the Local Advisory Board, as the primary information and referral center for all long-term care options. The Local Advisory Board, in collaboration with the Department*s* of Health, ***Human Services, and Community Affairs*** and each county information and referral center, should develop, maintain, and disseminate a current directory of the area's various long-term care options and supportive services.

(c) The Department of Health should design a Statewide media campaign focusing on long term care options with family caregivers as the audience.

(d) The Department of Health, in conjunction with the Departments of Human Services and Community Affairs, should develop and disseminate a public awareness campaign explaining adult day care and home care services and how to access them.

(e) To advance the development of long-term care options and improve coordination of services, the Department of Health, in collaboration with the Departments of Human Services and Community Affairs, Local Advisory Boards, and county-based agencies should hold regular information sharing sessions.

8:100-***[16.11]**18.11*** Care options for the ***[nursing home-eligible]*** ***long-term care*** population

(a) New Jersey residents who are ***[nursing home eligible]*** ***in need of long-term care*** by virtue of their functional impairments and needs for assistance should have access to a variety of care options, so that each person may choose the least restrictive, most affordable alternative which will result in a satisfying quality of life. The Department of Health shall encourage the creation, expansion, and/or appropriate utilization of ***[the following]*** long-term care options ***such as, but not limited to***:

1. Alternate family care placements;
2. Assisted living residencies;
3. Community Care Program for the Elderly and Disabled placements;
4. Adult day health care placements*, **for which four placements shall count as one long-term care placement***;
5. Upgraded residential health care facilities, otherwise to be known as comprehensive personal care homes; and
6. Nursing home beds.

(b) The Department of Health, in collaboration with an advisory committee including participation by the Departments of Human Services and Community Affairs, consumers, and health and social service providers, shall formulate a transition/implementation plan to assure that new and expanded home and community-based care options become available in an expeditious manner, in accordance with the provisions of this subchapter. The transition/implementation plan shall allow reasonable time periods for the development of new or amended licensing standards and reimbursement mechanisms and the infrastructure which is necessary to assure a diverse but well coordinated system of long-term care options.

(c) The Department of Health should assure the orderly development of new long-term care services in areas of the State where there is an identified need. The need for long-term care placements of the types identified in (a)1 through 6 above shall be determined by a formula, projecting five years into the future for each county, as follows: 0.07 placements per 100 population age 20 to 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.

1. 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, the Department shall ***accept applications and*** give consideration to the certificate of need approval of up to 9.2 nursing home beds per 100 population age 75 and over in each county, based on population projections for 1997.

2. 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, the Department of Health shall give consideration to the certificate of need approval of up to 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, the Department shall give consideration to the certificate of need approval of up to 9.2 nursing home beds per 100 population age 75 and over in each county, based on population projections for 1998.

(d) A proposal indicating the desired mix of new long-term care placement options should be developed for each county, taking into consideration local circumstances and consumers' diverse preferences. In each county where there is a need for new long-term care placements in accordance with (c) above, the Local Advisory Board shall establish a public process whereby the placement mix proposal may be devised with participation by area consumers, advocacy groups, health and social service providers, and others with an interest in long-term care. The number of placements allocated to each option identified in (a)1 through 6 above shall be specified in the proposal.

(e) The Department of Health should periodically conduct surveys of nursing home-eligible individuals and their families in New Jersey to determine their awareness of, preference for, access to, and satisfaction with various long-term care options. This information should be used to guide the future planning and development of services.

(f) By June 30, 1993, the Department of Health, in collaboration with the Departments of Human Services and Community Affairs, shall devise a formula to make available the options identified in (a)1 through 5 above in counties where no new long-term care placements are required in accordance with (c) above.

8:100-[16.12]**18.12* Alternate family care

(a) The Department of Health shall encourage and promote the development of high quality, accessible alternate family care programs, to be utilized by individuals who would prefer this alternative to nursing home ***[institutionalization]* *care***.

(b) The Department of Health, in collaboration with an advisory group, shall develop the requisite policies, procedures, and criteria to effectuate programs of alternate family care throughout New Jersey.

1. The advisory group referenced in (b) above shall include representation by the Departments of Community Affairs and Human Services as well as consumers and provider agencies.

2. Issues to be addressed in developing guidelines for alternate family care programs shall include but not be limited to:

- i. Appropriate patient selection;
- ii. Family screening;
- iii. Family training;
- iv. Quality assurance;
- v. Protection against patient abuse; and
- vi. Program evaluation.

(c) The Department of Health, in collaboration with the Attorney General, shall identify and endeavor to resolve potential guardianship, liability, and nursing practice issues to assure that alternate caregiving families may be trained to meet the nursing needs of patients who are placed in their homes.

8:100-[16.13]**18.13* Assisted living residences

(a) The Department of Health shall encourage and promote the development of high quality, accessible assisted living residences to be utilized by frail and disabled individuals including those who would prefer this alternative to nursing home institutionalization, but excluding those who are vegetative or who require ongoing, technically complex nursing care and supervision.

(b) The Department of Health, in collaboration with an advisory group, shall give consideration to the benefits and limitations of developing licensing, construction, and planning standards for assisted living residences as a means of promoting the orderly expansion of this long-term care alternative.

(c) Assisted living residences are intended to offer a maximum amount of privacy and independence in homelike surroundings,

while meeting residents' needs for long-term care. To be recognized by the Department of Health as an assisted living residence, the building shall at a minimum offer:

1. A private, unfurnished room or apartment for each occupant (unless double occupancy is requested by the resident). As an optional feature, kitchenettes in each room or apartment should be permitted;

2. A private bath in each room or apartment;

3. A lockable door to each room or apartment (occupant holds the key);

4. Congregate dining; and

5. Availability of 24 hour personal care assistance and health services which are provided to each occupant as needed.

(d) To promote access to assisted living for low income elderly and disabled adults, the Department*s* of Health*, Human Services, and Community Affairs* should explore the feasibility of making assisted living available in existing HUD-subsidized housing for the elderly and disabled.

8:100-[16.14]**18.14* Residential health care and *[similar]* *Class C boarding home* facilities

(a) The Department of Health *[should]* ***shall*** develop an enhanced level of residential health care in facilities that have the capacity to offer more supervision and personal care services than are traditionally offered in residential health care facilities and Class C boarding homes. This new type of facility shall be referred to as a "comprehensive personal care home." The Department of Health should convene an advisory committee to develop licensing and reimbursement standards and to identify that segment of the nursing home eligible population which would benefit most from comprehensive personal care homes.

(b) To assure the orderly development of long-term care options, certificate of need approval shall be required for the conversion of existing residential health care facilities to upgraded, service-enriched facilities ***to be known as "comprehensive personal care homes"**.

(c) The Departments of Health, Human Services, and Community Affairs should evaluate the current system of residential health care and Class C Boarding Homes, with the aim of eliminating duplicative oversight functions ***[for these very similar indistinguishable levels of care]***. The possibility of consolidating residential health care facility and Class C Boarding Home licensing within the Department of Community Affairs should be considered, insofar as it would not reduce the health maintenance and monitoring services and Supplemental Security Income payment for existing residential health care facility residents.

(d) The Department*s* of Health*, Human Services, and Community Affairs* should support legislative initiatives to increase the Supplemental Security Income ***[subsidy]* *State supplement*** for residential health care residents.

8:100-[16.15]**18.15* Continuing care retirement communities

(a) The Department of Health should recognize continuing care retirement communities (CCRCs) as a viable long-term care option. The minimum size requirements for CCRCs shall be eliminated, while maintaining a requirement for the construction of at least four independent living units for every one long-term care bed ***or assisted living unit or comprehensive personal care bed,*** up to a maximum of 120 long-term care beds*, assisted living units and/or comprehensive personal care beds*.

(b) Certificate of need applicants for new or expanding CCRCs shall document the potential demand for their projects by conducting and submitting a detailed marketing study.

8:100-[16.16]**18.16* Specialized long-term care services

(a) The Departments of Health and Human Services and Local Advisory Boards (LABs) should collaborate to develop strategies and criteria for improving access to long-term care services for persons requiring specialized long-term care. The circumstances under which specialized care should be regionalized should be identified.

(b) The Department of Health and LABs should annually conduct a survey to determine the number and characteristics of persons in each LAB region who need specialized long-term care services.

HIGHER EDUCATION

[(c) As part of their long-term care placement mix proposal, counties shall identify and address the service needs of area residents requiring specialized care.]

8:100-*[16.17]**18.17* Alzheimer's Disease and *[related dementias]* *other behavior problems*

(a) Eligibility criteria and licensing standards for community-based long-term care services, such as adult day health care, should be reviewed to assure accessibility for persons with dementia *and other behavior problems*.

(b) The Department of Health should encourage research to determine the most cost-effective and efficient methods to care for persons with dementia *and other behavior problems*.

(c) The Department of Health in collaboration with Local Advisory Boards should ensure that Alzheimer's Disease family support groups are available and accessible in all counties in the State.

(d) The Department of Health should develop and offer training for caregivers and professionals/paraprofessionals in community agencies and long-term care facilities on *[management]* *the care* of persons with dementia *and other behavior problems*.

8:100-*[16.18]**18.18* Comprehensive rehabilitation

(a) The Department of Health shall continue to conduct planning for rehabilitation hospitals in accordance with the provisions of N.J.A.C. 8:33M, the Rehabilitation Hospital Policy Manual for Certificate of Need Review. However, N.J.A.C. 8:33M shall be amended to include a new, LAB region-specific, patient-origin and age-based adult bed-need methodology.

HIGHER EDUCATION

(a)

NEW JERSEY HIGHER EDUCATION ASSISTANCE AUTHORITY (NJHEAA)

Policy Governing New Jersey College Loans to Assist State Students (NJCLASS) Program

Adopted Amendments: N.J.A.C. 9:9-7.2, 7.3 and 7.8

Proposed: May 4, 1992 at 24 N.J.R. 1675(b).

Adopted: June 24, 1992 by the New Jersey Higher Education Assistance Authority, Philip W. Koebig, Chairman.

Filed: June 25, 1992 as R.1992 d.293, **without change**.

Authority: N.J.S.A. 18A:72-10.

Effective Date: July 20, 1992.

Expiration Date: October 3, 1993.

Summary of Public Comments and Agency Responses:

The NJHEAA received one comment regarding the proposal from Harvey Kesselman, Vice President for Student Services, Stockton State College.

COMMENT: The commenter observed that the proposal will serve to broaden the number of families eligible to participate in the NJCLASS Program and provide needed relief to two wage-earner families, a constituency that generally has substantial debt yet is ineligible for grant and/or federal loans.

RESPONSE: The Authority concurs with the commenter.

Full text of the adoption follows:

9:9-7.2 Eligibility

(a) To be eligible for a NJCLASS loan, each applicant must:

1. Have an annual adjusted gross family income no greater than \$95,000;

2.-4. (No change.)

(b) (No change.)

9:9-7.3 Loan amounts

(a) The maximum amount a parent borrower may borrow for each student for each academic year is \$7,000; the maximum amount a student borrower may borrow for each academic year is \$7,000.

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(b) The total aggregate amount borrowed by any one student or parent borrower on behalf of a student shall not exceed \$35,000.

(c)-(d) (No change.)

9:9-7.8 Deferments and forbearance

(a) Under certain conditions borrowers will be permitted to defer payments of loan principal for specified periods of time. During periods of authorized deferment, borrowers remain responsible for the payment of the interest accruing on their loan(s). The following are available NJCLASS Program deferments and their requirements.

1. Full-time or half-time study at an eligible institution;

2. Unemployment:

i. The borrower must be currently unemployed and conscientiously seeking but unable to find full-time employment;

ii. Every three months the borrower must provide a signed written statement describing his or her conscientious search (at least three attempts) for full-time employment which includes:

(1) The names, addresses and phone numbers of the firms contacted;

(2) The name of the contact person at each firm; and

(3) A certification of registration with a public or private employment agency; and

iii. In order to remain eligible for the deferment, the borrower may not restrict his or her search to specific fields, positions, or salaries.

3. Service as an intern:

i. Borrower must be currently participating in an eligible internship which is supervised training which is required by a State licensing agency prior to certification for professional practice or service.

ii. Borrower must provide certification from the appropriate State licensing agency attesting to the necessity of the internship.

iii. Borrower must provide certification from the organization with which the internship is being undertaken which specifies:

(1) Acceptance of the borrower into the internship program; and

(2) Anticipated beginning and completion dates of the program.

4. Active duty status in the armed forces:

i. The borrower must provide a statement from his or her commanding officer attesting to full-time active duty status.

(b) Maximum allowable time periods for each of these deferments shall be established by the lender.

(c) Upon receipt of a borrower request for a deferment and all required documentation, the NJHEAA will notify the borrower regarding the deferment's authorization.

(d) Periods of authorized deferment do not extend the 15 year maximum loan repayment time.

(e) The lender may also, in its discretion, grant borrowers periods of forbearance in the repayment of their NJCLASS loan(s).

HUMAN SERVICES

(b)

DIVISION OF ECONOMIC ASSISTANCE

Notice of Administrative Correction

Assistance Standards Handbook

Determination of Calculated Earned Income: AFDC-C, -F and -N Procedures

N.J.A.C. 10:82-2.8

Take notice that the Division of Economic Assistance has discovered an error in the text of N.J.A.C. 10:82-2.8(a)4 as amended effective June 15, 1992 (operative July 1, 1992), the adoption of which was published in the June 15, 1992 issue of the New Jersey Register at 24 N.J.R. 2258(a). In both this adoption and the published proposal (see 24 N.J.R. 1194(a)), a portion of paragraph (a)4 currently in the Code, which was not changed by this rulemaking, was inadvertently omitted. Specifically, the following phrase which concludes the paragraph's first sentence did not appear in the Register: "... when any of the circumstances in (b) below apply to the eligible family." This notice of administrative correction is published pursuant to N.J.A.C. 1:30-2.7.

ADOPTIONS

Full text of the corrected amended rule as it should have appeared in the adoption follows:

10:82-2.8 Determination of calculated earned income: AFDC-C, -F and -N procedures

(a) From the total gross earnings of each employed person in the AFDC-C, -F and -N segments, deduct the cost of producing income if self-employed (see N.J.A.C. 10:82-4.3) and proceed as follows:

1.-3. (No change from adopted text.)

4. Deduct an amount equal to the actual expenditures for child care or for care of an incapacitated individual living in the same home as the AFDC-C, -F or -N eligible family when any of the circumstances in (b) below apply to the eligible family. In no event shall this deduction exceed the limits as follows:

i.-iv. (No change.)

(b) (No change from adopted text.)

CORRECTIONS

(a)

THE COMMISSIONER

Mail, Visits and Telephone

Readoption: N.J.A.C. 10A:18

Proposed: April 6, 1992, at 24 N.J.R. 1204(b).

Adopted: May 21, 1992 by William H. Fauver, Commissioner, Department of Corrections.

Filed May 27, 1992 as R.1992 d.262, **without change**.

Authority: N.J.S.A. 30:1B-6 and 30:1B-10.

Effective Date: May 27, 1992.

Expiration Date: May 27, 1997.

Summary of Public Comments and Agency Responses:

The Department received a total of 96 comments to the proposed readoption from the following individuals: Mary Williams, Adult Diagnostic Treatment Center, (A.D.T.C.); Karen Spinner, New Jersey Association on Corrections; Ann Jackson, Newark, NJ; John Mashell, Elysburg, PA; Christine White, Dudley, MA; Kathy Clement, Havertown, PA; Tom Worsley, Rockaway, NJ; Ev Hutchinson, Buffalo, NY; Mattie McMillan, Paterson, NJ; William Phillips, Paterson, NJ; Mr. & Mrs. Rigler, Collingswood, NJ; Margie Adams, Paterson, NJ; Mr. & Mrs. Toler, Newark, NJ; Mary Randazzo, Avenel, NJ; Lucille Jenkins, Hillside, NJ; Mr. & Mrs. Willie Speight, Newark, NJ; William Smith, Jr., Neptune, NJ; Jacqueline Gaskin, Montclair, NJ; Carol Murphy, Monmouth GMF; Ann Hood, Huntington Station, NY; Charlotte Oliver, Margate, NJ; Minister Curry, East Orange, NJ; Joanne Davis, Tinton Falls, NJ; Michale Davis, Tinton Falls, NJ; K.M. Barnes, Unknown address; Sandra Dabb, Newark, NJ; Vincent McBrearty, Belfort, NJ; Adrienne McBrearty, Belford, NJ; Sue Christian, Odessa, TX; Nicholas Muscio, Toms River, NJ; Ruth Culhane, Morrisville, NJ; JoAnn Hart, Wall, NJ; M. Reldan, Address unknown; Sandra O. Frey, Address unknown; Valerie Hairston, So. Plainfield, NJ; Susan Peck, Address unknown; Joan Kaldawi, Midland Park, NJ; David Russo, New Jersey State Prison (N.J.S.P.); James Howard, A.D.T.C.; Andrew Toohey, A.D.T.C.; Robert Walker, A.D.T.C.; Charles Leamer, A.D.T.C.; Frank Keown, A.D.T.C.; Vernon Morin, A.D.T.C.; Howard Johnson, A.D.T.C.; James Balfour, A.D.T.C.; Robert Muccigrosso, A.D.T.C.; George Riley, A.D.T.C.; William Allman, A.D.T.C.; William Greenawalt, A.D.T.C.; Thomas Murray, A.D.T.C.; Jay Hass, A.D.T.C.; Frank Appaluccio, A.D.T.C.; Joseph Hamilton, A.D.T.C.; Joseph Presher, A.D.T.C.; Raun Barretto, A.D.T.C.; David Heyboer, A.D.T.C.; Archie Hodges, East Jersey State Prison (E.J.S.P.); Patrick Welke, E.J.S.P.; Otis Terrell, E.J.S.P.; George O. Frey, III, E.J.S.P.; Curtis Smith, E.J.S.P.; Roy Terrell, Sr., E.J.S.P.; John Stewart, E.J.S.P.; David Frey, Sr., N.J.S.P.; Robert Reldan, N.J.S.P.; Marco DiGiovanni, N.J.S.P.; Nicholas Musio, N.J.S.P.; Daryle Pitts, N.J.S.P.; Richard Young, N.J.S.P.; Caplas Phillips, N.J.S.P.; Stephen Castellano, N.J.S.P.; Roy Myers, N.J.S.P.; Luis Ortiz, N.J.S.P.; James Williams, N.J.S.P.; James Clausell, N.J.S.P.; Lloyd Johnson, N.J.S.P.; Rob Marshall, N.J.S.P.; John Martini, N.J.S.P.; Michael McCullough, N.J.S.P.; Daud Tulam, N.J.S.P.; Michael D'Alessandro, N.J.S.P.; Marko Bey, N.J.S.P.; William Barron, N.J.S.P.; Carlos Colon, N.J.S.P.; Bruce Anderson, N.J.S.P.; Robert Cumber, N.J.S.P.; Steven

CORRECTIONS

Amos, N.J.S.P.; Warren Sneed, N.J.S.P.; Patrick Lanzel, N.J.S.P.; Thomas Fuller, N.J.S.P.; William Deeves, N.J.S.P.; Steven Bolling, N.J.S.P.; Thomas Bailiff, N.J.S.P.; James Williams, N.J.S.P.; Vernon Simmons, N.J.S.P.; David Stannard, N.J.S.P.; Sharif Abdur' Rageeb, N.J.S.P.; Kenneth Testa, N.J.S.P.; and Harry Ruggs, N.J.S.P.

COMMENT: One commenter objected to N.J.A.C. 10A:18-2.26(e), which prohibits inmates from using the inter-office mail system, commonly called "truck mail", to correspond with other State Departments or agencies. The commenter would prefer that inmates be able to use this system.

RESPONSE: "Truck mail" is not permitted when inmates correspond with other State Departments or agencies because inmate mail must be screened for contraband, proper return address, etc. Regular mail must, therefore, be used by inmates.

COMMENT: A commenter suggested that the Prosecutor's Office be added to the list for legal telephone calls at N.J.A.C. 10A:18-8.6(b).

RESPONSE: It is not intended that the Prosecutor's Office be included on that list, since the inmate's attorney-of-record is not a prosecutor. Any contact with the prosecutor may be made by written communication.

COMMENT: The New Jersey Association on Corrections objected to N.J.A.C. 10A:18-2.9, specifically a hand-stamp used by the New Jersey State Prison, which states "New Jersey State Prison Uncensored Contents." It was pointed out that use of this stamp exceeds the authority provided by the rule and is offensive.

RESPONSE: The Department of Corrections agrees with this comment and will take action to insure that the rule is carefully followed.

COMMENT: The New Jersey Association on Corrections feels that N.J.A.C. 10A:18-6.8 is too restrictive because it may result in denying a visit to certain children who have legal guardians.

RESPONSE: The term "relative" is intended to be liberally interpreted to include legal guardians and other relatives, such as foster parents. To change the rule would not be advisable, because no adequate controls could be enforced.

COMMENT: The New Jersey Association on Corrections suggested that N.J.A.C. 10A:18-8.4 permit inmate use of limited access telephone credit cards so as to reduce the charges to families for collect calls.

RESPONSE: This suggestion will be studied as soon as more information regarding such limited use telephone credit cards can be obtained.

COMMENTS: All of the remaining comments pertain to N.J.A.C. 10A:18-2.9(d) which requires the full name of the correctional facility to appear in the upper left corner of all outgoing envelopes. These comments may be summarized as follows:

1. There is no reason for the rule;
2. Merchants should have the responsibility to police and manage their correspondence;
3. The rule is an additional punishment for prisoners;
4. The rule will not have a chilling effect on inmate correspondence;
5. The rule causes stress to families and friends of inmates;
6. The stamp is offensive and embarrassing;
7. The stamp is an invasion of privacy;
8. Use of the stamp will cause loss of jobs or housing in the community;
9. The rule will adversely affect efforts at rehabilitation, search for jobs, etc.; and
10. The rule will not solve the problem for which it was designed.

RESPONSE: N.J.A.C. 10A:18-2.9 was amended January 6, 1992, to add (d), the subsection which has evoked the comments listed above. At that time the Department of Corrections responded to many of the same comments as follows:

"The Department of Corrections agrees that merchants should themselves be more careful in readily filling orders received by mail, but this does not mean that the Department of Corrections should simply "look the other way." It is also the responsibility of the Department of Corrections to protect the public in every way possible from fraud or other illicit activities sought to be carried out by inmates through correspondence.

The Department of Corrections is not insensitive to the frustration or pain which this policy may cause to some relatives or friends of inmates. But it is the inmates' actions resulting in their sentences which caused the situations of which they complain. The Department of Corrections has no desire to embarrass persons in the community; on the contrary, the Department of Corrections seeks to protect the community from further, unnecessary victimization.

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It is anticipated that rather than to discourage correspondence with friends and relatives, this policy will encourage inmates to interact more realistically with persons in the community so as to appreciate all the consequences of their criminal behavior and make genuine efforts towards rehabilitation. Thus, although in the short term some persons may experience discomfort, in the long term there will be more positive benefits."

The Department of Corrections believes that the response repeated above remains valid, and that the rule does not "punish" inmates or their correspondents. In fact, a number of inmates noted that the name stamp being used is repetitious because the inmates write the full name of the correctional facility as part of the return address. It is also doubtful whether the "chilling effect" claimed will occur, either on correspondence or on rehabilitation. Prospective employers have a right to know whether the persons they are hiring have prison records, and any attempt to hide such facts is not a sound basis on which to build a relationship, whether social or employment. Whether the rule will solve the problem for which it was intended remains to be seen. Although there may be inmates who are determined to circumvent this rule, at the expense of the general public, the Department of Corrections believes that it will greatly reduce the occurrence of such activities.

NOTE: A number of comments were complaints about policies or practices related to the manner in which the existing rules are applied in a given facility. Since the scope of the comments and responses is the substance of the rule and the rulemaking, the complaints regarding enforcement are, appropriately, not responded to in this document.

Full text of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 10A:18.

LAW AND PUBLIC SAFETY

(a)

VIOLENT CRIMES COMPENSATION BOARD

Eligibility of Claims and Compensable Damages

Adopted Amendment: N.J.A.C. 13:75-1.7

Proposed: May 18, 1992 at 24 N.J.R. 1862(a).

Adopted: June 22, 1992 by the Violent Crimes Compensation Board, Jacob C. Toporek, Chairman.

Filed: June 29, 1992 as R.1992 d.301, **without change**.

Effective Date: July 20, 1992.

Expiration Date: June 5, 1994.

Summary of Public Comments and Agency Responses:

No comments received.

Full text of the adoption follows:

13:75-1.7 Compensable damages

(a)-(j) (No change.)

(k) The Board may deny compensation to a claimant unless the claimant has satisfied any and all Violent Crimes Compensation Board assessments imposed pursuant to N.J.S.A. 2C:43-3.1 and restitution ordered by the courts to be paid specifically to the Board until such time as proper proof is submitted verifying satisfaction of said obligations.

1. Where possible the Board may forward the amount of the outstanding assessment and/or restitution directly to the proper collection authority from any proceeds of the award of compensation the Board may make to or on behalf of the victim or claimant.

(l) The Board shall make no award for compensation to or on behalf of a victim or claimant during any period of their incarceration and may close the claim without prejudice. Upon release from any period of incarceration the claimant may petition the Board to reopen the claim.

1. No compensation shall be awarded for incidents occurring on or after December 23, 1991 if the victim sustained injuries while incarcerated for the conviction of a crime. Factors to be considered in determining incarceration shall include, but not be limited to, restraints placed on personal liberty; freedom from mobility; and

whether the individual is under the care, custody and control of any penal institution or similar institution.

2. Where a victim is injured while serving a non-custodial sentence or while incarcerated for reasons other than conviction of a crime, or injured while incarcerated prior to December 23, 1991, the Board shall take all relevant matters into consideration including, but not limited to, the following:

i. The provisions of N.J.S.A. 52:4B-9 requiring the Board to consider the availability of funds as appropriated by the State in awarding compensation;

ii. Whether the victim assumed a reasonable risk of injury under all the circumstances of the case;

iii. Whether the victim had reason to believe that his or her actions would result in arrest, conviction, sentence and incarceration;

iv. The likelihood of the victim's conviction for the allegations serving as the basis for the victim's incarceration;

v. The nature of the offense and the sentence imposed; and

vi. The disposition of the charges by the criminal justice system.

TREASURY-TAXATION

(b)

DIVISION OF TAXATION

Corporation Business Tax

Indebtedness Owed Directly or Indirectly; Entire Net Income, How Computed

Adopted Amendments: N.J.A.C. 18:7-4.5 and 5.2

Proposed: January 21, 1992 at 24 N.J.R. 175(a).

Adopted: June 17, 1992 by Leslie A. Thompson, Director, Division of Taxation.

Filed: June 18, 1992 as R.1992 d.289, **with substantive changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 54:10A-27.

Effective Date: July 20, 1992.

Expiration Date: March 14, 1994.

Summary of Public Comments and Agency Responses:

Patrick J. Deo, CPA, Chairman of the State Tax Committee of the New Jersey Society of Certified Public Accountants, submitted comments on behalf of the Society. Although the comments were received after the 30 day period for public comments had ended, the Division nevertheless in this instance took them into account in adopting the proposal, as being in the public interest.

COMMENT: First, the commenter requested inclusion of an example at N.J.A.C. 18:7-4.5(f) to guide taxpayers.

RESPONSE: The Division agreed to include for clarity a new subsection (f), reflecting the *Centex* holding, an example in the rule adoption to assist taxpayers.

COMMENT: Second, the commenter suggested modifications to the last sentence of N.J.A.C. 18:7-5.2(a)lvii in connection with the changes made in the first comment.

RESPONSE: The Division agreed to make this change.

COMMENT: Third, the commenter inquired whether the effect of the rule was retroactive.

RESPONSE: The Division responded that in this particular instance, since it is codifying existing case law pursuant to the *Centex* opinion, the time for filing any refund claim would be governed by the finality of the *Centex* case rather than the rule itself.

Summary of Changes Between Proposal and Adoption:

The Division added N.J.A.C. 18:7-4.5(f) and an example for the convenience of taxpayers, and made a related change in the language of N.J.A.C. 18:7-5.2(a)lvii reflecting the added subsection and example.

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

18:7-4.5 Indebtedness owing directly or indirectly

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

***(f) For the purpose of determining the degree of stock ownership of a corporate creditor, the shares of the taxpayer's capital stock held by all corporations bearing the relationship of parent, subsidiary, or affiliate of the corporate creditor shall not be aggregated.**

Example: L corporation owns 100 percent of M corporation which in turn owns 100 percent of N corporation. M corporation has a valid business purpose. L corporation made loans or otherwise provided funds directly to N corporation. The source of such funds is not from M corporation. The indebtedness from N corporation to L corporation is not indebtedness owing directly or indirectly to a 10 percent stockholder.*

18:7-5.2 Entire net income; how computed

(a) "Taxable income before net operating loss deduction and special deductions," hereinafter referred to as Federal taxable income, is the starting point in the computation of the entire net income. After determining Federal taxable income, it must be adjusted as follows:

1. Add to Federal taxable income:

Recodify existing 1-6 as i.-vi. (No change in text.)

vii. The amount deducted, in computing Federal taxable income, for interest on indebtedness whether or not evidenced by a written instrument. To be added back, such interest must be owed directly or indirectly either to an individual stockholder or members of his or her immediate family who, in the aggregate, own beneficially 10 percent or more of the taxpayer's outstanding shares of capital stock or to a corporate stockholder which owns 10 percent or more of the taxpayer's outstanding shares of capital stock. The amount deducted shall be reduced by 10 percent of the amount so deducted or \$1,000, whichever is larger. Thus, if the amount of such interest is \$1,000 or less, then none of said amount need be added back. (For definition of ***and guidance in determining*** "directly" and "indirectly" see N.J.A.C. 18:7-4.5(d) ***[and]**,*** (e) ***and** (f).) However, there shall be allowed as a deduction:

Recodify existing i.-iv. as (1)-(4) (No change in text.)

viii. Recoveries with respect to war losses, regardless of whether such war losses were deducted in any return previously made for the purpose of computing the New Jersey Corporation Business Tax;

ix. All income from sources outside the United States which has not been included in computing Federal taxable income less all allowable deductions to the extent that such allowable deductions were not taken into account in computing Federal taxable income. See (a)2iii below for limitations respecting foreign tax deduction;

x. In any year or short period which ends after 1981, any depreciation or cost recovery (ACRS) which was deducted in arriving at Federal taxable income and which was determined in accordance with Section 168 of the Federal Internal Revenue Code in effect after December 31, 1980. See (a)2iv below for depreciation allowable in computing entire net income.

xi. In any year or short period ending after 1981, any interest, amortization or transactional costs, rent, or any other deduction which was claimed in arriving at Federal taxable income as a result of a "safe harbor leasing" election made under Section 168(f)(8) of the Federal Internal Revenue Code; provided, however, that for a fiscal year or short period which begins in 1981 and ends 1982, any such amount which relates to property placed in service during that part of the return year which occurs in 1981 shall be allowed as a deduction in arriving at entire income for that year only; and provided further that any such amount with respect to a qualified mass commuting vehicle pursuant to Federal Internal Revenue Code Section 168(f)(8)(D)(v) (formerly 168(f)(8)(D)(iii)) shall be allowed in any event.

(1) Where the "user/lessee" of qualified lease property which is precluded from claiming a deduction for rent under this rule would have been entitled to cost recovery on property which is subject to such "safe harbor lease" election in the absence of that election, it may claim depreciation on that property under the provisions of

(a)2iv and v below. See (a)2vi below for the treatment to be accorded related income on such "safe harbor lease" transactions.

xii. All income, from whatever sources derived not included in computing Federal taxable income and not otherwise required to be added back under (a)1i through ix above, less all allowable deductions attributable thereto, to the extent that those allowable deductions were not taken into account in computing Federal taxable income.

2. Deduct from Federal taxable income:

i. 100 percent of all dividends included in Federal taxable income which were received from subsidiaries meeting the definition of a subsidiary under N.J.A.C. 18:7-4.11 (Subsidiary corporations; definition) and 100 percent of all dividends from those subsidiaries which were added to Federal taxable income in accordance with (a)1 above;

ii. Fifty percent of all other dividends included in Federal taxable income or added to Federal taxable income in accordance with (a)1 above. Dividends received from a regulated investment company which are treated as interest for purposes of the Internal Revenue Code and/or which are not considered qualifying dividends for Internal Revenue purposes are not eligible for deduction or exclusion from entire net income under this subsection.

iii. Income, war-profits, and excess profits taxes imposed by foreign countries or possessions of the United States, allocable to income included in Federal taxable income subject to the following limitations:

(1) To the extent that these income, war-profits and excess profits taxes were allowed as a credit against the Federal income tax under the applicable provisions of the Internal Revenue Code;

(2) Provided, that such taxes were not reflected in deductions made in computing Federal taxable income or taken under (a)1xi above; and

(3) Also provided that the amount of the deductible income, war-profits and excess profits taxes paid to each foreign country or possession of the United States shall not exceed the net income earned by the taxpayer in such foreign country or possession.

iv. Depreciation on property placed in service after 1980 on which ACRS has been disallowed under (a)1x above using any method, file and salvage value which would have been allowable under the Federal Internal Revenue Code at December 31, 1980. A method, once adopted, must be used for all succeeding years for purposes of computing depreciation on that particular recovery property, except only that a taxpayer may make a change in method which would not have required the consent of the Commissioner of Internal Revenue. Personal property placed in service during any year after 1980 must be treated using the half year convention by claiming a half year of depreciation in the year that property is placed in service. No depreciation is allowable in the year of disposal. Aggregate depreciation claimed under this paragraph for all years is limited to the basis for depreciation under the Federal Internal Revenue Code at the date the property is placed in service less whatever salvage value would have been required to be considered under the Federal Internal Revenue Code at December 31, 1980.

v. Gain or loss on property sold or exchanged is to be determined with reference to the amount properly to be recognized in determination of Federal taxable income. However, on the physical disposal of recovery property, whether or not a gain or loss is properly to be recognized under the Federal Internal Revenue Code, there shall be allowed as a deduction any excess or there must be restored as an item of income any deficiency of depreciation disallowed under (a)1x above over related depreciation claimed on that property under (a)2iv above. A statutory merger or consolidation shall not constitute a disposal of recovery property.

vi. In any year or short period ending after 1981, any item of income included in arriving at Federal taxable income solely as a result of a "safe harbor leasing" election made under Section 168(f)(8) of the Federal Internal Revenue Code; provided, however, that for the accounting period which begins in 1981 and ends in 1982, such income which relates to property placed in service during 1981 is not to be excluded; and provided, further, that any such income which relates to qualified mass commuting vehicle pursuant

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to Federal Internal Revenue Code Section 168(f)(8)(D)(v) (formerly 168(f)(8)(D)(iii)) shall be included in entire net income in any event.

(1) Where income relating to such safe harbor leasing election would have been included in Federal taxable income whether or not the election is made, no exclusion is permitted.

Example: A corporation which finances the acquisition of machinery and equipment is not permitted to exclude interest income merely because it is one of the parties to a "safe harbor lease" whereby it agreed that all parties to the transaction characterize it as a lease for Federal income tax purposes.

(2) For treatment of deductions relating to such safe harbor lease transactions, see (a)1xi above.

vii. Any banking corporation which is operating an international banking facility (IBF) as part of its business may exclude the eligible net income of the IBF, as herein described, from its entire net income, as follows:

(1) Any deductions under this section can only be claimed to the extent that they are not deductible in determining Federal taxable income, or not deductible under N.J.S.A. 54:10A-4(k)(1) through (3).

(2) The eligible net income of an IBF is the amount of income remaining after subtracting the applicable expenses, as defined by (a)2viii(4) below.

(3) Eligible gross income is the gross income derived from an IBF. This will include gross income derived from the following:

(A) Making, arranging for, placing or carrying loans to foreign persons, provided, however, that in the case of a foreign person which is an individual, or which is a foreign branch of a domestic corporation (other than a bank), or which is a foreign corporation or foreign partnership which is controlled, by one or more domestic corporations (other than banks), domestic partnerships or resident individuals, all the proceeds of the loan are for use outside of the United States.

(B) Making or placing deposits with foreign persons which are banks or foreign branches of banks (including foreign subsidiaries) or foreign branches of the taxpayers or with other international banking facilities; or

(C) Entering into foreign exchange or hedging transactions relating to any transactions under (a)2vii(3)(A) and (B) above or (D) below.

(D) Any other activities which an IBF may be, at any time, authorized to engage in by Federal or state law, the Board of Governors of the Federal Reserve, the Comptroller of the Currency, the New Jersey Banking Commission, or any other authority.

(4) Applicable expenses are any expenses or deductions which are directly or indirectly attributable to eligible gross income as defined in (a)2vii(3) above.

(See: N.J.A.C. 18:7-16 regarding international banking facilities.)

PUBLIC NOTICES

ENVIRONMENTAL PROTECTION AND ENERGY

(a)

OFFICE OF ENERGY

Notice of Receipt of Petition For Rulemaking Required Provisions for Energy Conservation Equipment Sales Contracts

N.J.A.C. 12A:60-1.5(a)15i

Petitioner: Honeywell, Inc.

Take notice that on June 19, 1992, the Department of Environmental Protection and Energy (Department) received a petition for rulemaking concerning the amendment of rules governing financing of energy conservation measures, N.J.A.C. 12A:60.

N.J.A.C. 12A:60 applies to contracts, the entire price of which are established as a percentage of the resulting energy savings, which contracts involve work, services, materials, supplies or equipment furnished or performed for the purpose of conserving energy in the following:

1. Buildings owned or operations conducted by entities subject to the Local Public Contracts Law, N.J.S.A. 40A:11-15; and
2. Buildings owned by any board of education subject to N.J.S.A. 18A:18A-5 and 42.

Petitioner specifically requests that the Department amend N.J.A.C. 12A:60-1.5(a)15i. This provision requires that all contracts subject to N.J.A.C. 12A:60 provide that "no payment shall be required of the user until the energy conserving renovations have generated energy savings for the user."

Petitioner requests that the rule be amended to instead allow the user to enter into a contract guaranteeing the amount of energy savings, under which the vendor would provide the user with a bond securing the vendor's performance of its contractual obligations.

(b)

DIVISION OF PARKS AND FORESTRY

Notice of Public Hearing Lease on Portion of the Public Heritage Use Area of the Proprietary House, Perth Amboy

Take notice that the State of New Jersey, Department of Environmental Protection and Energy, Division of Parks and Forestry, will hold a public hearing to seek comments on a proposed 25 year lease including an option of five renewals of five years each with the Proprietary House Association on the portion of the State-owned structure known as the public heritage use area of the Proprietary House located in the City of Perth Amboy and administered by Cheesequake State Park for the purpose of maintaining, operating and interpreting the House as an historic site and making the facility available for public visitation and interpretation.

All that certain interior portion of the Proprietary House designated as the public heritage use area and consisting of a portion of the ground and first floor of the Main Block situated in the City of Perth Amboy, County of Middlesex, State of New Jersey.

The Proprietary House Association under the terms of this lease will furnish, maintain and operate the public heritage use area of the Proprietary House for public visitation and interpretive programs of the historic significance of the House. The Association may, with State Park Service and the Office of New Jersey Heritage approval, undertake specific projects for the preservation, restoration and/or improvement of the House.

The Association may conduct or allow to be conducted in the leased area cultural, social, membership, or community activities which are consistent with the purpose of this lease.

The Lease Agreement will be available for review at Cheesequake State Park Administration Building during regular office hours, Monday through Friday.

The proposed lease does not interfere with or affect the public use of State-owned structures but enhances the public use and enjoyment of the House.

The public hearing will be held on:

Thursday, August 20, 1992 at 7:00 P.M. at the
Proprietary House
149 Kearny Avenue
Perth Amboy, 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 Superintendent Paul Sedor at (908) 566-2161.

Interested persons may submit written comments until August 28, 1992 to:

Gregory A. Marshall
Director
Division of Parks and Forestry
Department of Environmental Protection and Energy
CN 404
Trenton, New Jersey 08625

(c)

OFFICE OF REGULATORY POLICY

Amendment to the Sussex County Water Quality Management Plan Public Notice

Take notice that on June 17, 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 Sussex County Water Quality Management Plan was adopted by the Department. The adopted amendment allows for a new on-site ground water disposal system to serve the Lake Ridge Townhouses, a residential townhouse development in the Borough of Hopatcong, Sussex County. The 18 unit townhouse development includes 12 two-bedroom units and six three-bedroom units.

(d)

OFFICE OF REGULATORY POLICY

Amendment to the Northeast Water Quality Management Plan Public Notice

Take notice that the New Jersey Department of Environmental Protection and Energy (NJDEPE) is seeking public comment on a proposed amendment to the Northeast Water Quality Management (WQM) Plan. This amendment proposal was submitted by the Pompton Lakes Borough Municipal Utilities Authority (PLBMUA). The amendment is for the PLBMUA Wastewater Management Plan (WMP). The WMP delineates the entire Borough of Pompton Lakes as within the future sewer service area to the PLBMUA sewage treatment plant. The WMP also modifies the treatment level for suspended solids as required in the Northeast Water Quality Management Plan. The modification will change the total suspended solids concentration in the PLBMUA New Jersey Pollutant Discharge Elimination System permit to 30 mg/l as a monthly average and 45 mg/l as a weekly average.

This notice is being given to inform the public that a plan amendment has been proposed for the Northeast WQM Plan. All information related to the WQM Plan and the proposed amendment is located at the NJDEPE, Office of Regulatory Policy, CN-029, 401 East State Street, 3rd Floor, Trenton, New Jersey 08625. It is available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appoint-

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ment to inspect the documents may be arranged by calling the Office of Regulatory Policy at (609) 633-7021.

Interested persons may submit written comments on the proposed amendment to Mr. Edward Frankel, at the NJDEPE address cited above with a copy sent to Ms. Delite Clegg, Lee T. Purcell Associates, 60 Hamilton Street, Paterson, New Jersey 07505. All comments must be submitted within 30 days of the date of this public notice. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by NJDEPE with respect to the amendment request.

Any interested persons may request in writing that NJDEPE hold a nonadversarial public hearing on the amendment or extend the public comment period in this notice up to 30 additional days. These requests must state the nature of the issues to be raised at the proposed hearing or state the reasons why the proposed extension is necessary. These requests must be submitted within 30 days of this public notice to Mr. Frankel at the NJDEPE address cited above. If a public hearing for the amendment is held, the public comment period in this notice shall be extended to close 15 days after the public hearing.

(a)

OFFICE OF PERMIT INFORMATION AND ASSISTANCE

Notice of Classification of Permits under the Environmental Management Accountability Act

Take notice that the Department of Environmental Protection and Energy (DEPE) has established categories within each permit program, based on the complexity of the application and of the necessary documentation, as well as on the potential environmental or health affects that could result from the approval of such an application. In addition, the DEPE has established general timeframes for the review of applications or other activities under each category. This classification system is required by P.L.1991, c.423 (the Environmental Management Accountability Act). In addition, P.L.1991, c.423 requires the DEPE to adopt guidelines to serve as the goals of the DEPE for reviewing and taking final action on an application in each category. These laws require the DEPE to publish notice on the classification system and scheduling guidelines in the *New Jersey Register*.

The following categories and timeframes of permits have been established for each of the permit programs listed in the Environmental Management Accountability Act (P.L. 1991, c. 421). The timeframes are the DEPE's goals for reviewing applications, taking into account the time required for coordination with other public agencies to review aspects of some types of applications, coordination with the applicants to amplify and clarify their application and to resolve potential conflicts with applicable laws and regulations, and the time needed to provide opportunities for receipt and review of written comments and to hold public hearings when there is sufficient public interest or a legislative requirement.

These categories are designed to help the DEPE better set priorities so that relatively small or simple applications can be processed more quickly without "standing in line" behind more complex projects. The timeframes are intended to help applicants and others affected by the permit process to anticipate the time that review of a permit application is likely to take so that they can plan accordingly.

In July, the DEPE will be producing checklists and, in January 1993, technical manuals to clarify what information is required in each type of permit application and how best to prepare those applications to comply with the relevant laws and regulations. Beginning in the fall of 1992, the DEPE will also be holding permit training seminars, and working to improve the quality of information for applicants.

The DEPE welcomes suggestions for improving review processes from potential permit applicants as well as from local officials, citizen groups, and individuals who may want to have input into the process for particular projects or types of projects. Please direct any suggestions, requests for additional information, or questions about the list that follows to Geoffrey Cromarty, Office of Permit Information and Assistance, NJDEPE, CN 401, Trenton, NJ 08625.

Except where noted, the following timeframes represent the time to review a project when it is both administratively and technically complete. For more complex permits, which require coordination and consultation with the applicant during the technical review, the timeframe for review starts once the application is administratively complete: these categories will include an accounting of how the times are derived.

PERMIT

Land Use Regulation Program

Waterfront Development Permits

90 days*

Wetlands, Type A, Type B

90 days*

Type A permits are for minor projects including excavation of small boat mooring slips; maintenance or repair of bridges, roads, and highways; and construction of catwalks, piers, docks, landings, and observation decks. Type B permits are for projects that dredge, fill, excavate, or alter the marsh contour.

Stream Encroachment Permits

Major

90 days*

Projects that require hydrologic and/or hydraulic review to determine the impact on flood carrying capacity of the stream or review of stormwater detention basins for compliance with Stormwater Management Regulations, or involves fill or structures necessitating review for compliance with the 20 percent net fill limitation; also developments involving more than one acre in a flood plain for commercial use and developments or subdivisions involving more than ten acres.

Minor

70 days*

Freshwater Wetlands Permits

General Permit

60 days

Letter of Interpretation

75 days

Transition Area Waiver

90 days

Letter of Exemption

75 days

Individual Permit

6 months

Coastal Area Facility Review Act Permits

90 days*

*For these programs, permits are automatically approved if a decision is not issued by the 90th day after the application is deemed technically complete under the 90 Day Act (N.J.S.A. 13:1D-29 et seq.).

Wastewater Facilities Regulation Program

(New Jersey Pollutant Discharge Elimination System (NJPDES) permits)

Request for Authorization

90 days

Authorization to discharge wastewater from fuel cleanups, non-contact cooling water, industrial site stormwater runoff, and auto dealers carwash under existing general permits. The DEPE is developing other categories of general permits for adoption during the first quarter of 1993.

Terminations

90 days

Treatment Works Approvals

90 days*

Sewer Ban Exemptions

90 days

Significant Indirect User Permits

6 months

Permit Modifications

6 months

Modifications to SIU permits, Surface Water Discharge permits, Land Application of Sludge/Residuals, Ground Water Discharge permits, and Discharge Allocation Certificates.

Sewerage Facility for 50 or more Realty Improvements

6 months

Surface Water Discharge Permits

6 months

Permits for the discharge of industrial/commercial process wastewater, sanitary wastewater, cooling water, non-contact cooling water, stormwater runoff, and groundwater decontamination that do not qualify for a general permit.

Discharge Allocation Certificate

6 months

Land Application of Sludge/Residuals

6 months

Ground Water Discharge

6 months

Once a NJPDES application is administratively and technically complete, the review schedule is as follows:

Draft permit	45 days
DEPE review and coordination	30 days
Public Notice and Comments	45 days
Response to comments	60 days
	180 days
	(6 months)

*For these programs, permits are automatically approved if a decision is not issued by the 90th day after the application is deemed technically complete under the 90 Day Act (N.J.S.A. 13:1D-29 et seq.).

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Air Quality Regulation Program

- Level 1** 30 days
- Storage and Transfer of Service Station Fuels (Stage I)
Storage and Transfer of Service Station Fuels (Stage II)
Retail Dry Cleaning Operations
Commercial Oil and Gas Combustion of less than 10 million BTU/hr. maximum rated gross heat input, not including reciprocating engines, cogeneration or power generation.
Non-floating roof storage tanks of less than 40,000 gallons capacity and not storing a toxic substance listed in N.J.A.C. 7:27-17.3.
Emergency generators with less than 10 megawatts of electrical output that operate less than 500 hours per year.
Any tank, reservoir, container, or bin that is used for the storage of solid particles.
Burning of dangerous materials, as defined in N.J.A.C. 7:27-2.
Any Control apparatus that serves one or more laboratory hoods, ducts, or vents.
- Level 2** 90 days
- Other source operations not included in another level, which emit less than 25 tons per year of each air contaminant.
Liquid Storage Tanks storing a toxic substance listed in N.J.A.C. 7:27-17.3.
Liquid storage tanks greater than 40,000 gallons.
Commercial Oil and Gas combustion greater than or equal to 10 million BTU per hour, not including reciprocating engines, cogeneration, or power generation.
Air stripping and soil venting operations using carbon absorption, thermal or catalytic oxidation to control VOC emissions.
All permit applications submitted under the NON-Reactive permitting procedure with emissions less than 25 tons per year.
Stationary solid material handling equipment using pneumatic, bucket, or belt conveying systems.
Grinders processing hospital waste.
- Level 3** 4.5 months
- Source operations with emissions greater than 25 tons per year (considering enforceable operating conditions) that are not in Level 4 or 5.
Source operations subject to emission offset reviews under N.J.A.C. 7:27-18 netting out of offsets, that are not in Level 4 or 5.
All permit applications submitted under the Batch, Pilot, or Dual permitting procedure.
Source operations subject to Prevention of Significant Deterioration (PSD) and not in level 4 or 5.
Cogeneration and power generation equipment using gas or oil and less than or equal to 10 million/BTU/hr.
Wastewater treatment equipment, other than in Level 2.
Sludge dewatering equipment.
Composting facilities.
All Solid waste applications other than solid waste combustion.
All permits submitted under the NON-Reactive permitting procedure with emissions greater than or equal to 25 tons per year.
Flares.
Reciprocating engines with a heat input less than 10 million/BTU/hr.
Hospital waste processing using autoclaves, microwaves, and technologies other than grinding.
- Level 4** 12 months
- All liquid and gaseous fuel combustion for energy equipment having a heat input rate greater than 100 million BTU/hr.
All incinerators, except Hazardous Waste incinerators.
All coal-fired or other solid fuel fired equipment.
Sludge incinerators.
Permits involving Superfund site mitigation.
Reciprocating engines with a heat input greater than 10 million/BTU/hr.
All boiler projects with a combined heat input of greater than 100 million BTU/hr.
Commercial facilities that treat offsite generated waste.
Waste oil process by-products or other non-commercial fuel combustion.

Cogeneration and power generation equipment greater than 10 million BTU/hr.

Once a Level 4 Air Permit application is administratively complete, the aforementioned 12-month review schedule is as follows:

First technical review	30 days
Response from applicant	30 days
Second technical review	30 days
Response from applicant	30 days
Final review and draft permit	30 days
Public comment period	45 days
Response to comments	90 days
Management review of response	30 days
Finalize permit/decision	20 days
	365 days
	(12 months)

- Level 5** 16 months
- Hazardous waste incinerators and associated equipment.
Site Clean-up with hazardous waste incinerators or treatment equipment.
Site Clean-up with innovative technology.

Once a Level 5 Air Permit application is administratively complete, the aforementioned 12-month review schedule is as follows:

First technical review	30 days
Response from applicant	30 days
Second technical review	30 days
Response from applicant	30 days
Final technical review	30 days
Response from applicant	30 days
Coordination with DEPE programs and federal agencies	30 days
Draft permit	30 days
Comments from applicant	30 days
Finalize public notice, permit conditions, and public information document	15 days
Public hearing and comments	45 days
Prepare response document	90 days
Management review of response	30 days
Finalize permit/decision	30 days
	480 days
	(16 months)

Hazardous Waste Regulation Program

- Minor Modifications to a Hazardous Waste Facility (HWF) Permit 3 months
- Less than 90 Day Accumulation Tank 3 months
- Laboratory/Testing Facility Approval 3 months
- On-site Recycling to Produce Fuel 3 months
- Closure Plan Approval 6 months
- Major Modifications to a HWF Permit 6 months
- Hazardous Waste Facility Permit:
- Storage/Treatment 14.5 months
- Incinerators 16.5 months
- Land Disposal 19.5 months

Once a Hazardous Waste Facility application is administratively complete, the aforementioned review schedules are as follows:

Storage/Treatment	
Technical Review	90 days
Response from applicant	60 days
Review of applicant's response	30 days
Complete draft permit, fact sheet, and Public Notice	90 days
Lead time for Notice of Draft Permit, Public Hearing	15 days
Public Comment Period, Public Hearing	45 days
Response to Comments, Permit Decision	105 days
	435 days
	(14.5 months)

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Incinerators	
Technical Review	120 days
Response from applicant	60 days
Review of applicant's response	60 days
Complete draft permit, fact sheet, and Public Notice	90 days
Lead time for Notice of Draft Permit, Public Hearing	15 days
Public Comment Period, Public Hearing	45 days
Response to Comments, Permit Decision	105 days
	495 days
	(16.5 months)

Land Disposal	
Technical Review	150 days
Response from applicant	60 days
Review of applicant's response	90 days
Complete draft permit, fact sheet, and Public Notice	120 days
Lead time for Notice of Draft Permit, Public Hearing	15 days
Public Comment Period, Public Hearing	45 days
Response to Comments, Permit Decision	105 days
	585 days
	(19.5 months)

Water Supply Element

Safe Drinking Water (Public Water Works Permits)

Treatment Modifications	6 months
Distribution Modifications	10 months
New Surface Source	15 months
New Public Water Systems	31 months
New Well	32 months

Once a Public Water Works permit application is received, the aforementioned review schedules are as follows:

New Surface Source	
Technical Review	3 months
Construction of intake (by applicant)	7 months
DEPE test	2 months
Response from applicant	3 months
	15 months

New Public Water Systems	
Technical Review	3 months
Construction of system (by applicant)	18 months
DEPE inspection and testing	2 months
Response from applicant	8 months
	31 months

New Well	
Technical Review	3 months
Construction of well (by applicant)	15 months
DEPE inspection and testing	2 months
Response from applicant	12 months
	32 months

Water Allocation Permits

Dewatering—no public hearing	5 months
Modifications—no public hearing	7 months
New Permit—Surface/Groundwater	9 months
Renewals	12 months*
Dewatering, Modifications, Initial—public hearing	12 months

*As a policy, the DEPE reviews new applications and modifications before renewals, thus creating a longer review time for renewals. Permits up for renewal are often extended for up to 12 months after the expiration date of the permit in order to accommodate the permittee.

Pesticide Control

Pesticide Operator License	21 days
Aquatic Use Permits	30 days
Mosquito/Fly Control Permits	30 days
Routine Pesticide Product Registration	30 days
Pesticide Applicator/Dealer Business License	30 days
Certified Pesticide Applicator/Dealer License	35 days
Special Pesticide Product Registrations	60 days

Solid Waste Management

Limited Transporter Registration**	Over the counter
	1 hour
Certificates of Public Convenience**	14 days
Renewals	45 days
Medical Waste Generators**	14 days
Renewals	45 days

**New owners/operators in these categories are required to obtain A-901 Disclosure Statement Approval prior to operations.

A-901 Disclosure Statement Approval 6 months
A-901 Disclosure Statement Approval review times do not include the time necessary for the applicant to respond to formal requests for information and depositions. The following schedule for A-901 Disclosure Statement Approvals is an average timeframe for processing an average size company with limited corporate levels and partnerships.

Background investigation NJDEPE/	
State Police	90 days
Attorney General's Report	60 days
Disclosure Statement final review decision making	30 days
	180 days
	(6 months)

Resource Recovery Service Contracts 6.5 months

Review of Resource Recovery Service Contracts follow the following schedule:

Review of Service Contract	
Notice of Intention to Submit (prior to submission)	10 days
Initial Review/Discovery Request	15 days
Discovery Response	10 days
Supplemental Request	5 days
Response to Supplemental	10 days

Public Hearing	
Public Hearing	45 days
(No sooner than 30, no later than 45 days following submission of the proposed contract)	
Comment Period	15 days
Submission of Hearing report	45 days
Contract approval	30 days
	195 days
	(6.5 months)

Solid Waste Facility Permits

Landfills:

Solid Waste Facility (SWF) Permits require two to six months to review technical information because of the level of detail of the submittal and the complexities of the evaluation. The technical reviews include evaluation of noise modelling, traffic modelling, facility and equipment design and redundancy analysis, surface and ground water modelling, air modelling, and health risk assessment of environmental impacts. The Division of Solid Waste Management must coordinate the review of SWF permit applications with up to 27 different State, county, and local agencies, including administration and divisions within the DEPE.

In addition, after the Division coordinates and conducts a technical review, it issues a draft permit and holds a public hearing. In addition to the administrative time required to notice and hold a public hearing, responding to public comments through the Hearing Officer's Report can take up to six months because of the complexity of technical responses.

PUBLIC NOTICES

New Permits	17 months
Technical Review	6 months
Response from applicant	3 months
Follow-up Technical Review	3 months
Draft Permit	1 month
Public Participation	4 months
	17 months
Major Modification of Permit	6 months
Minor Modification of Permit	3 months
Closure Plans (pre-1982)	6 months
Closure Plans (post-1982)	11 months
Permit Renewals	6 months
Transfers of Ownership	6 months
Minor Technical Reviews	4 months
Annual Topographic Map Reviews	4 months
Disruptions	5 months
Methane Venting Systems	5 months
Cover Material Requests	4 months
On-site Disposal Requests	4 months
ID-27 Soil Requests	1.5 months
Preliminary Environmental and Health Impact Statement	5 months
Small Scale Incinerators:	
New Permits	5 months
Major Modification of Permit	4 months
Minor Modification of Permit	4 months
Permit Renewals	5 months
Transfers of Ownership	5 months
Minor Technical Reviews	3 months
Transfer Station/Materials Recovery Facilities (Large):	
New Permits	11 months
Major Modification of Permit	8 months
Minor Modification of Permit	4 months
Permit Renewals	8 months
Transfer of Ownership	8 months
Minor Technical Reviews	4 months
Transfer Station/Materials Recovery Facilities (Small):	
New Permits	8 months
Major Modification of Permit	7 months
Minor Modification of Permit	4 months
Permit Renewals	7 months
Transfer of Ownership	7 months
Minor Technical Reviews	4 months
Resource Recovery Facilities:	
New Permits	17 months
New Permits	
Technical Review	6 months
Applicant's Response	3 months
Follow-up technical Review	3 months
Draft permit	4 months
Public Participation	4 months
	17 months
Major Modification of Permit	8 months
Minor Modification of Permit	4 months
Permit Renewals	8 months*
Transfer of Ownership	8 months*
Minor Technical Reviews	4 months
Preliminary Environmental and Health Impact Statement	5 months
MSW Compost Facilities:	
New Permits	11 months
Major Modification of Permit	8 months
Minor Modification of Permit	4 months
Permit Renewals	8 months*
Transfer of Ownership	8 months*
Minor Technical Reviews	4 months
Preliminary Environmental and Health Impact Statement	5 months

ENVIRONMENTAL PROTECTION

Vegetative Waste Compost Facilities:

New Permits	8 months
Major Modification of Permit	5 months
Minor Modification of Permit	4 months
Permit Renewals	4 months*
Transfer of Ownership	5 months*
Minor Technical Reviews	4 months
Preliminary Environmental and Health Impact Statement	5 months

*Renewals and transfers of ownership require the compilation of existing technical data on the facility and matching the design impacts that were submitted as part of the original application and formed the basis of the permit to the current operational impacts to determine if the facility is operating within the design limits or whether the site requires environmental upgrading. The DEPE also compares existing facility operations to current regulations to determine whether a facility upgrade is required.

The Solid Waste Facility regulations were adopted in June, 1987; a majority of the renewals and transfers will require upgrading to meet new standards.

Class B Recycling Center Approval (General):

New Permits	90 days
Modification of Permit	60 days
Permit Renewals	60 days
Transfer of Ownership	60 days

Class B Recycling Center Approval (Limited):

New Permits	30 days
Major Modification of Permit	30 days

Site Remediation Program

Site Remediation activities are not permit activities. They are case management activities. The timeframes to complete the process may vary greatly, depending on a number of factors outside the control of the DEPE. The following timeframes are averages for the entire process, and include not only DEPE review time, but also time spent by other entities preparing reports, studies, analyses, or correcting omissions.

Environmental Cleanup Responsibility Act

The Department can work with the owner or operator of an industrial establishment to allow their sale or transaction to proceed prior to full compliance with ECRA through an Administrative Consent Order (ACO). Typically, the Department processes requests for ACOs within a week.

Letters of Non-Applicability	7 days
Administrative Consent Orders	7 days
Low Environmental Concern Cases	2 months
Site Investigation	4 months
Medium Environmental Concern Cases	12 months
High Environmental Concern Cases	26 months

Medium Environmental Concern Cases require the following reviews and studies:

Remedial Investigation	7.5 months
Feasibility Study	2 months
Remedial Action Workplan	4 months
	13.5 months*

*The overall review time for a Medium Environmental Concern Case differs from the aggregate time because the reviews are conducted together as much as possible, thus reducing the overall case management time.

High Environmental Concern Cases require the following reviews and studies:

Remedial Investigation	18 months
Feasibility Study	4 months
Remedial Action Workplan	4 months
	22 months

HEALTH

Underground Storage Tank Program

Closures	2 months
Site Assessment Survey	2 months
Permits	2 months
Site Investigation	4 months
Cleanup Approval—with groundwater impact	12 months

Underground Storage Tank approvals with groundwater impacts require the following reviews and studies:

Remedial Investigation	7.5 months
Feasibility Study	2 months
Remedial Action Workplan	4 months
	13.5 months*

*The overall review time for an Underground Storage Tank approval differs from the aggregate time because the reviews are conducted together as much as possible, thus reducing the overall case management time.

Groundwater Quality

(NJDES-Discharge to Ground Water)

Permit-by-rule Site Remediation	7 days
NJPDES-DGW Site Remediation	6 months

(a)

BUREAU OF HAZARDOUS SUBSTANCES INFORMATION

Notice of Receipt of Petition For Rulemaking List of Environmental Hazardous Substances under N.J.A.C. 7:1G

N.J.A.C. 7:1G-2.1

Petitioner: Dry Color Manufacturers' Association.

Take notice that on June 25, 1992, the Department of Environmental Protection and Energy (Department) received a petition for rulemaking concerning the amendment of the Department's rules implementing the Worker and Community Right to Know Act, N.J.S.A. 34:5A-1 et seq., N.J.A.C. 7:1G.

Petitioner, the Dry Color Manufacturers' Association ("DCMA"), is a trade association representing pigment color manufacturers throughout the United States and Canada. A number of petitioner's members have manufacturing facilities located in New Jersey, and are subject to the Worker and Community Right to Know Act and the rules promulgated under that Act.

N.J.A.C. 7:1G establishes reporting requirements concerning substances designated as "Environmental Hazardous Substances" under N.J.A.C. 7:1G-2.1 (the "EHS List"). Petitioner points out that the following three phthalocyanine pigments are not specifically listed on the EHS List:

1. C.I. Pigment Blue 15, Phthalocyanine Blue CAS No. 147-14-8
2. C.I. Pigment Green 7, Phthalocyanine Green CAS No. 1328-53-6
3. C.I. Pigment Green 36, Phthalocyanine Green CAS No. 14302-13-7

However, petitioner notes that these three compounds arguably are included into the EHS List, under the listed category "Copper and Compounds."

Petitioner requests that if the three compounds are currently included in the EHS List, that N.J.A.C. 7:1G-2.1 be amended to exclude them from the list.

HEALTH

(b)

DIVISION OF FAMILY HEALTH SERVICES

Notice of Availability of Grants Injury Prevention and Control

Take notice that, in compliance with N.J.S.A. 52:14-34.4 et seq. (June 26, 1987, c.7), the Department of Health hereby publishes notice of the availability of the following grant:

Name of grant program: Injury Prevention and Control, Grant Program No. 93-75-IPC.

A. Purpose for which the grant program funds will be used:

Community-based Projects To Prevent Violence and Burn Related Injuries Among High Risk Youth. The purpose of the funding is to reduce the effects of injury and injury consequences among the following high risk populations: (1) injuries among youth related to violence; (2) injuries among children related to fires. Funds are available to support existing intervention strategies and to develop new programs. Plans to evaluate implementation and the extent to which objectives are met are required.

B. Amount of money in the grant program:

The availability of funds for this program is contingent on appropriation of funds to the Department. Contact the person identified in this notice to determine whether the funds have been awarded and to receive further information.

C. Groups or entities which may apply for the grant program:

Applications may be submitted by a community-based nonprofit organization, a local health department or other public health agency. Applications may be submitted jointly by a community-based nonprofit organization and a public health agency.

D. Qualifications needed by an applicant to be considered for a grant:

Applicants must reflect a commitment to develop a community-based intervention that targets a high risk youth population. Applicants also should demonstrate established working relationships with entities such as a school, police or local fire department as required for proposed project implementation.

E. Procedures for eligible entities to apply for grant funds:

Complete and timely submission of application.

F. For information contact:

Linda Janet Holmes, MPA
Research Scientist
Division of Family Health Services
CN 364
Trenton, New Jersey 08625-0364
(609) 984-6137

G. Deadline by which applications must be submitted:

The deadline will be specified in the request for application (RFA).

H. Date by which applicant shall be notified whether they will receive funds:

Approximately eight weeks after completed applications are returned to the Department.

(c)

DIVISION OF FAMILY HEALTH SERVICES

Notice of Availability of Grants Cancer Control Services

Take notice that, in compliance with N.J.S.A. 52:14-34.4 et seq. (P.L. 1987, c.7), the Department of Health hereby publishes notice of the availability of the following grant:

Name of grant program: Cancer Control Services, Grant Program No. 93-74-CCS.

A. Purpose for which the grant program funds will be used:

To implement cancer control activities aimed at breast, cervical and colon/rectal cancers through programs at the local/county level. Types of grant programs and amount of funds released varies annually.

B. Amount of money in the grant program:

The availability of funds for this program is contingent on appropriation of funds to the Department. Contact the person identified in this notice to determine whether the funds have been awarded and to receive further information.

C. Groups or entities which may apply for the grant program:

Depending on types of proposals released; applicable agencies may be health departments, hospitals, home health agencies, community-based organizations, etc.

D. Qualifications needed by an applicant to be considered for a grant:

Depending on exact requests for applications (RFA(s)) released, agencies funded may need specialized staff (health educators, nurse practitioners, etc.) to conduct grant activities.

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E. Procedures for eligible entities to apply for grant funds:

Completion of request for application which is available through program office.

F. For information contact:

Elizabeth Congdon, Program Manager, Prevention Program
Division of Family Health Services
New Jersey State Department of Health
CN 364
Trenton, New Jersey 08625-0364

G. Deadline by which applications must be submitted:

The deadline will be specified in the request for application.

H. Date by which applicant shall be notified whether they will receive funds:

Approximately eight weeks after completed RFA's are returned to the Department.

HUMAN SERVICES

(a)

CHILD LIFE PROTECTION COMMISSION

Ruth S. Fath, Chair

Notice of Grant Fund Availability Children's Trust Fund

Take notice, that, in compliance with N.J.S.A. 52-14.34.4, 34.5 and 34.6, the Child Life Protection Commission (CLPC) hereby announces the availability of the following grant program funds for the Children's Trust Fund's fiscal year July 1, 1993 to June 30, 1994:

Name of Program: Children's Trust Fund.

Purpose: The Children's Trust Fund is a private/public foundation, established by the New Jersey legislature to provide funds for programs designed to prevent child abuse and neglect. The fund is administered by the Child Life Protection Commission, which is appointed by the Governor. The Children's Trust Fund is staffed by and located in, but not of, the Department of Human Services. Contracts with grantees are awarded by the New Jersey Department of Human Services.

Amount of money in the program: The amount of money available for 1993-94 is dependent upon the total amount of monies derived from direct contributions, a State income tax check-off and a Federal Challenge Grant. In 1992, the largest grant award was \$45,400 and the average was \$18,162. The minimum award is \$5,000.

Organizations which may apply for funding under this program: Public agencies and private non-profit agencies with 501(c)3 Federal tax determination letters may apply to develop community-based child abuse and neglect prevention programs. Documentation of 501(c)3 status is required in the application for private agencies.

Funding: Funding for all grantees is annual, with eligibility for funding consideration for three consecutive years. Second and third year funding follows a step-down policy, with local match requirements.

Qualifications needed by an applicant to be considered for funding: A recipient of a grant from the Children's Trust Fund shall use the grant funds only to fund primary or secondary child abuse and child neglect prevention programs. Grants from the Children's Trust Fund may not be used to meet the non-federal matching requirements of Federal law. Priority is given to target populations at high risk of child abuse and neglect. Applicants are encouraged to consider successful prevention strategies when designing a Children's Trust Fund grant application. **Note:** Tertiary prevention programs serving adults who have abused or neglected children are ineligible for funding.

Please note the revised Procedure for eligible organizations to apply: There is a different procedure with different forms for (A) first year funding applicants and for (B) continuation applicants.

A. First Year Funding Applications

First year funding applicants must complete a Preliminary Grant Application. These may be obtained by calling the Community Education Office of the New Jersey Department of Human Services' Division of Youth and Family Services, (609) 292-8469, Monday through Friday from 9:00 A.M. to 5:00 P.M., or by writing to them at Capital Center, 50 E. State Street, CN 717, Trenton, NJ 08625. Current third year grantees

HUMAN SERVICES

must submit a Preliminary Grant Application for first year funding of new proposals. Preliminary Grant Applications will be available for distribution commencing July 15, 1992. Completed Preliminary Applications must be submitted by August 21, 1992. **Only by completing a Preliminary Grant Application may a first year funding applicant be eligible for a grant.** On or about October 7, 1992, the Child Life Protection Commission will invite selected applicants to submit a Full Grant Application on a form supplied by the CLPC, which will be due on November 16, 1992.

B. Continuation Applications

Current first and second year grantees must complete a Continuation Grant Application to be eligible for further funding consideration. The Child Life Protection Commission will mail these applications directly to current first and second year grantees on or about August 14, 1992. Grantees who wish to apply for continuation funding must submit the Continuation Grant Application by October 15, 1992. No further application forms will be required of these applicants for the 1993-94 funding year.

Technical Assistance Meetings have been scheduled for those who are invited to submit a Full Grant Application, to provide information and answer questions. The meetings are scheduled for the following dates:

October 14, 1992
DYFS Regional Office
153 Halsey Street
3rd Floor Conference Room
Newark, NJ
1:00 P.M.-3:00 P.M.

October 16, 1992
State Museum Auditorium
205 West State Street
Trenton, NJ
10:00 A.M.-12:00 P.M.

October 21, 1992
Atlantic County Library
2 South Farragut Avenue
2nd Floor Meeting Room
Mays Landing, NJ
10:00 A.M.-12 P.M.

Address to which applications must be submitted: Preliminary Grant Applications must be postmarked on or before August 21, 1992 to:

Children's Trust Fund
CN 711
Trenton, New Jersey 08625

or hand-delivered before 5:00 P.M. on August 21, 1992 to:

Children's Trust Fund Office
N.J. Department of Human Services
222 South Warren Street
5th Floor
Trenton, New Jersey 08625

No facsimile will be accepted.

Deadline by which applications must be submitted: Preliminary Grant Applications must be postmarked or hand-delivered on or before August 21, 1992.

Continuation Grant Applications must be postmarked or hand-delivered on or before October 14, 1992.

Full Grant Applications may be submitted by invitation only, after approval of the Preliminary Grant Application, and must be postmarked or hand-delivered on or before November 16, 1992.

Date by which notices shall be mailed of approval or disapproval of applications:

Preliminary Grant Applicants, October 7, 1992.
Continuation Grant Applicants, February 25, 1993.
Full Grant Applicants, February 25, 1993.

Questions may be directed to the Children's Trust Fund, (609) 633-3992.

EMERGENCY ADOPTION

LABOR

(a)

OFFICE OF WAGE AND HOUR COMPLIANCE

Wage and Hour

Housing Credit for Migrant Seasonal Farmworkers

Adopted Emergency New Rule and Concurrent

Proposed New Rule: N.J.A.C. 12:56-8.10

Emergency New Rule Adopted and Concurrent

Proposed New Rule

Authorized: July 2, 1992 by Raymond L. Bramucci,
Commissioner, Department of Labor.

Gubernatorial Approval (see N.J.S.A. 52:14B-4(c)): July 7, 1992.

Emergency New Rule Filed: July 8, 1992 as R. 1992 d.306.

Authority: N.J.S.A. 34:1-20, 34:1A-3(e), 2A:150-1 and 34:11-56a,
specifically 34:11-56a5.

Emergency New Rule Effective Date: July 8, 1992.

Emergency New Rule Expiration Date: September 6, 1992.

Concurrent Proposal Number: PRN 1992-347.

Submit written comments by August 19, 1992 to:

Linda Flores
Special Assistant for External
and Regulatory Affairs
Office of the Commissioner
CN 110
Trenton, New Jersey 08625-0110

This new rule was adopted on an emergency basis and became effective upon acceptance for filing by the Office of Administrative Law (see N.J.S.A. 52:14B-4(c) as implemented by N.J.A.C. 1:30-4.4). Concurrently, the provisions of this emergency new rule are being proposed for readoption in compliance with the normal rulemaking requirements of the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. The readopted rule becomes effective upon the acceptance for filing by the Office of Administrative Law (see N.J.A.C. 1:30-4.4(d)), if filed on or before the emergency expiration date.

The agency emergency adoption and concurrent proposal follow:

Summary

The Secretary of Agriculture has formally advised the Commissioner of Labor that the unexpected frost in May 1992 has adversely affected the cultivation of certain fruit, vegetable and nursery crops in the State of New Jersey, especially blueberries and peaches. The Secretary has further alerted the Commissioner of Labor that as a result of the frost, the industry will suffer significant economic hardship this year, thus affecting the number of migrant seasonal farmworkers who will be gainfully employed in the State during this year's season.

The Commissioner has independently determined that a number of migrant seasonal farmworkers remain unemployed and have been living in cars while they wait to be hired by farmers. These conditions pose a serious threat to the health and safety of the farmworkers.

The Commissioner has determined that it will be in the best interests of the farmworkers, farmers and the State's economy to respond to this emergency. The Commissioner proposes to ameliorate the adverse economic impact and the detriment to the health, safety and welfare of farmworkers occasioned by the unexpected frost by affording a degree of economic relief to both the industry and the migrant seasonal farmworker. The emergency new rule, and the concurrent proposed new rule, provides for a housing credit of \$0.40 per hour per farmworker for a maximum of 40 hours per week (or up to \$16.00 per farmworker) under certain conditions. As a result of the savings realized by farmers due to the housing credit, it is anticipated that farmers will be able to increase immediately the number of farmworkers hired and thereby ensure their access to safe housing. The proposed new rule at N.J.A.C. 12:56-8.10 sets forth the conditions under which the housing credit may be implemented.

The proposed new rule is self-expiring as set forth in N.J.A.C. 12:56-8.10, which lists the effective date of July 8, 1992 and also the expiration date of December 31, 1992.

Social Impact

The proposed new rule will result in proper living quarters being available to migrant seasonal farmworkers. The allowable credit per worker will be up to \$16.00 per week. According to the Secretary of Agriculture, this represents 50 percent of the farmers' reported housing costs.

This housing credit will be allowed only to farmers harvesting fruit, vegetable and nursery crops in those counties, and contiguous counties, certified by the Secretary of Agriculture to the Commissioner of Labor as being significantly impacted by the frost of May 21, 1992.

This proposed new rule also mandates that the Department of Labor monitor compliance with laws setting forth the standards governing farm labor housing. This will ensure that the housing for which the credit is taken is clean, safe, and adequate as well as in compliance with Federal, State, and local laws.

Economic Impact

The proposed new rule will have no economic effect on the total wages and benefit level for migrant seasonal farmworkers and will have a salutary effect upon their employment opportunities in the industry. There will be only a minimal cost to the enforcing agencies because compliance programs are currently in place.

Regulatory Flexibility Analysis

The new rule imposes requirements on eligible farmers who would use the allowed housing credit, some of which are small businesses as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The rule requires written notice to employees prior to implementation of the credit; that housing provided be clean, safe, and adequate, and in compliance with all applicable standards and health codes; and that the employer not be in violation of any laws, codes and/or standards in the employment of the migrant seasonal farm worker. In utilizing the housing credit, the employer would be subject to the recordkeeping requirements of N.J.A.C. 12:56-4.9. The cost of the requirements imposed by this rule alone are administrative in nature (written notice and recordkeeping) and are not anticipated to be significant. No professional services will be required. Because of the minimal nature of these requirements, and the purpose of the rule to benefit migrant seasonal farmworkers, no lesser requirements or exemptions based on business size are provided.

Full text of the adopted emergency and concurrent proposed new rule follows:

12:56-8.10 Housing credit for migrant seasonal farmworkers

(a) When an employer provides housing in connection with the employment of migrant seasonal farmworkers, the employer shall be allowed a housing credit of \$0.40 per hour for a maximum of 40 hours per work week per worker provided the following criteria are met:

1. The employee shall be notified in writing of the housing credit prior to the implementation of such credit and the employee shall acknowledge in writing receipt of said notice;
2. The housing shall be clean, safe, and adequate and shall comply with all Federal, State, and local standards and health codes;
3. The employer shall not be in violation of any Federal, State, or local laws, codes, and/or ordinances in the employment of the migrant seasonal farmworker;
4. Nothing in this section shall be deemed to interfere with, impede, or in any way diminish the right of employees to bargain collectively through representatives of their own choosing; and
5. The provisions of this section may only be applied to employers and farmworkers engaged in the harvesting of fruit, vegetable and nursery crops in counties, and contiguous counties thereto, as certified by letter by the Secretary of Agriculture to the Commissioner of Labor as having been significantly impacted by the frost of May 21, 1992.

(b) The Commissioner or his or her representative shall affirmatively monitor compliance with the above mentioned criteria.

(c) This section shall be effective on July 8, 1992 and shall expire on December 31, 1992.

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 June 1, 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 MAY 18, 1992

NEXT UPDATE: SUPPLEMENT JUNE 15, 1992

Note: If no changes have occurred in a Title during the previous month, no update will be issued for that Title.

N.J.R. CITATION LOCATOR

If the N.J.R. citation is between:	Then the rule proposal or adoption appears in this issue of the Register	If the N.J.R. citation is between:	Then the rule proposal or adoption appears in this issue of the Register
23 N.J.R. 2079 and 2204	July 15, 1991	24 N.J.R. 319 and 508	February 3, 1992
23 N.J.R. 2205 and 2446	August 5, 1991	24 N.J.R. 509 and 672	February 18, 1992
23 N.J.R. 2447 and 2560	August 19, 1991	24 N.J.R. 673 and 888	March 2, 1992
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		

N.J.A.C. CITATION

ADMINISTRATIVE LAW—TITLE 1

1:6A-9.2, 14.1, 14.4, Special Education Program
18.1, 18.3, 18.5

1:13A-1.2, 18.1, 18.2 Lemon Law hearings: exceptions to initial decision

PROPOSAL NOTICE (N.J.R. CITATION)

24 N.J.R. 1936(a)

24 N.J.R. 1843(a)

DOCUMENT NUMBER

ADOPTION NOTICE (N.J.R. CITATION)

Most recent update to Title 1: TRANSMITTAL 1992-3 (supplement May 18, 1992)

AGRICULTURE—TITLE 2

2:22 Insect control
2:24-4 Volunteer Inspector Program: noncommercial apiaries and bees
2:32 Sire Stakes Program
2:50 Milk producers
2:69-1.11 Commercial values of primary plant nutrients
2:71-2.2, 2.4, 2.5, 2.6 Jersey Fresh Quality Grading Program
2:71-2.28, 2.29 Inspection and grading charges for fruits and vegetables
2:76-3.12, 4.11 Farmland Preservation Program: pre-existing nonagricultural uses of enrolled lands
2:76-6.15 Farmland Preservation Program: pre-existing nonagricultural uses on lands permanently deed restricted

24 N.J.R. 1662(a)

24 N.J.R. 1141(a)

24 N.J.R. 1142(a)

24 N.J.R. 893(a)

24 N.J.R. 2318(a)

24 N.J.R. 2318(b)

24 N.J.R. 2321(a)

24 N.J.R. 893(b)

24 N.J.R. 896(a)

R.1992 d.294

R.1992 d.278

R.1992 d.239

R.1992 d.229

24 N.J.R. 2556(a)

24 N.J.R. 2421(a)

24 N.J.R. 2241(a)

24 N.J.R. 2048(a)

Most recent update to Title 2: TRANSMITTAL 1992-1 (supplement May 18, 1992)

BANKING—TITLE 3

3:1-6.6 Entity examination charges
3:1-19 Consumer checking accounts
3:4-1 Capital requirements for depository institutions
3:12-1.1, 1.2, 1.3, 2.1, 2.2, 2.3, 2.5, 3.1, 3.2, 3.3, 4.1, 4.2, 4.3, 5.1-5.5, 5.7 Qualified corporations as fiscal or transfer agents
3:23 Department license fees
3:25 Debt adjustment and credit counseling
3:38-1.1, 1.9, 4.1, 5 Mortgage financing activities and real estate licensees
3:38-1.1, 1.9, 4.1, 5 Mortgage financing activities and real estate licensees: extension of comment period
3:38-1.9, 5.2, 5.3 Branch offices; mortgage services licensure exemption; solicitor registration

24 N.J.R. 1420(a)

24 N.J.R. 1662(b)

24 N.J.R. 1665(a)

24 N.J.R. 675(b)

24 N.J.R. 1667(a)

24 N.J.R. 2106(a)

23 N.J.R. 3406(b)

23 N.J.R. 3686(c)

24 N.J.R. 1937(a)

R.1992 d.250

R.1992 d.242

R.1992 d.226

24 N.J.R. 2242(a)

24 N.J.R. 2242(b)

24 N.J.R. 2048(b)

Most recent update to Title 3: TRANSMITTAL 1992-4 (supplement April 20, 1992)

CIVIL SERVICE—TITLE 4

Most recent update to Title 4: TRANSMITTAL 1990-3 (supplement July 16, 1990)

PERSONNEL—TITLE 4A

4A:1, 2, 5, 7, 9, 10 Preproposal regarding readoption of chapters
4A:2-2.13 Expungement from personnel files of references to disciplinary action
4A:4-3.7, 7.10, 7.12 Reinstatement of permanent employee following disability retirement

24 N.J.R. 1667(b)

23 N.J.R. 2906(a)

24 N.J.R. 2107(a)

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
4A:6-16	Sick leave injury (SLI) benefits: carpal tunnel syndrome and asbestosis	24 N.J.R. 2108(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, 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)
5:18C-4.2	Firefighter I certification	23 N.J.R. 2084(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)		
5:23-2.15, 2.18, 2.20, 3.14	Uniform Construction Code: special inspections	24 N.J.R. 1147(a)	R.1992 d.244	24 N.J.R. 2243(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)
5:23-3.21	UCC: one and two family dwelling subcode	23 N.J.R. 3444(b)		
5:23-4.3	Elevator Safety Subcode: enforcement	24 N.J.R. 1148(a)	R.1992 d.245	24 N.J.R. 2244(a)
5:23-4.5	Municipal enforcing agencies: UCC standardized forms	24 N.J.R. 168(a)	R.1992 d.230	24 N.J.R. 2052(a)
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)
5:23-4.18, 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)		
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)
5:23-12.2	Elevator Safety Subcode: referenced standards	23 N.J.R. 2046(a)	Expired	
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)
5:25-2.5, 5.2, 5.4, 5.5	New home warranty and builders' registration: violations and penalties; claim eligibility	24 N.J.R. 1149(a)	R.1992 d.246	24 N.J.R. 2244(b)
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)
5:80-32	Housing and Mortgage Finance Agency: project cost certification	24 N.J.R. 2208(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 1992-5 (supplement May 18, 1992)

MILITARY AND VETERANS' AFFAIRS—TITLE 5A

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)		
6:11-6.2	Early childhood instructional certificate	23 N.J.R. 2210(b)		
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)		
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)

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
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)		
7:1A	Water supply loan programs	24 N.J.R. 707(a)	R.1992 d.252	24 N.J.R. 2245(a)
7:1H	County environmental health standards: request for public input	23 N.J.R. 2237(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(a)		
7:6-1.24, 9.2	Boating rules: rotating lights; "personal watercraft"	24 N.J.R. 1694(a)		
7:7-4.5, 4.6	Coastal Permit Program: public hearings; final review of applications	23 N.J.R. 3280(a)		
7:7A	Freshwater Wetlands Protection Act rules: waiver of sunset provision of Executive Order No. 66(1978)	24 N.J.R. 912(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-9.2	Freshwater wetlands protection: Statewide general permits	_____	_____	24 N.J.R. 2252(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)		
7:11-2.2, 2.3, 2.9	Sale of water from Delaware and Raritan Canal and Spruce Run/Round Valley Reservoirs System	23 N.J.R. 3686(d)	R.1992 d.238	24 N.J.R. 2053(a)
7:11-4.3, 4.4, 4.9, 4.13	Sale of water from Manasquan Reservoir Water Supply System	23 N.J.R. 3688(a)	R.1992 d.237	24 N.J.R. 2056(a)
7:11-4.3, 4.4, 4.9, 4.13	Sale of water from Manasquan Reservoir Water Supply System: change of public hearing and extension of comment period	24 N.J.R. 344(a)		
7:14-8.3	Water Pollution Control Act: administrative correction regarding affirmative defense by violator	_____	_____	24 N.J.R. 2448(a)
7:14-8.13	Water Pollution Control Act: request for public input regarding economic benefit derived from noncompliance and determination of civil administrative penalties	23 N.J.R. 2241(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)		
7:25-5	1992-93 Game Code	24 N.J.R. 1847(b)		
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)		
7:26-1.4, 2.13, 6.3, 6.8	Solid waste management: scrap metal shredding residue, animal manure, interdistrict and intradistrict flow	24 N.J.R. 1995(a)		
7:26-2.4	Small scale solid waste facility permits: request for comment on draft revisions	23 N.J.R. 2458(a)		
7:26-4.3	Resource recovery facilities: administrative correction regarding compliance monitoring fees	_____	_____	24 N.J.R. 2058(a)
7:26-4.3	Thermal destruction facilities: compliance monitoring fees and postponed operative date	24 N.J.R. 1999(a)		
7:26-4.6	Solid waste program fees	23 N.J.R. 3690(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)		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
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: extension of comment period	24 N.J.R. 1281(a)		
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-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)		
7:27B-3.10	Air pollution by volatile organic compounds: corrections to proposal and addresses for inspection of copies	23 N.J.R. 2119(a)		
7:36-9	Green Acres Program: nonprofit land acquisition	24 N.J.R. 2405(a)		
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8:21-3.13	Repeal (see 8:21-3A)	24 N.J.R. 2410(b)		
8:21-3A	Registration of wholesale drug distributors and device manufacturers and wholesale distributors	24 N.J.R. 2410(b)		
8:21A	Good drug manufacturing practices; tamper-resistant packaging for over-the-counter products	24 N.J.R. 2003(c)		
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-7.4, 7.5	SHARE Hospital system: rebasing and Minimum Base Period Challenge	24 N.J.R. 734(b)	R.1992 d.249	24 N.J.R. 2255(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)		
8:33	Health care facilities and services: Certificate of Need application and review process	24 N.J.R. 2222(a)		
8:33C	Regionalized perinatal services: Certificate of Need criteria and standards	24 N.J.R. 2005(a)		
8:33H	Long-term care services: Certificate of Need policy manual	24 N.J.R. 2014(a)		
8:34-1.7	Licensure examination fee for nursing home administrator	24 N.J.R. 2414(a)		
8:35A	Maternal and child health consortia: licensing standards	24 N.J.R. 2027(a)		
8:42	Home health agencies: standards for licensure	24 N.J.R. 2031(a)		
8:43G-19	Hospital licensing standards: obstetrics	24 N.J.R. 2045(a)		
8:65-2.5	Controlled Dangerous Substances: physical security controls	24 N.J.R. 174(a)		
8:65-2.4, 2.5, 6.6, 6.13, 6.16	Controlled dangerous substances: handling of carfentanil, etorphine hydrochloride, and diprenorphine	23 N.J.R. 1911(a)	R.1992 d.241	24 N.J.R. 2256(a)
8:65-10.1	Controlled dangerous substances: addition of methcathinone to Schedule I	_____	_____	24 N.J.R. 2451(a)
8:65-10.3	Controlled dangerous substances: correction regarding anabolic steroids	_____	_____	24 N.J.R. 2256(b)

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
8:71	Interchangeable drug products (see 23 N.J.R. 3334(b); 24 N.J.R. 144(b), 948(a))	23 N.J.R. 2610(a)	R.1992 d.295	24 N.J.R. 2558(a)
8:71	Interchangeable drug products (see 24 N.J.R. 145(b))	23 N.J.R. 3258(a)	R.1992 d.136	24 N.J.R. 948(b)
8:71	Interchangeable drug products	24 N.J.R. 59(b)	R.1992 d.137	24 N.J.R. 949(a)
8:71	Interchangeable drug products (see 24 N.J.R. 947(b), 1897(a))	24 N.J.R. 61(a)	R.1992 d.297	24 N.J.R. 2560(a)
8:71	Interchangeable drug products (see 24 N.J.R. 1896(a))	24 N.J.R. 735(a)	R.1992 d.298	24 N.J.R. 2560(b)
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. 1674(a)	R.1992 d.300	24 N.J.R. 2557(b)
8:71	Interchangeable drug products	24 N.J.R. 2414(b)		
8:100	State Health Plan	24 N.J.R. 1164(a)	R.1992 d.299	24 N.J.R. 2561(a)
8:100-16	State Health Plan regarding Long-Term Care Services: correction to Economic Impact statement	24 N.J.R. 1675(a)		

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9:1-1.2, 3.1, 3.2, 3.4, 3.5	Teaching university	24 N.J.R. 1464(a)		
9:7-2.3, 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)
9:11-1.5	Educational Opportunity Fund Program: financial eligibility for undergraduate grants	24 N.J.R. 1859(a)		
9:16-1	Primary Care Physician and Dentist Loan Redemption Program	24 N.J.R. 1192(a)		

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10:8	Administration of State-provided Personal Needs Allowance	24 N.J.R. 681(a)		
10:15B-1.2	IV-A "At Risk" Child Care Program: client eligibility income schedules	_____	_____	24 N.J.R. 2257(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 of State psychiatric hospitals	24 N.J.R. 1728(a)		
10:46-1.3, 2.1, 3.2, 4.1, 5	Developmental Disabilities: determination of eligibility for division services	24 N.J.R. 211(a)		
10:49	New Jersey Medicaid Program: basic requirements for recipients and providers	24 N.J.R. 1728(b)		
10:52-1.6	Medicaid reimbursement for outpatient laboratory services	24 N.J.R. 917(a)		
10:53-1.5	Medicaid reimbursement for outpatient laboratory services	24 N.J.R. 917(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)		
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)		
10:81-14.21	Public Assistance Manual: administrative correction concerning REACH assistance	_____	_____	24 N.J.R. 2257(b)
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)		
10:82-1.2, 1.6, 1.7, 1.10, 1.11, 2.1, 2.2, 2.3, 2.6-2.9, 2.11-2.14, 2.19, 2.20, 3.13, 3.14, 4.4, 4.5, 4.15, 5.10, 5.11	Assistance Standards Handbook: AFDC program revisions regarding Standard of Need, prospective budgeting, and AFDC-N equalization	24 N.J.R. 1194(a)	R.1992 d.261	24 N.J.R. 2258(a)
10:82-2.8	Assistance Standards Handbook: administrative correction regarding earned income in AFDC segments	_____	_____	24 N.J.R. 2626(b)

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10:82-4.9	Assistance Standards Handbook: DYFS monthly foster care rates	24 N.J.R. 2160(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)		
10:85-3.1, 3.3, 4.1	General Assistance allowance determination: household size concept	24 N.J.R. 926(a)	R.1992 d.260	24 N.J.R. 2263(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)		
10:120-1.2	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)		
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)		

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10A:1	Department administration, organization, and management	24 N.J.R. 1465(a)	R.1992 d.269	24 N.J.R. 2451(c)
10A:5-1.3, 7	Temporary close custody	24 N.J.R. 1676(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)		
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)

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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)		
11:2-17.7	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)		
11:2-27	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)		
11:3-2	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)		
11:3-20.5, App.	Automobile insurance: Excess Profits Report	24 N.J.R. 529(a)	R.1992 d.254	24 N.J.R. 2264(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)		
11:3-35.5	Automobile insurance rating: eligibility points of principal driver	24 N.J.R. 2331(a)		
11:3-41	Association Producer Voluntary Placement Plan	23 N.J.R. 2275(a)		
11:3-42	Association Producer Assignment Program	23 N.J.R. 2297(a)		
11:3-43	Private passenger automobile insurance: personal lines rating plans	23 N.J.R. 3221(a)		
11:4-14.1, 15.1, 16.2, 19.2, 28.3, 36	BASIC health care coverage	24 N.J.R. 1205(a)		
11:4-16.5	Individual health insurance: disability income benefits riders	24 N.J.R. 338(a)		
11:4-16.8, 23, 25	Medicare supplement coverage: minimum standards	24 N.J.R. 12(a)		
11:5-1.9, 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)		

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11:5-1.38-1.42	Real Estate Commission: dual agency for dual compensation practices; kickbacks for referrals; written disclosures; exclusion of outside mortgage lenders	23 N.J.R. 3424(b)	R.1992 d.232	24 N.J.R. 2058(b)
11:5-1.38-1.42	Real Estate Commission: extension of comment period regarding dual agency for dual compensation practices; kickbacks for referrals; written disclosures; exclusion of outside mortgage lenders	23 N.J.R. 3739(b)		
11:7	Insurance of municipal bonds	24 N.J.R. 1958(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)		
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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)		
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)		
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13:18-6.9	Replacement license plates fee upon verification of motor vehicle liability coverage	24 N.J.R. 1467(a)	R.1992 d.263	24 N.J.R. 2283(a)
13:20-34.2, 34.3, 34.5, 34.7	License plate identifying marks	24 N.J.R. 1467(b)	R.1992 d.264	24 N.J.R. 2283(b)
13:28-5.1, 6.35	Schools of cosmetology and hairstyling: use of annex classrooms	24 N.J.R. 2333(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)		
13:35-2.6-2.12, 2.14, 2A	Certified nurse midwife practice	23 N.J.R. 3632(a)		
13:35-6.5	Medical practice: preparation of patient records	24 N.J.R. 50(a)		
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)		
13:37	Certification of homemaker-home health aides: open public forum	24 N.J.R. 1861(a)		
13:38-1.2, 1.3	Practice of optometry: permissible advertising	23 N.J.R. 2002(a)	Expired	
13:39-3.9	Pharmaceutical practice: reciprocal registration	24 N.J.R. 553(a)	R.1992 d.235	24 N.J.R. 2062(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)		
13:40-6.1	Board of Professional Engineers and Land Surveyors: fee schedule	24 N.J.R. 1231(a)	R.1992 d.247	24 N.J.R. 2285(a)
13:41-3.2	Board of Professional Planners: fee schedule	24 N.J.R. 554(b)	R.1992 d.240	24 N.J.R. 2062(b)
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)		
13:44F-8.1	Board of Respiratory Care: fee schedule	24 N.J.R. 52(a)	R.1992 d.248	24 N.J.R. 2285(b)
13:45A-9.2, 9.3, 9.4	Advertising of merchandise by manufacturer	24 N.J.R. 684(a)		
13:45A-26.1, 26.2, 26.4, 26.14	Automotive dispute resolution: motor vehicles purchased or leased in State	24 N.J.R. 53(a)	R.1992 d.236	24 N.J.R. 2063(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)		
13:47K-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)		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
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)
13:70-15.1	List of racing officials: administrative correction			24 N.J.R. 2063(b)
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)

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14:0	Open Network Architecture (ONA): preproposal and public hearing regarding Board regulation of enhanced telecommunications services	23 N.J.R. 3239(a)		
14:1	Rules of practice of Board of Regulatory Commissioners	23 N.J.R. 2487(a)	R.1992 d.224	24 N.J.R. 2063(c)
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)		
14:3-7.5	Interest rate on customer deposits	24 N.J.R. 686(b)	R.1992 d.225	24 N.J.R. 2073(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)		
14:18-3.19	Cable television: interest on uncorrected billing errors	24 N.J.R. 1470(b)		

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14A:11-2	Reporting of energy information by home heating oil suppliers	23 N.J.R. 2830(b)		
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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)		

Most recent update to Title 15: TRANSMITTAL 1992-1 (supplement May 18, 1992)

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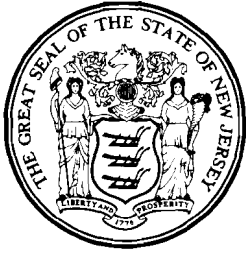
16:28-1.25	Speed limit zones along Route 23 in Wayne	24 N.J.R. 1688(b)	R.1992 d.276	24 N.J.R. 2462(c)
16:28-1.113	Speed limits along Route 139 in Jersey City	24 N.J.R. 928(a)	R.1992 d.227	24 N.J.R. 2074(a)
16:28A-1.8	Bus stop zones along Route 10 in Parsippany-Troy Hills	24 N.J.R. 1967(a)		
16:28A-1.15, 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	No stopping or standing zone along U.S. 206 in Lawrence Township	24 N.J.R. 929(a)	R.1992 d.228	24 N.J.R. 2074(b)
16:28A-1.57	Parking along U.S. 206 in Lawrence Township	24 N.J.R. 2342(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)		
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)		
16:54	Licensing of aeronautical and aerospace facilities: preproposed new rules	24 N.J.R. 80(a)		

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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)		
17:32-6, 7, 8	State Planning Rules: letters of clarification; consistency review of plans; Resource Planning and Management Map	24 N.J.R. 1241(a)	R.1992 d.253	24 N.J.R. 2287(a)
17:42-1	Lottery prize offset against overdue child support and public assistance overpayments	24 N.J.R. 2343(b)		
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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)
18:7-5.1, 5.10, 14.17	Corporation Business Tax: intercompany and shareholder transactions	23 N.J.R. 1522(a)	R.1992 d.231	24 N.J.R. 2074(c)
18:7-13.1	Corporation Business Tax: abatements of penalty and interest	23 N.J.R. 3275(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 1992-3 (supplement April 20, 1992)				
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19:4-6.28	Official Zoning Map: redesignation of site in Kearny	24 N.J.R. 2346(a)		
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19:16	Compulsory interest arbitration of labor disputes in public fire and police departments: summary of public comments and agency responses to preproposal	24 N.J.R. 704(a)		
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19:44-8.3	Implementation of pai gow poker	24 N.J.R. 569(a)		
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19:45-1.15, 1.40	Slot machine jackpot payout slips	24 N.J.R. 932(a)	R.1992 d.258	24 N.J.R. 2296(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)		
19:45-1.24	Refund of patron cash deposits: use of counter check as documentation	24 N.J.R. 933(a)	R.1992 d.234	24 N.J.R. 2079(a)
19:45-1.41	Slot machine hopper fill procedure	23 N.J.R. 2921(a)	R.1992 d.255	24 N.J.R. 2297(a)
19:46-1.1, 1.13D, 1.17, 1.18, 1.20	Implementation of game of pokette	24 N.J.R. 2140(a)		
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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)		
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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)		
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)		
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19:47-8.2, 12	Implementation of game of pokette	24 N.J.R. 2140(a)		
19:65	Casino Reinvestment Development Authority: project criteria and conditions	24 N.J.R. 1692(b)		

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