CHAPTER 17

AN ACT reorganizing and renaming the Department of Health and Senior Services as the Department of Health, establishing a Division of Aging Services in the Department of Human Services and transferring certain services for senior citizens from the Department of Health and Senior Services to the division, revising various parts of the statutory law, and supplementing Titles 26 and 30 of the Revised Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. Section 10 of P.L.2004, c.17 (C.2A:62A-1.3) is amended to read as follows:

C.2A:62A-1.3 Immunity from civil liability for certain health care professionals, certain situations.

10. a. If an individual's actual health care facility duty, including on-call duty, does not require a response to a patient emergency situation, a health care professional who, in good faith, responds to a life-threatening emergency or responds to a request for emergency assistance in a life-threatening emergency within a hospital or other health care facility, is not liable for civil damages as a result of an act or omission in the rendering of emergency care. The immunity granted pursuant to this section shall not apply to acts or omissions constituting gross negligence, recklessness, or willful misconduct.

b. The provisions of subsection a. of this section shall not apply to a health care professional if a provider-patient relationship existed before the emergency, or if consideration in any form is provided to the health care professional for the service rendered.

c. The provisions of subsection a. of this section do not diminish a general hospital's responsibility to comply with all Department of Health licensure requirements concerning medical staff availability at the hospital.

d. A health care professional shall not be liable for civil damages for injury or death caused in an emergency situation occurring in the health care professional's private practice or in a health care facility on account of a failure to inform a patient of the possible consequences of a medical procedure when the failure to inform is caused by any of the following:

(1) the patient was unconscious;

(2) the medical procedure was undertaken without the consent of the patient because the health care professional reasonably believed that the medical procedure should be undertaken immediately and that there was insufficient time to fully inform the patient; or

(3) the medical procedure was performed on a person legally incapable of giving informed consent, and the health care professional reasonably believed that the medical procedure should be undertaken immediately and that there was insufficient time to obtain the informed consent of the person authorized to give such consent for the patient.

The provisions of this subsection shall apply only to actions for damages for an injury or death arising as a result of a health care professional's failure to inform, and not to actions for damages arising as a result of a health care professional's negligence in rendering or failing to render treatment.

e. As used in this section:

(1) "Health care professional" means a physician, dentist, nurse, or other health care professional whose professional practice is regulated pursuant to Title 45 of the Revised Statutes and an emergency medical technician or mobile intensive care paramedic certified by the Commissioner of Health pursuant to Title 26 of the Revised Statutes; and

(2) "Health care facility" means a health care facility licensed by the Department of Health pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) and a psychiatric hospital operated by the Department of Human Services and listed in R.S.30:1-7.

2. N.J.S.2C:35-2 is amended to read as follows:

Definitions.

2C:35-2. As used in this chapter:

"Administer" means the direct application of a controlled dangerous substance or controlled substance analog, whether by injection, inhalation, ingestion, or any other means, to the body of a patient or research subject by: (1) a practitioner (or, in his presence, by his lawfully authorized agent), or (2) the patient or research subject at the lawful direction and in the presence of the practitioner.

"Agent" means an authorized person who acts on behalf of or at the direction of a manufacturer, distributor, or dispenser but does not include a common or contract carrier, public warehouseman, or employee thereof.

"Controlled dangerous substance" means a drug, substance, or immediate precursor in Schedules I through V, any substance the distribution of which is specifically prohibited in N.J.S.2C:35-3, in section 3 of P.L.1997, c.194 (C.2C:35-5.2), in section 5 of P.L.1997, c.194 (C.2C:35-5.3), or in section 2 of P.L.2011, c.120 (C.2C:35-5.3a), and any drug or substance which, when ingested, is metabolized or otherwise becomes a controlled dangerous substance in the human body. When any statute refers to controlled dangerous substances, or to a specific controlled dangerous substance, it shall also be deemed to refer to any drug or substance which, when ingested, is metabolized or otherwise becomes a controlled dangerous substance or the specific controlled dangerous substance, and to any substance that is an immediate precursor of a controlled dangerous substance or the specific controlled dangerous substance. The term shall not include distilled spirits, wine, malt beverages, as those terms are defined or used in R.S.33:1-1 et seq., or tobacco and tobacco products. The term, wherever it appears in any law or administrative regulation of this State, shall include controlled substance analogs.

"Controlled substance analog" means a substance that has a chemical structure substantially similar to that of a controlled dangerous substance and that was specifically designed to produce an effect substantially similar to that of a controlled dangerous substance. The term shall not include a substance manufactured or distributed in conformance with the provisions of an approved new drug application or an exemption for investigational use within the meaning of section 505 of the "Federal Food, Drug and Cosmetic Act," 52 Stat. 1052 (21 U.S.C. s.355).

"Counterfeit substance" means a controlled dangerous substance or controlled substance analog which, or the container or labeling of which, without authorization, bears the trademark, trade name, or other identifying mark, imprint, number, or device, or any likeness thereof, of a manufacturer, distributor, or dispenser other than the person or persons who in fact manufactured, distributed, or dispensed the substance and which thereby falsely purports or is represented to be the product of, or to have been distributed by, such other manufacturer, distributor, or dispenser.

"Deliver" or "delivery" means the actual, constructive, or attempted transfer from one person to another of a controlled dangerous substance or controlled substance analog, whether or not there is an agency relationship.

"Dispense" means to deliver a controlled dangerous substance or controlled substance analog to an ultimate user or research subject by or pursuant to the lawful order of a practitioner, including the prescribing, administering, packaging, labeling, or compounding necessary to prepare the substance for that delivery. "Dispenser" means a practitioner who dispenses.

"Distribute" means to deliver other than by administering or dispensing a controlled dangerous substance or controlled substance analog. "Distributor" means a person who distributes.

“Drugs" means (a) substances recognized in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States, or official National Formulary, or any supplement to any of them; and (b) substances intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals; and (c) substances (other than food) intended to affect the structure or any function of the body of man or other animals; and (d) substances intended for use as a component of any article specified in subsections (a), (b), and (c) of this section; but does not include devices or their components, parts, or accessories.

"Drug or alcohol dependent person" means a person who as a result of using a controlled dangerous substance or controlled substance analog or alcohol has been in a state of psychic or physical dependence, or both, arising from the use of that controlled dangerous substance or controlled substance analog or alcohol on a continuous or repetitive basis. Drug or alcohol dependence is characterized by behavioral and other responses, including but not limited to a strong compulsion to take the substance on a recurring basis in order to experience its psychic effects, or to avoid the discomfort of its absence.

"Hashish" means the resin extracted from any part of the plant Genus Cannabis L. and any compound, manufacture, salt, derivative, mixture, or preparation of such resin.

“Manufacture" means the production, preparation, propagation, compounding, conversion, or processing of a controlled dangerous substance or controlled substance analog, either directly or by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, and includes any packaging or repackaging of the substance or labeling or relabeling of its container, except that this term does not include the preparation or compounding of a controlled dangerous substance or controlled substance analog by an individual for his own use or the preparation, compounding, packaging, or labeling of a controlled dangerous substance: (1) by a practitioner as an incident to his administering or dispensing of a controlled dangerous substance or controlled substance analog in the course of his professional practice, or (2) by a practitioner (or under his supervision) for the purpose of, or as an incident to, research, teaching, or chemical analysis and not for sale.

"Marijuana" means all parts of the plant Genus Cannabis L., whether growing or not; the seeds thereof, and every compound, manufacture, salt, derivative, mixture, or preparation of the plant or its seeds, except those containing resin extracted from the plant; but shall not include the mature stalks of the plant, fiber produced from the stalks, oil, or cake made from the seeds of the plant, any other compound, manufacture, salt, derivative, mixture, or preparation of mature stalks, fiber, oil, or cake, or the sterilized seed of the plant which is incapable of germination.

"Narcotic drug" means any of the following, whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis:

(a) Opium, coca leaves, and opiates;

(b) A compound, manufacture, salt, derivative, or preparation of opium, coca leaves, or opiates;

(c) A substance (and any compound, manufacture, salt, derivative, or preparation thereof) which is chemically identical with any of the substances referred to in subsections (a) and (b), except that the words "narcotic drug" as used in this act shall not include decocainized coca leaves or extracts of coca leaves, which extracts do not contain cocaine or ecogine.

"Opiate" means any dangerous substance having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having such addiction-forming or addiction-sustaining liability. It does not include, unless specifically designated as controlled pursuant to the provisions of section 3 of P.L.1970, c.226 (C.24:21-3), the dextrorotatory isomer of 3-methoxy-n-methylmorphinan and its salts (dextromethorphan). It does include its racemic and levorotatory forms.

"Opium poppy" means the plant of the species Papaver somniferum L., except the seeds thereof.

"Person" means any corporation, association, partnership, trust, other institution or entity, or one or more individuals.

"Plant" means an organism having leaves and a readily observable root formation, including, but not limited to, a cutting having roots, a rootball or root hairs.

"Poppy straw" means all parts, except the seeds, of the opium poppy, after mowing.

"Practitioner" means a physician, dentist, veterinarian, scientific investigator, laboratory, pharmacy, hospital, or other person licensed, registered, or otherwise permitted to distribute, dispense, conduct research with respect to, or administer a controlled dangerous substance or controlled substance analog in the course of professional practice or research in this State.

(a) "Physician" means a physician authorized by law to practice medicine in this or any other state and any other person authorized by law to treat sick and injured human beings in this or any other state.

(b) "Veterinarian" means a veterinarian authorized by law to practice veterinary medicine in this State.

(c) "Dentist" means a dentist authorized by law to practice dentistry in this State.

(d) "Hospital" means any federal institution, or any institution for the care and treatment of the sick and injured, operated or approved by the appropriate State department as proper to be entrusted with the custody and professional use of controlled dangerous substances or controlled substance analogs.

(e) "Laboratory" means a laboratory to be entrusted with the custody of narcotic drugs and the use of controlled dangerous substances or controlled substance analogs for scientific, experimental, and medical purposes and for purposes of instruction approved by the Department of Health.

"Production" includes the manufacture, planting, cultivation, growing, or harvesting of a controlled dangerous substance or controlled substance analog.

"Immediate precursor" means a substance which the Division of Consumer Affairs in the Department of Law and Public Safety has found to be and by regulation designates as being the principal compound commonly used or produced primarily for use, and which is an immediate chemical intermediary used or likely to be used in the manufacture of a controlled dangerous substance or controlled substance analog, the control of which is necessary to prevent, curtail, or limit such manufacture.

"Residential treatment facility" means any facility licensed and approved by the Department of Human Services and which is approved by any county probation department for the inpatient treatment and rehabilitation of drug or alcohol dependent persons.

"Schedules I, II, III, IV, and V" are the schedules set forth in sections 5 through 8 of P.L.1970, c.226 (C.24:21-5 through 24:21-8) and in section 4 of P.L.1971, c.3 (C.24:21-8.1) and as modified by any regulations issued by the Director of the Division of Consumer Affairs in the Department of Law and Public Safety pursuant to the director's authority as provided in section 3 of P.L.1970, c.226 (C.24:21-3).

"State" means the State of New Jersey.

"Ultimate user" means a person who lawfully possesses a controlled dangerous substance or controlled substance analog for his own use or for the use of a member of his household or for administration to an animal owned by him or by a member of his household.

"Prescription legend drug" means any drug which under federal or State law requires dispensing by prescription or order of a licensed physician, veterinarian, or dentist and is required to bear the statement "Rx only" or similar wording indicating that such drug may be sold or dispensed only upon the prescription of a licensed medical practitioner and is not a controlled dangerous substance or stramonium preparation.

"Stramonium preparation" means a substance prepared from any part of the stramonium plant in the form of a powder, pipe mixture, cigarette, or any other form with or without other ingredients.

"Stramonium plant" means the plant Datura Stramonium Linne, including Datura Tatula Linne.

3. Section 6 of P.L.1999, c.90 (C.2C:36-6.1) is amended to read as follows:

C.2C:36-6.1 Discarding hypodermic needle or syringe.

6. Discarding hypodermic needle or syringe.

a. A person commits a petty disorderly persons offense if:

(1) the person discards, in a place accessible to other persons, a hypodermic needle or syringe without destroying the hypodermic needle or syringe; or

(2) he is the owner, lessee, or person in control of real property and, knowing that needles and syringes in an intact condition have been discarded or abandoned on his real property, allows them to remain.

b. A hypodermic needle is destroyed if the needle is broken from the hub or mangled. A syringe is destroyed if the nipple of the barrel is broken from the barrel, or the plunger and barrel are melted. Alternatively, a hypodermic needle or syringe is destroyed if it is discarded as a single unit, without recapping, into a rigid container and the container is destroyed by grinding or crushing in a compactor, or by burning in an incinerator approved by the Department of Environmental Protection, or by another method approved by the Department of Health.

4. Section 1 of P.L.2011, c.183 (C.2C:36-6.2) is amended to read as follows:

C.2C:36-6.2 Sale by licensed pharmacy of hypodermic syringe or needle under certain circumstances.

1. a. Notwithstanding any State law, rule, or regulation to the contrary, a licensed pharmacy may sell a hypodermic syringe or needle, or any other instrument adapted for the administration of drugs by injection, to a person over 18 years of age who presents valid photo identification to demonstrate proof of age or who otherwise satisfies the seller that he is over 18 years of age, as follows:

(1) without a prescription if sold in quantities of 10 or fewer; and

(2) pursuant to a prescription issued by a person authorized to prescribe under State law if sold in quantities of more than 10.

b. A licensed pharmacy that provides hypodermic syringes or needles for sale shall also be required to:

(1) maintain its supply of such instruments under or behind the pharmacy sales counter such that they are accessible only to a person standing behind a pharmacy sales counter; and

(2) make available to each person who purchases any such instrument, at the time of purchase, information to be developed by the Department of Health to the purchaser, about:

(a) the safe disposal of the instrument, including local disposal locations or a telephone number to call for that information; and

(b) substance abuse treatment, including a telephone number to call for assistance in obtaining treatment.

c. In addition to any other provision of law that may apply, a person who purchases a hypodermic syringe or needle pursuant to subsection a. of this section and sells that needle or syringe to another person is guilty of a disorderly persons offense.

d. The Department of Health, in consultation with the Department of Human Services and the New Jersey State Board of Pharmacy, may, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), adopt rules and regulations to effectuate the purposes of subsection b. of this section. The Department of Health shall make the information that is to be developed pursuant to subsection b. of this section available to pharmacies and purchasers of hypodermic syringes or needles through its Internet website.

5. Section 8 of P.L.1941, c.151 (C.4:19-15.8) is amended to read as follows:

C.4:19-15.8 Licensing of kennel, pet shop, shelter, pound.

8. a. Any person who keeps or operates or proposes to establish a kennel, a pet shop, a shelter or a pound shall apply to the clerk or other official designated to license dogs in the municipality where such establishment is located, for a license entitling him to keep or operate such establishment.

The application shall describe the premises where the establishment is located or is proposed to be located, the purpose or purposes for which it is to be maintained, and shall be accompanied by the written approval of the local municipal and health authorities showing compliance with the local and State rules and regulations governing location of and sanitation at such establishments.

b. All licenses issued for a kennel, pet shop, shelter, or pound shall state the purpose for which the establishment is maintained, and all licenses shall expire on the last day of June of each year, and be subject to revocation by the municipality on recommendation of the Department of Health or the local board of health for failure to comply with the rules and regulations of the State department or local board governing the same, after the owner has been afforded a hearing by either the State department or local board, except as provided in subsection c. of this section.

Any person holding a license shall not be required to secure individual licenses for dogs owned by a licensee and kept at the establishments; the licenses shall not be transferable to another owner or different premises.

c. The license for a pet shop shall be subject to review by the municipality, upon recommendation by the Department of Health or the local health authority for failure by the pet shop to comply with the rules and regulations of the State department or local health

authority governing pet shops or if the pet shop meets the criteria for recommended suspension or revocation provided under subsection c. or d. of section 5 of P.L.1999, c.336 (C.56:8-96), after the owner of the pet shop has been afforded a hearing pursuant to subsection e. of section 5 of P.L.1999, c.336 (C.56:8-96).

The municipality, based on the criteria for the recommendation of the local health authority provided under subsections c. and d. of section 5 of P.L.1999, c.336 (C.56:8-96), may suspend the license for 90 days or may revoke the license if it is determined at the hearing that the pet shop: (1) failed to maintain proper hygiene and exercise reasonable care in safeguarding the health of animals in its custody or (2) sold a substantial number of animals that the pet shop knew, or reasonably should have known, to be unfit for purchase.

d. The municipality may issue a license for a pet shop that permits the pet shop to sell pet supplies for all types of animals, including cats and dogs, and sell animals other than cats and dogs but restricts the pet shop from selling cats or dogs, or both.

e. Every pet shop licensed in the State shall submit annually and no later than May 1 of each year records of the total number of cats and dogs, respectively, sold by the pet shop each year to the municipality in which it is located, and the municipality shall provide this information to the local health authority.

6. Section 12 of P.L.1941, c.151 (C.4:19-15.12) is amended to read as follows:

C.4:19-15.12 Fee for dog license.

12. a. The governing body of each municipality may, by ordinance, fix the sum to be paid annually for a dog license and each renewal thereof, as required by section 3 of this act, which sum shall be not less than $1.50 or more than $21; provided however, that the governing body may by ordinance, provide for a reduction or waiver of the sum to be paid by an owner who presents a certificate signed by a licensed veterinarian stating that the dog has been spayed or neutered. In the absence of any local ordinance, the fee for all dog licenses shall be $1.50.

b. The governing body of each municipality, may, by ordinance, fix the sum to be paid for a 3-year dog license and each renewal thereof, which sum shall be not more than 3 times the sum charged for an annual license under subsection a. of this section. In the absence of such a local ordinance, the license fee for a 3-year dog license shall be $4.50. The Department of Health shall promulgate appropriate regulations concerning veterinarians' certificates for rabies inoculations of dogs for 3-year periods in connection with licenses issued under this subsection.

7. Section 16 of P.L.1941, c.151 (C.4:19-15.16) is amended to read as follows:

C.4:19-15.16 Unclaimed dogs or other animals to be euthanized, offered for adoption.

16. a. The certified animal control officer appointed by the governing body of the municipality shall take into custody and impound any animal, to thereafter be euthanized or offered for adoption, as provided in this section:

(1) Any dog off the premises of the owner or of the person charged with the care of the dog, which is reasonably believed to be a stray dog;

(2) Any dog off the premises of the owner or the person charged with the care of the dog without a current registration tag on its collar or elsewhere;

(3) Any female dog in season off the premises of the owner or the person charged with the care of the dog;

(4) Any dog or other animal which is suspected to be rabid; or

(5) Any dog or other animal off the premises of the owner or the person charged with its care that is reported to, or observed by, a certified animal control officer to be ill, injured, or creating a threat to public health, safety, or welfare, or otherwise interfering with the enjoyment of property.

b. If an animal taken into custody and impounded pursuant to subsection a. of this section has a collar or harness with identification of the name and address of any person, or has a registration tag, or has a microchip with an identification number that can be traced to the owner or person charged with the care of the animal, or the owner or the person charged with the care of the animal is otherwise known, the certified animal control officer shall ascertain the name and address of the owner or the person charged with the care of the animal, and serve to the identified person as soon as practicable, a notice in writing that the animal has been seized and will be liable to be offered for adoption or euthanized if not claimed within seven days after the service of the notice.

c. A notice required pursuant to this section may be served: (1) by delivering it to the person on whom it is to be served, or by leaving it at the person's usual or last known place of residence or the address given on the collar, harness, or microchip identification; or (2) by mailing the notice to that person at the person's usual or last known place of residence, or to the address given on the collar, harness or microchip identification.

d. A shelter, pound, or kennel operating as a shelter or pound receiving an animal from a certified animal control officer pursuant to subsection a. of this section, or from any other individual, group, or organization, shall hold the animal for at least seven days before offering it for adoption, or euthanizing, relocating, or sterilizing the animal, except if:

(1) the animal is surrendered voluntarily by its owner to the shelter, pound, or kennel operating as a shelter or pound, in which case the provisions of subsection e. of this section shall apply; or

(2) the animal is suspected of being rabid, in which case the provisions of subsection j. of this section shall apply.

e. If a shelter, pound or kennel operating as a shelter or pound is not required to hold an animal for at least seven days pursuant to paragraph (1) of subsection d. of this section, the shelter, pound, or kennel operating as a shelter or pound:

(1) shall offer the animal for adoption for at least seven days before euthanizing it; or

(2) may transfer the animal to an animal rescue organization facility or a foster home prior to offering it for adoption if such a transfer is determined to be in the best interest of the animal by the shelter, pound, or kennel operating as a shelter or pound.

f. Except as otherwise provided for under subsection e. of this section, no shelter, pound, or kennel operating as a shelter or pound receiving an animal from a certified animal control officer may transfer the animal to an animal rescue organization facility or a foster home until the shelter, pound, or kennel operating as a shelter or pound has held the animal for at least seven days.

g. If the owner or the person charged with the care of the animal seeks to claim it within seven days, or after the seven days have elapsed but before the animal has been adopted or euthanized, the shelter, pound, or kennel operating as a shelter or pound:

(1) shall, in the case of a cat or dog, release it to the owner or person charged with its care, provided the owner or person charged with the care of the animal provides proof of ownership, which may include a valid cat or dog license, registration, rabies inoculation certificate, or documentation from the owner's veterinarian that the cat or dog has received regular care from that veterinarian;

(2) may, in the case of a cat or dog, charge the cost of sterilizing the cat or dog, if the owner requests such sterilizing when claiming it; and

(3) may require the owner or person charged with the care of the animal to pay all the animal's expenses while in the care of the shelter, pound, or kennel operating as a shelter or pound, not to exceed $4 per day.

h. If the animal remains unclaimed, is not claimed due to the failure of the owner or other person to comply with the requirements of this section, or is not adopted after seven days after the date on which notice is served pursuant to subsection c. of this section or, if no notice can be served, not less than seven days after the date on which the animal was impounded, the impounded animal may be placed in a foster home, transferred to another shelter, pound, kennel operating as a shelter or pound, or animal rescue organization facility, or euthanized in a manner causing as little pain as possible and consistent with the provisions of R.S.4:22-19.

i. At the time of adoption, the right of ownership in the animal shall transfer to the new owner. No dog or other animal taken into custody, impounded, sent or otherwise brought to a shelter, pound, or kennel operating as a shelter or pound shall be sold or otherwise be made available for the purpose of experimentation. Any person who sells or otherwise makes available any such dog or other animal for the purpose of experimentation shall be guilty of a crime of the fourth degree.

j. Any animal seized under this section suspected of being rabid shall be immediately reported to the executive officer of the local board of health and to the Department of Health, and shall be quarantined, observed, and otherwise handled and dealt with as appropriate for an animal suspected of being rabid or as required by the Department of Health for the animals.

k. When a certified animal control officer takes into custody and impounds, or causes to be taken into custody and impounded, an animal, the certified animal control officer may place the animal in the custody of, or cause the animal to be placed in the custody of, only a licensed shelter, pound, or kennel operating as a shelter or pound. The certified animal control officer may not place the animal in the custody of, or cause the animal to be placed in the custody of, any animal rescue organization facility, foster home, or other unlicensed facility. However, the licensed shelter, pound, or kennel operating as a shelter or pound may place the animal in an animal rescue organization facility, foster home, or other unlicensed facility if necessary pursuant to subsection e. or h. of this section.

l. Notwithstanding the provisions of this section and sections 3 and 4 of P.L.2011, c.142 (C.4:19-15.30 and C.4:19-15.31) to the contrary, no cat or dog being transferred between shelters, pounds, or kennels operating as shelters or pounds, or being transferred to an animal rescue organization facility or placed in a foster home, shall be required to be sterilized prior to that transfer.

8. Section 3 of P.L.1983, c.525 (C.4:19-15.16a) is amended to read as follows:

C.4:19-15.16a Rules, regulations concerning training, educational qualifications for animal control officers.

3. a. The Commissioner of Health shall, within 120 days after the effective date of P.L.1983, c.525, and pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), adopt rules and regulations concerning the training and educational qualifications for the certification of animal control officers, including, but not limited to, a course of study approved by the commissioner and the Police Training Commission, in

consultation with the New Jersey Certified Animal Control Officers Association, which acquaints a person with:

(1) The law as it affects animal control, animal welfare, and animal cruelty;

(2) Animal behavior and the handling of stray or diseased animals;

(3) Community safety as it relates to animal control; and

(4) The law enforcement methods and techniques required for an animal control officer to properly exercise the authority to investigate and sign complaints and arrest without warrant pursuant to section 8 of P.L.1997, c.247 (C.4:19-15.16c), including, but not limited to, those methods and techniques which relate to search, seizure, and arrest. The training in law enforcement methods and techniques described pursuant to this paragraph shall be part of the course of study for an animal control officer only when required by the governing body of a municipality pursuant to section 4 of P.L.1983, c.525 (C.4:19-15.16b).

Any person 18 years of age or older may satisfy the courses of study established pursuant to this subsection at that person's own time and expense; however, nothing in this section shall be construed as authorizing a person to exercise the powers and duties of an animal control officer absent municipal appointment or authorization pursuant to section 4 of P.L.1983, c.525 (C.4:19-15.16b).

b. (1) The commissioner shall provide for the issuance of a certificate to a person who possesses, or acquires, the training and education required to qualify as a certified animal control officer pursuant to paragraphs (1) through (3) of subsection a. of this section and to a person who has been employed in the State of New Jersey in the capacity of, and with similar responsibilities to those required of, a certified animal control officer pursuant to the provisions of P.L.1983, c.525, for a period of three years before January 17, 1987. The commissioner shall not issue a certificate to any person convicted of, or found civilly liable for, a violation of any provision of chapter 22 of Title 4 of the Revised Statutes.

(2) The commissioner shall revoke the certificate of any person convicted of, or found civilly liable for, a violation of any provision of chapter 22 of Title 4 of the Revised Statutes, and shall place the name of the person on the list established pursuant to subsection c. of this section.

c. (1) The commissioner shall establish a list of all persons issued a certificate pursuant to subsection b. of this section (a) for whom that certificate has been revoked, or (b) who have been convicted of, or found civilly liable for, a violation of any provision of chapter 22 of Title 4 of the Revised Statutes. The commissioner shall provide each municipality in the State with a copy of this list within 30 days after the list is established and not less often than annually thereafter if no revised list required pursuant to paragraph (2) of this subsection has been issued in the interim.

(2) Upon receipt of a notice required pursuant to section 3 or 4 of P.L.2003, c.67 (C.4:22-57 or C.2B:12-17.1) involving a person who has been issued a certificate pursuant to subsection b. of this section, the commissioner shall add to the list the name of the person convicted of, or found civilly liable for, a violation of any provision of chapter 22 of Title 4 of the Revised Statutes according to the notice, and shall issue a copy of the revised list to each municipality within 30 days after receipt of any notice.

9. Section 4 of P.L.1983, c.525 (C.4:19-15.16b) is amended to read as follows:

C.4:19-15.16b Appointment of certified animal control officer.

4. The governing body of a municipality shall, within three years of the effective date of P.L.1983, c.525, appoint a certified animal control officer who shall be responsible for

animal control within the jurisdiction of the municipality and who shall enforce and abide by the provisions of section 16 of P.L.1941, c.151 (C.4:19-15.16). The governing body shall not appoint a certified animal control officer, shall not contract for animal control services with any company that employs a certified animal control officer, and shall revoke the appointment of a certified animal control officer, who has been convicted of, or found civilly liable for, a violation of any provision of chapter 22 of Title 4 of the Revised Statutes or whose name is on the list or any revision thereto established and provided by the Commissioner of Health pursuant to subsection c. of section 3 of P.L.1983, c.525 (C.4:19-15.16a). The governing body shall, within 30 days after receipt thereof, review any such list or revision thereto received by the municipality and shall, within that 30-day period, take action accordingly as required pursuant to this section.

The governing body may authorize the certified animal control officer to investigate and sign complaints, arrest violators, and otherwise act as an officer for detection, apprehension, and arrest of offenders against the animal control, animal welfare and animal cruelty laws of the State, and ordinances of the municipality, if the officer has completed the training required pursuant to paragraph 4 of subsection a. of section 3 of P.L.1983, c.525 (C.4:19-15.16a). Only certified animal control officers who have completed the training may be authorized by the governing body to so act as an officer for detection, apprehension, and arrest of offenders; however, officers who have completed the training shall not have the authority to so act unless authorized by the governing body which is employing the officer or contracting for the officer's services.

10. Section 19 of P.L.1941, c.151 (C.4:19-15.19) is amended to read as follows:

C.4:19-15.19 Violations of act or rules; penalty.

19. Except as otherwise provided in this act, any person who violates or who fails or refuses to comply with sections 2, 4, 6, 7, 8, 10, or 18 of this act or the rules and regulations promulgated by the Department of Health pursuant to section 14 of this act, shall be liable to a penalty of not less than $5.00 nor more than $50 for each offense, to be recovered by and in the name of the Commissioner of Health, or by and in the name of the local board of health of the municipality, or by and in the name of the municipality, as the case may be, except that for the first offense in cases of violations of sections 2, 4, and 6 of this act, the penalty shall be not less than $1.00 nor more than $50, to be recovered in the same manner.

11. Section 20 of P.L.1941, c.151 (C.4:19-15.20) is amended to read as follows:

C.4:19-15.20 Penalty to be paid to plaintiff; disposition.

20. Any penalty recovered in an action brought under the provisions of this act shall be paid to the plaintiff therein. When the plaintiff is the Commissioner of Health, the penalty shall be paid by the commissioner into the treasury of the State. When the plaintiff is a local board of health the penalty shall be paid by the local board into the treasury of the municipality within which the local board has jurisdiction.

12. Section 3 of P.L.2011, c.142 (C.4:19-15.30) is amended to read as follows:

C.4:19-15.30 “Pet Sterilization Pilot Program.”

3. a. The Department of Health shall develop and establish a pilot program to be known as the "Pet Sterilization Pilot Program." The pilot program shall operate in any county with

significant animal overpopulation issues that is selected for the program by the Commissioner of Health and agrees to participate in the program. Upon the county's agreement to participate, every shelter, pound, and kennel operating as a shelter or pound in the county shall participate in the pilot program.

b. A shelter, pound, or kennel operating as a shelter or pound in a county participating in the pilot program established under subsection a. of this section shall require every cat or dog to be sterilized before releasing it to a person adopting a cat or dog from the shelter, pound, or kennel operating as a shelter or pound when adoption is permitted pursuant to section 16 of P.L.1941, c.151 (C.4:19-15.16), except as provided under section 4 of P.L.2011, c.142 (C.4:19-15.31). The shelter, pound, or kennel operating as a shelter or pound may charge the person adopting the animal the cost of sterilization.

c. The pilot program shall operate for a period of at least two years. No later than two years after the pilot program is established and becomes operative, the Commissioner of Health shall submit a written report to the Governor and, pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), to the Legislature. The report shall contain information on the implementation of the pilot program and shall include the recommendation of the commissioner on the feasibility of implementing the pilot program on a Statewide basis.

13. Section 6 of P.L.2011, c.142 (C.4:19-15.33) is amended to read as follows:

C.4:19-15.33 Registry of animal rescue organizations, facilities.

6. a. The Department of Health shall establish a registry of animal rescue organizations and their facilities in the State. Any animal rescue organization may voluntarily participate in the registry.

b. The department, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), may adopt any rules and regulations determined necessary to implement the voluntary registry and coordinate its use with the provisions of P.L.2011, c.142 (C.4:19-15.30 et al.) and section 16 of P.L.1941, c.151 (C.4:19-15.16).

14. Section 4 of P.L.2002, c.102 (C.4:19-41) is amended to read as follows:

C.4:19-41 Statement filed by veterinarian.

4. Whenever a duly licensed veterinarian surgically debarks or silences a dog, the veterinarian shall prepare and file a written statement with the Department of Health setting forth the veterinary basis for administering the surgery and providing the name and address of the owner, keeper or harborer of the debarked or silenced dog. A veterinarian who fails to comply with the provisions of this section shall be subject to disciplinary action by the State Board of Veterinary Medical Examiners.

15. Section 15 of P.L.1997, c.236 (C.4:27-15) is amended to read as follows:

C.4:27-15 Aquaculture statistics, reporting assistance programs.

15. The Department of Agriculture:

a. in consultation with the Aquaculture Technology Transfer Center, the Rutgers Cooperative Extension and the Department of Environmental Protection, shall implement an aquaculture statistics reporting program which may include the collection of information on the numbers of jobs being created in aquaculture, the amount, value and type of product being produced, and the overall economic activity in the aquaculture industry;

b. in consultation with the Aquaculture Technology Transfer Center, and the Rutgers Cooperative Extension, shall assist aquaculturists in obtaining coverage from federal crop insurance programs;

c. in consultation with the Aquaculture Technology Transfer Center and the Rutgers Cooperative Extension, shall assist aquaculturists in completing the proper paperwork and other information necessary to develop eligibility for economic emergency loans for disaster relief through the Farmers Services Agency and other programs;

d. in consultation with the United States Department of Agriculture and the National Association of State Aquaculture Coordinators, shall develop a monthly wholesale market report for aquaculture products;

e. in conjunction with the Aquaculture Technology Transfer Center and the Department of Health, shall assist the aquaculture industry in the development of necessary quality control guidelines and specifications for production, processing, and marketing of aquaculture products;

f. in conjunction with the Aquaculture Technology Transfer Center, shall assist (1) the aquaculture industry in promoting its products through techniques that may include the establishment and use of a trademark and other specialized marketing efforts; and (2) aquaculturists interested in developing coordinated efforts or arrangements, including producer cooperatives, joint ventures, market orders, and other forms of association; and

g. in conjunction with the Department of Health, the Department of Commerce and Economic Development, the Department of Environmental Protection shall explore the possibilities of establishing private sector joint processing facilities to accommodate agriculture, seafood, and aquaculture products.

16. Section 2 of P.L.2001, c.39 (C.5:12-71.3) is amended to read as follows:

C.5:12-71.3 Penalties for gaming by prohibited persons.

2. a. A person who is prohibited from gaming in a licensed casino or simulcasting facility by any provision of P.L.1977, c.110 (C.5:12-1 et seq.) or any order of the director, commission, or court of competent jurisdiction, including any person on the self-exclusion list pursuant to section 1 of P.L.2001, c.39 (C.5:12-71.2), shall not collect, in any manner or proceeding, any winnings or recover any losses arising as a result of any prohibited gaming activity.

b. For the purposes of P.L.1977, c.110 (C.5:12-1 et seq.), any gaming activity in a licensed casino or simulcasting facility which results in a prohibited person obtaining any money or thing of value from, or being owed any money or thing of value by, the casino or simulcasting facility shall be considered, solely for purposes of this section, to be a fully executed gambling transaction.

c. In addition to any other penalty provided by law, any money or thing of value which has been obtained by, or is owed to, any prohibited person by a licensed casino or simulcasting facility as a result of wagers made by a prohibited person shall be subject to forfeiture following notice to the prohibited person and opportunity to be heard. A licensed casino or simulcasting facility shall inform a prohibited person of the availability of such notice on the division's Internet website when ejecting the prohibited person and seizing any chips, vouchers or other representative of money owed by a casino to the prohibited person as authorized by this subsection.

Of any forfeited amount under $100,000, one-half shall be deposited into the State General Fund for appropriation by the Legislature to the Department of Human Services to

provide funds for compulsive gambling treatment and prevention programs in the State and the remaining one-half shall be deposited into the Casino Revenue Fund. Of any forfeited amount of $100,000 or more, $50,000 shall be deposited into the State General Fund for appropriation by the Legislature to the Department of Human Services to provide funds for compulsive gambling treatment and prevention programs and the remainder shall be deposited into the Casino Revenue Fund.

d. In any proceeding brought by the division against a licensee or registrant pursuant to section 108 of P.L.1977, c.110 (C.5:12-108) for a willful violation of the commission's self-exclusion regulations, the division may order, in addition to any other sanction authorized by section 129 of P.L.1977, c.110 (C.5:12-129), the forfeiture of any money or thing of value obtained by the licensee or registrant from any self-excluded person. Any money or thing of value so forfeited shall be disposed of in the same manner as any money or thing of value forfeited pursuant to subsection c. of this section.

17. Section 145 of P.L.1977, c.110 (C.5:12-145) is amended to read as follows:

C.5:12-145 “Casino Revenue Fund.”

145. a. There is hereby created and established in the Department of the Treasury a separate special account to be known as the "Casino Revenue Fund," into which shall be deposited all revenues from the tax imposed by section 144 of this act; the investment alternative tax imposed by section 3 of P.L.1984, c.218 (C.5:12-144.1); the taxes and fees imposed by sections 3, 4 and 6 of P.L.2003, c.116 (C.5:12-148.1, C.5:12-148.2 and C.5:12-145.8) and any interest and penalties imposed by the division relating to those taxes; the percentage of the value of expired gaming related obligations pursuant to section 24 of P.L.2009, c.36 (C.5:12-141.2); and all penalties levied and collected by the division pursuant to P.L.1977, c.110 (C.5:12-1 et seq.) and the regulations promulgated thereunder, except that the first $600,000 in penalties collected each fiscal year shall be paid into the General Fund for appropriation by the Legislature to the Department of Human Services, $500,000 of which is to provide funds to the Council on Compulsive Gambling of New Jersey and $100,000 of which is to provide funds for compulsive gambling treatment programs in the State. In the event that less than $600,000 in penalties are collected, the Department of Human Services shall determine the allocation of funds between the Council and the treatment programs eligible under the criteria developed pursuant to section 2 of P.L.1993, c.229 (C.26:2-169).

b. The division shall require at least monthly deposits by the licensee of the tax established pursuant to subsection a. of section 144 of P.L.1977, c.110 (C.5:12-144), at such times, under such conditions, and in such depositories as shall be prescribed by the State Treasurer. The deposits shall be deposited to the credit of the Casino Revenue Fund. The division may require a monthly report and reconciliation statement to be filed with it on or before the 10th day of each month, with respect to gross revenues and deposits received and made, respectively, during the preceding month.

c. Moneys in the Casino Revenue Fund shall be appropriated exclusively for reductions in property taxes, rentals, telephone, gas, electric, and municipal utilities charges of eligible senior citizens and disabled residents of the State, and for additional or expanded health services or benefits or transportation services or benefits to eligible senior citizens and disabled residents, as shall be provided by law. On or about March 15 and September 15 of each year, the State Treasurer shall publish in at least 10 newspapers circulating generally in the State a report accounting for the total revenues received in the Casino Revenue Fund and

the specific amounts of money appropriated therefrom for specific expenditures during the preceding six months ending December 31 and June 30.

18. Section 1 of P.L.1992, c.108 (C.5:12-145.3) is amended to read as follows:

C.5:12-145.3 “Casino Revenue Fund Advisory Commission.”

1. There is created a commission to be known as the "Casino Revenue Fund Advisory Commission." The commission shall consist of 15 members to be appointed as follows: two members of the Senate, appointed by the President of the Senate, not more than one of whom shall be of the same political party; two members of the General Assembly, appointed by the Speaker of the General Assembly, not more than one of whom shall be of the same political party; three public members who are senior citizens, one of whom is appointed by the President of the Senate, one of whom is appointed by the Speaker of the General Assembly, and one of whom is appointed by the Governor; three public members who are disabled, one of whom is appointed by the President of the Senate, one of whom is appointed by the Speaker of the General Assembly, and one of whom is appointed by the Governor; one public member who is a representative of the casino industry to be appointed by the Governor upon the recommendation of the Casino Association of New Jersey; the President of the New Jersey Association of Directors of Area Agencies on Aging, the Chairperson of the New Jersey Association of County Representatives for Disabled Persons, the Director of the Division of Aging Services in the Department of Human Services, and the Legislative Budget and Finance Officer, or their designees, who shall serve as ex officio members.

The legislative members shall serve during the two-year legislative session in which the appointment is made. The senior citizen and disabled members shall serve for three year terms or until a successor is appointed; but of the members initially appointed, one of the senior citizens and one of the disabled members shall serve for a term of one year, one of the senior citizens and one of the disabled members shall serve for a term of two years, and one of the senior citizens and one of the disabled members shall serve for a term of three years.

Vacancies in the membership of the commission shall be filled in the same manner as the original appointments are made and a member may be eligible for reappointment. Vacancies occurring other than by expiration of a term shall be filled for the unexpired term.

Members shall be eligible for reimbursement for necessary and reasonable expenses incurred in the performance of their official duties but reimbursement of expenses shall be within the limits of funds appropriated or otherwise made available to the commission for its purposes.

19. Section 3 of P.L.1991, c.290 (C.9:6B-3) is amended to read as follows:

C.9:6B-3 Definitions.

3. As used in this act:

"Child placed outside his home" means a child placed outside his home by the Department of Human Services, the Department of Children and Families, the Department of Health, or a board of education.

"Department" means the Department of Human Services, the Department of Children and Families, the Department of Health, or board of education, as applicable.

20. Section 5 of P.L.1991, c.290 (C.9:6B-5) is amended to read as follows:

C.9:6B-5 Public information.

5. The Departments of Human Services, Children and Families, Health, and Education shall each prepare and update at least every six months, and shall make available to the public upon request, aggregate non-identifying data about children under their care, custody, or supervision who are placed in out-of-home settings, by category as appropriate. The data shall include the following:

a. The number of children placed outside their homes during the six-month period and the cumulative number of children residing in out-of-home settings;

b. The age, sex, and race of the children residing in out-of-home settings;

c. The reasons for placement of these children;

d. The types of settings in which these children reside;

e. The length of time that these children have resided in these settings;

f. The number of placements for those children who have been placed in more than one setting;

g. The number of children who have been placed in the same county in which their parents or legal guardians reside and the number who have been placed outside of the State;

h. The number of children who have been permanently placed or returned to their homes during the six-month period, and a projection of the number of children who will be permanently placed or returned to their homes during the following six-month period; and

i. The number of children who have been permanently placed or returned to their homes who are subsequently returned to an out-of-home setting during the six-month period.

21. Section 6 of P.L.1991, c.290 (C.9:6B-6) is amended to read as follows:

C.9:6B-6 Rules, regulations.

6. The Commissioners of Human Services, Children and Families, Health, and Education, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall each adopt rules and regulations to effectuate the purposes of this act.

22. Section 9 of P.L.1999, c.145 (C.9:17A-1.8) is amended to read as follows:

C.9:17A-1.8 Fact sheet for distribution to unemancipated pregnant minors.

9. The Department of Health shall prepare a fact sheet for distribution to unemancipated pregnant minors who are seeking abortion services.

a. The fact sheet shall be written in terms generally understood by a teenager and shall explain the parental notification requirements of this act, including, but not limited to:

(1) that a minor may, by petition or motion, seek a waiver of parental notification from a judge of the Superior Court;

(2) that a minor may participate in proceedings in the court on her own behalf, that the court may appoint a guardian ad litem for her and that the minor has a right to court appointed counsel, which shall be provided to her by the court upon her request; and

(3) the procedure established by the court for petitioning or making a motion before the court.

b. The department shall distribute the fact sheet, at no charge, to ambulatory care facilities and hospitals licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.), public and private agencies and physicians' offices that provide family planning services and prenatal care.

c. The physician who is responsible for providing notification to an unemancipated minor's parent pursuant to this act, or his designee, shall provide the unemancipated minor with a copy of the fact sheet at the time the minor initially requests abortion services from the physician.

23. Section 12 of P.L.1999, c.145 (C.9:17A-1.11) is amended to read as follows:

C.9:17A-1.11 Rules, regulations.

12. The Commissioner of Health, in consultation with the Department of Law and Public Safety, shall promulgate rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), concerning procedures for physicians to follow in effectuating the notice required pursuant to the provisions of P.L.1999, c.145 (C.9:17A-1.1 et al.).

24. N.J.S.11A:11-2 is amended to read as follows:

Department of Personnel abolished.

11A:11-2. a. The Department of Personnel is abolished as a principal department in the Executive Branch of State government. The offices and terms of the Commissioner of Personnel, the deputy commissioner, assistant commissioners, and the directors of the various divisions and offices of the Department of Personnel are terminated, except as otherwise provided by P.L.2008, c.29.

b. The functions, powers, and duties of the Department of Personnel, the Commissioner of Personnel, the deputy commissioner, assistant commissioners, and directors of the various divisions and offices of the Department of Personnel are continued and transferred as provided by P.L.2008, c.29. The State Treasurer may allocate the functions, powers, and duties transferred to the Department of the Treasury or the State Treasurer by P.L.2008, c.29 among such divisions or subdivisions in the Department of the Treasury as the State Treasurer deems appropriate or as the State Treasurer may establish.

c. (1) The Division of Equal Employment Opportunity and Affirmative Action as constituted in the Department of Personnel, with its functions, powers, and duties, and those of the Commissioner of Personnel and the Merit System Board with regard to that division, is continued and transferred to the Department of the Treasury, except with regard to the power to adjudicate complaints of violations of the State policy against discrimination which power shall remain with the Civil Service Commission. The functions, powers, and duties of the Division of Equal Employment Opportunity and Affirmative Action shall be allocated within the department as the State Treasurer shall determine.

The Equal Employment Opportunity Advisory Commission as constituted in the Department of Personnel is continued and transferred to the Department of the Treasury to be allocated within that department as the State Treasurer shall determine. The members of the Equal Employment Opportunity Advisory Commission shall continue as members of the commission for the duration of their current terms and any reappointments and until their successors are appointed, unless removed for cause.

(2) The planning and research unit and function as constituted in the Department of Personnel is continued and transferred to the Department of the Treasury to be allocated within that department as the State Treasurer shall determine.

d. The Working Well NJ State employee wellness program as constituted in the Department of Personnel is continued and transferred to the Department of Health to be allocated within that department as the commissioner shall determine.

e. The toll-free information "Law Enforcement Officer Crisis Intervention Services" telephone hotline as constituted in the Department of Personnel is continued and transferred to the Department of Human Services, pursuant to sections 115 to 116 of P.L.2008, c.29 (C.26:2NN-1 to C.26:2NN-2), to be allocated within that department as the commissioner shall determine.

f. The New Jersey Employee Awards Committee as constituted in the Department of Personnel is continued and transferred to the Civil Service Commission. The members of the New Jersey Employee Awards Committee shall continue as members of the committee for the duration of their current terms and any reappointments and until their successors are appointed, unless removed for cause.

g. The commission shall develop a plan for the consolidation and coordination of personnel and related functions, including, but not limited to, classification, compensation, and workforce planning, in the executive branch of State government and for transfer to the commission of employees, positions, funding, facilities, equipment, powers, and duties from throughout the executive branch of State government as necessary and appropriate to effectuate such consolidation and coordination.

h. The commission shall submit the plan prepared pursuant to subsection g. of this section to the Governor for review and approval. With the approval of the Governor and in accordance with regulations adopted by the commission, the commission, pursuant to the approved plan, shall direct the consolidation and coordination of personnel and related functions, including, but not limited to, classification, compensation, and workforce planning, in the executive branch of State government and transfer to the commission employees, positions, funding, facilities, equipment, powers, duties, and functions from throughout the executive branch of State government to effectuate the consolidation and coordination. The commission shall organize these functions in the units as the commission determines are necessary for the efficient operation of the commission and in a manner as will provide the appointing authorities and all State employees with proper support in personnel matters. The consolidation shall not apply to those functions which the commission has determined are unique to each department or agency in its capacity as an appointing authority.

i. Each department, office, division, bureau, or agency in the executive branch of State government shall cooperate with the commission and make available to the commission such information, personnel and assistance necessary to effectuate the purposes of P.L.2008, c.29.

j. This section shall not be construed to permit or require negotiations pursuant to the "New Jersey Employer-Employee Relations Act," P.L.1941, c.100 (C.34:13A-1 et seq.), of any rule or regulation promulgated by the State Treasurer or Civil Service Commission pursuant to this section or any other section of this title.

25. N.J.S.11A:11-3 is amended to read as follows:

Names.

11A:11-3. Any law, rule, regulation, order, reorganization plan, contract, document, judicial or administrative proceeding, appropriation, or otherwise which refers to the Department of Personnel, Commissioner of Personnel, or Merit System Board shall mean the

Department of the Treasury, State Treasurer, Civil Service Commission, the Department of Health, or the Department of Human Services, as provided by P.L.2008, c.29.

26. N.J.S.11A:11-4 is amended to read as follows:

Rules.

11A:11-4. All rules of the Merit System Board or the Department of Personnel in effect on the effective date of P.L.2008, c.29 shall remain in effect except as changed or modified by this title or action of the Civil Service Commission, State Treasurer, Commissioner of Health, Commissioner of Human Services, or other authority, as appropriate.

27. Section 20 of P.L.1989, c.34 (C.13:1E-48.20) is amended to read as follows:

C.13:1E-48.20 Enforcement.

20. a. This act, and any rule or regulation adopted pursuant thereto, shall be enforced by the departments and by every local board of health, or county health department, as the case may be.

The departments and the local board of health, or the county health department, as the case may be, shall have the right to enter the premises of a generator, transporter, or facility at any time in order to determine compliance with this act.

The municipal attorney or an attorney retained by a municipality in which a violation of this act is alleged to have occurred shall act as counsel to a local board of health.

The county counsel or an attorney retained by a county in which a violation of this act is alleged to have occurred shall act as counsel to the county health department.

All enforcement activities undertaken by county health departments pursuant to this subsection shall conform to all applicable performance and administrative standards adopted pursuant to section 10 of the "County Environmental Health Act," P.L.1977, c.443 (C.26:3A2-28).

b. Whenever the Commissioner of Environmental Protection or the Commissioner of Health finds that a person has violated this act, or any rule or regulation adopted pursuant thereto, that commissioner shall:

(1) issue an order requiring the person found to be in violation to comply in accordance with subsection c. of this section;

(2) bring a civil action in accordance with subsection d. of this section;

(3) levy a civil administrative penalty in accordance with subsection e. of this section;

(4) bring an action for a civil penalty in accordance with subsection f. of this section; or

(5) petition the Attorney General to bring a criminal action in accordance with subsections g. through j. of this section.

Pursuit of any of the remedies specified under this section shall not preclude the seeking of any other remedy specified.

c. Whenever the Commissioner of Environmental Protection or the Commissioner of Health finds that a person has violated this act, or any rule or regulation adopted pursuant thereto, that commissioner may issue an order specifying the provision or provisions of this act, or the rule or regulation adopted pursuant thereto, of which the person is in violation, citing the action that constituted the violation, ordering abatement of the violation, and giving notice to the person of the person's right to a hearing on the matters contained in the order. The ordered party shall have 20 days from receipt of the order within which to deliver to the commissioner a written request for a hearing. After the hearing and upon finding that a

violation has occurred, the commissioner may issue a final order. If no hearing is requested, the order shall become final after the expiration of the 20-day period. A request for hearing shall not automatically stay the effect of the order.

d. The Commissioner of Environmental Protection, the Commissioner of Health, a local board of health, or a county health department may institute an action or proceeding in the Superior Court for injunctive and other relief, including the appointment of a receiver for any violation of this act, or of any rule or regulation adopted pursuant thereto, and the court may proceed in the action in a summary manner. In any proceeding the court may grant temporary or interlocutory relief.

The relief may include, singly or in combination:

(1) a temporary or permanent injunction;

(2) assessment of the violator for the costs of any investigation, inspection, or monitoring survey that led to the establishment of the violation, and for the reasonable costs of preparing and litigating the case under this subsection;

(3) assessment of the violator for any cost incurred by the State in removing, correcting, or terminating the adverse effects upon environmental quality or public health resulting from any violation of this act, or any rule or regulation adopted pursuant thereto, for which the action under this subsection may have been brought;

(4) assessment against the violator of compensatory damages for any loss or destruction of wildlife, fish or aquatic life, and for any other actual damages caused by any violation of this act, or any rule or regulation adopted pursuant thereto, for which the action under this subsection may have been brought; and

(5) assessment against the violator of the actual amount of any economic benefits accruing to the violator from a violation. Economic benefits may include the amount of any savings realized from avoided capital or noncapital costs resulting from the violation; the return earned or that may be earned on the amount of avoided costs; any benefits accruing to the violator as a result of a competitive market advantage enjoyed by reason of the violation; or any other benefits resulting from the violation.

Assessments under this subsection shall be paid to the State Treasurer, or to the local board of health, or to the county health department, as the case may be, except that compensatory damages may be paid by specific order of the court to any persons who have been aggrieved by the violation.

If a proceeding is instituted by a local board of health or county health department, notice thereof shall be served upon the commissioners in the same manner as if the commissioners were named parties to the action or proceeding. Either of the departments may intervene as a matter of right in any proceeding brought by a local board of health or county health department.

e. Either of the commissioners, as the case may be, may assess a civil administrative penalty of not more than $100,000 for each violation. Each day that a violation continues shall constitute an additional, separate, and distinct offense. A commissioner may not assess a civil administrative penalty in excess of $25,000 for a single violation, or in excess of $2,500 for each day during which a violation continues, until the departments have respectively adopted, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), regulations requiring the appropriate commissioner, in assessing a civil administrative penalty, to consider the operational history of the violator, the severity of the violation, the measures taken to mitigate or prevent further violations, and whether the penalty will maintain an appropriate deterrent. No assessment may be levied pursuant to this section until after the violator has been notified by certified mail or personal service. The

notice shall include a reference to the section of the statute, rule, regulation, or order violated, a concise statement of the facts alleged to constitute a violation, a statement of the amount of the civil administrative penalties to be imposed, and a statement of the party's right to a hearing. The ordered party shall have 20 calendar days from receipt of the notice within which to deliver to the appropriate commissioner a written request for a hearing. After the hearing and upon finding that a violation has occurred, that commissioner may issue a final order after assessing the amount of the fine specified in the notice. If no hearing is requested, the notice shall become a final order after the expiration of the 20-day period. Payment of the assessment is due when a final order is issued or the notice becomes a final order. The authority to levy a civil administrative penalty is in addition to all other enforcement provisions in this act, and the payment of any assessment shall not be deemed to affect the availability of any other enforcement provisions in connection with the violation for which the assessment is levied. Each department may compromise any civil administrative penalty assessed under this section in an amount the department determines appropriate.

f. A person who violates this act, or any rule or regulation adopted pursuant thereto, shall be liable for a penalty of not more than $100,000 per day for each violation, to be collected in a civil action commenced by the Commissioner of Environmental Protection, the Commissioner of Health, a local board of health, or a county health department.

A person who violates an administrative order issued pursuant to subsection c. of this section, or a court order issued pursuant to subsection d. of this section, or who fails to pay an administrative assessment in full pursuant to subsection e. of this section is subject upon order of a court to a civil penalty not to exceed $200,000 per day for each violation.

Of the penalty imposed pursuant to this subsection, 10% or $250, whichever is greater, shall be paid to the appropriate department from the General Fund if the Attorney General determines that a person is entitled to a reward pursuant to section 24 of this act.

Any penalty imposed pursuant to this subsection may be collected, with costs, in a summary proceeding pursuant to the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.). The Superior Court and the municipal court shall have jurisdiction to enforce the provisions of the "Penalty Enforcement Law of 1999" in connection with this act.

g. A person who purposely or knowingly:

(1) disposes or stores regulated medical waste without authorization from either the Department of Environmental Protection or the Department of Health, as appropriate, or in violation of this act, or any rule or regulation adopted pursuant thereto;

(2) makes any false or misleading statement to any person who prepares any regulated medical waste application, registration, form, label, certification, manifest, record, report, or other document required by this act, or any rule or regulation adopted pursuant thereto;

(3) makes any false or misleading statement on any regulated medical waste application, registration, form, label, certification, manifest, record, report, or other document required by this act, or any rule or regulation adopted pursuant thereto; or

(4) fails to properly treat certain types of regulated medical waste designated by the Department of Health in a prescribed manner; shall, upon conviction, be guilty of a crime of the third degree and, notwithstanding the provisions of N.J.S.2C:43-3, shall be subject to a fine of not more than $100,000 for the first offense, and not more than $200,000 for each subsequent offense, and restitution, in addition to any other appropriate disposition authorized by subsection b. of N.J.S.2C:43-2.

h. A person who recklessly or negligently:

(1) disposes or stores regulated medical waste without authorization from either the Department of Environmental Protection or the Department of Health, as appropriate, or in violation of this act, or any rule or regulation adopted pursuant thereto;

(2) makes any false or misleading statement to any person who prepares any regulated medical waste application, registration, form, label, certification, manifest, record, report, or other document required by this act, or any rule or regulation adopted pursuant thereto;

(3) makes any false or misleading statement on any regulated medical waste application, registration, form, label, certification, manifest, record, report, or other document required by this act, or any rule or regulation adopted pursuant thereto; or

(4) fails to properly treat certain types of regulated medical waste designated by the Department of Health in a manner prescribed thereby; shall, upon conviction, be guilty of a crime of the fourth degree.

i. A person who, regardless of intent:

(1) transports any regulated medical waste to a facility or any other place in the State that does not have authorization from the Department of Environmental Protection to accept the waste, or in violation of this act, or any rule or regulation adopted pursuant thereto; or

(2) transports, or receives transported, regulated medical waste without completing and submitting a manifest in accordance with this act, or any rule or regulation adopted pursuant thereto; shall, upon conviction, be guilty of a crime of the fourth degree.

j. A person who purposely, knowingly, or recklessly:

(1) generates and causes or permits to be transported any regulated medical waste to a facility or any other place in the State that does not have authorization from the Department of Environmental Protection to accept the waste, or in violation of this act, or any rule or regulation adopted pursuant thereto; or

(2) violates any other provision of this act, or any rule or regulation adopted pursuant thereto, for which no other criminal penalty has been specifically provided for; shall, upon conviction, be guilty of a crime of the fourth degree.

k. All conveyances used or intended for use in the willful discharge, in violation of this act, or any rule or regulation adopted pursuant thereto, of regulated medical waste are subject to forfeiture to the State pursuant to P.L.1981, c.387 (C.13:1K-1 et seq.).

l. (Deleted by amendment, P.L.1997, c.325.)

m. No prosecution for a violation under this act shall be deemed to preclude a prosecution for the violation of any other applicable statute.

28. Section 1 of P.L.1998, c.18 (C.17:23A-13.1) is amended to read as follows:

C.17:23A-13.1 Notification of test results by insurer to applicants; “reportable communicable disease” defined.

1. An insurer who requires an applicant for insurance to submit to medical testing as a condition of issuing, extending or renewing the insurance shall obtain the applicant's written consent for the test. If in the course of the testing the insurer determines that the applicant has a reportable communicable disease, the insurer shall promptly notify the applicant of the determination and recommend that the applicant contact a physician or other medical professional regarding the significance of the test result. The insurer shall also promptly provide the Department of Health and a physician or other medical professional designated by the applicant with a copy of the results of the test. The provisions of this act shall not be construed to require a physician or other medical professional who receives a copy of the test result to initiate contact with the applicant regarding the test result.

The insurer shall provide the notification required pursuant to this section regardless of whether the existence of the disease will result in an adverse underwriting decision for the applicant.

For the purposes of this act, "reportable communicable disease" means those diseases required to be reported to the Department of Health pursuant to N.J.A.C.8:57-1.3 through 8:57-1.6 and N.J.A.C.8:57-2.2 and 8:57-2.3.

29. Section 2 of P.L.1998, c.18 (C.17:23A-13.2) is amended to read as follows:

C.17:23A-13.2 Regulations.

2. The Commissioner of Banking and Insurance, in consultation with the Commissioner of Health, shall adopt regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) which establish procedures that insurers shall use to notify applicants of test results pursuant to this act.

30. Section 1 of P.L.1970, c.22 (C.17:27A-1) is amended to read as follows:

C.17:27A-1 Definitions.

1. Definitions.

As used in P.L.1970, c.22 (C.17:27A-1 et seq.), the following terms shall have the respective meanings hereinafter set forth, unless the context shall otherwise require:

a. An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

b. The term "commissioner" shall mean the Commissioner of Banking and Insurance or the commissioner’s deputies, except that when a health maintenance organization is the subject of an acquisition of control or merger, the commissioner shall consult with the Commissioner of Health on matters relating to quality of, and access to, health care services.

c. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, 10% or more of the voting securities of any other person, provided that no such presumption of control shall of itself relieve any person so presumed to have control from any requirement of P.L.1970, c.22 (C.17:27A-1 et seq.). This presumption may be rebutted by a showing made in the manner provided by subsection j. of section 3 of P.L.1970, c.22 (C.17:27A-3) that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and an opportunity to be heard, and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

d. An "insurance holding company system" consists of two or more affiliated persons, one or more of which is an insurer.

e. The term "insurer" means any person or persons, corporation, partnership, or company authorized by the laws of this State to transact the business of insurance or to operate a health maintenance organization in this State, except that it shall not include

agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

f. A "person" is an individual, a corporation, a partnership, an association, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing acting in concert.

g. (Deleted by amendment, P.L.1993, c.241).

h. A "subsidiary" of a specified person is an affiliate controlled by such person directly, or indirectly through one or more intermediaries.

i. The term "voting security" shall include any security convertible into or evidencing a right to acquire a voting security.

j. "Acquisition" means any agreement, arrangement or activity, the consummation of which results in a person acquiring directly or indirectly the control of another person, and includes but is not limited to the acquisition of voting securities, and assets, and bulk reinsurance and mergers.

k. "Health maintenance organization" means any person operating under a certificate of authority issued pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.).

31. Section 1 of P.L.1998, c.129 (C.17:29A-35.1) is amended to read as follows:

C.17:29A-35.1 Surcharge debts of driver extinguished upon death.

1. Notwithstanding the provisions or any law, rule or regulation to the contrary, upon the death of a driver on whom surcharges have been levied by the New Jersey Motor Vehicle Commission pursuant to section 6 of P.L.1983, c.65 (C.17:29A-35), any debt established by the imposition of those surcharges is extinguished and the commission, or any agent or representative thereof, shall cease to seek payment of that debt.

Whenever the division is unable to obtain a death certificate from a person representing the estate of any driver on whom surcharges have been levied and who was a resident of the State, the commission shall obtain a copy of the death certificate by contacting the State registrar of vital statistics in the Department of Health and, in these cases, the commission shall not require the estate of the driver to furnish a death certificate.

32. Section 27 of P.L.2004, c.17 (C.17:30D-29) is amended to read as follows:

C.17:30D-29 Medical Malpractice Liability Insurance Premium Assistance Fund.

27. a. There is established a Medical Malpractice Liability Insurance Premium Assistance Fund within the Department of the Treasury as a nonlapsing, revolving fund.

b. The fund shall be comprised of the following revenue:

(1) an annual surcharge of $3 per employee for all employers who are subject to the New Jersey "unemployment compensation law," R.S.43:21-1 et seq., collected by the comptroller for the New Jersey Unemployment Compensation Fund and paid over to the State Treasurer for deposit in the fund annually, as provided by the commissioner, which surcharge may, at the option of the employer, be treated as a payroll deduction to each covered employee;

(2) an annual charge of $75 to be imposed by the State Board of Medical Examiners on every physician and podiatrist licensed by the board pursuant to the provisions of R.S.45:9-1 et seq., collected by the board and remitted to the State Treasurer for deposit into the fund;

(3) an annual charge of $75 to be imposed by the State Board of Chiropractic Examiners on every chiropractor licensed by the board pursuant to the provisions of P.L.1989, c.153

(C.45:9-41.17 et seq.), collected by the board and remitted to the State Treasurer for deposit into the fund;

(4) an annual charge of $75 to be imposed by the New Jersey State Board of Dentistry on every dentist licensed pursuant to the provisions of R.S.45:6-1 et seq., collected by the board and remitted to the State Treasurer for deposit into the fund;

(5) an annual charge of $75 to be imposed by the New Jersey State Board of Optometrists on every optometrist licensed by the board pursuant to the provisions of R.S.45:12-1 et seq., collected by the board and remitted to the State Treasurer for deposit into the fund; and

(6) an annual fee of $75 to be assessed by the State Treasurer and payable by each person licensed to practice law in this State, for deposit into the fund.

The provisions of paragraphs (2) through (5) of this subsection shall not apply to physicians, podiatrists, chiropractors, dentists, or optometrists who: are statutorily or constitutionally barred from the practice of their respective profession; can show that they do not maintain a bona fide office for the practice of their profession in this State; are completely retired from the practice of their profession; are on full-time duty with the armed forces, VISTA, or the Peace Corps and not engaged in practice; or have not practiced their profession for at least one year.

The provisions of paragraph (6) of this subsection shall not apply to attorneys who: are constitutionally or statutorily barred from the practice of law; can show that they do not maintain a bona fide office for the practice of law in this State; are completely retired from the practice of law; are on full-time duty with the armed forces, VISTA, or the Peace Corps and not engaged in practice; are ineligible to practice law because they have not made their New Jersey Lawyers' Fund for Client Protection payment; or have not practiced law for at least one year.

c. The State Treasurer shall deposit all monies collected pursuant to this section into the fund. Monies credited to the fund may be invested in the same manner as assets of the General Fund and any investment earnings on the fund shall accrue to the fund and shall be available subject to the same terms and conditions as other monies in the fund.

d. The fund shall be administered by the Department of Banking and Insurance in accordance with the provisions of P.L.2004, c.17 (C.2A:53A-37 et al.).

e. The monies in the fund are specifically dedicated and shall be utilized exclusively for the following purposes:

(1) $17 million shall be allocated annually for the purpose of providing relief towards the payment of medical malpractice liability insurance premiums to health care providers in the State who have experienced or are experiencing a liability insurance premium increase in an amount as established by the commissioner by regulation and meet the criteria established pursuant to section 28 of P.L.2004, c.17 (C.17:30D-30);

(2) $6.9 million shall be allocated annually to the Health Care Subsidy Fund established pursuant to section 8 of P.L.1992, c.160 (C.26:2H-18.58) for the purpose of providing payments to hospitals in accordance with the formula used for the distribution of charity care subsidies that are provided pursuant to P.L.1992, c.160 (C.26:2H-18.51 et al.);

(3) $1 million shall be allocated annually for a student loan expense reimbursement program for obstetrician/gynecologists, to be established pursuant to section 29 of P.L.2004, c.17 (C.18A:71C-49); and

(4) $1.2 million shall be allocated annually to the Division of Medical Assistance and Health Services in the Department of Human Services for the purposes provided in section 30 of P.L.2004, c.17 (C.30:4J-7).

f. The fund and the annual surcharge, charges, and fee provided for in subsection b. of this section shall expire three years after the effective date of P.L.2004, c.17 (C.2A:53A-37 et al.).

g. The commissioner, in consultation with the Commissioner of Health, shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), to carry out the purposes of sections 26 through 29 of P.L.2004, c.17 (C.17:30D-28 through C.17:30D-30 and C.18A:71C-49); except that, notwithstanding any provision of P.L.1968, c.410 to the contrary, the commissioner may adopt, immediately upon filing with the Office of Administrative Law, such regulations as the commissioner deems necessary to implement the provisions of sections 26 through 29 of P.L.2004, c.17 (C.17:30D-28 through C.17:30D-30 and C.18A:71C-49), which shall be effective for a period not to exceed six months and may thereafter be amended, adopted, or readopted by the commissioner in accordance with the requirements of P.L.1968, c.410.

33. Section 28 of P.L.2004, c.17 (C.17:30D-30) is amended to read as follows:

C.17:30D-30 Responsibilities of commissioner.

28. a. In order to carry out the purposes of section 27 of P.L.2004, c.17 (C.17:30D-29), the commissioner shall, at a minimum:

(1) establish a program to provide medical malpractice liability insurance premium subsidies to health care providers from monies that are contained in the fund;

(2) establish a methodology and procedures for determining eligibility for, and providing subsidies from, the fund;

(3) maintain confidential records on each health care provider who receives assistance from the fund;

(4) take all necessary action to recover the cost of the subsidy provided to a health care provider that the commissioner determines to have been incorrectly provided; and

(5) provide for subsidies to all practitioners who are members of specialties and subspecialties who qualify for relief under subsection b. of this section, including those whose professional liability insurance protection is provided by hospital funding supplemented by purchased commercial insurance coverage.

b. The commissioner shall certify classes of practitioners by specialty and subspecialty for each type of practitioner, whose average medical malpractice premium, as a class, on or after December 31, 2002, is in excess of an amount per year as determined by the commissioner by regulation. In certifying classes eligible for the subsidy, the commissioner, in consultation with the Commissioner of Health, may also consider if access to care is threatened by the inability of a significant number of practitioners, as applicable, in a particular specialty or subspecialty, to continue practicing in a geographic area of the State.

(1) In order to be eligible for a subsidy from the fund, a practitioner shall have received a medical malpractice liability insurance premium increase in an amount as determined by the commissioner by regulation, for one or more of the following: upon renewal on or after January 1, 2004, from the amount paid by that practitioner in calendar year 2003; upon renewal on or after January 1, 2005, from the amount paid by that practitioner in calendar year 2004; and upon renewal on or after January 1, 2006, from the amount paid by that practitioner in calendar year 2005; or

(2) In the case of a health care provider providing professional liability insurance protection through self-insured hospital funding supplemented with purchased commercial insurance coverage, in order to be eligible for a subsidy from the fund, that provider shall

have increased its total professional liability funding obligation in an amount as determined by the commissioner by regulation, for one or more of the following: upon renewal on or after January 1, 2004, from the professional liability funding obligation paid by that provider in calendar year 2003; upon renewal on or after January 1, 2005, from the professional liability funding obligation paid by that provider in calendar year 2004; and upon renewal on or after January 1, 2006, from the professional liability funding obligation paid by that provider in calendar year 2005.

(3) The amount of the subsidy shall be an amount, as determined by the commissioner by regulation, of the increase from the preceding year's premium or self-insured professional liability funding obligation; except that no health care provider shall receive a subsidy in any year that is greater than an amount as determined by the commissioner by regulation.

c. A practitioner who has been subject to a disciplinary action or civil penalty by the practitioner's respective licensing board pursuant to section 8, 9 or 12 of P.L.1978, c.73 (C.45:1-21, 22 or 25), when that action or penalty relates to the practitioner's provision of, or failure to provide, treatment or care to a patient, is not eligible for a subsidy from the fund.

d. (1) A practitioner who receives a subsidy from the fund shall be required to practice in that practitioner's specialty or subspecialty in this State for a period of at least two years after receipt of the subsidy.

(2) A practitioner who fails to comply with the provisions of paragraph (1) of this subsection shall be required to repay to the commissioner the amount of the subsidy, in whole or in part as determined by the commissioner.

e. The commissioner may waive the criteria for eligibility for a subsidy established pursuant to this section, if the commissioner determines that access to care for a particular specialty is threatened because of an inability of a sufficient number of practitioners in that specialty or subspecialty to practice in a geographic area of the State.

f. The State Board of Medical Examiners, the State Board of Chiropractic Examiners, the New Jersey State Board of Dentistry, and the New Jersey Board of Nursing shall each provide to the commissioner, on a quarterly basis, the names of the practitioners who have been subject to a disciplinary action or civil penalty by the practitioner's respective licensing board.

g. For the purposes of section 29 of P.L.2004, c.17 (C.18A:71C-49), the commissioner, in consultation with the State Board of Medical Examiners, shall provide to the Higher Education Student Assistance Authority the names of obstetrician/gynecologists licensed by the board who may qualify for the student loan reimbursement program established pursuant to P.L.2004, c.17. A physician who has been subject to a disciplinary action or civil penalty by the board, as provided in subsection c. of this section, shall not be eligible for the program.

34. Section 34 of P.L.1998, c.21 (C.17:33A-18) is amended to read as follows:

C.17:33A-18 Establishment of liaison between office, other departments; responsibilities.

34. a. A section of the Office of Insurance Fraud Prosecutor shall be designated to be responsible for establishing a liaison and continuing communication between the office and the Department of Health, the Department of Human Services, the Department of Labor and Workforce Development, any professional board in the Division of Consumer Affairs in the Department of Law and Public Safety, the Department of Banking and Insurance, the Division of State Police, every county prosecutor's office, local government units as may be necessary or practicable, and insurers.

b. The section of the office responsible for such liaison shall establish procedures: (1) for receiving notice from all entities enumerated in subsection a. of this section of any case in which fraud is suspected or has been substantiated; (2) for receiving referrals for the investigation of alleged fraud; (3) for receiving referrals for the prosecution of fraud by the office; (4) for receiving and referring information regarding cases, administrative or otherwise, under investigation by any department or other entity to the appropriate authority; and (5) for providing information to and coordinating information among any referring entities on pending cases of insurance fraud which are under investigation or being litigated or prosecuted. The liaison section of the office shall maintain a record of every referral or investigation.

35. Section 2 of P.L.1995, c.316 (C.17:48-6m) is amended to read as follows:

C.17:48-6m Hospital service corporation contracts, child screening, blood lead, hearing loss; immunizations.

2. No hospital service corporation contract providing hospital or medical expense benefits for groups with greater than 50 persons shall be delivered, issued, executed, or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), unless the contract provides benefits to any named subscriber or other person covered thereunder for expenses incurred in the following:

a. Screening by blood lead measurement for lead poisoning for children, including confirmatory blood lead testing as specified by the Department of Health pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any necessary medical follow-up and treatment for lead poisoned children.

b. All childhood immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Service and the Department of Health pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A hospital service corporation shall notify its subscribers, in writing, of any change in coverage with respect to childhood immunizations and any related changes in premium. Such notification shall be in a form and manner to be determined by the Commissioner of Banking and Insurance.

c. Screening for newborn hearing loss by appropriate electrophysiologic screening measures and periodic monitoring of infants for delayed onset hearing loss, pursuant to P.L.2001, c.373 (C.26:2-103.1 et al.). Payment for this screening service shall be separate and distinct from payment for routine new baby care in the form of a newborn hearing screening fee as negotiated with the provider and facility.

The benefits provided pursuant to this section shall be provided to the same extent as for any other medical condition under the contract, except that a deductible shall not be applied for benefits provided pursuant to this section; however, with respect to a contract that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied for any benefits provided pursuant to this section which represent preventive care as permitted by that federal law, and shall not be applied as provided pursuant to section 6 of P.L.2005, c.248 (C.17:48-6dd). This section shall apply to all hospital service corporation contracts in which the health service corporation has reserved the right to change the premium.

36. Section 11 of P.L.1979, c.478 (C.17:48D-11) is amended to read as follows:

C.17:48D-11 Books, records; examination, inspection by commissioner.

11. a. The commissioner or the commissioner's designee may, as often as the commissioner may reasonably determine, investigate the business and examine the books, accounts, records, and files of every dental plan organization. For that purpose the commissioner or the commissioner's designee shall have reasonably free access to the offices and places of business, books, accounts, papers, records, and files of all dental plan organizations. A dental plan organization shall keep and use in its business such books, accounts, and records as will enable the commissioner to determine whether the dental plan organization is complying with the provisions of this act and with the rules and regulations promulgated pursuant to it. A dental plan organization shall preserve its books, accounts, and records for at least 7 years; except that preservation by photographic reproduction or records in photographic form shall constitute compliance with this act.

b. For the purpose of the examination, the commissioner may, within the limits of funds appropriated for such purpose, contract with such persons as the commissioner may deem advisable to conduct the same or assist therein.

c. At the discretion of the commissioner, the Commissioner of Health and the New Jersey State Board of Dentistry may participate in the investigations and examinations described in this section to verify the existence of an effective dental plan.

d. The expenses incurred in making any examination pursuant to this section shall be assessed against and paid by the dental plan organization so examined. A dental plan organization having direct premiums written in this State of less than $2,000,000 in any calendar year shall be subject to a limited scope examination with expenses for that examination not to exceed $5,000. Upon written notice by the commissioner of the total amount of an assessment, a dental plan organization shall become liable for and shall pay the assessment to the commissioner.

37. Section 1 of P.L.1985, c.236 (C.17:48E-1) is amended to read as follows:

C.17:48E-1 Definitions.

1. As used in this act:

a. "Commissioner" means the Commissioner of Banking and Insurance.

b. "Board" and "board of directors" means the board of directors of the health service corporation.

c. "Elective surgical procedure" means any nonemergency surgical procedure which may be scheduled at the convenience of the patient or the surgeon without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions.

d. "Eligible physician" means a physician licensed to practice medicine and surgery who holds the rank of Diplomate of an American Board (M.D.) or Certified Specialist (D.O.) in the surgical or medical specialty for which surgery is proposed.

e. "Health service corporation" means a health service corporation established pursuant to the provisions of this act, which is organized, without capital stock and not for profit, for the purpose of (1) establishing, maintaining, and operating a nonprofit health service plan and (2) supplying services in connection with (a) the providing of health care or (b) conducting the business of insurance as provided for in this act.

f. "Health service plan" means a plan under which contracts are issued providing complete or partial prepayment or postpayment of health care services and supplies eligible under the contracts for a given period to persons covered under the contracts where

arrangements are made for payment for health care services and supplies directly to the provider thereof or to a covered person under those contracts.

g. "Hospital service corporation" means a hospital service corporation established pursuant to the provisions of P.L.1938, c.366 (C.17:48-1 et seq.).

h. "Medical service corporation" means a medical service corporation established pursuant to the provisions of P.L.1940, c.74 (C.17:48A-1 et seq.).

i. "Provider of health care services" shall include, but not be limited to: (1) a health service corporation, a hospital service corporation or medical service corporation; (2) a hospital or health care facility under contract with a health service corporation to provide health care services or supplies to persons who become subscribers under contracts with the health service corporation; (3) a hospital or health care facility which is maintained by a state or any of its political subdivisions; (4) a hospital or health care facility licensed by the Department of Health; (5) other hospitals or health care facilities, as designated by the Department of Health to provide health care services; (6) a registered nursing home providing convalescent care; (7) a nonprofit voluntary visiting nurse organization providing health care services other than in a hospital; (8) hospitals or other health care facilities located in other states, which are subject to the supervision of those states, which if located in this State would be eligible to be licensed or designated by the Department of Health; (9) nonprofit hospital, medical or health service plans of other states approved by the commissioner; (10) physicians licensed to practice medicine and surgery; (11) licensed chiropractors; (12) licensed dentists; (13) licensed optometrists; (14) licensed pharmacists; (15) licensed podiatrists; (16) registered bio-analytical laboratories; (17) licensed psychologists; (18) registered physical therapists; (19) certified nurse-midwives; (20) registered professional nurses; (21) licensed health maintenance organizations; (22) licensed audiologists; (23) licensed speech-language pathologists; and (24) providers of other similar health care services or supplies as are approved by the commissioner.

j. "Second surgical opinion" means an opinion of an eligible physician based on that physician's examination of a person for the purpose of evaluating the medical advisability of that person undergoing an elective surgical procedure, but prior to the performance of the surgical procedure.

k. "Subscriber" means a person to whom a subscription certificate is issued by a health service corporation, and the term shall also include "policyholder," "member," or "employer" under a group contract where the context requires.

38. Section 1 of P.L.1995, c.316 (C.17:48E-35.10) is amended to read as follows:

C.17:48E-35.10 Health service corporation contracts, child screening, blood lead, hearing loss; immunizations.

1. No health service corporation contract providing hospital or medical expense benefits for groups with greater than 50 persons shall be delivered, issued, executed, or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), unless the contract provides benefits to any named subscriber or other person covered thereunder for expenses incurred in the following:

a. Screening by blood lead measurement for lead poisoning for children, including confirmatory blood lead testing as specified by the Department of Health pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any necessary medical follow-up and treatment for lead poisoned children.

b. All childhood immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Service and the Department of Health pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A health service corporation shall notify its subscribers, in writing, of any change in coverage with respect to childhood immunizations and any related changes in premium. The notification shall be in a form and manner to be determined by the Commissioner of Banking and Insurance.

c. Screening for newborn hearing loss by appropriate electrophysiologic screening measures and periodic monitoring of infants for delayed onset hearing loss, pursuant to P.L.2001, c.373 (C.26:2-103.1 et al.). Payment for this screening service shall be separate and distinct from payment for routine new baby care in the form of a newborn hearing screening fee as negotiated with the provider and facility.

The benefits provided pursuant to this section shall be provided to the same extent as for any other medical condition under the contract, except that a deductible shall not be applied for benefits provided pursuant to this section; however, with respect to a contract that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied for any benefits provided pursuant to this section which represent preventive care as permitted by that federal law, and shall not be applied as provided pursuant to section 3 of P.L.2005, c.248 (C.17:48E-35.28). This section shall apply to all health service corporation contracts in which the health service corporation has reserved the right to change the premium.

39. Section 3 of P.L.1999, c.409 (C.17:48H-3) is amended to read as follows:

C.17:48H-3 Application for certification.

3. a. An organized delivery system which is not subject to licensure requirements pursuant to this act shall submit an application for certification to the Commissioner of Banking and Insurance. The organized delivery system may continue to operate during the pendency of its application, but in no case longer than 12 months after the date of submission of the application to the Department of Banking and Insurance, unless the commissioner, by regulation, extends the 12-month limitation. In the event the application is denied, the applicant shall be treated as an organized delivery system whose certification has been revoked pursuant to sections 7 and 8 of this act.

Notwithstanding the obligations imposed by this act regarding certification requirements, nothing in this subsection shall operate to impair any contract in force on the effective date of this act, but this act shall apply to any contract renewed on or after the effective date of this act.

b. The certification shall be valid for a period of three years.

c. A certified organized delivery system shall not directly issue health benefits plans.

40. Section 4 of P.L.1999, c.409 (C.17:48H-4) is amended to read as follows:

C.17:48H-4 Form, contents of application.

4. Application for certification to operate an organized delivery system shall be made to the Commissioner of Banking and Insurance on a form prescribed by the commissioner, shall be certified by an officer or authorized representative of the applicant and shall include the following:

a. A copy of the applicant's basic organizational documents. For purposes of this subsection, "basic organizational documents" means the articles of incorporation, articles of association, partnership agreement, management agreement, trust agreement, or other applicable documents as appropriate to the applicant's form of business entity, and all amendments to those documents;

b. A copy of the executed bylaws, rules, and regulations, or similar documents, regulating the conduct of the applicant's internal affairs;

c. A list, in a form approved by the Commissioner of Banking and Insurance, of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including, but not limited to, the members of the board of directors, executive committee, or other governing board or committee, the principal officers, and any person or entity owning or having the right to acquire 10% or more of the voting securities of the applicant; in the case of a partnership or association, the names of the partners or members; and a statement of any criminal convictions or civil, enforcement, or regulatory action, including actions relating to professional licenses, taken against any person who is a member of the board, the executive committee, or other governing board or committee, the principal officers, or the persons who are responsible for the conduct of the affairs of the applicant;

d. A statement generally describing the applicant, its facilities, personnel, and the health care services to be offered by the organized delivery system;

e. A copy of the standard form of any provider agreement made or to be made between the applicant and any providers relative to the provision of health care services;

f. A copy of the form of any contract made or to be made between the applicant and any carrier for the provision of or arrangement to provide health care services, which contract shall contain provisions establishing the respective duties of the carrier and the applicant with respect to compliance with P.L.1997, c.192 (C.26:2S-1 et seq.);

g. With respect to each contract made or to be made between the applicant and any other person who will provide comprehensive or limited health care services:

(1) A list of the persons who are to provide the health care services, and the geographical area in which they are located and in which the services are to be performed;

(2) A list of any affiliate of the applicant which provides services to the applicant in this State and a description of any material transaction between the affiliate and the applicant;

(3) A description of the health care services or benefits to be offered or proposed to be offered by the applicant;

(4) A description of the means which will be utilized to assure the availability and accessibility of the health care services to enrollees or contract holders; and

(5) A description of the means by which the organized delivery system shall be compensated for each contract entered into with a carrier; and

h. A list of all administrative, civil, or criminal actions and proceedings to which the applicant, or any of its affiliates, or persons who are responsible for the conduct of the affairs of the applicant or affiliate, have been subject and the resolution of those actions and proceedings. If a license, certificate, or other authority to operate has been refused, suspended, or revoked by any jurisdiction, the applicant shall provide a copy of any orders, proceedings, and determinations relating thereto.

In addition to the information required pursuant to this section, the Commissioner of Banking and Insurance may establish additional reporting requirements or make detailed reporting requirements for any class of certified organized delivery system.

41. Section 5 of P.L.1999, c.409 (C.17:48H-5) is amended to read as follows:

C.17:48H-5 Review of application.

5. Following receipt of an application for certification, the Commissioner of Banking and Insurance shall review it and notify the applicant of any deficiencies contained therein.

a. The Commissioner of Banking and Insurance shall issue a certification to an organized delivery system if the commissioner finds that the system meets the standards provided for in this act, including, but not limited to:

(1) All of the material required by section 4 of this act has been filed;

(2) The persons responsible for conducting the applicant's affairs are competent, trustworthy, and possess good reputations, and have had appropriate experience, training, and education;

(3) The persons who are to perform the health care services are properly qualified;

(4) The organized delivery system has demonstrated the ability to assure that health care services will be provided in a manner which will assure the availability and accessibility of the services;

(5) The standard forms of provider agreements to be used by the organized delivery system are acceptable; and

(6) The organized delivery system's contracts to provide services do not entail or will not result in the assumption of financial risk by the system.

b. The commissioner may deny an application for certification if the applicant fails to meet any of the standards provided in this act or on any other reasonable grounds. If certification is denied, the commissioner shall notify the applicant and shall set forth the reasons for the denial in writing. The applicant may request a hearing by notice to the commissioner within 30 days of receiving the notice of denial. Upon such denial, the applicant shall submit to the commissioner a plan for bringing the organized delivery system into compliance or providing for the closing down of its business.

42. Section 6 of P.L.1999, c.409 (C.17:48H-6) is amended to read as follows:

C.17:48H-6 Notice of change, modification.

6. a. A certified organized delivery system, unless otherwise provided for in this act, shall not materially modify any matter or document furnished to the Commissioner of Banking and Insurance pursuant to section 4 of this act unless the organized delivery system files with the commissioner, at least 60 days prior to use or adoption of the change, a notice of the change or modification, together with that information required by the commissioner to explain the change or modification. If the commissioner fails to affirmatively approve or disapprove the change or modification within 60 days of submission of the notice, the notice of modification shall be deemed approved. The commissioner may extend the 60-day review period for not more than 30 additional days by giving written notice of the extension before the expiration of the 60-day period. If a change or modification is disapproved, the commissioner shall notify the system in writing and specify the reason for the disapproval.

b. Prior to entering into any contract with a carrier, a certified organized delivery system shall file with the commissioner, for the commissioner's approval, a copy of that contract. The filing shall be made no later than 60 days prior to the date that the contract is intended to be in effect. If the contract is not disapproved prior to the effective date by the commissioner, the contract shall be deemed approved.

43. Section 7 of P.L.1999, c.409 (C.17:48H-7) is amended to read as follows:

C.17:48H-7 Suspension, revocation of certification, grounds.

7. The Commissioner of Banking and Insurance may suspend or revoke a certification issued to an organized delivery system pursuant to this act upon the commissioner's determination that:

a. The certified organized delivery system is operating in contravention of its basic organizational documents;

b. The certified organized delivery system is unable to fulfill its obligations to the carriers with whom it contracts;

c. The continued operation of the certified organized delivery system would be hazardous to the health and welfare of the enrollees or contract holders to whom it is obligated to provide health care services or detrimental to a carrier with whom it has contracted to provide the services;

d. The certified organized delivery system is unable to maintain the standards as set forth by the commissioner by regulation;

e. The certified organized delivery system has failed, as provided by the contract, to comply with the provisions of P.L.1997, c.192 (C.26:2S-1 et seq.);

f. The certified organized delivery system has failed to provide the health care services for which it has been certified or has provided health care services which are in contravention of the contract or contracts filed with the commissioner;

g. The certified organized delivery system has otherwise failed to comply with this act or with other applicable law; or

h. There are other reasonable grounds that warrant suspension or revocation.

44. Section 8 of P.L.1999, c.409 (C.17:48H-8) is amended to read as follows:

C.17:48H-8 Notification of grounds for suspension, revocation of certification.

8. a. If the Commissioner of Banking and Insurance has cause to believe that grounds exist for the suspension or revocation of the certification issued to an organized delivery system, the commissioner shall notify the system, in writing, specifically stating the grounds for suspension or revocation and fixing a time for a hearing in accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). If the certification is revoked, the organized delivery system shall submit a plan to the commissioner within 15 days of the revocation, for the winding up of its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of its business. The commissioner may, by written order, permit such further operation of the organized delivery system as the commissioner finds to be in the best interest of individuals receiving health care services from the system.

b. The commissioner shall notify all carriers with contracts with the system that are on file with the Department of Banking and Insurance of the proceedings.

45. Section 9 of P.L.1999, c.409 (C.17:48H-9) is amended to read as follows:

C.17:48H-9 Fees.

9. A certified organized delivery system shall pay to the Commissioner of Banking and Insurance those application and examination fees as are established by the commissioner by regulation.

46. Section 10 of P.L.1999, c.409 (C.17:48H-10) is amended to read as follows:

C.17:48H-10 Civil administrative penalty.

10. The Commissioner of Banking and Insurance may, upon notice and hearing, assess a civil administrative penalty in an amount not less than $250 nor more than $10,000 for each day that a certified organized delivery system is in violation of this act. Penalties imposed by the commissioner pursuant to this section may be in lieu of, or in addition to, suspension or revocation of a certification pursuant to this act. A penalty may be recovered in a summary proceeding pursuant to "The Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

47. Section 11 of P.L.1999, c.409 (C.17:48H-11) is amended to read as follows:

C.17:48H-11 Application for licensure.

11. a. An organized delivery system which receives compensation on a basis that entails the assumption of financial risk shall submit an application for licensure to the Commissioner of Banking and Insurance. The organized delivery system may continue to operate during the pendency of its application, but in no case longer than 12 months after the date of submission of the application to the Department of Banking and Insurance, unless the commissioner, by regulation, extends the 12-month limitation. In the event the application is denied, the applicant shall be treated as an organized delivery system whose license has been revoked pursuant to sections 23 and 24 of this act.

Notwithstanding the obligations imposed by this act regarding licensure requirements, nothing in this subsection shall operate to impair any contract in force on the effective date of this act, but this act shall apply to any contract renewed on or after the effective date of this act.

b. An organized delivery system which receives compensation on a basis that entails the assumption of financial risk, but meets the criteria set forth in this subsection, may apply to the commissioner for an exemption from the licensure requirements of this act based on the system's current contractual arrangements.

The commissioner may grant the exemption for such period of time that the commissioner determines that the financial risk of the organized delivery system is de minimis because the organized delivery system's exposure to financial loss is limited in amount or likelihood to the degree that it reasonably will not prevent the system from satisfying the liabilities imposed under the terms of its contracts.

The commissioner may revoke the organized delivery system's exemption from licensure, after notice and an opportunity to be heard, if the commissioner determines that the system's contracts no longer meet the requirements for exemption set forth in this subsection. Upon revocation of the exemption, the system shall be required to obtain licensure from the department within 90 days.

c. An organized delivery system that is granted an exemption from licensure shall apply to and obtain certification as an organized delivery system from the Department of Banking and Insurance pursuant to the provisions of this act.

d. A licensed organized delivery system shall not directly issue health benefits plans.

48. Section 12 of P.L.1999, c.409 (C.17:48H-12) is amended to read as follows:

C.17:48H-12 Form, contents of application.

12. Application for a license to operate an organized delivery system shall be made to the Commissioner of Banking and Insurance on a form prescribed by the commissioner, shall be certified by an officer or authorized representative of the applicant, and shall include the following:

a. A copy of the applicant's basic organizational documents. For purposes of this subsection, "basic organizational documents" means the articles of incorporation, articles of association, partnership agreement, management agreement, trust agreement, or other applicable documents as appropriate to the applicant's form of business entity and all amendments to those documents;

b. A copy of the executed bylaws, rules, and regulations, or similar documents, regulating the conduct of the applicant's internal affairs;

c. A list, in a form approved by the Commissioner of Banking and Insurance, of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including, but not limited to, the members of the board of directors, executive committee or other governing board or committee, the principal officers, and any person or entity owning or having the right to acquire 10% or more of the voting securities of the applicant; in the case of a partnership or association, the names of the partners or members; each person who has loaned funds to the applicant for the operation of its business; and a statement of any criminal convictions or civil, enforcement or regulatory action, including actions relating to professional licenses, taken against any person who is a member of the board, the executive committee or other governing board or committee, or the principal officers, or the persons who are responsible for the conduct of the affairs of the applicant;

d. A statement generally describing the applicant, its facilities, personnel, and the health care services to be offered by the organized delivery system;

e. A copy of the standard form of any provider agreement made or to be made between the applicant and any providers relative to the provision of health care services;

f. A copy of the form of any contract made or to be made between the applicant and any carrier for the provision of or arrangement to provide health care services, which contract shall contain provisions establishing the respective duties of the carrier and the applicant with respect to compliance with P.L.1997, c.192 (C.26:2S-1 et seq.);

g. A copy of the applicant's most recent financial statements audited by an independent certified public accountant. If the financial affairs of the applicant's parent company are audited by an independent certified public accountant, but those of the applicant are not, then a copy of the most recent audited financial statement of the applicant's parent company, audited by an independent certified public accountant, shall be submitted. A consolidated financial statement of the applicant and its parent company shall satisfy this requirement unless the Commissioner of Banking and Insurance determines that additional or more recent financial information is required for the proper administration of this act;

h. A copy of the applicant's financial plan, including a three-year projection of anticipated operating results, a statement of the sources of working capital and any other sources of funding and provisions for contingencies;

i. With respect to each contract made or to be made between the applicant and any other person who will provide comprehensive or limited health care services:

(1) A list of the persons who are to provide the health care services, and the geographical area in which they are located and in which the services are to be performed;

(2) A list of any affiliate of the applicant which provides services to the applicant in this State and a description of any material transaction between the affiliate and the applicant;

(3) A description of the health care services or benefits to be offered or proposed to be offered;

(4) A description of the means which will be utilized to assure the availability and accessibility of the health care services to enrollees or contract holders;

(5) A plan, in the event of the insolvency of the organized delivery system, for continuation of the health care services to be provided for under the contract; and

(6) A description of the means by which the organized delivery system shall be compensated for each contract entered into with a carrier;

j. A power of attorney, duly executed by the applicant, if not domiciled in this State, appointing the Commissioner of Banking and Insurance and the commissioner's successors in office as the true and lawful attorney of the applicant in and for this State upon whom all lawful process in any legal action or proceeding against the organized delivery system in a cause of action arising in this State may be served;

k. A list of all administrative, civil, or criminal actions and proceedings to which the applicant, or any of its affiliates, or persons who are responsible for the conduct of the affairs of the applicant or affiliate, have been subject and the resolution of those actions and proceedings. If a license, certificate or other authority to operate has been refused, suspended, or revoked by any jurisdiction, the applicant shall provide a copy of any orders, proceedings and determinations relating thereto; and

l. Other information as may be required by the Commissioner of Banking and Insurance.

49. Section 13 of P.L.1999, c.409 (C.17:48H-13) is amended to read as follows:

C.17:48H-13 Review of application.

13. Following receipt of an application for licensure, the Commissioner of Banking and Insurance shall review it and notify the applicant of any deficiencies contained therein.

a. The Commissioner of Banking and Insurance shall issue a license to an organized delivery system if the commissioner finds that the system meets the standards provided for in this act, including, but not limited to:

(1) All of the material required by section 12 of this act has been filed;

(2) The persons responsible for conducting the applicant's affairs are competent, trustworthy, and possess good reputations, and have had appropriate experience, training, and education;

(3) The persons who are to perform the health care services are properly qualified;

(4) The organized delivery system has demonstrated the ability to assure that health care services will be provided in a manner which will assure the availability and accessibility of the services;

(5) The standard forms of provider agreements to be used by the organized delivery system are acceptable;

(6) The applicant is financially sound and may reasonably be expected to meet its obligations to enrollees, contract holders and carriers. In making this determination, the commissioner shall consider:

(a) The financial soundness of the applicant's compensation arrangements for the provision of health care services;

(b) The adequacy of working capital, other sources of funding and provisions for contingencies; and

(c) Whether any deposit of cash or securities, or any other evidence of financial protection submitted, meets the requirements set forth in this act or by the commissioner by regulation;

(7) Any deficiencies identified by the commissioner have been corrected; and

(8) Any other factors determined by the commissioner to be relevant have been addressed to the satisfaction of the commissioner.

b. (Deleted by amendment, P.L.2012, c.17).

c. The Commissioner of Banking and Insurance, may deny an application for a license if the applicant fails to meet any of the standards provided in this act or on any other reasonable grounds. If the license is denied, the Commissioner of Banking and Insurance shall notify the applicant and shall set forth the reasons for the denial in writing. The applicant may request a hearing by notice to the commissioner within 30 days of receiving the notice of denial. Upon such denial, the applicant shall submit to the commissioner a plan for bringing the organized delivery system into compliance or providing for the closing down of its business.

50. Section 15 of P.L.1999, c.409 (C.17:48H-15) is amended to read as follows:

C.17:48H-15 Services provided by licensed organized delivery system.

15. A licensed organized delivery system may:

a. Contract with an insurer licensed in this State for the provision of indemnity coverage against the cost of services provided by the system or other obligations of the system, either on an individual or aggregate attachment basis; and

b. In addition to comprehensive or limited services, as applicable, provided by the system for enrollees or contract holders, provide:

(1) Additional services as approved by the Commissioner of Banking and Insurance;

(2) Indemnity benefits covering urgent care or emergency services;

(3) Coverage for services from providers, other than participating providers, in accordance with the terms of the contract; and

(4) Any other function provided by law, in the system's organizational documents or in the license.

51. Section 31 of P.L.1999, c.409 (C.17:48H-31) is amended to read as follows:

C.17:48H-31 Notification of change of means for receipt of compensation.

31. Any certified organized delivery system which intends to change the means by which it receives compensation so that it will be compensated on a basis that entails the assumption of financial risk shall make application for licensure to the Commissioner of Banking and Insurance pursuant to this act.

52. Section 32 of P.L.1999, c.409 (C.17:48H-32) is amended to read as follows:

C.17:48H-32 Rules, regulations.

32. The Commissioner of Banking and Insurance shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), to effectuate the purposes of this act.

The commissioner shall adopt the rules and regulations within 180 days of the date of enactment of this act.

53. Section 33 of P.L.1999, c.409 (C.17:48H-33) is amended to read as follows:

C.17:48H-33 Applicability of health care quality act.

33. An organized delivery system which is licensed by the Department of Banking and Insurance shall be subject to the "Health Care Quality Act," P.L.1997, c.192 (C.26:2S-1 et seq.) and the regulations promulgated thereunder.

54. Section 35 of P.L.1999, c.409 (C.17:48H-35) is amended to read as follows:

C.17:48H-35 Documents deemed proprietary, confidential.

35. Any documents provided by a organized delivery system to the Department of Banking and Insurance pursuant to this act that are deemed by the Commissioner of Banking and Insurance to be proprietary, shall be confidential and shall not be considered public documents pursuant to P.L.1963, c.73 (C.47:1A-2).

55. Section 3 of P.L.1995, c.316 (C.17B:27-46.1l) is amended to read as follows:

C.17B:27-46.11 Group health insurance policy, child screening, blood lead, hearing loss; immunizations.

3. No group health insurance policy providing hospital or medical expense benefits for groups with more than 50 persons shall be delivered, issued, executed, or renewed in this State, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), unless the policy provides benefits to any named insured or other person covered thereunder for expenses incurred in the following:

a. Screening by blood lead measurement for lead poisoning for children, including confirmatory blood lead testing as specified by the Department of Health pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any necessary medical follow-up and treatment for lead poisoned children.

b. All childhood immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Service and the Department of Health pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A health insurer shall notify its policyholders, in writing, of any change in coverage with respect to childhood immunizations and any related changes in premium. Such notification shall be in a form and manner to be determined by the Commissioner of Banking and Insurance.

c. Screening for newborn hearing loss by appropriate electrophysiologic screening measures and periodic monitoring of infants for delayed onset hearing loss, pursuant to P.L.2001, c.373 (C.26:2-103.1 et al.). Payment for this screening service shall be separate and distinct from payment for routine new baby care in the form of a newborn hearing screening fee as negotiated with the provider and facility.

The benefits provided pursuant to this section shall be provided to the same extent as for any other medical condition under the policy, except that a deductible shall not be applied for benefits provided pursuant to this section; however, with respect to a policy that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of

1986 (26 U.S.C. s.223), a deductible shall not be applied for any benefits provided pursuant to this section that represent preventive care as permitted by that federal law, and shall not be applied as provided pursuant to section 9 of P.L.2005, c.248 (C.17B:27-46.1dd). This section shall apply to all group health insurance policies in which the health insurer has reserved the right to change the premium.

56. Section 4 of P.L.2001, c.368 (C.17B:27A-4.7) is amended to read as follows:

C.17B:27A-4.7 Carrier offering plans pursuant to C.17B:27A-2 et seq. may offer additional plan with certain limited benefits.

4. In addition to the health benefits plans offered by a carrier on the effective date of this act, a carrier that writes individual health benefits plans pursuant to P.L.1992, c.161 (C.17B:27A-2 et al.) may also offer one or more of the plans through the carrier's network of providers, with no reimbursement for any out-of-network benefits other than emergency care, urgent care, and continuity of care. A carrier's network of providers shall be subject to review and approval or disapproval by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health, pursuant to regulations promulgated by the Department of Banking and Insurance, including review and approval or disapproval before plans with benefits provided through a carrier's network of providers pursuant to this section may be offered by the carrier. Policies or contracts written on this basis shall be rated in a separate rating pool for the purposes of establishing a premium, but for the purpose of determining a carrier's losses, these policies or contracts shall be aggregated with the losses on the carrier's other business written pursuant to the provisions of P.L.1992, c.161 (C.17B:27A-2 et al.).

57. Section 6 of P.L.1992, c.161 (C.17B:27A-7) is amended to read as follows:

C.17B:27A-7 Establishment of policy; contract forms; high deductible health plan; benefit levels.

6. The commissioner shall approve the policy and contract forms and benefit levels to be made available by all carriers for the health benefits plans required to be issued pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4), and shall adopt such modifications to one or more plans as the board determines are necessary to make available a "high deductible health plan" or plans consistent with section 301 of Title III of the "Health Insurance Portability and Accountability Act of 1996," Pub.L.104-191 (26 U.S.C. s.220), regarding tax-deductible medical savings accounts, within 60 days after the enactment of P.L.1997, c.414 (C.54A:3-4 et al.). The commissioner shall provide the board with an informational filing of the policy and contract forms and benefit levels it approves.

a. The individual health benefits plans established by the board may include cost containment measures such as, but not limited to: utilization review of health care services, including review of medical necessity of hospital and physician services; case management benefit alternatives; selective contracting with hospitals, physicians, and other health care providers; and reasonable benefit differentials applicable to participating and nonparticipating providers; and other managed care provisions.

b. An individual health benefits plan offered pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4) shall contain a limitation of no more than 12 months on coverage for preexisting conditions. An individual health benefits plan offered pursuant to section 3 of

P.L.1992, c.161 (C.17B:27A-4) shall not contain a preexisting condition limitation of any period under the following circumstances:

(1) to an individual who has, under creditable coverage, with no intervening lapse in coverage of more than 31 days, been treated or diagnosed by a physician for a condition under that plan or satisfied a 12-month preexisting condition limitation; or

(2) to a federally defined eligible individual who applies for an individual health benefits plan within 63 days of termination of the prior coverage.

c. In addition to the standard individual health benefits plans provided for in section 3 of P.L.1992, c.161 (C.17B:27A-4), the board may develop up to five rider packages. Premium rates for the rider packages shall be determined in accordance with section 8 of P.L.1992, c.161 (C.17B:27A-9).

d. After the board's establishment of the individual health benefits plans required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4), and notwithstanding any law to the contrary, a carrier shall file the policy or contract forms with the commissioner and certify to the commissioner that the health benefits plans to be used by the carrier are in substantial compliance with the provisions in the corresponding approved plans. The certification shall be signed by the chief executive officer of the carrier. Upon receipt by the commissioner of the certification, the certified plans may be used until the commissioner, after notice and hearing, disapproves their continued use.

e. Effective immediately for an individual health benefits plan issued on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.) and effective on the first 12-month anniversary date of an individual health benefits plan in effect on the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), the individual health benefits plans required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4), including any plan offered by a federally qualified health maintenance organization, shall contain benefits for expenses incurred in the following:

(1) Screening by blood lead measurement for lead poisoning for children, including confirmatory blood lead testing as specified by the Department of Health pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any necessary medical follow-up and treatment for lead poisoned children.

(2) All childhood immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Service and the Department of Health pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A carrier shall notify its insureds, in writing, of any change in the health care services provided with respect to childhood immunizations and any related changes in premium. Such notification shall be in a form and manner to be determined by the Commissioner of Banking and Insurance.

(3) Screening for newborn hearing loss by appropriate electrophysiologic screening measures and periodic monitoring of infants for delayed onset hearing loss, pursuant to P.L.2001, c.373 (C.26:2-103.1 et al.). Payment for this screening service shall be separate and distinct from payment for routine new baby care in the form of a newborn hearing screening fee as negotiated with the provider and facility.

The benefits provided pursuant to this subsection shall be provided to the same extent as for any other medical condition under the health benefits plan, except that a deductible shall not be applied for benefits provided pursuant to this subsection; however, with respect to a health benefits plan that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied for any benefits provided pursuant to this subsection that represent preventive care as

permitted by that federal law, and shall not be applied as provided pursuant to section 14 of P.L.2005, c.248 (C.17B:27A-7.11). This subsection shall apply to all individual health benefits plans in which the carrier has reserved the right to change the premium.

f. Effective immediately for a health benefits plan issued on or after the effective date of P.L.2001, c.361 (C.17:48-6z et al.) and effective on the first 12-month anniversary date of a health benefits plan in effect on the effective date of P.L.2001, c.361 (C.17:48-6z et al.), the health benefits plans required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4) that provide benefits for expenses incurred in the purchase of prescription drugs shall provide benefits for expenses incurred in the purchase of specialized non-standard infant formulas, when the covered infant's physician has diagnosed the infant as having multiple food protein intolerance and has determined such formula to be medically necessary, and when the covered infant has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk. The coverage may be subject to utilization review, including periodic review, of the continued medical necessity of the specialized infant formula.

The benefits shall be provided to the same extent as for any other prescribed items under the health benefits plan.

This subsection shall apply to all individual health benefits plans in which the carrier has reserved the right to change the premium.

g. Effective immediately for an individual health benefits plan issued on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.) and effective on the first 12-month anniversary date of an individual health benefits plan in effect on the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), the health benefits plans required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4) that qualify as high deductible health plans for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), including any plan offered by a federally qualified health maintenance organization, shall contain benefits for expenses incurred in connection with any medically necessary benefits provided in-network which represent preventive care as permitted by that federal law.

The benefits provided pursuant to this subsection shall be provided to the same extent as for any other medical condition under the health benefits plan, except that a deductible shall not be applied for benefits provided pursuant to this subsection. This subsection shall apply to all individual health benefits plans in which the carrier has reserved the right to change the premium.

58. Section 3 of P.L.1992, c.162 (C.17B:27A-19) is amended to read as follows:

C.17B:27A-19 Health benefits plans offered to small employers; exceptions.

3. a. Except as provided in subsection f. of this section, every small employer carrier shall, as a condition of transacting business in this State, offer to every small employer at least three of the health benefit plans established by the board, as provided in this section, and also offer and make a good faith effort to market individual health benefits plans as provided in section 3 of P.L.1992, c.161 (C.17B:27A-4). The board shall establish a standard policy form for each of the plans, which except as otherwise provided in subsection j. of this section, shall be the only plans offered to small groups on or after January 1, 1994. One policy form shall contain the benefits provided for in sections 55, 57, and 59 of P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3). In the case of indemnity carriers, one policy form shall be established which contains benefits and cost sharing levels which are

equivalent to the health benefits plans of health maintenance organizations pursuant to the "Health Maintenance Organization Act of 1973," Pub.L.93-222 (42 U.S.C. s.300e et seq.). The remaining policy forms shall contain basic hospital and medical-surgical benefits, including, but not limited to:

(1) Basic inpatient and outpatient hospital care;

(2) Basic and extended medical-surgical benefits;

(3) Diagnostic tests, including X-rays;

(4) Maternity benefits, including prenatal and postnatal care; and

(5) Preventive medicine, including periodic physical examinations and inoculations.

At least three of the forms shall provide for major medical benefits in varying lifetime aggregates, one of which shall provide at least $1,000,000 in lifetime aggregate benefits. The policy forms provided pursuant to this section shall contain benefits representing progressively greater actuarial values.

Notwithstanding the provisions of this subsection to the contrary, the board also may establish additional policy forms by which a small employer carrier, other than a health maintenance organization, may provide indemnity benefits for health maintenance organization enrollees by direct contract with the enrollees' small employer through a dual arrangement with the health maintenance organization. The dual arrangement shall be filed with the commissioner for approval. The additional policy forms shall be consistent with the general requirements of P.L.1992, c.162 (C.17B:27A-17 et seq.).

b. Initially, a carrier shall offer a plan within 90 days of the approval of such plan by the commissioner. Thereafter, the plans shall be available to all small employers on a continuing basis. Every small employer which elects to be covered under any health benefits plan who pays the premium therefor and who satisfies the participation requirements of the plan shall be issued a policy or contract by the carrier.

c. The carrier may establish a premium payment plan which provides installment payments and which may contain reasonable provisions to ensure payment security, provided that provisions to ensure payment security are uniformly applied.

d. In addition to the standard policies described in subsection a. of this section, the board may develop up to five rider packages. Any such package which a carrier chooses to offer shall be issued to a small employer who pays the premium therefor, and shall be subject to the rating methodology set forth in section 9 of P.L.1992, c.162 (C.17B:27A-25).

e. (Deleted by amendment, P.L.2008, c.38).

f. Notwithstanding the provisions of this section to the contrary, a health maintenance organization which is a qualified health maintenance organization pursuant to the "Health Maintenance Organization Act of 1973," Pub.L.93-222 (42 U.S.C. s.300e et seq.) shall be permitted to offer health benefits plans formulated by the board and approved by the commissioner which are in accordance with the provisions of that law in lieu of the plans required pursuant to this section.

Notwithstanding the provisions of this section to the contrary, a health maintenance organization which is approved pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.) shall be permitted to offer health benefits plans formulated by the board and approved by the commissioner which are in accordance with the provisions of that law in lieu of the plans required pursuant to this section, except that the plans shall provide the same level of benefits as required for a federally qualified health maintenance organization, including any requirements concerning copayments by enrollees.

g. A carrier shall not be required to own or control a health maintenance organization or otherwise affiliate with a health maintenance organization in order to comply with the

provisions of this section, but the carrier shall be required to offer at least three of the health benefits plans which are formulated by the board and approved by the commissioner, including one plan which contains benefits and cost sharing levels that are equivalent to those required for health maintenance organizations.

h. Notwithstanding the provisions of subsection a. of this section to the contrary, the board may modify the benefits provided for in sections 55, 57 and 59 of P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3).

i. (1) In addition to the rider packages provided for in subsection d. of this section, every carrier may offer, in connection with the health benefits plans required to be offered by this section, any number of riders which may revise the coverage offered by the plans in any way, provided, however, that any form of such rider or amendment thereof which decreases benefits or decreases the actuarial value of a plan shall be filed for informational purposes with the board and for approval by the commissioner before such rider may be sold. Any rider or amendment thereof which adds benefits or increases the actuarial value of a plan shall be filed with the board for informational purposes before such rider may be sold. The added premium or reduction in premium for each rider, as applicable, shall be listed separately from the premium for the standard plan.

The commissioner shall disapprove any rider filed pursuant to this subsection that is unjust, unfair, inequitable, unreasonably discriminatory, misleading, contrary to law or the public policy of this State. The commissioner shall not approve any rider which reduces benefits below those required by sections 55, 57 and 59 of P.L.1991, c.187 (C.17:48E-22.2, 17B:26B-2 and 26:2J-4.3) and required to be sold pursuant to this section. The commissioner's determination shall be in writing and shall be appealable.

(2) The benefit riders provided for in paragraph (1) of this subsection shall be subject to the provisions of section 2, subsection b. of section 3, and sections 6, 7, 8, 9 and 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19, 17B:27A-22, 17B:27A-23, 17B:27A-24, 17B:27A-25, and 17B:27A-27).

j. (1) Notwithstanding the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) to the contrary, a health benefits plan issued by or through a carrier, association, or multiple employer arrangement prior to January 1, 1994 or, if the requirements of subparagraph (c) of paragraph (6) of this subsection are met, issued by or through an out-of-State trust prior to January 1, 1994, at the option of a small employer policy or contract holder, may be renewed or continued after February 28, 1994, or in the case of such a health benefits plan whose anniversary date occurred between March 1, 1994 and the effective date of P.L.1994, c.11 (C.17B:27A-19.1 et al.), may be reinstated within 60 days of that anniversary date and renewed or continued if, beginning on the first 12-month anniversary date occurring on or after the sixtieth day after the board adopts regulations concerning the implementation of the rating factors permitted by section 9 of P.L.1992, c.162 (C.17B:27A-25) and, regardless of the situs of delivery of the health benefits plan, the health benefits plan renewed, continued or reinstated pursuant to this subsection complies with the provisions of section 2, subsection b. of section 3, and sections 6, 7, 8, 9 and 11 of P.L.1992, c.162 (C.17B:27A-18, 17B:27A-19, 17B:27A-22, 17B:27A-23, 17B:27A-24, 17B:27A-25 and 17B:27A-27) and section 7 of P.L.1995, c.340 (C.17B:27A-19.3).

Nothing in this subsection shall be construed to require an association, multiple employer arrangement or out-of-State trust to provide health benefits coverage to small employers that are not contemplated by the organizational documents, bylaws, or other regulations governing the purpose and operation of the association, multiple employer arrangement or out-of-State trust. Notwithstanding the foregoing provision to the contrary, an association,

multiple employer arrangement or out-of-State trust that offers health benefits coverage to its members' employees and dependents:

(a) shall offer coverage to all eligible employees and their dependents within the membership of the association, multiple employer arrangement or out-of-State trust;

(b) shall not use actual or expected health status in determining its membership; and

(c) shall make available to its small employer members at least one of the standard benefits plans, as determined by the commissioner, in addition to any health benefits plan permitted to be renewed or continued pursuant to this subsection.

(2) Notwithstanding the provisions of this subsection to the contrary, a carrier or out-of-State trust which writes the health benefits plans required pursuant to subsection a. of this section shall be required to offer those plans to any small employer, association or multiple employer arrangement.

(3) (a) A carrier, association, multiple employer arrangement, or out-of-State trust may withdraw a health benefits plan marketed to small employers that was in effect on December 31, 1993 with the approval of the commissioner. The commissioner shall approve a request to withdraw a plan, consistent with regulations adopted by the commissioner, only on the grounds that retention of the plan would cause an unreasonable financial burden to the issuing carrier, taking into account the rating provisions of section 9 of P.L.1992, c.162 (C.17B:27A-25) and section 7 of P.L.1995, c.340 (C.17B:27A-19.3).

(b) A carrier which has renewed, continued or reinstated a health benefits plan pursuant to this subsection that has not been newly issued to a new small employer group since January 1, 1994, may, upon approval of the commissioner, continue to establish its rates for that plan based on the loss experience of that plan if the carrier does not issue that health benefits plan to any new small employer groups.

(4) (Deleted by amendment, P.L.1995, c.340).

(5) A health benefits plan that otherwise conforms to the requirements of this subsection shall be deemed to be in compliance with this subsection, notwithstanding any change in the plan's deductible or copayment.

(6) (a) Except as otherwise provided in subparagraphs (b) and (c) of this paragraph, a health benefits plan renewed, continued or reinstated pursuant to this subsection shall be filed with the commissioner for informational purposes within 30 days after its renewal date. No later than 60 days after the board adopts regulations concerning the implementation of the rating factors permitted by section 9 of P.L.1992, c.162 (C.17B:27A-25) the filing shall be amended to show any modifications in the plan that are necessary to comply with the provisions of this subsection. The commissioner shall monitor compliance of any such plan with the requirements of this subsection, except that the board shall enforce the loss ratio requirements.

(b) A health benefits plan filed with the commissioner pursuant to subparagraph (a) of this paragraph may be amended as to its benefit structure if the amendment does not reduce the actuarial value and benefits coverage of the health benefits plan below that of the lowest standard health benefits plan established by the board pursuant to subsection a. of this section. The amendment shall be filed with the commissioner for approval pursuant to the terms of sections 4, 8, 12 and 25 of P.L.1995, c.73 (C.17:48-8.2, 17:48A-9.2, 17:48E-13.2 and 26:2J-43), N.J.S.17B:26-1 and N.J.S.17B:27-49, as applicable, and shall comply with the provisions of sections 2 and 9 of P.L.1992, c.162 (C.17B:27A-18 and 17B:27A-25) and section 7 of P.L.1995, c.340 (C.17B:27A-19.3).

(c) A health benefits plan issued by a carrier through an out-of-State trust shall be permitted to be renewed or continued pursuant to paragraph (1) of this subsection upon

approval by the commissioner and only if the benefits offered under the plan are at least equal to the actuarial value and benefits coverage of the lowest standard health benefits plan established by the board pursuant to subsection a. of this section. For the purposes of meeting the requirements of this subparagraph, carriers shall be required to file with the commissioner the health benefits plans issued through an out-of-State trust no later than 180 days after the date of enactment of P.L.1995, c.340. A health benefits plan issued by a carrier through an out-of-State trust that is not filed with the commissioner pursuant to this subparagraph, shall not be permitted to be continued or renewed after the 180-day period.

(7) Notwithstanding the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) to the contrary, an association, multiple employer arrangement or out-of-State trust may offer a health benefits plan authorized to be renewed, continued or reinstated pursuant to this subsection to small employer groups that are otherwise eligible pursuant to paragraph (1) of subsection j. of this section during the period for which such health benefits plan is otherwise authorized to be renewed, continued or reinstated.

(8) Notwithstanding the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) to the contrary, a carrier, association, multiple employer arrangement or out-of-State trust may offer coverage under a health benefits plan authorized to be renewed, continued or reinstated pursuant to this subsection to new employees of small employer groups covered by the health benefits plan in accordance with the provisions of paragraph (1) of this subsection.

(9) Notwithstanding the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.) or P.L.1992, c.161 (C.17B:27A-2 et al.) to the contrary, any individual, who is eligible for small employer coverage under a policy issued, renewed, continued or reinstated pursuant to this subsection, but who would be subject to a preexisting condition exclusion under the small employer health benefits plan, or who is a member of a small employer group who has been denied coverage under the small employer group health benefits plan for health reasons, may elect to purchase or continue coverage under an individual health benefits plan until such time as the group health benefits plan covering the small employer group of which the individual is a member complies with the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.).

(10) In a case in which an association made available a health benefits plan on or before March 1, 1994 and subsequently changed the issuing carrier between March 1, 1994 and the effective date of P.L.1995, c.340, the new issuing carrier shall be deemed to have been eligible to continue and renew the plan pursuant to paragraph (1) of this subsection.

(11) In a case in which an association, multiple employer arrangement or out-of-State trust made available a health benefits plan on or before March 1, 1994 and subsequently changes the issuing carrier for that plan after the effective date of P.L.1995, c.340, the new issuing carrier shall file the health benefits plan with the commissioner for approval in order to be deemed eligible to continue and renew that plan pursuant to paragraph (1) of this subsection.

(12) In a case in which a small employer purchased a health benefits plan directly from a carrier on or before March 1, 1994 and subsequently changes the issuing carrier for that plan after the effective date of P.L.1995, c.340, the new issuing carrier shall file the health benefits plan with the commissioner for approval in order to be deemed eligible to continue and renew that plan pursuant to paragraph (1) of this subsection.

Notwithstanding the provisions of subparagraph (b) of paragraph (6) of this subsection to the contrary, a small employer who changes its health benefits plan's issuing carrier pursuant to the provisions of this paragraph, shall not, upon changing carriers, modify the benefit structure of that health benefits plan within six months of the date the issuing carrier was changed.

k. Effective immediately for a health benefits plan issued on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.) and effective on the first 12-month anniversary date of a health benefits plan in effect on the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), the health benefits plans required pursuant to this section, including any plans offered by a State approved or federally qualified health maintenance organization, shall contain benefits for expenses incurred in the following:

(1) Screening by blood lead measurement for lead poisoning for children, including confirmatory blood lead testing as specified by the Department of Health pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any necessary medical follow-up and treatment for lead poisoned children.

(2) All childhood immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Service and the Department of Health pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A carrier shall notify its insureds, in writing, of any change in the health care services provided with respect to childhood immunizations and any related changes in premium. Such notification shall be in a form and manner to be determined by the Commissioner of Banking and Insurance.

(3) Screening for newborn hearing loss by appropriate electrophysiologic screening measures and periodic monitoring of infants for delayed onset hearing loss, pursuant to P.L.2001, c.373 (C.26:2-103.1 et al.). Payment for this screening service shall be separate and distinct from payment for routine new baby care in the form of a newborn hearing screening fee as negotiated with the provider and facility.

The benefits provided pursuant to this subsection shall be provided to the same extent as for any other medical condition under the health benefits plan, except that a deductible shall not be applied for benefits provided pursuant to this subsection; however, with respect to a small employer health benefits plan that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied for any benefits that represent preventive care as permitted by that federal law, and shall not be applied as provided pursuant to section 16 of P.L.2005, c.248 (C.17B:27A-19.14). This subsection shall apply to all small employer health benefits plans in which the carrier has reserved the right to change the premium.

l. The board shall consider including benefits for speech-language pathology and audiology services, as rendered by speech-language pathologists and audiologists within the scope of their practices, in at least one of the standard policies and in at least one of the five riders to be developed under this section.

m. Effective immediately for a health benefits plan issued on or after the effective date of P.L.2001, c.361 (C.17:48-6z et al.) and effective on the first 12-month anniversary date of a health benefits plan in effect on the effective date of P.L.2001, c.361 (C.17:48-6z et al.), the health benefits plans required pursuant to this section that provide benefits for expenses incurred in the purchase of prescription drugs shall provide benefits for expenses incurred in the purchase of specialized non-standard infant formulas, when the covered infant's physician has diagnosed the infant as having multiple food protein intolerance and has determined such formula to be medically necessary, and when the covered infant has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk. The coverage may be subject to utilization review, including periodic review, of the continued medical necessity of the specialized infant formula.

The benefits shall be provided to the same extent as for any other prescribed items under the health benefits plan.

This subsection shall apply to all small employer health benefits plans in which the carrier has reserved the right to change the premium.

n. Effective immediately for a health benefits plan issued on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.) and effective on the first 12-month anniversary date of a small employer health benefits plan in effect on the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), the health benefits plans required pursuant to this section that qualify as high deductible health plans for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), including any plans offered by a State approved or federally qualified health maintenance organization, shall contain benefits for expenses incurred in connection with any medically necessary benefits provided in-network that represent preventive care as permitted by that federal law.

The benefits provided pursuant to this subsection shall be provided to the same extent as for any other medical condition under the health benefits plan, except that no deductible shall be applied for benefits provided pursuant to this subsection. This subsection shall apply to all small employer health benefits plans in which the carrier has reserved the right to change the premium.

59. Section 5 of P.L.2001, c.368 (C.17B:27A-19.11) is amended to read as follows:

C.17B:27A-19.11 Carrier offering plans pursuant to C.17B:27A-17 et seq. may offer additional plan with certain limited benefits.

5. In addition to the standard health benefits plans offered by a carrier on the effective date of this act, a carrier that writes small employer health benefits plans pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) may also offer one or more of the plans through the carrier's network of providers, with no reimbursement for any out-of-network benefits other than emergency care, urgent care, and continuity of care. A carrier's network of providers shall be subject to review and approval or disapproval by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health, pursuant to regulations promulgated by the Department of Banking and Insurance, including review and approval or disapproval before plans with benefits provided through a carrier's network of providers pursuant to this section may be offered by the carrier. Policies or contracts written on this basis shall be rated in a separate rating pool for the purposes of establishing a premium, but for the purpose of determining a carrier's losses, these policies or contracts shall be aggregated with the losses on the carrier's other business written pursuant to the provisions of P.L.1992, c.162 (C.17B:27A-17 et seq.).

60. Section 13 of P.L.1992, c.162 (C.17B:27A-29) is amended to read as follows:

C.17B:27A-29 Meetings, organization of board; terms.

13. a. Within 60 days of the effective date of this act, the commissioner shall give notice to all members of the time and place for the initial organizational meeting, which shall take place within 90 days of the effective date. The members shall elect the initial board, subject to the approval of the commissioner. The board shall consist of 10 elected public members and two ex officio members who include the Commissioner of Health and the commissioner or their designees. Initially, three of the public members of the board shall be elected for a three-year term, three shall be elected for a two-year term, and three shall be elected for a

one-year term. Thereafter, all elected board members shall serve for a term of three years. The following categories shall be represented among the elected public members:

(1) Three carriers whose principal health insurance business is in the small employer market;

(2) One carrier whose principal health insurance business is in the large employer market;

(3) A health service corporation or a domestic stock insurer which converted from a health service corporation pursuant to the provisions of P.L.2001, c.131 (C.17:48E-49 et al.) and is primarily engaged in the business of issuing health benefit plans in this State;

(4) Two health maintenance organizations; and

(5) (Deleted by amendment, P.L.1995, c.298).

(6) (Deleted by amendment, P.L.1995, c.298).

(7) Three persons representing small employers, at least one of whom represents minority small employers.

No carrier shall have more than one representative on the board.

The board shall hold an election for the two members added pursuant to P.L.1995, c.298 within 90 days of the date of enactment of that act. Initially, one of the two new members shall serve for a term of one year and one of the two new members shall serve for a term of two years. Thereafter, the new members shall serve for a term of three years. The terms of the risk-assuming carrier and reinsuring carrier shall terminate upon the election of the two new members added pursuant to P.L.1995, c.298, notwithstanding the provisions of this section to the contrary.

In addition to the 10 elected public members, the board shall include six public members appointed by the Governor with the advice and consent of the Senate who shall include:

Two insurance producers licensed to sell health insurance pursuant to P.L.1987, c.293 (C.17:22A-1 et seq.);

One representative of organized labor;

One physician licensed to practice medicine and surgery in this State; and

Two persons who represent the general public and are not employees of a health benefits plan provider.

The public members shall be appointed for a term of three years, except that of the members first appointed, two shall be appointed for a term of one year, two for a term of two years and two for a term of three years.

A vacancy in the membership of the board shall be filled for an unexpired term in the manner provided for the original election or appointment, as appropriate.

b. If the initial board is not elected at the organizational meeting, the commissioner shall appoint the public members within 15 days of the organizational meeting, in accordance with the provisions of paragraphs (1) through (7) of subsection a. of this section.

c. (Deleted by amendment, P.L.1995, c.298).

d. All meetings of the board shall be subject to the requirements of the "Open Public Meetings Act," P.L.1975, c.231 (C.10:4-6 et seq.).

e. At least two copies of the minutes of every meeting of the board shall be delivered forthwith to the commissioner.

61. Section 4 of P.L.2003, c.193 (C.17B:27D-4) is amended to read as follows:

C.17B:27D-4 Membership; terms; vacancies.

4. The commission shall consist of 17 voting members as follows: the Commissioners of Health, Human Services and Banking and Insurance or their designees, who shall serve ex

officio; three public members appointed by the President of the Senate, who shall include a representative of a commercial health insurance company, a physician licensed in this State who is a member of the Medical Society of New Jersey, and a representative of the New Jersey Business and Industry Association, no more than two of whom shall be from the same political party; three public members appointed by the Speaker of the General Assembly, who shall include a representative of a health service corporation, a physician licensed in this State, and a representative of organized labor, no more than two of whom shall be from the same political party; and eight public members appointed by the Governor, who shall include a medical educator from the University of Medicine and Dentistry of New Jersey whose major field of expertise is the study and evaluation of the cost of health care and health insurance, a representative of the New Jersey Association of Health Plans, a representative of the New Jersey Hospital Association, a representative of the New Jersey State Nurses Association, a representative of the New Jersey Dental Association, a representative of a consumer advocacy organization and two representatives of the general public who are knowledgeable about health benefits plans.

The President of the Senate may appoint two members of the Senate, no more than one of whom shall be from the same political party, to serve as nonvoting members of the commission. The Speaker of the General Assembly may appoint two members of the General Assembly, no more than one of whom shall be from the same political party, to serve as nonvoting members of the commission. The legislative members shall serve during their legislative term of office.

Of the voting members first appointed, four shall serve for a term of two years, four for a term of three years, and three for a term of four years.

Voting members appointed thereafter shall serve four-year terms, and any vacancy shall be filled by appointment for the unexpired term only. A member is eligible for reappointment. Vacancies in the membership of the commission shall be filled in the same manner as the original appointments were made.

62. Section 5 of P.L.2003, c.193 (C.17B:27D-5) is amended to read as follows:

C.17B:27D-5 Election of chairman, vice chairman, appointment of secretary; meetings.

5. a. The commission shall organize and hold its first meeting within 90 days after the appointment of its members and shall elect a chairman and a vice chairman from among its members. The commission may appoint a secretary, who need not be a member of the commission.

b. The members of the commission shall serve without compensation but may be allowed their actual and necessary expenses incurred in the performance of their duties within the limits of funds appropriated or otherwise made available to the commission for this purpose.

c. The Department of Banking and Insurance, in consultation with the Department of Health, shall assist the commission in the performance of its duties.

d. The commission shall be entitled to call upon the services of any State, county or municipal department, board, commission or agency as it may require and as may be available to it for these purposes, and to incur such traveling and other miscellaneous expenses as it may deem necessary for the proper execution of its duties and as may be within the limit of funds appropriated or otherwise made available to it for these purposes.

e. The commission shall meet regularly, and at a minimum of four times per year. Special meetings may be called by the chairman of the commission.

63. Section 6 of P.L.2003, c.193 (C.17B:27D-6) is amended to read as follows:

C.17B:27D-6 Duties of commission relative to review of bills.

6. It shall be the duty of the commission to review any bill introduced in either House of the Legislature that would require a carrier to provide a mandated health benefit, as provided in this section.

a. Whenever a bill containing a mandated health benefit is introduced in the Legislature, the chairman of the standing reference committee to which the bill has been referred in the House in which it was introduced shall, upon introduction of the bill, request the commission to prepare a written report that assesses the social and financial effects and the medical efficacy of the proposed mandated health benefit.

If the bill is subsequently amended, a prime sponsor or the presiding officer of the House in which the bill is pending may request the commission to amend or revise its report to reflect the changes made by the amendment.

b. (1) For the period ending December 31, 2003, the commission shall complete its review of a bill within 90 days after the date the review is requested, and provide its comments and recommendations in writing to the prime sponsor, committee chairman and presiding officer of the House in which the bill is pending. The commission may request an extension prior to the 90th day, in which case the presiding officer of the House in which the bill is pending may grant an extension of up to 45 days for the commission to complete its review.

(2) Beginning January 1, 2004, the commission shall complete its review of a bill within 60 days after the date the review is requested, and provide its comments and recommendations in writing to the prime sponsor, committee chairman and presiding officer of the House in which the bill is pending. The commission may request an extension prior to the 60th day, in which case the presiding officer of the House in which the bill is pending may grant an extension of up to 45 days for the commission to complete its review.

c. The House or standing reference committee, as applicable, shall not consider or vote upon the bill until either: (1) the commission completes its review and provides its comments and recommendations in writing to the prime sponsor, committee chairman and presiding officer of the House in which the bill is pending, or (2) the 90th or 60th day, as applicable, after the date the review is requested, if no extension was granted, or the designated day for the end of the extension period, whichever is later.

d. (1) If the presiding officer of the House in which the bill is pending determines that the bill is an urgent matter, the presiding officer shall so notify in writing the commission and the chairman of the standing reference committee to which the bill was referred, and the House or committee may consider and vote upon the bill as soon as practicable.

(2) If the chairman of the standing reference committee to which the bill is referred, in consultation with the Commissioner of Health, determines that the bill is of such an urgent nature that it would seriously impair the public health to wait for the commission to issue its report, the chairman shall so notify in writing the presiding officer of the House in which the bill is pending, and the commission, of that determination, and the standing reference committee, with the agreement of the presiding officer of the House, may consider and vote upon the bill as soon as practicable.

64. Section 7 of P.L.2003, c.193 (C.17B:27D-7) is amended to read as follows:

C.17B:27D-7 Contents of review of bill.

7. The review of a bill containing a proposed mandated health benefit by the commission shall include the following:

a. The social impact of mandating the health benefit, which shall include:

(1) the extent to which the proposed mandated health benefit and the services it would provide are needed by, available to and utilized by the population of New Jersey;

(2) the extent to which insurance coverage for the proposed mandated health benefit already exists or, if no coverage exists, the extent to which the lack of coverage results in inadequate health care or financial hardship for the affected population of New Jersey;

(3) the demand for the proposed mandated health benefit from the public and the source and extent of opposition to mandating the health benefit;

(4) relevant findings bearing on the social impact of the lack of the proposed mandated health benefit; and

(5) such other information with respect to the social impact as the commission deems appropriate.

b. The financial impact of mandating the health benefit, which shall include:

(1) the extent to which the proposed mandated health benefit would increase or decrease the cost for treatment or service;

(2) the extent to which similar mandated health benefits in other states have affected charges, costs and payments for services;

(3) the extent to which the proposed mandated health benefit would increase the appropriate use of the treatment or service;

(4) the impact of the proposed mandated health benefit on total costs to carriers and on administrative costs;

(5) the impact of the proposed mandated health benefit on total costs to purchasers and benefit costs;

(6) the impact of the proposed mandated health benefit on the total cost of health care within New Jersey; and

(7) such other information with respect to the financial impact as the commission deems appropriate.

c. The medical efficacy of mandating the health benefit, which shall include:

(1) if the proposed health benefit mandates coverage of a particular treatment or therapy, the recommendation of a clinical study or review article in a major peer-reviewed professional journal;

(2) if the proposed benefit mandates coverage of the services provided by an additional class of practitioners, the results of at least one professionally accepted, controlled trial comparing the medical results achieved by the additional class of practitioners and the practitioners already covered by benefits;

(3) the results of other research;

(4) the impact of the proposed benefit on the general availability of health benefits coverage in New Jersey; and

(5) such other information with respect to the medical efficacy as the commission deems appropriate.

d. The effects of balancing the social, economic and medical efficacy considerations, which shall include, but not be limited to:

(1) the extent to which the need for coverage outweighs the costs of mandating the health benefit; and

(2) the extent to which the problem of coverage may be solved by mandating the availability of the coverage as an option under a health benefits plan.

e. An analysis of information collected from various sources, including, but not limited to:

(1) a State data collection system;

(2) the Departments of Health and Banking and Insurance;

(3) health planning organizations;

(4) proponents and opponents of the proposed health benefit mandate, who shall be encouraged to provide appropriate documentation supporting their positions. The commission shall examine such documentation to determine whether:

(a) the documentation is complete;

(b) the assumptions upon which the research is based are valid;

(c) the research cited in the documentation meets professional standards;

(d) all relevant research respecting the proposed benefit has been cited in the documentation;

(e) the conclusions and interpretations in the documentation are consistent with the data submitted; and

(5) such other data sources as the commission deems appropriate.

In analyzing information from the various sources, the commission shall give substantial weight to the documentation provided by the proponents and opponents of the mandate to the extent that such documentation is made available to them.

65. Section 8 of P.L.2003, c.193 (C.17B:27D-8) is amended to read as follows:

C.17B:27D-8 Development of system of data collection; review, comment.

8. In the course of studying and evaluating proposed mandated health benefits, the commission shall:

a. develop criteria for a system and program of data collection, for use by the Departments of Health and Banking and Insurance, to assess the impact of mandated health benefits, including the cost to employers and carriers, impact of treatment, cost savings in the health care system, number of providers, and other data as may be appropriate; and

b. review and comment to any State department, board, bureau, commission, or agency, with respect to any order or regulations proposed or implemented thereby that affect mandated health benefits.

66. Section 1 of P.L.1999, c.154 (C.17B:30-23) is amended to read as follows:

C.17B:30-23 Timetable for implementation of electronic receipt, transmission of health care claim information; standard forms.

1. a. (1) The Commissioner of Banking and Insurance, in consultation with the Commissioner of Health, shall establish, by regulation, a timetable for implementation of the electronic receipt and transmission of health care claim information by each hospital, medical, and health service corporation, individual and group health insurer, health maintenance organization, dental service corporation, dental plan organization, and prepaid prescription service organization, respectively, and a subsidiary of such corporation, insurer, or organization that processes health care benefits claims as a third party administrator, authorized to do business in this State.

The Commissioner of Banking and Insurance shall establish the timetable within 90 days of the date the federal Department of Health and Human Services adopts rules establishing standards for health care transactions, including: health claims or equivalent encounter

information, including institutional, professional, pharmacy, and dental health claims; enrollment and disenrollment in a health plan; eligibility for a health plan; health care payment and remittance advice; health care premium payments; first report of injury; health claim status; and referral certification and authorization, respectively, pursuant to section 262 of Pub.L.104-191 (42 U.S.C.s.1320d et seq.). The commissioner may adopt more than one timetable, if necessary, to conform the requirements of this section with the dates of adoption of the federal rules.

(2) The timetable for implementation adopted by the commissioner shall provide for extensions and waivers of the implementation requirement pursuant to paragraph (1) of this subsection in cases when it has been demonstrated to the commissioner's satisfaction that compliance with the timetable for implementation will result in an undue hardship to a hospital, medical or health service corporation, individual or group health insurer, health maintenance organization, dental service corporation, dental plan organization, or prepaid prescription service organization, respectively, or a subsidiary of such corporation, insurer, or organization that processes health care benefits claims as a third party administrator, authorized to do business in this State.

(3) The Commissioner of Banking and Insurance shall report to the Governor and the Legislature within one year of establishing the timetable pursuant to this subsection, on the number of extensions and waivers of the implementation requirement that he has granted pursuant to paragraph (2) of this subsection, and the reasons therefor.

b. The Commissioner of Banking and Insurance, in consultation with the Commissioner of Health, shall adopt, by regulation for each type of contract, as he deems appropriate, one set of standard health care enrollment and claim forms in paper and electronic formats to be used by each hospital, medical, or health service corporation, individual and group health insurer, health maintenance organization, dental service corporation, dental plan organization, and prepaid prescription service organization, and a subsidiary of such corporation, insurer, or organization that processes health care benefits claims as a third party administrator, authorized to do business in this State.

The Commissioner of Banking and Insurance shall establish the standard health care enrollment and claim forms within 90 days of the date the federal Department of Health and Human Services adopts rules establishing standards for the forms.

67. Section 15 of P.L.1999, c.154 (C.17B:30-24) is amended to read as follows:

C.17B:30-24 Regulations.

15. The Commissioner of Banking and Insurance, in consultation with the Commissioner of Health, shall adopt regulations to effectuate the purposes of sections 1 through 10 of this act, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). To the extent practicable, the regulations shall include any provisions the commissioner deems appropriate that seek to reduce the amount of, or to consolidate, the paper forms sent by hospital, medical, health, and dental service corporations, and commercial insurers, health maintenance organizations, dental plan organizations, and prepaid prescription service organizations to health care providers and covered persons.

68. Section 16 of P.L.1999, c.154 (C.17B:30-25) is amended to read as follows:

C.17B:30-25 Thomas A. Edison State College to study, monitor effectiveness of electronic data interchange technology, electronic health records.

16. Thomas A. Edison State College shall study and monitor the effectiveness of electronic data interchange technology and electronic health records in reducing administrative costs, identify means by which new electronic data interchange technology and electronic health records can be implemented to effect health care system cost savings, and determine the extent of electronic data interchange technology and electronic health records use in the State's health care system.

The Departments of Health and Banking and Insurance or any other department upon request shall cooperate with and provide assistance to the college in carrying out its study pursuant to this section.

The college shall report to the Legislature and the Governor from time to time on its findings and recommendations.

69. Section 2 of P.L.2003, c.112 (C.17B:30-42) is amended to read as follows:

C.17B:30-42 Definitions relative to collection of unpaid hospital accounts.

2. As used in this act:

"Coinsurance" means the percentage of a charge covered by a health plan that must be paid by a person covered under the health plan.

"Collection agency" means the Department of the Treasury and any company, agency, or law firm engaged in collecting debts that the Department of the Treasury may determine to engage to assist it in collecting debts.

"Debt" means money owed by a patient to a hospital, or by someone who is legally responsible for payment for a patient, and includes late payment penalties and interest thereon. It does not include monies owed to a hospital by a health plan for services provided by the hospital to a person with coverage under that plan, or amounts subject to dispute between a health plan and a hospital.

"Debtor" means an individual owing money to or having a delinquent account with a hospital, which obligation has not been adjudicated, satisfied by court order, set aside by court order, or discharged in bankruptcy.

"Deductible" means the amount of covered charges under a health plan that an individual must pay for services before a health plan begins to pay on a covered charge.

"Department" means the Department of Health.

"General Hospital" and "hospital" have the meanings set forth in N.J.A.C.8:43G-1.2.

"Health plan" means an individual or group health benefits plan that provides or pays the cost of hospital and medical expenses, dental or vision care, or prescription drugs, and is provided by or through an insurer, health maintenance organization, the Medicaid program, the Medicare program, a Medicare+Choice provider or Medicare supplemental insurer, an employer-sponsored group health benefits plan, government or church-sponsored health benefits plan or a multi-employer welfare arrangement.

"Medicaid" means the program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

"Medicare" means the program established by Pub.L.89-97 (42 U.S.C. s.1395 et seq.) as amended, or its successor plan or plans.

"Patient" means a person who receives services in a hospital on an inpatient or outpatient basis.

70. Section 7 of P.L.2003, c.112 (C.17B:30-47) is amended to read as follows:

C.17B:30-47 Procedures for participating hospitals.

7. a. The following procedures shall apply for those hospitals that wish to participate in the voluntary assignment program created by this act.

b. The hospital shall file with the department a notice signifying its intent to participate voluntarily and certifying the following:

(1) the hospital has determined that the patient is not eligible for charity care under the New Jersey Hospital Care Payment Assistance Program established by the Department of Health pursuant to section 10 of P.L.1992, c.160 (C.26:2H-18.60);

(2) the hospital has submitted a "clean claim" pursuant to P.L.1999, c.154 (C.17B:30-23 et al.) and P.L.1999, c.155 (C.17B:30-26 et seq.) to the patient, a responsible party, Medicaid, Medicare or a health plan, as applicable, within a reasonable time following the patient's discharge, or in the case of outpatient service, the date of service;

(3) the claims have been fully adjudicated by a health plan, Medicare or Medicaid, where applicable, and a debt remains outstanding;

(4) the hospital has not initiated collection procedures against the patient or responsible party while a claim was pending adjudication with Medicare or a health plan, for which a debt remains outstanding;

(5) the hospital has notified the patient of the hospital's intention, if the account is not paid in full, or alternatively through a payment plan with the hospital, to proceed with legal action, or to turn the bill over to the department for collection.

c. Nothing herein shall be deemed to create any new right to collection of hospital debts by hospitals beyond existing law; nor shall it be deemed to preclude any existing right to collection.

d. The department may determine the content of the notice required by paragraph (5) of subsection b. of this section to the patient concerning the likelihood that the account will be turned over to the department for collection.

e. The minimum amount of an unpaid bill that may be assigned to the department by a hospital is $100, or such other minimum as the department shall determine by regulation.

f. Upon receipt of the voluntary assignment, the Department of the Treasury shall send, on behalf of the department, a notice to the person named as a debtor of the hospital, notifying the person as to receipt of the assignment by the department, providing the person with 30 days to challenge the validity of the debt, and providing notice that in the absence of such challenge, a Certificate of Debt will be filed with the Superior Court of New Jersey. The notice shall also include a statement on the department's intention to take action to set off the liability against any refund of taxes pursuant to the "New Jersey Gross Income Tax Act" including an earned income tax credit, a NJ SAVER rebate or a homestead rebate, or other such funds as may be authorized by law.

g. If the person named as a debtor responds within the 30-day period, the person shall be provided with an opportunity to present, either in writing or in person, evidence as to why the person does not believe he is responsible for the debt. The department shall provide written notice to both the person and the hospital as to its determination regarding the validity of the debt, including the imposition of collection fees and interest, if applicable.

h. If the person fails to respond within 30 days to the department, the department may utilize the provisions of the Set off of Individual Liability (SOIL) program established pursuant to P.L.1981, c.239 (C.54A:9-8.1 et seq.), to collect any surcharge levied under this section that is unpaid on or after the effective date of this act.

As additional remedies, the department may utilize the services of a collection agency to settle the debt and may also issue a certificate to the Clerk of the Superior Court stating that

the person identified in the certificate is indebted under this law in such amount as shall be stated in the certificate. The certificate shall reference this act. Thereupon the clerk to whom such certificate shall have been issued shall immediately enter upon the record of docketed judgments: the name of the person as debtor; the State as creditor; the address of the person, if shown in the certificate; the amount of the debt so certified; a reference to this act under which the debt is assessed; and the date of making the entries. The docketing of the entries shall have the same force and effect as a civil judgment docketed in the Superior Court, and the department shall have all the remedies and may take all of the proceedings for the collection thereof which may be had or taken upon the recovery of a judgment in an action, but without prejudice to any right of appeal. Upon entry by the clerk of the certificate in the record of docketed judgments in accordance with this provision, interest in the amount specified by the court rules for post-judgment interest shall accrue from the date of the docketing of the certificate; however, payment of the interest may be waived by the department.

i. Any collection efforts undertaken pursuant to this act shall be undertaken in accordance with the "Health Insurance Portability and Accountability Act of 1996," Pub.L.104-191 and 45 C.F.R. 160.101 to 164.534, or any other similar law. The department and any other entity performing collection activities pursuant to this act is authorized to enter into any agreements required to comply with such laws, including, but not limited to, entering into agreements with the hospitals and collection agencies to provide for appropriate safeguarding of information.

71. Section 3 of P.L.2005, c.352 (C.17B:30-50) is amended to read as follows:

C.17B:30-50 Definitions relative to processing health claims.

3. As used in sections 3 through 7 of P.L.2005, c.352 (C.17B:30-50 through C.17B:30-54):

"Authorization" means a determination required under a health benefits plan, that based on the information provided, satisfies the requirements under the member's health benefits plan for medical necessity.

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation, or health maintenance organization authorized to issue health benefits plans in this State.

"Commissioner" means the Commissioner of Banking and Insurance.

"Covered person" means a person on whose behalf a carrier offering the plan is obligated to pay benefits or provide services pursuant to the health benefits plan.

"Covered service" means a health care service provided to a covered person under a health benefits plan for which the carrier is obligated to pay benefits or provide services.

"Generally accepted standards of medical practice" means standards that are based on: credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; physician and health care provider specialty society recommendations; the views of physicians and health care providers practicing in relevant clinical areas; and any other relevant factor as determined by the commissioner by regulation.

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. Health benefits plan includes, but is not limited to, Medicare supplement coverage and Medicare+Choice contracts to the extent not otherwise prohibited

by federal law. For the purposes of sections 3 through 7 of P.L.2005, c.352 (C.17B:30-50 through C.17B:30-54), health benefits plan shall not include the following plans, policies, or contracts: accident only, credit, disability, long-term care, Civilian Health and Medical Program for the Uniformed Services, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), or hospital confinement indemnity coverage.

"Hospital" means a general acute care facility licensed by the Commissioner of Health pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.), including rehabilitation, psychiatric, and long-term acute facilities.

"Medical necessity" or "medically necessary" means or describes a health care service that a health care provider, exercising his prudent clinical judgment, would provide to a covered person for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that is: in accordance with the generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the covered person's illness, injury, or disease; not primarily for the convenience of the covered person or the health care provider; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered person's illness, injury, or disease.

"Network provider" means a participating hospital or physician under contract or other agreement with a carrier to furnish health care services to covered persons.

"Payer" means a carrier which requires that utilization management be performed to authorize the approval of a health care service and includes an organized delivery system that is certified by the Commissioner of Banking and Insurance or licensed by the commissioner pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.).

"Payer's agent" or "agent" means an intermediary contracted or affiliated with the payer to provide authorization for service or perform administrative functions including, but not limited to, the payment of claims or the receipt, processing, or transfer of claims or claim information.

"Physician" means a physician licensed pursuant to Title 45 of the Revised Statutes.

"Utilization management" means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines, in order to recommend or determine whether, or to what extent, a health care service given or proposed to be given to a covered person should or will be reimbursed, covered, paid for, or otherwise provided under the health benefits plan. The system may include, but shall not be limited to: preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory care procedures, and retrospective review.

72. Section 1 of P.L.2007, c.194 (C.17B:30-58) is amended to read as follows:

C.17B:30-58 Definitions relative to reimbursement for certain ambulance services.

1. As used in this act:

"Ambulance service" means the provision of emergency health care services, basic life support services, advanced life support services, critical care services, mobile intensive care services, or emergency medical transportation in a vehicle that is licensed, equipped, and staffed in accordance with the requirements set forth by the Commissioner of Health.

"Assignment of benefits" means any written instrument executed by the covered person or his authorized representative which assigns a service provider the covered person's right to receive reimbursement for a covered service rendered to the covered person.

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation, or health maintenance organization authorized to issue health benefits plans in this State.

"Claim" means a claim by a covered person for payment of benefits under a health benefits plan.

"Commissioner" means the Commissioner of Banking and Insurance.

"Covered person" means a person on whose behalf a carrier offering the health benefits plan is obligated to pay benefits or provide services pursuant to the health benefits plan.

"Covered service" means an ambulance service provided to a covered person under a health benefits plan for which the carrier is obligated to pay benefits or provide services.

"Health benefits plan" means a hospital and medical expense insurance policy; health service corporation contract; hospital service corporation contract; medical service corporation contract; health maintenance organization subscriber contract; or other plan for medical care delivered or issued for delivery in this State. For purposes of this act, health benefits plan shall not include one or more, or any combination of, the following: coverage only for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; stop loss or excess risk insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; coverage for Medicaid services pursuant to a contract with the State; and any other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health benefits plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health benefits plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.

"Payer" means a carrier or any agent thereof who is doing business in the State and is under a contractual obligation to pay claims.

"Service provider" means any person, public or private institution, agency, or business concern lawfully providing an ambulance service.

73. Section 1 of P.L.2011, c.214 (C.18A:3B-69) is amended to read as follows:

C.18A:3B-69 Emergency operations plan for institutions of higher education.

1. a. The governing board of each institution of higher education shall develop and coordinate an emergency operations plan to ensure the continuity of essential institution functions under all circumstances. The plan shall:

(1) identify a baseline of preparedness for all potential emergencies, including pandemics, to establish a viable capability to perform essential functions during any emergency that disrupts normal operations; and

(2) be coordinated with State and local authorities including, but not limited to, the State Office of Emergency Management, local law enforcement officers, county and local health officers, county offices of emergency management, and other emergency responders.

b. The plan shall include, but not be limited to, the following components: identification of essential functions, programs, and personnel; procedures to implement the plan; delegation of authority and lines of succession; identification of alternative facilities and related infrastructure, including those for communications; identification and protection of vital records and databases; and schedules and procedures for periodic tests, training, and exercises. The plan shall be consistent with the local emergency operations plan of the municipality in which the institution is located.

c. The governing board of the institution shall adopt and submit for review an emergency operations plan to the Secretary of Higher Education, the State Office of Emergency Management, the Department of Health, and the Office of Homeland Security and Preparedness within six months of the effective date of this act. The governing board shall review, update, and resubmit the plan to the offices every five years. If an emergency incident occurs at an institution during the five-year period, the plan shall be reviewed immediately.

d. The Office of Homeland Security and Preparedness, the State Office of Emergency Management, the Department of Health, and the Secretary of Higher Education shall review the emergency operations plan submitted by an institution of higher education pursuant to subsection c. of this section and, when necessary, shall in coordination with other State agencies make recommendations to the institution for improving the plan that are deemed necessary.

e. Any plan prepared pursuant to this section shall not be considered a government record as defined in section 1 of P.L.1995, c.23 (C.47:1A-1.1) and shall not be available for public inspection, copying, or the purchase of copies.

74. Section 2 of P.L.1997, c.368 (C.18A:40-12.6) is amended to read as follows:

C.18A:40-12.6 Policy for administration of epinephrine to pupil.

2. The policy for the administration of medication to a pupil shall provide that the school nurse shall have the primary responsibility for the administration of the epinephrine. The school nurse shall designate, in consultation with the board of education, or chief school administrator of a nonpublic school additional employees of the school district or nonpublic school who volunteer to administer epinephrine via a pre-filled auto-injector mechanism to a pupil for anaphylaxis when the nurse is not physically present at the scene. The school nurse shall determine that:

a. the designees have been properly trained in the administration of the epinephrine via a pre-filled auto-injector mechanism using standardized training protocols established by the Department of Education in consultation with the Department of Health;

b. the parents or guardians of the pupil consent in writing to the administration of the epinephrine via a pre-filled auto-injector mechanism by the designees;

c. the board or chief school administrator of a nonpublic school informs the parents or guardians of the pupil in writing that the district and its employees or agents or the nonpublic

school and its employees and agents shall have no liability as a result of any injury arising from the administration of the epinephrine to the pupil;

d. the parents or guardians of the pupil sign a statement acknowledging their understanding that the district or nonpublic school shall have no liability as a result of any injury arising from the administration of the epinephrine via a pre-filled auto-injector mechanism to the pupil and that the parents or guardians shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the administration of the epinephrine via a pre-filled auto-injector mechanism to the pupil; and

e. the permission is effective for the school year for which it is granted and is renewed for each subsequent school year upon fulfillment of the requirements in subsections a. through d. of this section.

The Department of Education, in consultation with the Department of Health, shall require trained designees for students enrolled in a school who may require the emergency administration of epinephrine for anaphylaxis when the school nurse is not available.

Nothing in this section shall be construed to prohibit the emergency administration of epinephrine via a pre-filled auto-injector mechanism to a pupil for anaphylaxis by the school nurse or other employees designated pursuant to this section when the pupil is authorized to self-administer epinephrine pursuant to section 1 of P.L.1993, c.308 (C.18A:40-12.3), or when there is a coexisting diagnosis of asthma, or when a prescription is received from a licensed health care professional for epinephrine coupled with another form of medication.

75. Section 4 of P.L.2007, c.57 (C.18A:40-12.6a) is amended to read as follows:

C.18A:40-12.6a Guidelines for schools for management of food allergies, administration of epinephrine.

4. The Department of Education, in consultation with the Department of Health, appropriate medical experts, and professional organizations representing school nurses, principals, teachers, and the food allergy community, shall establish and disseminate to each board of education and chief school administrator of a nonpublic school guidelines for the development of a policy by a school district or nonpublic school for the management of food allergies in the school setting and the emergency administration of epinephrine to students for anaphylaxis.

76. Section 6 of P.L.2007, c.57 (C.18A:40-12.6c) is amended to read as follows:

C.18A:40-12.6c Training protocols for volunteer designees to administer epinephrine.

6. a. In an effort to assist the certified school nurse in a public school district and the school nurse in a nonpublic school in recruiting and training additional school employees as volunteer designees to administer epinephrine for anaphylaxis when the school nurse is not physically present, the Department of Education and the Department of Health shall jointly develop training protocols, in consultation with the New Jersey School Nurses Association.

b. The certified school nurse in consultation with the board of education, or the school nurse in consultation with the chief school administrator of a nonpublic school, shall recruit and train volunteer designees who are determined acceptable candidates by the school nurse within each school building as deemed necessary by the nursing service plan.

77. Section 3 of P.L.2001, c.61 (C.18A:40-12.8) is amended to read as follows:

C.18A:40-12.8 Regulations for use of nebulizer in schools.

3. The State Board of Education, in consultation with the Commissioner of Health, shall adopt regulations requiring each public school board of education to develop policies for the administration of asthma medication through the use of a nebulizer by the school nurse or other person authorized by regulation. The regulations shall include:

a. a requirement that each certified nurse or other person authorized to administer asthma medication receive training in airway management and in the use of nebulizers and inhalers consistent with nationally recognized standards, including, but not limited to, those of the National Institutes of Health and the American Association of Allergy and Immunology; and

b. a requirement that each pupil authorized to use asthma medication pursuant to section 1 of P.L.1993, c.308 (C.18A:40-12.3), or a nebulizer have an asthma treatment plan prepared by the physician of the pupil, which shall identify, at a minimum, asthma triggers, the treatment plan, and such other elements as shall be determined by the State Board of Education.

78. Section 3 of P.L.2002, c.58 (C.18A:40-21.1) is amended to read as follows:

C.18A:40-21.1 Hepatitis B vaccination required for public, private school students in grades nine through twelve.

3. The Commissioner of Health shall require the immunization of a child for hepatitis B as a condition of enrollment in grades nine through 12.

b. Beginning with the 2003-2004 school year, a principal, director or other person in charge of a public or private school in this State shall not knowingly admit or retain in grades nine through 12 a child whose parent or guardian has not submitted acceptable evidence of the child's immunization for hepatitis B prior to or during enrollment in ninth grade, as provided by regulation of the Commissioner of Health.

c. The Commissioner of Health shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to carry out the purposes of this section.

79. Section 3 of P.L.2007, c.122 (C.18A:40-37) is amended to read as follows:

C.18A:40-37 Three-year comprehensive eye examination pilot program for second grade students.

3. a. The Commissioner of Education, in consultation with the Commissioner of Health, shall establish a three-year comprehensive eye examination pilot program for second grade students. The purpose of the program shall be to eliminate inappropriate referrals for special education programs and services by examining students at the end of second grade for vision-related problems that may go undiagnosed and result in special education classification.

b. The commissioner shall select for participation in the pilot program one school district in each of the northern, central, and southern regions of the State, including an urban school district, a suburban school district, and a rural school district. In selecting the pilot school districts, the commissioner may consider the percentage of students in the district classified as eligible for special education programs and services, the percentage increase in such classifications over the prior five school years, and the district's interest in participating in the program. The commissioner shall collaborate with each pilot school district on the

procedures to be implemented to conduct the comprehensive eye examinations, including the coverage of any costs associated with the examinations. In any agreement concerning the cost of providing examinations, no parent or guardian of a student shall be required to make any payment to the optometrist or ophthalmologist providing a comprehensive eye examination, or the school district or any other entity; except that if the student is covered by a health insurance plan which has a copayment requirement, the parent or guardian shall pay the health care provider the required copayment. In this case, the parent or guardian may apply to the Comprehensive Eye Examination Fund for reimbursement of the copayment.

c. The commissioner shall develop and distribute to the pilot districts a form to document and provide information on each comprehensive eye examination conducted under the program.

80. Section 1 of P.L.2007, c.125 (C.18A:40-41) is amended to read as follows:

C.18A:40-41 Sudden cardiac death, pamphlet; development, distribution to school districts, parents of athletes.

1. a. The Commissioner of Education, in consultation with the Commissioner of Health, the American Heart Association, and the American Academy of Pediatrics, shall develop a pamphlet that provides information about sudden cardiac death to the parents or guardians of student athletes. The pamphlet shall include an explanation of sudden cardiac death, its incidence among student athletes, a description of early warning signs, and an overview of the options that are privately available to screen for cardiac conditions that may lead to sudden cardiac death, including a statement about the limitations of these options.

b. The commissioner shall distribute the pamphlet, at no charge, to all school districts in the State. The commissioner shall update the pamphlet as necessary, and shall make additional copies available to nonpublic schools upon request.

c. In the 2007-2008 school year and in each school year thereafter, each school district shall distribute the pamphlet to the parents or guardians of students participating in school sports.

81. Section 2 of P.L.2007, c.134 (C.18A:40-42) is amended to read as follows:

C.18A:40-42 Educational fact sheet about HPV.

2. a. The Commissioner of Education, in consultation with the Commissioner of Health, shall develop an educational fact sheet about the human papillomavirus (HPV) for distribution to parents or guardians of students in grades seven through 12. The educational fact sheet shall include information about the causes, symptoms and means of transmission of HPV, and where additional information can be obtained.

b. For the 2007-2008 school year, a school district shall distribute to parents and guardians of students in grades seven through 12 the educational fact sheet on HPV, in a manner prescribed by the Commissioner of Education.

c. Beginning with the 2008-2009 school year, a school district shall distribute the educational fact sheet annually to parents or guardians of students in grade seven in a manner prescribed by the Commissioner of Education.

d. The Commissioner of Education also shall make the educational fact sheet available to private schools educating students in grades seven through 12. Such schools are encouraged, but not required, to distribute the fact sheet to parents or guardians of students at the school.

82. Section 5 of P.L.1987, c.387 (C.18A:40A-12) is amended to read as follows:

C.18A:40A-12 Reporting of pupils under influence; examination; report; return home; evaluation of possible need for treatment; referral for treatment.

5. a. Whenever it shall appear to any teaching staff member, school nurse or other educational personnel of any public school in this State that a pupil may be under the influence of substances as defined pursuant to section 2 of this act, other than anabolic steroids, that teaching staff member, school nurse, or other educational personnel shall report the matter as soon as possible to the school nurse or medical inspector, as the case may be, or to a student assistance coordinator, and to the principal or, in his absence, to his designee. The principal or his designee, shall immediately notify the parent or guardian and the superintendent of schools, if there be one, or the administrative principal and shall arrange for an immediate examination of the pupil by a doctor selected by the parent or guardian, or if that doctor is not immediately available, by the medical inspector, if he is available. If a doctor or medical inspector is not immediately available, the pupil shall be taken to the emergency room of the nearest hospital for examination accompanied by a member of the school staff designated by the principal and a parent or guardian of the pupil if available. The pupil shall be examined as soon as possible for the purpose of diagnosing whether or not the pupil is under such influence. A written report of that examination shall be furnished within 24 hours by the examining physician to the parent or guardian of the pupil and to the superintendent of schools or administrative principal. If it is determined that the pupil was under the influence of a substance, the pupil shall be returned to the pupil's home as soon as possible and shall not resume attendance at school until the pupil submits to the principal a written report certifying that the pupil is physically and mentally able to return thereto, which report shall be prepared by a personal physician, the medical inspector, or the physician who examined the pupil pursuant to the provisions of this act.

In addition, the pupil shall be interviewed by a student assistance coordinator or another appropriately trained teaching staff member for the purpose of determining the extent of the pupil's involvement with these substances and possible need for treatment. In order to make this determination the coordinator or other teaching staff member may conduct a reasonable investigation which may include interviews with the pupil's teachers and parents. The coordinator or other teaching staff member may also consult with experts in the field of substance abuse as may be necessary and appropriate. If it is determined that the pupil's involvement with and use of these substances represents a danger to the pupil's health and well-being, the coordinator or other teaching staff member shall refer the pupil to an appropriate treatment program which has been approved by the Commissioner of Health.

b. Whenever any teaching staff member, school nurse, or other educational personnel of any public school in this State shall have reason to believe that a pupil has used or may be using anabolic steroids, that teaching staff member, school nurse, or other educational personnel shall report the matter as soon as possible to the school nurse or medical inspector, as the case may be, or to a student assistance coordinator, and to the principal or, in his absence, to his designee. The principal or his designee, shall immediately notify the parent or guardian and the superintendent of schools, if there be one, or the administrative principal and shall arrange for an examination of the pupil by a doctor selected by the parent or guardian or by the medical inspector. The pupil shall be examined as soon as possible for the purpose of diagnosing whether or not the pupil has been using anabolic steroids. A written report of that examination shall be furnished by the examining physician to the parent

or guardian of the pupil and to the superintendent of schools or administrative principal. If it is determined that the pupil has been using anabolic steroids, the pupil shall be interviewed by a student assistance coordinator or another appropriately trained teaching staff member for the purpose of determining the extent of the pupil's involvement with these substances and possible need for treatment. In order to make this determination the coordinator or other teaching staff member may conduct a reasonable investigation which may include interviews with the pupil's teachers and parents. The coordinator or other teaching staff member may also consult with experts in the field of substance abuse as may be necessary and appropriate. If it is determined that the pupil's involvement with and use of these substances represents a danger to the pupil's health and well-being, the coordinator or other teaching staff member shall refer the pupil to an appropriate treatment program which has been approved by the Commissioner of Health.

83. Section 11 of P.L.1987, c.387 (C.18A:40A-18) is amended to read as follows:

C.18A:40A-18 Employment of student assistance coordinators in certain school districts.

11. The Commissioner of Education, in consultation with the Commissioner of Health, shall develop and administer a program which provides for the employment of student assistance coordinators in certain school districts.

a. Within 90 days of the effective date of this act, the Commissioner of Education shall forward to each local school board a request for a proposal for the employment of a student assistance coordinator. A board which wants to participate in the program shall submit a proposal to the commissioner which outlines the district's plan to provide substance abuse prevention, intervention, and treatment referral services to students through the employment of a student assistance coordinator. Nothing shall preclude a district which employs a student assistance coordinator at the time of the effective date of this act from participating in this program. The commissioner shall select school districts to participate in the program through a competitive grant process. The participating districts shall include urban, suburban, and rural districts from the north, central, and southern geographic regions of the State with at least one school district per county. In addition to all other State aid to which the local district is entitled under the provisions of P.L.2007, c.260 (C.18A:7F-43 et al.) and other pertinent statutes, each board of education participating in the program shall receive from the State, for a three-year period, the amount necessary to pay the salary of its student assistance coordinator.

b. The position of student assistance coordinator shall be separate and distinct from any other employment position in the district, including, but not limited to district guidance counselors, school social workers, and school psychologists. The State Board of Education shall approve the education and experience criteria necessary for employment as a student assistance coordinator. The criteria shall include a requirement for certification by the State Board of Examiners. In addition to the criteria established by the State board, the Department of Education and the Department of Health shall jointly conduct orientation and training programs for student assistance coordinators, and shall also provide for continuing education programs for coordinators.

c. It shall be the responsibility of student assistance coordinators to assist local school districts in the effective implementation of this act. Coordinators shall assist with the in service training of school district staff concerning substance abuse issues and the district program to combat substance abuse; serve as an information resource for substance abuse curriculum development and instruction; assist the district in revising and implementing

substance abuse policies and procedures; develop and administer intervention services in the district; provide counseling services to pupils regarding substance abuse problems; and, where necessary and appropriate, cooperate with juvenile justice officials in the rendering of substance abuse treatment services.

d. The Commissioner of Education, in consultation with the Commissioner of Health, shall implement a plan to collect data on the effectiveness of the program in treating problems associated with substance abuse and in reducing the incidence of substance abuse in local school districts. Six months prior to the expiration of the program authorized pursuant to this section, the Commissioner of Education shall submit to the Governor and the Legislature an evaluation of the program and a recommendation on the advisability of its continuation or expansion to all school districts in the State.

84. Section 9 of P.L.2003, c.117 (C.24:2-9) is amended to read as follows:

C.24:2-9 Fees for issuance of “Certificate of Free Sale.”

9. The Department of Health may, pursuant to regulation adopted in accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), establish and charge reasonable fees not to exceed $100 to cover administrative costs associated with the issuance of a "Certificate of Free Sale." For the purpose of this act, a "Certificate of Free Sale" is defined as a certificate completed and issued by the department attesting that a specific food, drug, cosmetic, or medical device product regulated under Title 24 of the Revised Statutes, and manufactured, distributed, and offered for sale in this State is labeled in conformance with the applicable food, drug, cosmetic, or medical device laws and rules of this State and further attests to the results of the most recently conducted sanitary inspection of the manufacturer or distributor of the subject product.

Further, the Department of Health, may pursuant to regulation adopted in accordance with the "Administrative Procedure Act," establish and charge reasonable fees not to exceed $100 to cover administrative costs associated with the issuance of other certifications or affidavits related to matters regulated by the department under Title 24 of the Revised Statutes.

85. Section 13 of P.L.1961, c.52 (C.24:6B-12) is amended to read as follows:

C.24:6B-12 Definitions.

13. For the purposes of this registration act, unless otherwise required by the context:

(a) "Commissioner" means Commissioner of Health or the commissioner’s designated representative.

(b) "Department" means the Department of Health.

(c) "Drugs" means "drugs" and "devices" as defined in R.S.24:1-1.

(d) "Person" means a natural person, partnership, corporation, or any other business association.

(e) "Registrant" means the person in whose name a drug manufacturing business or wholesale non-prescription drug business is registered.

(f) "Drug manufacturing business" means the business of creating, making, or producing drugs by compounding, growing, or other process. This definition shall apply to persons engaged in the drug manufacturing business who do not maintain a manufacturing location in this State but do operate distribution depots or warehouses of such business in this State. This definition shall not apply to licensed pharmacies or to licensed professional individuals

such as, but not limited to, pharmacists, physicians, dentists, or veterinarians when engaged in the lawful pursuit of their professions.

(g) "Wholesale drug business" means the business of supplying non-prescription drugs to persons other than the ultimate consumer. This definition shall not apply to licensed pharmacies or to licensed professional individuals such as, but not limited to, pharmacists, physicians, dentists, or veterinarians when engaged in the lawful pursuit of their professions, and shall not apply to a registered drug manufacturing business.

86. Section 5 of P.L.2005, c.206 (C.24:6B-14) is amended to read as follows:

C.24:6B-14 Definitions relative to pharmaceutical wholesale distributors.

5. As used in sections 5 through 24 of P.L.2005, c.206 (C.24:6B-14 et seq.):

"Adulterated" means a prescription drug that is adulterated pursuant to R.S.24:5-10.

"Authenticate" means to affirmatively verify before any distribution of a prescription drug that each transaction listed on the pedigree has occurred.

"Authorized distributor" or "authorized distributor of record" means a wholesale distributor with whom a manufacturer has established an ongoing relationship to distribute the manufacturer's product. An ongoing relationship is deemed to exist when the wholesale distributor, or any member of its affiliated group as defined in section 1504 of the Internal Revenue Code of 1986 (26 U.S.C. s.1504): is listed on the manufacturer's list of authorized distributors; has a written agreement currently in effect with the manufacturer; or has a verifiable account with the manufacturer and meets or exceeds the following transaction or volume requirement thresholds:

a. 5,000 sales units per company within 12 months; or

b. 12 purchases by invoice at the manufacturer's minimum purchasing requirement per invoice within 12 months.

"Centralized prescription processing" means the processing by a pharmacy of a request from another pharmacy to fill or refill a prescription drug order or to perform processing functions such as dispensing, drug utilization review, claims adjudication, refill authorizations and therapeutic interventions.

"Chain pharmacy distribution center" means a distribution facility or warehouse owned by and operated for the primary use of a group of pharmacies that are under common or affiliated control or ownership.

"Commissioner" means the Commissioner of Health.

"Contraband" with respect to a prescription drug means: counterfeit; stolen; misbranded; obtained by fraud; purchased by a nonprofit institution for its own use and placed in commerce in violation of the own use agreement; or the existing documentation or pedigree, if required, for the prescription drug has been forged, counterfeited, falsely created, or contains any altered, false, or misrepresented information.

"Counterfeit prescription drug" means a prescription drug, or the container, shipping container, seal, or labeling thereof, which, without authorization, bears the trademark, trade name or other identifying mark, imprint, or any likeness thereof, of a manufacturer, processor, packer, or distributor other than the person or persons who in fact manufactured, processed, packed, or distributed the prescription drug and which thereby falsely purports or is represented to be the product of, or to have been packed or distributed by, such other manufacturer, processor, packer, or distributor.

"DEA" means the federal Drug Enforcement Administration.

"Department" means the Department of Health.

"Designated representative" means an individual who is designated by a wholesale prescription drug distributor to serve as the primary contact person for the wholesale distributor with the department, and who is responsible for managing the company's operations at that licensed location.

"Distribute" means to sell, offer to sell, deliver, offer to deliver, broker, give away, or transfer a prescription drug, whether by passage of title, physical movement, or both. The term does not mean to: dispense or administer; deliver or offer to deliver in the usual course of business as a common carrier or logistics provider, or provide a sample to a patient by a licensed practitioner, a health care professional acting at the direction and under the supervision of a practitioner, or the pharmacist of a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) acting at the direction of a practitioner.

"Drug" means: a. an article or substance recognized in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States or official National Formulary, or any supplement to any of them; b. an article or substance intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals; c. an article or substance, other than food, intended to affect the structure of any function of the body of man or animals; and d. an article or substance intended for use as a component of any article or substance specified in clause a., b., or c.; but does not include devices or their components, parts, or accessories. Drug includes a prefilled syringe or needle.

"Immediate container" means a container but does not include package liners.

"Logistics provider" means an entity that receives drugs from the original manufacturer and delivers them at the direction of that manufacturer, and does not purchase, sell, trade, or take title to the drugs.

"Misbranded" means a prescription drug with respect to which the label is: false or misleading in any particular; does not bear the name and address of the manufacturer, packer, or distributor and does not have an accurate statement of the quantities of the active ingredients; or does not show an accurate monograph for legend drugs; or is misbranded based upon other considerations as provided in the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. s.301 et seq.

"Pedigree" means a statement or record identifying each previous sale of a prescription drug, from the sale by a manufacturer through acquisition and sale by a wholesale distributor, including each distribution to an authorized distributor, starting with the last authorized distributor, or the manufacturer if the prescription drug has not been purchased previously by an authorized distributor or is a prescription drug on the specified list of susceptible products. A pedigree shall include the following information: the proprietary and established name of the prescription drug; the dosage; container size; number of containers; and the date, business name, and address of all parties to each prior transaction involving the prescription drug starting with the last authorized distributor or the manufacturer if the prescription drug has not been purchased previously by an authorized distributor or is a prescription drug on the specified list of susceptible products.

"Repackage" means changing the container, wrapper, quantity, or labeling of a prescription drug to further its distribution.

"Sales unit" means the unit of measure that the manufacturer uses to invoice its customer for the particular product.

"Specified list of susceptible products" means a specific list of prescription drugs, to be determined by the commissioner, that are considered to be potential targets for adulteration, counterfeiting, or diversion, which the commissioner shall provide to wholesale distributors

as prescription drugs are added to or removed from the list, along with notification of those changes.

"Wholesale distribution" means the distribution of prescription drugs in or into the State by a wholesale distributor to a person other than a consumer or patient, and includes transfers of prescription drugs from one pharmacy to another pharmacy if the value of the goods transferred exceeds 5% of total prescription drug sales revenue of either the transferor or transferee pharmacy during any consecutive 12-month period. The term excludes:

a. the sale, purchase or trade of a prescription drug, an offer to sell, purchase, or trade a prescription drug, or the dispensing of a prescription drug pursuant to a prescription;

b. the sale, purchase or trade of a prescription drug, or an offer to sell, purchase, or trade a prescription drug for emergency medical reasons;

c. the sale, purchase or trade of a prescription drug, or an offer to sell, purchase, or trade a prescription drug by pharmacies, chain pharmacy distribution centers, and the associated transfer of goods between chain pharmacy distribution centers and their servicing wholesale distributors or manufacturers;

d. intracompany transactions or sales among wholesale distributors, chain pharmacy distribution centers, and pharmacies, and which are limited to those sales or transfers of a prescription drug among members of an affiliated group, even if the members of the affiliated group are separate legal entities;

e. the sale, purchase or trade of a prescription drug, or an offer to sell, purchase, or trade a prescription drug among hospitals or other health care entities licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) that are under common control;

f. the sale, purchase or trade of a prescription drug, or offer to sell, purchase, or trade a prescription drug by a charitable organization exempt from taxation pursuant to section 501(c)(3) of the Internal Revenue Code of 1986 (26 U.S.C. s.501(c)(3)) to a nonprofit affiliate of the organization;

g. the purchase or other acquisition by a hospital or other similar health care entity licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) that is a member of a group purchasing organization of a prescription drug for its own use from the group purchasing organization or from other hospitals or similar health care entities that are members of these organizations;

h. the transfer of prescription drugs between pharmacies pursuant to a centralized prescription processing agreement;

i. the distribution of prescription drug samples by manufacturers' representatives or wholesale distributors' representatives;

j. the sale, purchase or trade of blood and blood components intended for transfusion;

k. prescription drug returns, when conducted by a pharmacy, chain pharmacy distribution center, hospital, health care entity licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.), or charitable institution in accordance with regulations established by the commissioner;

l. the sale of minimal quantities of prescription drugs by retail pharmacies to licensed practitioners for office use;

m. the stockpiling and distribution of drugs under the authorization of a State agency for the purpose of providing those products in an emergency situation; or

n. the sale, transfer, merger, or consolidation of all or part of the business of a pharmacy or pharmacies from or with another pharmacy or pharmacies whether accomplished as a purchase and sale of stock or business assets.

"Wholesale distributor" means any person, other than the manufacturer, pharmacy, logistics provider, or chain pharmacy distribution center, engaged in wholesale distribution of prescription drugs in or into the State and includes repackagers, own-label distributors, private-label distributors, jobbers, brokers, warehouses including distributors' warehouses, independent prescription drug traders, and retail pharmacies that conduct wholesale distribution.

87. Section 5 of P.L.1977, c.240 (C.24:6E-4) is amended to read as follows:

C.24:6E-4 Definitions.

5. As used in this act unless the context clearly indicates otherwise:

a. "Drug product" means a dosage form containing one or more active therapeutic ingredients along with other substances included during the manufacturing process.

b. "Brand name" means the proprietary name assigned to a drug by the manufacturer thereof.

c. "Established name" with respect to a drug or ingredient thereof, means (1) the applicable official name designated pursuant to the Federal Food, Drug and Cosmetic Act (Title 21, U.S.C. s.301 et seq.), or (2) if there is no such official name and such drug or ingredient is recognized in an official compendium, then the official title thereof in such compendium, except that where a drug or ingredient is recognized in the United States Pharmacopoeia and in the Homeopathic Pharmacopoeia under different official titles, the official title used in the United States Pharmacopoeia shall apply unless it is labeled and offered for sale as a homeopathic drug, in which case the official title used in the Homeopathic Pharmacopoeia shall apply, or (3) if neither (1) nor (2) is applicable, then the common or usual name, if any, of such drug or ingredient.

d. "Prescription" means an order for drugs or combinations or mixtures thereof, written or signed by a duly licensed physician, dentist, veterinarian, or other medical practitioner licensed to write prescriptions intended for the treatment or prevention of disease in man or animals, and includes orders for drugs or medicines or combinations or mixtures thereof transmitted to pharmacists through word of mouth, telephone, telegraph, or other means of communication by a duly licensed physician, dentist, veterinarian, or other medical practitioner licensed to write prescriptions intended for the treatment or prevention of disease in man or animals.

e. "Department" means the Department of Health.

f. "Chemical equivalents" means those drug products that contain the same amounts of the same therapeutically active ingredients in the same dosage forms and that meet present compendial standards.

g. "Reference drug product" means the product which is adopted by the department as the standard for other chemically equivalent drugs in terms of testing for the therapeutic equivalence. In all cases, the reference drug product shall be a currently marketed drug which is the subject of a full (not abbreviated) new drug application approved by the Federal Food and Drug Administration.

h. "Therapeutic equivalents" means chemical equivalents which, when administered to the same individuals in the same dosage regimen, will provide essentially the same efficacy or toxicity as their respective reference drug products.

i. "Bioavailability" means the extent and rate of absorption from a dosage form as reflected by the time-concentration curve of the administered drug in the systemic circulation.

j. "Bioequivalents" means chemical equivalents which, when administered to the same individuals in the same dosage regimen, will result in comparable bioavailability.

k. "Pharmaceutical equivalents" means those drug products that contain the same amounts of the same therapeutically active ingredients in the same dosage form and that meet established standards.

l. "Interchangeable drug products" means pharmaceutical equivalents or bioequivalents that are determined to be therapeutic equivalents by the department.

m. "Present compendial standards" means the official standards for drug excipients and drug products listed in the latest revision of the United States Pharmacopoeia (USP) and the National Formulary (NF).

n. "Dosage form" means the physical formulation or medium in which the product is intended, manufactured and made available for use, including, but not limited to: tablets, capsules, oral solutions, aerosols, inhalers, gels, lotions, creams, ointments, transdermals and suppositories, and the particular form of the above which utilizes a specific technology or mechanism to control, enhance, or direct the release, targeting, systemic absorption, or other delivery of a dosage regimen in the body.

88. Section 2 of P.L.2003, c.57 (C.24:6H-2) is amended to read as follows:

C.24:6H-2 Label required on ephedrine alkaloid products.

2. A product that contains ephedrine alkaloids that is not a drug as defined in R.S.24:1-1, shall not be sold or offered for sale in this State after the effective date of this act unless its label indicates that the sale of the product to minors under 18 years of age is prohibited by State law, in accordance with regulations adopted by the Commissioner of Health.

89. Section 3 of P.L.2003, c.57 (C.24:6H-3) is amended to read as follows:

C.24:6H-3 Rules, regulations.

3. The Commissioner of Health shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to carry out the purposes of this act.

90. Section 3 of P.L.2009, c.307 (C.24:6I-3) is amended to read as follows:

C.24:6I-3 Definitions relative to the medical use of marijuana.

3. As used in this act:

"Bona fide physician-patient relationship" means a relationship in which the physician has ongoing responsibility for the assessment, care, and treatment of a patient's debilitating medical condition.

"Certification" means a statement signed by a physician with whom a qualifying patient has a bona fide physician-patient relationship, which attests to the physician's authorization for the patient to apply for registration for the medical use of marijuana.

"Commissioner" means the Commissioner of Health.

"Debilitating medical condition" means:

(1) one of the following conditions, if resistant to conventional medical therapy: seizure disorder, including epilepsy; intractable skeletal muscular spasticity; or glaucoma;

(2) one of the following conditions, if severe or chronic pain, severe nausea or vomiting, cachexia, or wasting syndrome results from the condition or treatment thereof: positive status for human immunodeficiency virus; acquired immune deficiency syndrome; or cancer;

(3) amyotrophic lateral sclerosis, multiple sclerosis, terminal cancer, muscular dystrophy, or inflammatory bowel disease, including Crohn's disease;

(4) terminal illness, if the physician has determined a prognosis of less than 12 months of life; or

(5) any other medical condition or its treatment that is approved by the department by regulation.

"Department" means the Department of Health.

"Marijuana" has the meaning given in section 2 of the "New Jersey Controlled Dangerous Substances Act," P.L.1970, c.226 (C.24:21-2).

"Medical marijuana alternative treatment center" or "alternative treatment center" means an organization approved by the department to perform activities necessary to provide registered qualifying patients with usable marijuana and related paraphernalia in accordance with the provisions of this act. This term shall include the organization's officers, directors, board members, and employees.

"Medical use of marijuana" means the acquisition, possession, transport, or use of marijuana or paraphernalia by a registered qualifying patient as authorized by this act.

"Minor" means a person who is under 18 years of age and who has not been married or previously declared by a court or an administrative agency to be emancipated.

"Paraphernalia" has the meaning given in N.J.S.2C:36-1.

"Physician" means a person licensed to practice medicine and surgery pursuant to Title 45 of the Revised Statutes with whom the patient has a bona fide physician-patient relationship and who is the primary care physician, hospice physician, or physician responsible for the ongoing treatment of a patient's debilitating medical condition, provided, however, that the ongoing treatment shall not be limited to the provision of authorization for a patient to use medical marijuana or consultation solely for that purpose.

"Primary caregiver" or "caregiver" means a resident of the State who:

a. is at least 18 years old;

b. has agreed to assist with a registered qualifying patient's medical use of marijuana, is not currently serving as primary caregiver for another qualifying patient, and is not the qualifying patient's physician;

c. has never been convicted of possession or sale of a controlled dangerous substance, unless such conviction occurred after the effective date of this act and was for a violation of federal law related to possession or sale of marijuana that is authorized under this act;

d. has registered with the department pursuant to section 4 of this act, and has satisfied the criminal history record background check requirement of section 4 of this act; and

e. has been designated as primary caregiver on the qualifying patient's application or renewal for a registry identification card or in other written notification to the department.

"Qualifying patient" or "patient" means a resident of the State who has been provided with a certification by a physician pursuant to a bona fide physician-patient relationship.

"Registry identification card" means a document issued by the department that identifies a person as a registered qualifying patient or primary caregiver.

"Usable marijuana" means the dried leaves and flowers of marijuana, and any mixture or preparation thereof, and does not include the seeds, stems, stalks or roots of the plant.

91. Section 15 of P.L.2009, c.307 (C.24:6I-13) is amended to read as follows:

C.24:6I-13 Exchange of data, information.

15. a. The Department of Health is authorized to exchange fingerprint data with, and receive information from, the Division of State Police in the Department of Law and Public Safety and the Federal Bureau of Investigation for use in reviewing applications for individuals seeking to serve as primary caregivers pursuant to section 4 of P.L.2009, c.307 (C.24:6I-4), and for permits to operate as, or to be a director, officer, or employee of, alternative treatment centers pursuant to section 7 of P.L.2009, c.307 (C.24:6I-7).

b. The Division of State Police shall promptly notify the Department of Health in the event an applicant seeking to serve as a primary caregiver or an applicant for a permit to operate as, or to be a director, officer, or employee of, an alternative treatment center, who was the subject of a criminal history record background check conducted pursuant to subsection a. of this section, is convicted of a crime involving possession or sale of a controlled dangerous substance.

92. Section 2 of P.L.1970, c.226 (C.24:21-2) is amended to read as follows:

C.24:21-2 Definitions.

2. As used in this act:

"Administer" means the direct application of a controlled dangerous substance, whether by injection, inhalation, ingestion, or any other means, to the body of a patient or research subject by: (1) a practitioner (or, in his presence, by his lawfully authorized agent), or (2) the patient or research subject at the lawful direction and in the presence of the practitioner.

"Agent" means an authorized person who acts on behalf of or at the direction of a manufacturer, distributor, or dispenser but does not include a common or contract carrier, public warehouseman, or employee thereof.

"Commissioner" means the Commissioner of Health.

"Controlled dangerous substance" means a drug, substance, or immediate precursor in Schedules I through V of article 2 of P.L.1970, c.226 (C.24:21-1 et seq.). The term shall not include distilled spirits, wine, malt beverages, as those terms are defined or used in R.S.33:1-1 et seq., or tobacco and tobacco products.

"Counterfeit substance" means a controlled dangerous substance which, or the container or labeling of which, without authorization, bears the trademark, trade name, or other identifying mark, imprint, number or device, or any likeness thereof, of a manufacturer, distributor, or dispenser other than the person or persons who in fact manufactured, distributed, or dispensed such substance and which thereby falsely purports or is represented to be the product of, or to have been distributed by, such other manufacturer, distributor, or dispenser.

"Deliver" or "delivery" means the actual, constructive, or attempted transfer from one person to another of a controlled dangerous substance, whether or not there is an agency relationship.

"Director" means the Director of the Division of Consumer Affairs in the Department of Law and Public Safety.

"Dispense" means to deliver a controlled dangerous substance to an ultimate user or research subject by or pursuant to the lawful order of a practitioner, including the prescribing, administering, packaging, labeling, or compounding necessary to prepare the substance for that delivery. "Dispenser" means a practitioner who dispenses.

"Distribute" means to deliver other than by administering or dispensing a controlled dangerous substance. "Distributor" means a person who distributes.

"Division" means the Division of Consumer Affairs in the Department of Law and Public Safety.

"Drug Enforcement Administration" means the Drug Enforcement Administration in the United States Department of Justice.

"Drugs" means (a) substances recognized in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States, or official National Formulary, or any supplement to any of them; and (b) substances intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals; and (c) substances (other than food) intended to affect the structure or any function of the body of man or other animals; and (d) substances intended for use as a component of any article specified in subsections (a), (b), and (c) of this section; but does not include devices or their components, parts or accessories.

"Drug dependent person" means a person who is using a controlled dangerous substance and who is in a state of psychic or physical dependence, or both, arising from the use of that controlled dangerous substance on a continuous basis. Drug dependence is characterized by behavioral and other responses, including but not limited to a strong compulsion to take the substance on a recurring basis in order to experience its psychic effects, or to avoid the discomfort of its absence.

"Hashish" means the resin extracted from any part of the plant Genus Cannabis L. and any compound, manufacture, salt, derivative, mixture, or preparation of such resin.

"Marihuana" means all parts of the plant Genus Cannabis L., whether growing or not; the seeds thereof; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant or its seeds, except those containing resin extracted from the plant; but shall not include the mature stalks of the plant, fiber produced from the stalks, oil or cake made from the seeds of the plant, any other compound, manufacture, salt, derivative, mixture, or preparation of such mature stalks, fiber, oil, or cake, or the sterilized seed of the plant which is incapable of germination.

"Manufacture" means the production, preparation, propagation, compounding, conversion, or processing of a controlled dangerous substance, either directly or by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, and includes any packaging or repackaging of the substance or labeling or relabeling of its container, except that this term does not include the preparation or compounding of a controlled dangerous substance by an individual for his own use or the preparation, compounding, packaging, or labeling of a controlled dangerous substance: (1) by a practitioner as an incident to his administering or dispensing of a controlled dangerous substance in the course of his professional practice, or (2) by a practitioner (or under his supervision) for the purpose of, or as an incident to, research, teaching, or chemical analysis and not for sale.

"Narcotic drug" means any of the following, whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis:

(a) Opium, coca leaves, and opiates;

(b) A compound, manufacture, salt, derivative, or preparation of opium, coca leaves, or opiates;

(c) A substance (and any compound, manufacture, salt, derivative, or preparation thereof) which is chemically identical with any of the substances referred to in subsections (a) and (b), except that the words "narcotic drug" as used in this act shall not include decocainized coca leaves or extracts of coca leaves, which extracts do not contain cocaine or ecgonine.

"Official written order" means an order written on a form provided for that purpose by the Attorney General of the United States or his delegate, under any laws of the United States making provisions therefor, if such order forms are authorized and required by the federal law, and if no such form is provided, then on an official form provided for that purpose by the division. If authorized by the Attorney General of the United States or the division, the term shall also include an order transmitted by electronic means.

"Opiate" means any dangerous substance having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having such addiction-forming or addiction-sustaining liability. It does not include, unless specifically designated as controlled under section 3 of this act, the dextrorotatory isomer of 3-methoxy-n-methylmorphinan and its salts (dextromethorphan). It does include its racemic and levorotatory forms.

"Opium poppy" means the plant of the species Papaver somniferum L., except the seeds thereof.

"Person" means any corporation, association, partnership, trust, other institution or entity, or one or more individuals.

"Pharmacist" means a registered pharmacist of this State.

"Pharmacy owner" means the owner of a store or other place of business where controlled dangerous substances are compounded or dispensed by a registered pharmacist; but nothing in this chapter contained shall be construed as conferring on a person who is not registered or licensed as a pharmacist any authority, right, or privilege that is not granted to him by the pharmacy laws of this State.

"Poppy straw" means all parts, except the seeds, of the opium poppy, after mowing.

"Practitioner" means a physician, dentist, veterinarian, scientific investigator, laboratory, pharmacy, hospital, or other person licensed, registered, or otherwise permitted to distribute, dispense, conduct research with respect to, or administer a controlled dangerous substance in the course of professional practice or research in this State.

(a) "Physician" means a physician authorized by law to practice medicine in this or any other state and any other person authorized by law to treat sick and injured human beings in this or any other state.

(b) "Veterinarian" means a veterinarian authorized by law to practice veterinary medicine in this State.

(c) "Dentist" means a dentist authorized by law to practice dentistry in this State.

(d) "Hospital" means any federal institution, or any institution for the care and treatment of the sick and injured, operated or approved by the appropriate State department as proper to be entrusted with the custody and professional use of controlled dangerous substances.

(e) "Laboratory" means a laboratory to be entrusted with the custody of narcotic drugs and the use of controlled dangerous substances for scientific, experimental, and medical purposes and for purposes of instruction approved by the Department of Health.

"Production" includes the manufacture, planting, cultivation, growing, or harvesting of a controlled dangerous substance.

"Immediate precursor" means a substance which the division has found to be and by regulation designates as being the principal compound commonly used or produced primarily for use, and which is an immediate chemical intermediary used or likely to be used in the manufacture of a controlled dangerous substance, the control of which is necessary to prevent, curtail, or limit such manufacture.

"State" means the State of New Jersey.

"Ultimate user" means a person who lawfully possesses a controlled dangerous substance for his own use or for the use of a member of his household or for administration to an animal owned by him or by a member of his household.

C.26:1A-2.1 Redesignation as Department of Health, Commissioner of Health.

93. a. The Department of Health, established pursuant to P.L.1947, c.177 (C.26:1A-1 et seq.), and continued and constituted and redesignated as the Department of Health and Senior Services pursuant to Reorganization Plan No. 001-1996, is continued and constituted and redesignated as the Department of Health. The Commissioner of Health and Senior Services shall be redenominated as the Commissioner of Health.

b. Whenever the terms “Department of Health and Senior Services” and “Commissioner of Health and Senior Services” occur or any references are made thereto in any law, rule, regulation, order, contract, document, judicial or administrative proceeding, or otherwise, the same shall be deemed to mean or refer to the “Department of Health” and the “Commissioner of Health,” respectively.

c. The Commissioner of Health shall have the power, not inconsistent with section 13 of P.L.1947, c.177 (C.26:1A-13) or the provisions of P.L.2012, c.17 (C.26:1A-2.1 et al.), to organize the work of the Department of Health in such organizational units as the commissioner may determine to be necessary for its efficient and effective operation.

94. Section 11 of P.L.1999, c.154 (C.26:1A-15.1) is amended to read as follows:

C.26:1A-15.1 Advisory board on health information electronic data interchange technology, Statewide electronic health record policy.

11. The Commissioner of Health, in consultation with the Commissioner of Banking and Insurance, shall establish an advisory board to make recommendations to the commissioners on health information electronic data interchange technology policy, including a Statewide policy on electronic health records, and measures to protect the confidentiality of medical information. The members of the board shall include, at a minimum, representation from health insurance carriers, health care professionals and facilities, higher education, business and organized labor, health care consumers, and the commissioner of each department in the State that uses individuals' medical records or processes claims for health care services. The members of the board shall serve without compensation but shall be entitled to reimbursement for reasonable expenses incurred in the performance of their duties.

95. Section 12 of P.L.1999, c.154 (C.26:1A-15.2) is amended to read as follows:

C.26:1A-15.2 Annual report to Governor, Legislature.

12. The Commissioner of Health, in conjunction with the Commissioner of Banking and Insurance, shall present an annual report to the Governor and the Legislature on the development and use of health information electronic data interchange technology in New Jersey. The report shall be prepared in consultation with the advisory board established pursuant to section 11 of P.L.1999, c.154 (C.26:1A-15.1). The report shall include any recommendations, including proposals for regulatory and legislative changes, to promote the development and use of health information electronic data interchange technology in this State.

96. Section 2 of P.L.1993, c.309 (C.26:1A-36.7) is amended to read as follows:

C.26:1A-36.7 Early intervention services established.

2. The Department of Health, in conjunction with the Departments of Education and Human Services, shall establish a Statewide system of early intervention services for eligible infants and toddlers from birth to age two, inclusive, with physical, cognitive, communication, social, or emotional, and adaptive developmental delays or disabilities in accordance with Part H of the "Individuals with Disabilities Education Act," Pub.L.91-230 (20 U.S.C. s.1471 et seq.).

97. Section 2 of P.L.2007, c.172 (C.26:1A-36.7a) is amended to read as follows:

C.26:1A-36.7a Activities of Early Intervention Program relative to autism spectrum disorders.

2. The Early Intervention Program in the Department of Health, established pursuant to section 2 of P.L.1993, c.309 (C.26:1A-36.7), shall conduct activities to address the specific needs of children with autism spectrum disorders and their families. These activities shall include, but not be limited to, the following:

a. developing, in consultation with autism experts and advocates, including, but not limited to, the Governor's Council for Medical Research and Treatment of Autism, Autism Speaks, The New Jersey Center for Outreach and Services for the Autism Community, The Autism Center of New Jersey Medical School at the University of Medicine and Dentistry of New Jersey, the Statewide Parent Advocacy Network, Inc., and the New Jersey chapter of the American Academy of Pediatrics, guidelines for health care professionals to use in evaluating infants and toddlers living in the State for autism and to ensure the timely referral by health care professionals of infants and toddlers who are identified as having autism or suspected of being on the autism spectrum to the Early Intervention Program in order to provide appropriate services to those infants and toddlers as early as possible;

b. referring affected children who are identified as having autism or suspected of being on the autism spectrum and their families to schools and agencies, including community, consumer, and parent-based agencies, and organizations and other programs mandated by Part C of the "Individuals with Disabilities Education Act" (20 U.S.C. s.1431 et seq.), which offer programs specifically designed to meet the unique needs of children with autism;

c. collecting data on Statewide autism screening, diagnosis, and intervention programs and systems that can be used for applied research, program evaluation, and policy development; and

d. disseminating information on the medical care of individuals with autism to health care professionals and the general public.

98. Section 2 of P.L.1999, c.265 (C.26:1A-37.6) is amended to read as follows:

C.26:1A-37.6 New Jersey Council on Physical Fitness and Sports.

2. There is established in the Department of Health a New Jersey Council on Physical Fitness and Sports which shall serve the citizens of the State by developing safe, healthful, and enjoyable physical fitness and sports programs. The council shall provide instruments of motivation and education, and shall promote public awareness to ensure that all citizens of the State have the opportunity to pursue a more healthful lifestyle.

99. Section 3 of P.L.1999, c.265 (C.26:1A-37.7) is amended to read as follows:

C.26:1A-37.7 Council, members, terms, compensation, administration.

3. a. The council shall consist of 16 members, including: the Commissioner of Health, or the commissioner's designee, who shall serve as an ex officio member; and 15 public members to be appointed by the Governor as follows: one member each from the New Jersey Association of Health, Physical Education, Recreation and Dance; the New Jersey Recreation and Parks Association; the Medical Society of New Jersey; the New Jersey State Interscholastic Athletic Association; and such other persons or professionals as are interested in the physical fitness of the citizens of the State. The council shall meet and organize immediately after appointment of the members and shall elect from its membership a chairperson and vice chairperson.

b. Each public member of the council shall serve for a term of three years, expiring on January 1 in the appropriate year; except that of the members first appointed, four shall be appointed for a term of one year, five shall be appointed for a term of two years and six shall be appointed for a term of three years, as determined by the Governor. Each member shall hold office for the term of appointment and until a successor is appointed and qualified. A public member of the council shall be eligible for reappointment. Members appointed to fill a vacancy occurring for any reason other than the expiration of the term shall serve for the unexpired term only.

c. Public members shall serve without compensation, but shall be reimbursed for necessary expenses incurred in the performance of their duties.

d. The council shall adopt rules for the transaction of its business and shall keep a record of its business, including a record of its resolutions, transactions, findings and determinations. A majority of the members of the council shall constitute a quorum, but a lesser number may hold a hearing.

e. The council shall meet at least once in each quarter of the fiscal year, and as often thereafter as shall be deemed necessary by the chairperson.

f. By a two-thirds vote of the council, a member may be dismissed from membership for such reasons as the council may establish, which reasons shall include lack of interest in council duties or repeated absences from council meetings.

g. The council shall be administrated by the Department of Health. The department shall employ necessary staff to carry out the duties and functions of the council as otherwise provided in this act or as otherwise provided by law.

100. Section 41 of P.L.1947, c.177 (C.26:1A-41) is amended to read as follows:

C.26:1A-41 Issuance of licenses for health officer, registered environmental health specialist.

41. The commissioner shall, in the name of the department, issue the following licenses:

a. Health officer's license;

b. (Deleted by amendment, P.L.1997, c.416).

c. (Deleted by amendment, P.L.1997, c.416).

d. (Deleted by amendment, P.L.1997, c.416).

e. (Deleted by amendment, P.L.1997, c.416).

f. (Deleted by amendment, P.L.1997, c.416).

g. (Deleted by amendment, P.L.1997, c.416).

h. (Deleted by amendment, P.L.1997, c.416).

i. (Deleted by amendment, P.L.1997, c.416).

j. (Deleted by amendment, P.L.1997, c.416).

k. Registered environmental health specialist's license.

However, any health officer's license, sanitary inspector's license, and plumbing inspector's license issued before the effective date of P.L.1947, c.177 (C.26:1A-1 et seq.) by the Department of Health shall, unless suspended or revoked in accordance with the provisions of sections 43 and 44 of that act, remain in effect during the employment as such of the holder thereof. Upon enactment of P.L.1997, c.416 (C.26:1A-42.1 et al.) any existing Sanitary Inspector, First Grade license shall become a Registered Environmental Health Specialist license without any further action required of the licensee.

Any license eliminated by P.L.1997, c.416 (C.26:1A-42.1 et al.) shall, unless suspended or revoked in accordance with the provisions of sections 43 and 44 of P.L.1947, c.177 (C.26:1A-43 and C.26:1A-44), remain in effect until the holder thereof does not renew the license within two years from the date of its expiration, or the commissioner does not renew the license in accordance with section 42 of that act, whichever comes first.

101. Section 43 of P.L.1947, c.177 (C.26:1A-43) is amended to read as follows:

C.26:1A-43 Suspension, revocation of license.

43. Any license issued in accordance with the provisions of this article, and any health officer's license or sanitary inspector's license heretofore issued by the Department of Health, may be suspended or revoked, after notice and hearing conducted by an administrative law judge pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), for any of the following causes:

a. Violation of any of the provisions of this act or of any law relating to public health;

b. Violation of any provision of the State Sanitary Code;

c. Violation of any applicable local health regulation or ordinance;

d. Any act or happening occurring after the making of application for such license which, if the same had occurred prior to said time, would have prevented the issuance of such license; or

e. A conviction in a court of competent jurisdiction, either within or outside this State, of a crime involving moral turpitude, except that if the conviction is reversed and the holder of the license is discharged or acquitted, or if the holder is pardoned or the civil rights of the holder are restored, the holder may obtain a license.

Notwithstanding any provision of section 10 of P.L.1968, c.410 (C.52:14B-10) to the contrary, the commissioner, before adopting, rejecting or modifying the recommended report and decision of an administrative law judge, shall consult with the Public Health Council.

The suspension or revocation of a license shall be effected by a notice in writing of the suspension or revocation, designating the effective date thereof, and in the case of a suspension, the term of the suspension, which notice may be served upon the licensee personally or by mailing the same by registered mail addressed to the licensee at the licensee's home address.

The commissioner shall file a copy of the notice of suspension or revocation of license with the local board of health.

102. Section 1 of P.L.1957, c.72 (C.26:1A-107) is amended to read as follows:

C.26:1A-107 Division of Aging Services.

1. There is hereby established in the Department of Human Services, a Division of Aging Services, consisting of a director and the New Jersey State Commission on Aging in accordance with the provisions of section 398 of P.L.2012, c.17 (C.30:1A-14).

103. Section 6 of P.L.1957, c.72 (C.26:1A-112) is amended to read as follows:

C.26:1A-112 Appointment of staff, compensation.

6. The Commissioner of Human Services may appoint such professional, technical, and clerical assistants and employees as may be necessary to enable the division and the commission to perform the duties imposed upon it by this act and their compensation shall be fixed within the limits of available appropriations and as shall be provided by law. The assistants and employees, together with the director of the division, shall be deemed to be the staff of the division and the commission. The advisory commission shall meet at regular intervals and at least 4 times annually. The times and places for the said meetings shall be fixed by the commission and special meetings may be called by the director on not less than 10 days' written notice to each member, and any such notice shall specify the object of the meeting.

104. Section 9 of P.L.1966, c.61 (C.26:1A-113.1) is amended to read as follows:

C.26:1A-113.1 Powers and duties of commission.

9. The commission shall:

(1) Furnish consultation and advice to the Division of Aging Services on programs designed to carry out the division's mandate.

(2) Provide leadership in the field of aging.

(3) Make recommendations to the Governor and Legislature regarding new legislation needed in areas related to aging.

(4) Maintain liaison with other commissions and groups whose activities relate to the broad field of aging.

105. Section 10 of P.L.1966, c.61 (C.26:1A-115.1) is amended to read as follows:

C.26:1A-115.1 Agreements with federal government; reimbursement.

10. The Commissioner of Human Services, subject to the approval of the Governor, is authorized, on behalf of the State of New Jersey, to enter into agreements with the Federal Government or any agency thereof, under which the Division of Aging Services (1) will provide or otherwise secure the adoption of programs consonant with the objectives of this act and (2) will receive reimbursement from the United States for any such costs incurred, expenses paid, or allowances and benefits paid in connection with said programs in accordance with said agreement and the laws of this State or of the United States.

106. Section 2 of P.L.2001, c.376 (C.26:1A-124) is amended to read as follows:

C.26:1A-124 Office of Women’s Health.

2. There is established the Office on Women's Health in the Department of Health.

The office shall:

a. Provide grants to community-based organizations to conduct special research, demonstration, and evaluation projects on women's health concerns;

b. Develop and implement model public and private partnerships throughout the State for health awareness campaigns and to improve the access, acceptability, and use of public health services;

c. Serve as an information and resource center for women's health information and data;

d. Function as an advocate for the adoption and implementation of effective measures to improve women's health;

e. Convene such task forces of experienced, knowledgeable persons on specific women's health issues as the director deems appropriate; and

f. Review the programs of the Departments of Health, Human Services, Children and Families, and Education and any other department of State government, as appropriate, that concern women's health and make recommendations to the departments that will enable them to better coordinate and improve the effectiveness of their efforts.

107. Section 3 of P.L.2001, c.376 (C.26:1A-125) is amended to read as follows:

C.26:1A-125 Appointment of director.

3. The Commissioner of Health shall appoint a director for the office who shall serve at the pleasure of the commissioner during the commissioner's term of office and until the appointment and qualification of the director's successor. The director shall devote his entire time to the duties of the position and shall receive a salary as provided by law.

108. Section 5 of P.L.2001, c.376 (C.26:1A-127) is amended to read as follows:

C.26:1A-127 Women’s Health Advisory Commission.

5. There is established a Women's Health Advisory Commission.

The commission shall consist of nine members, including the Commissioner of Health or his designee, who shall serve ex officio, and eight public members who are residents of the State and who shall be appointed as follows: one member who is a health care professional shall be appointed by the President of the Senate; one member who is a health care professional shall be appointed by the Speaker of the General Assembly; and six members, at least two of whom are health care professionals, at least one of whom represents health care facilities, at least one of whom represents the health insurance industry, and at least one of whom is a woman with a disability, shall be appointed by the Governor with the advice and consent of the Senate. No less than five of the public members shall be women.

The term of office of each public member shall be three years, but of the members first appointed, two shall be appointed for a term of one year, three shall be appointed for a term of two years and three shall be appointed for a term of three years. A member shall hold office for the term of his appointment and until his successor has been appointed and qualified. All vacancies shall be filled for the balance of the unexpired term in the same manner as the original appointment. A member of the commission is eligible for reappointment.

The public members of the commission shall not receive any compensation for their services, but shall be reimbursed for the actual and necessary expenses incurred in the performance of their duties as members of the commission, within the limits of funds available to the commission.

The members of the commission shall annually elect a chairman and a vice-chairman from among the public members and may select a secretary, who need not be a member of the commission.

The Office on Women's Health in the Department of Health shall provide staff and assistance which the commission requires to carry out its work.

109. Section 9 of P.L.2001, c.376 (C.26:1A-131) is amended to read as follows:

C.26:1A-131 Rules, regulations.

9. The Commissioner of Health shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to carry out the purposes of this act.

110. Section 5 of P.L.2007, c.330 (C.26:1A-136) is amended to read as follows:

C.26:1A-136 New Jersey Health Information Technology Commission.

5. a. There is established the New Jersey Health Information Technology Commission. For the purpose of complying with the provisions of Article V, Section IV, paragraph 1 of the New Jersey Constitution, the commission is established within the Department of Health, but, notwithstanding the establishment, the commission shall be independent of any supervision or control by the department or any board or officer thereof.

b. The commission shall collaborate with the Office for e-HIT established pursuant to section 8 of this act (C.17:1D-1), concerning all activities related to the development, implementation, and oversight of the plan.

The commission shall be responsible for approving the Statewide health information technology plan.

c. In providing advice on the development of the plan, the commission shall, at a minimum, consider the following:

(1) the importance of the education of the general public and health care professionals about the value of an electronic health infrastructure for improving the delivery of patient care;

(2) the means for the creation of an effective, efficient, Statewide use of electronic health information in patient care, health care policymaking, clinical research, health care financing, and continuous quality improvements;

(3) the means for the promotion of the use of national standards for the development of an interoperative system, including provisions relating to security, privacy, data content, structures and format, vocabulary, and transmission protocols;

(4) the nature of proper strategic investments in equipment and other infrastructure elements that will facilitate the ongoing development of a Statewide infrastructure;

(5) funding needs for the ongoing development of health information technology projects;

(6) actions needed to incorporate existing health care information technology initiatives into the plan in order to avoid incompatible systems and duplicative efforts;

(7) the proper means for the review and integration of the recommendations, findings, and conclusions of the New Jersey Health Information Security and Privacy Collaboration;

(8) the importance of recommending steps for the proper resolution of issues related to data ownership, governance, and confidentiality and security of patient information;

(9) the importance of promoting the deployment of health information technology in primary care provider settings; and

(10) the roles that the development and use of open-source electronic medical record software and the use of application service provider software can play in effectuating the purposes of paragraph (9) of this subsection.

d. The commission shall review the plan submitted by the Office for e-HIT and notify it of any changes needed to approve the plan.

111. Section 6 of P.L.2007, c.330 (C.26:1A-137) is amended to read as follows:

C.26:1A-137 Membership of commission; terms; authority.

6. a. The New Jersey Health Information Technology Commission shall be comprised of 19 members as follows:

(1) the Commissioners of Health, Banking and Insurance, Children and Families, and Human Services, and the State Treasurer, or their designees, who shall serve ex officio; and

(2) 14 public members, who shall be appointed by the Governor no later than the 60th day after the effective date of this act, as follows: three physicians engaged in private practice in this State, one of whom is a pediatrician and one a psychiatrist; two persons who represent acute care hospitals in this State, one of whom represents a teaching hospital and the other a non-teaching hospital; a registered professional nurse practicing in this State; a pharmacist practicing in this State; a person who represents a clinical laboratory operating in this State; an attorney practicing in this State with demonstrated expertise in health privacy issues; a person who represents a health insurance carrier operating in this State; a person who represents a Quality Improvement Organization located in New Jersey that contracts with the federal Centers for Medicare & Medicaid Services to improve the efficiency and effectiveness, economy, and quality of services provided to Medicare beneficiaries; and three members of the public with a demonstrated professional expertise in issues relating to the work of the commission, including one member with expertise in electronic health information technology.

(3) The Governor shall designate a public member as chair of the commission.

b. The public members shall serve for a term of three years; except that, of the public members first appointed, five shall serve for a term of three years, five for a term of two years, and four for a term of one year. Vacancies in the membership of the commission shall be filled in the same manner as the original appointments were made.

c. The commission shall organize as soon as may be practicable, but no later than the 45th day after the appointment of its members. The public members shall serve without compensation, but may be reimbursed for necessary expenses incurred in the performance of their duties.

d. A majority of the total authorized membership of the commission shall constitute a quorum at any meeting thereof. Action may be taken and motions and resolutions adopted by the commission at any meeting of the commission by the affirmative vote of a majority of the quorum of the members who are present. A vacancy in the membership of the commission shall not impair the right of a quorum of the members to exercise all the powers and perform all the duties of the commission.

e. The commission shall meet and confer with the Office for e-HIT at least quarterly and may meet at other times at the call of the commission chair. The meetings of the commission shall comply with the provisions of the "Senator Byron M. Baer Open Public Meetings Act," P.L.1975, c.231 (C.10:4-6 et seq.).

f. In addition to any other powers authorized by law, the commission shall have the authority, in accordance with State law, to:

(1) make and enter into contracts to purchase services and supplies;

(2) develop and submit a proposed budget, not to exceed $1 million annually;

(3) apply for, receive, and expend grants from governmental or private nonprofit sources;

(4) recommend to the Department of Banking and Insurance the necessary charges and assessments to be levied to collect payments from persons and entities for the provision of services or as the Office for e-HIT otherwise determines necessary to effectuate the purposes of this act;

(5) receive and expend appropriations;

(6) provide such other services and perform such other functions as the commission deems necessary to fulfill its responsibilities under this act; and

(7) appoint, retain, or employ consultants on a contract basis or otherwise, who are deemed necessary, and as may be within the limits of funds appropriated or otherwise made available to it for its purposes.

g. In collaboration with the Office for e-HIT, the commission shall, no later than 18 months after its initial meeting and annually thereafter, submit a joint report to the Governor, and to the Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), concerning its activities and the status of, and actions taken regarding development, implementation, and oversight of the Statewide health information technology plan. The commission shall include in that report any findings and recommendations that it desires to make, along with any legislative bills that it desires to recommend for adoption by the Legislature.

h. The commission shall develop and submit a proposed budget to the Commissioner of Health to effectuate its duties as set forth in this act.

The budget shall be subject to approval by the Commissioner of Health.

i. The commission shall appoint a full-time executive director, who shall serve as secretary to the commission. The executive director shall serve at the pleasure of the commission and shall be qualified by training and experience to perform the duties of the position. The executive director shall be in the unclassified service of the Civil Service and may hire properly qualified employees, within the limits of funds appropriated or otherwise made available to the commission, who shall also be employed in the unclassified service of the Civil Service; except that employees performing stenographic or clerical duties shall be in the career service and appointed pursuant to Title 11A of the New Jersey Statutes.

112. Section 2 of P.L.2001, c.373 (C.26:2-103.2) is amended to read as follows:

C.26:2-103.2 Definitions relative to universal newborn hearing screening.

2. As used in this act:

"Commissioner" means the Commissioner of Health.

"Department" means the Department of Health.

"Electrophysiologic screening measures" means the electrical result of the application of physiologic agents and includes, but is not limited to, the procedures currently known as Auditory Brainstem Response testing (ABR) and Otoacoustic Emissions testing (OAE) and any other procedure adopted by regulation by the commissioner.

"Hearing loss" means a hearing loss of 30dB or greater in the frequency region important for speech recognition and comprehension in one or both ears, which is approximately 500 through 4000 Hz., except that the commissioner may adopt a standard which establishes a less severe hearing loss, as appropriate.

"Newborn" means a child up to 28 days old.

"Parent" means a biological parent, stepparent, adoptive parent, legal guardian, or other legal custodian of a child.

113. Section 2 of P.L.1977, c.266 (C.26:2-105) is amended to read as follows:

C.26:2-105 Establishment, maintenance of State cancer registry.

2. The Department of Health shall establish and maintain an up-to-date registry which shall include a record of cases of cancer and specified cases of tumorous or precancerous disease that occur in New Jersey, and such information concerning these cases as it shall

deem necessary and appropriate in order to conduct thorough and complete epidemiologic surveys of cancer and cancer-related diseases in this State and to apply appropriate preventive and control measures.

114. Section 3 of P.L.1977, c.266 (C.26:2-106) is amended to read as follows:

C.26:2-106 Reports; rules, regulations; enforcement.

3. a. The Commissioner of Health, in consultation with the Public Health Council, shall require the reporting of cases of cancer and other specified tumorous and precancerous diseases, and the submission of such specified additional information on reported cases or control populations as he deems necessary and appropriate for the recognition, prevention, cure, or control of such diseases.

b. Pursuant to subsection a. of this section, the Commissioner of Health is hereby authorized to adopt and promulgate, in the manner prescribed by the applicable provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) rules and regulations specifying the health care providers, individuals, and other organizations obliged to make the report and submissions required by subsection a. of this section, the related information to be included in such reports, and the methods for such reporting.

c. All abstracting work performed by a health care facility in accordance with this section shall be performed by a certified tumor registrar.

d. (1) The Department of Health shall contract out its registry services to health care facilities which lack adequate internal capabilities to report cases on a timely basis, as provided in the regulations adopted pursuant to this section. Such health care facilities shall reimburse the department for services rendered.

(2) If a health care facility fails to correct deficiencies in its reporting that are discovered on audit by the Department of Health within 30 days, the department will conduct the appropriate registrar activities and charge the facility for all costs related to its services.

e. Health insurers and other third party health care payers providing health benefits plans to residents of the State shall report to the Department of Health cases of cancer of State residents based upon selection criteria and in a format specified by the department.

f. (1) A health care facility, health care provider, or health insurer that fails to comply with the provisions of this section shall be liable to a penalty of up to $500 per unreported cancer case.

(2) A health care facility that fails to report cases of cancer electronically, as required by regulation, shall be liable to a penalty not to exceed $1,000 per business day.

(3) A penalty sued for under the provisions of this subsection shall be recovered by and in the name of the Department of Health and shall be dedicated to the cancer registry.

g. All information reported to the Department of Health for inclusion in the cancer registry pursuant to this section shall be verified for accuracy by the department within six months of receiving the information and shall be incorporated in the registry. Aggregate or summary information, to include gender distribution, age groupings of cases, and cancer types, shall be made available to the public no later than six months after verification by the department. The department shall not make public any information reported to the department which discloses the identity of any person to whom the information relates.

115. Section 4 of P.L.1977, c.266 (C.26:2-107) is amended to read as follows:

C.26:2-107 Confidentiality of reports.

4. The reports made pursuant to this act are to be used only by the Department of Health and such other agencies as may be designated by the Commissioner of Health and shall not otherwise be divulged or made public so as to disclose the identity of any person to whom they relate; and to that end, such reports shall not be included under materials available to public inspection pursuant to P.L.1963, c.73 (C.47:1A-1 et seq.).

116. Section 5 of P.l.1977, c.266 (C.26:2-108) is amended to read as follows:

C.26:2-108 Immunity from liability for individuals, organizations providing information.

5. No individual or organization providing information to the Department of Health in accordance with this act shall be deemed to be, or held liable for, divulging confidential information.

117. Section 1 of P.L.2004, c.12 (C.26:2-111.1) is amended to read as follows:

C.26:2-111.1 Option of additional screening for disorders in infant required; cost.

1. a. A health care provider shall give an infant's parent or guardian the option of consenting to the performance of testing by qualified laboratories for disorders in infants for which testing is not required pursuant to P.L.1977, c.321 (C.26:2-110 et seq.), on a form and in a manner prescribed by the Commissioner of Health. The health care provider shall not be required to assume the cost of such testing.

As used in this section:

"Health care provider" means a health care professional licensed pursuant to Title 45 of the Revised Statutes or a health care facility licensed pursuant to Title 26 of the Revised Statutes that provides health care services to newborn infants.

"Qualified laboratory" means a clinical laboratory not operated by the Department of Health, which is certified by the Secretary of Health and Human Services pursuant to the federal "Clinical Laboratory Improvement Amendments of 1988," Pub.L.100-578 (42 U.S.C. s.263a) and reports its test results by using normal pediatric reference ranges.

b. (1) The Commissioner of Health shall prepare and make available electronically, on the Internet website of the Department of Health, information that explains the availability of testing performed by qualified laboratories for disorders in infants for which testing is not required pursuant to P.L.1977, c.321 (C.26:2-110 et seq.).

(2) A health care provider shall give an infant's parent or guardian a hard copy of the information prepared pursuant to paragraph (1) of this subsection and provide the parent or guardian with a reasonable opportunity to read the information when giving the parent or guardian the option of consenting to the performance of testing pursuant to subsection a. of this section.

118. Section 4 of P.L.2007, c.218 (C.26:2-111.2) is amended to read as follows:

C.26:2-111.2 HIV testing required for certain newborns.

4. a. The Commissioner of Health shall require each birthing facility in the State to administer to a newborn in its care a test for human immunodeficiency virus (HIV) if the HIV status of the mother of the newborn is unknown.

A newborn shall not be denied testing for HIV on the basis of the newborn's economic status.

b. The commissioner shall establish a comprehensive program for the follow-up testing of newborns who test positive for HIV pursuant to subsection a. of this section or whose mother is HIV-positive, which shall include, but not be limited to, procedures for the administration of HIV testing, counseling of the newborn's mother, tracking the newborn, disclosure of HIV test results to the mother, facility compliance reviews, and educational activities related to the HIV testing.

c. The provisions of this section shall not apply to a newborn whose parents object to the test as being in conflict with their religious tenets and practices. The parents shall provide the health care facility with a written statement of the objection, and the statement shall be included in the newborn's medical record.

d. As used in this section, "birthing facility" means an inpatient or ambulatory health care facility licensed by the Department of Health that provides birthing and newborn care services.

e. The Commissioner of Health shall adopt rules and regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), necessary to carry out the purposes of this section.

119. Section 2 of P.L.2011, c.74 (C.26:2-111.4) is amended to read as follows:

C.26:2-111.4 Birthing facilities required to perform pulse oximetry screening; rules, regulations.

2. a. The Commissioner of Health shall require each birthing facility licensed by the Department of Health to perform a pulse oximetry screening, a minimum of 24 hours after birth, on every newborn in its care.

b. As used in this section, "birthing facility" means an inpatient or ambulatory health care facility licensed by the Department of Health that provides birthing and newborn care services.

c. The commissioner shall adopt rules and regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), necessary to carry out the purposes of this act.

120. Section 1 of P.L.2011, c.175 (C.26:2-111.5) is amended to read as follows:

C.26:2-111.5 Testing of newborns for certain lysomal storage disorders required.

1. a. All infants born in this State shall be tested for the lysosomal storage disorders known as Krabbe, Pompe, Gaucher, Fabry, and Niemann-Pick diseases within six months following the occurrence of all of the following:

(1) the registration with the federal Food and Drug Administration of the necessary reagents;

(2) the availability of the necessary reagents from the federal Centers for Disease Control and Prevention;

(3) the availability of quality assurance testing methodology for these processes; and

(4) the acquisition by the Department of Health of the equipment necessary to implement the expanded screening tests.

b. The Department of Health may charge a reasonable fee for the tests performed pursuant to this section. The amount of the fee and the procedures for collecting the fee shall be determined by the Commissioner of Health.

121. Section 4 of P.L.1987, c.370 (C.26:2-151) is amended to read as follows:

C.26:2-151 Catastrophic Illness in Children Relief Fund Commission.

4. There is established in the Executive Branch of the State government, the Catastrophic Illness in Children Relief Fund Commission. For the purposes of complying with the provisions of Article V, section IV, paragraph 1 of the New Jersey Constitution, the commission is allocated within the Department of Human Services, but notwithstanding that allocation, the commission shall be independent of any supervision or control by the department or by any board or officer thereof.

The commission shall consist of the Commissioner of Health, the Commissioner of Human Services, the Commissioner of Children and Families, the Commissioner of Banking and Insurance, and the State Treasurer, who shall be members ex officio, and seven public members who are residents of this State, appointed by the Governor with the advice and consent of the Senate for terms of five years, two of whom are appointed upon the recommendation of the President of the Senate, one of whom is a provider of health care services to children in this State and two of whom are appointed upon the recommendation of the Speaker of the General Assembly, one of whom is a provider of health care services to children in this State. The five public members first appointed by the Governor shall serve for terms of one, two, three, four and five years, respectively.

Each member shall hold office for the term of his appointment and until his successor has been appointed and qualified. A member of the commission is eligible for reappointment.

Each ex officio member of the commission may designate an officer or employee of the ex officio member’s department to represent the member at meetings of the commission, and each designee may lawfully vote and otherwise act on behalf of the member for whom he constitutes the designee. Any designation shall be in writing delivered to the commission and filed with the office of the Secretary of State and shall continue in effect until revoked or amended in the same manner as provided for designation.

122. Section 2 of P.L.1991, c.401 (C.26:2-161) is amended to read as follows:

C.26:2-161 New Jersey Office on Minority and Multicultural Health.

2. a. There is established the New Jersey Office on Minority and Multicultural Health in the Department of Health.

b. Whenever the term "New Jersey Office on Minority Health" occurs or any reference is made thereto in any law, contract, or document, the same shall be deemed to mean or refer to the "New Jersey Office on Minority and Multicultural Health."

123. Section 3 of P.L.1991, c.401 (C.26:2-162) is amended to read as follows:

C.26:2-162 Duties of the office.

3. The office shall:

a. Provide grants to community-based organizations to conduct special research, demonstration, and evaluation projects for targeted at-risk racial and ethnic minority populations and to support ongoing community-based programs that are designed to reduce or eliminate racial and ethnic health disparities in the State;

b. Develop and implement model public and private partnerships in racial and ethnic minority communities for health awareness campaigns and to improve the access, acceptability, and use of public health services;

c. Serve as an information and resource center for racial and ethnic minority specific health information and data and develop a clearinghouse to collate and organize data on a county-by-county basis and disseminate it upon request to interested parties;

d. Review, recommend, and develop culturally appropriate health education materials;

e. Provide assistance to local school districts to develop programs in elementary and secondary schools which stress good nutrition and healthy lifestyles;

f. Function as an advocate for the adoption and implementation of effective measures to improve the health of racial and ethnic minority populations in this State, which measures should lead to the elimination of disparities among the various racial and ethnic populations of this State with respect to access to high-quality health care, utilization of health care services, and health status;

g. Improve existing data systems to ensure that the health information that is collected includes specific race and ethnicity identifiers;

h. Review the programs of the Departments of Health, Human Services, Community Affairs, and Education and any other department of State government, as appropriate, that concern multicultural or minority health and make recommendations to the departments that will enable them to better coordinate and improve the effectiveness of their efforts;

i. Develop a Statewide plan for increasing the number of racial and ethnic minority health care professionals which includes recommendations for the financing mechanisms and recruitment strategies necessary to carry out the plan;

j. Work collaboratively with colleges of medicine and dentistry in this State and other health care professional training programs to develop cultural and language competency courses that are designed to address the problem of racial and ethnicity disparities in health care access, utilization, treatment decisions, quality, and outcomes;

k. Develop recommendations for the most effective means of providing outreach to racial and ethnic minority communities throughout the State to ensure their maximum participation in publicly funded health benefits programs;

l. Seek to establish a Statewide alliance with community-based agencies and organizations, health care facilities, health care provider organizations, managed care organizations, and pharmaceutical manufacturers to promote the objectives of the office; and

m. Evaluate multicultural or racial and ethnic minority health programs in other states to assess their efficacy and potential for replication in this State and make recommendations regarding the adoption of such programs, as appropriate.

124. Section 4 of P.L.1991, c.401 (C.26:2-163) is amended to read as follows:

C.26:2-163 Powers of the office.

4. The office is authorized to:

a. Adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), concerning the operation of the office and other matters that may be necessary to carry out the purposes of this act;

b. Maintain offices at such places within the State as it may designate;

c. Employ a director and other personnel as may be necessary. The director shall be appointed by the Commissioner of Health and shall serve at the pleasure of the commissioner during the commissioner's term of office and until the appointment and qualification of the director's successor. The director shall devote his entire time to the duties of the position and shall receive a salary as provided by law;

d. Apply for and accept any grant of money from the federal government, private foundations or other sources, which may be available for programs related to multicultural or minority health;

e. Serve as the designated State agency for receipt of federal funds specifically designated for multicultural or racial and ethnic minority health programs; and

f. Enter into contracts with individuals, organizations, and institutions necessary for the performance of its duties under this act.

125. Section 5 of P.L.1991, c.401 (C.26:2-164) is amended to read as follows:

C.26:2-164 New Jersey Office on Minority and Multicultural Health Advisory Commission.

5. There is established a New Jersey Office on Minority and Multicultural Health Advisory Commission.

The commission shall consist of nine members, including the Commissioner of Health or his designee, who shall serve ex officio, and eight public members who are residents of the State and who shall be appointed as follows: one member who is a health care professional shall be appointed by the President of the Senate; one member who is a health care professional shall be appointed by the Speaker of the General Assembly; and six members, at least two of whom are health care professionals, at least one of whom represents health care facilities and at least one of whom represents the health insurance industry, shall be appointed by the Governor with the advice and consent of the Senate.

The term of office of each public member shall be three years, but of the members first appointed, two shall be appointed for a term of one year, three shall be appointed for a term of two years and three shall be appointed for a term of three years. A member shall hold office for the term of his appointment and until his successor has been appointed and qualified. All vacancies shall be filled for the balance of the unexpired term in the same manner as the original appointment. A member of the commission is eligible for reappointment.

The public members of the commission shall not receive any compensation for their services, but shall be reimbursed for the actual and necessary expenses incurred in the performance of their duties as members of the commission, within the limits of funds available to the commission.

The members of the commission shall annually elect a chairman and a vice-chairman from among the public members and may select a secretary, who need not be a member of the commission.

The New Jersey Office on Minority and Multicultural Health shall provide such staff and assistance as the commission requires to carry out its work.

126. Section 1 of P.L.2004, c.137 (C.26:2-167.1) is amended to read as follows:

C.26:2-167.1 “Eliminating Health Disparities Initiative.”

1. The Commissioner of Health shall establish the "Eliminating Health Disparities Initiative" in the Office on Minority and Multicultural Health. The commissioner shall require the office to develop and implement a comprehensive, coordinated plan to reduce health disparities between White and racial and ethnic minority populations in the State in the following priority areas: asthma; infant mortality; breast, cervical, prostate and colorectal cancer screening; kidney disease; HIV/AIDS; hepatitis C; sexually transmitted diseases; adult and child immunizations; cardiovascular disease; diabetes; and accidental

injuries and violence. As used in this act, "office" means the New Jersey Office on Minority and Multicultural Health.

127. Section 3 of P.L.2004, c.137 (C.26:2-167.3) is amended to read as follows:

C.26:2-167.3 Rules, regulations.

3. The Commissioner of Health shall adopt rules and regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), to effectuate the purposes of this act.

128. Section 2 of P.L.1993, c.229 (C.26:2-169) is amended to read as follows:

C.26:2-169 Criteria for compulsive gambling programs; grants.

2. The Department of Human Services shall develop criteria which prevention, education, and treatment programs for compulsive gamblers shall meet in order to become eligible for a grant from the funds made available for such programs pursuant to section 145 of P.L.1977, c.110 (C.5:12-145). The department shall also develop a formula for the distribution of available funds which will result in an equitable distribution among the programs which meet the eligibility criteria and apply for grants.

The department shall submit a report to the Senate Budget and Appropriations Committee and the Assembly Appropriations Committee, or their successors, describing the criteria developed pursuant to this section and detailing the amount of grants distributed and the names of the programs receiving grants. The department shall submit the report annually to both committees.

129. Section 2 of P.L.1997, c.229 (C.26:2-171) is amended to read as follows:

C.26:2-171 Advisory Council on Adolescent Pregnancy.

2. a. There is established in the Executive Branch of the State Government an Advisory Council on Adolescent Pregnancy. For the purposes of complying with the provisions of Article V, Section IV, paragraph 1 of the New Jersey Constitution, the advisory council is allocated within the Department of Health, but notwithstanding that allocation, the advisory council shall be independent of any supervision or control by the department or by any board or officer thereof.

b. The advisory council shall consist of 24 members as follows: the Commissioners of the Departments of Health, Human Services, Children and Families, Education, Community Affairs, and Labor and Workforce Development, who shall serve as ex officio members, and 18 public members, four of whom shall be teenagers, including two teenage parents and two teenagers who are not parents, and fourteen of whom shall be representatives of community based religious, health, and social service organizations which serve adolescents and health professionals and educators with recognized expertise in the field of adolescent pregnancy. Of the public members, three shall be appointed by the President of the Senate, no more than two of whom shall be of the same political party; three shall be appointed by the Speaker of the General Assembly, no more than two of whom shall be of the same political party; and 12 shall be appointed by the Governor. Eight of the persons appointed by the Governor shall be appointed with the advice and consent of the Senate, no more than four of whom shall be of the same political party; and four of the persons appointed by the Governor shall be teenagers. The advisory council shall organize within 30 days after the appointment of its

members. The members shall select one person from among them to serve as the chairperson and the members shall select a secretary, who need not be a member of the advisory council.

c. Each ex officio member may designate an employee of the member's department to represent the member at hearings of the advisory council. All designees may lawfully vote and otherwise act on behalf of the member for whom they constitute the designee.

d. Each public member shall be appointed for a term of three years, but of the members first appointed, six shall serve for a term of one year, six for a term of two years, and six for a term of three years. Members shall serve until their successors are appointed and qualified. Vacancies shall be filled in the same manner as the original appointments were made.

e. Members of the advisory council shall serve without compensation but, within the limits of funds appropriated or otherwise made available to it, shall be eligible for reimbursement of necessary expenses incurred in the performance of their duties.

f. The Department of Health shall provide such staff as the advisory council requests to carry out the purposes of this act.

130. Section 2 of P.L.2000, c.167 (C.26:2-176) is amended to read as follows:

C.26:2-176 Development of policies, procedures for care.

2. The Commissioner of Health, in conjunction with the State Board of Medical Examiners and the New Jersey Board of Nursing, shall work with health care facilities and licensed health care professionals in the State to develop policies and procedures to achieve the following requirements concerning postpartum depression:

a. Physicians, nurse midwives, and other licensed health care professionals providing prenatal care to women shall provide education to women and their families about postpartum depression in order to lower the likelihood that new mothers will continue to suffer from this illness in silence;

b. All birthing facilities in the State shall provide departing new mothers and fathers and other family members, as appropriate, with complete information about postpartum depression, including its symptoms, methods of coping with the illness, and treatment resources;

c. Physicians, nurse midwives, and other licensed health care professionals providing postnatal care to women shall screen new mothers for postpartum depression symptoms prior to discharge from the birthing facility and at the first few postnatal check-up visits; and

d. Physicians, nurse midwives, and other licensed health care professionals providing prenatal and postnatal care to women shall include fathers and other family members, as appropriate, in both the education and treatment processes to help them better understand the nature and causes of postpartum depression so that they too can overcome the spillover effects of the illness and improve their ability to be supportive of the new mother.

131. Section 3 of P.L.2000, c.167 (C.26:2-177) is amended to read as follows:

C.26:2-177 Public awareness campaign.

3. The Commissioner of Health shall establish a public awareness campaign to inform the general public about the nature and causes of postpartum depression and its health implications, including its symptoms, methods of coping with the illness, and the most effective means of treatment.

132. Section 4 of P.L.2000, c.167 (C.26:2-178) is amended to read as follows:

C.26:2-178 Rules, regulations.

4. The Commissioner of Health, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this act.

133. Section 1 of P.L.2003, c.174 (C.26:2-179) is amended to read as follows:

C.26:2-179 Consumer’s mercury alert notice, posting, distribution.

1. The Department of Health, in consultation with the Department of Environmental Protection, shall prepare a consumer's mercury alert notice for posting in all patient areas of professional medical offices that provide gynecological, obstetrical, or pediatric care and in the patient or client areas of all maternal and child health and nutrition programs. The notice shall explain the danger to women who expect to become pregnant, women who are pregnant or breast feeding their children, and young children, of eating mercury contaminated fish. The notice shall summarize the State's and the federal government's most current mercury health advisories concerning fish consumption and shall contain such other information as the department deems appropriate. The notice also shall list any telephone number that may be established for State residents to call for further information about the health advisories.

The department shall distribute the notice, at no charge, to all professional medical offices that provide gynecological, obstetrical, or pediatric care and to all publicly funded maternal and child health and nutrition programs in the State. The department shall update the notice as necessary, and shall make additional copies of the notice available to health care providers upon request.

134. Section 2 of P.L.2005, c.98 (C.26:2-181) is amended to read as follows:

C.26:2-181 Public awareness campaign relative to post-polio sequelae.

2. The Commissioner of Health shall establish a public awareness campaign to inform the general public about post-polio sequelae, for which purpose the commissioner shall provide for the development of educational materials, in consultation with health care facilities and providers that have a demonstrated record of expertise and interest in this subject, which shall be made available to local boards of health, physicians, hospitals, and clinics for distribution to consumers.

135. Section 1 of P.L.2005, c.280 (C.26:2-182) is amended to read as follows:

C.26:2-182 “Task Force on Cancer Prevention, Early Detection and Treatment in New Jersey.”

1. a. There is established the "Task Force on Cancer Prevention, Early Detection and Treatment in New Jersey" within the Department of Health.

b. The task force shall be comprised of the following members:

(1) the Commissioner of Health, or his designee, who shall serve ex officio; and

(2) no more than 20 public members to be appointed by the Governor, who shall include representatives from: the Public Health Council; the New Jersey State Commission on Cancer Research; the New Jersey Office on Minority and Multicultural Health; the Medical Society of New Jersey; academic medical centers and universities engaged in cancer education, research, and treatment; providers of cancer treatment and support services;

pharmaceutical companies engaged in cancer research; community-based organizations and coalitions engaged in cancer outreach, education, and screening; and cancer survivors.

c. The public members shall serve for a term of one year. Vacancies in the membership of the task force shall be filled in the same manner as the original appointments were made.

d. The task force shall organize as soon as may be practicable, but no later than the 30th day after the appointment of its members, and shall select a chairperson from among the public members. The chairperson shall appoint a secretary who need not be a member of the task force. The public members shall serve without compensation, but may be reimbursed for necessary expenses incurred in the performance of their duties.

e. The Department of Health shall supply such staff and resources, including a person to serve as executive director of the task force, as the task force requires to carry out its duties.

f. The task force is entitled to the assistance and services of the employees of any State department, board, bureau, commission, or agency as it may require and as may be available to its for its purposes, and to incur traveling and other miscellaneous expenses necessary to perform its duties, within the limits of funds appropriated or otherwise made available to it for its purpose.

136. Section 2 of P.L.2005, c.280 (C.26:2-183) is amended to read as follows:

C.26:2-183 Duties of task force.

2. a. The task force shall:

(1) evaluate current trends in cancer incidence, morbidity and mortality, screening, diagnosis, and behaviors that increase risk;

(2) evaluate historic, current, and emerging cancer control strategies;

(3) establish cancer reduction goals, which shall seek to reduce mortality rates for breast, cervical, prostate, lung, and colorectal cancer;

(4) establish specific goals for:

(a) reducing behavior that increases the risk of cancer, including behavior related to smoking and diet;

(b) reversing the present trend of annual increases in the rate of invasive melanoma;

(c) closing the gap in cancer mortality rates between the total population and minorities;

(d) increasing the use of screening tests for cancer, especially among elderly and minority populations; and

(e) increasing the percentage of cancers diagnosed at early stages;

(5) develop an integrated set of priority strategies that are necessary to achieve the goals established pursuant to this act; and

(6) delineate the respective roles and responsibilities for the State and other entities in implementing the priority strategies identified pursuant to this act.

b. (1) The task force shall report to the Governor, the Commissioner of Health, and the Legislature on its findings, recommendations, and activities at least biennially.

(2) In addition, the cervical cancer workgroup, which the task force shall establish in addition to such other workgroups as it deems appropriate, shall report to the Governor, the Commissioner of Health, and the Legislature at least biennially on its findings and recommendations regarding strategies and actions to reduce the occurrence of, and burdens suffered from, cervical cancer, along with any legislative bills that it desires to recommend for adoption by the Legislature.

137. Section 3 of P.L.2005, c.280 (C.26:2-184) is amended to read as follows:

C.26:2-184 Task force established by E.O.114 continued as this task force.

3. The task force established pursuant to Executive Order No. 114 of 2000, together with its functions, powers, duties, and workgroups, is continued in the Department of Health as the "Task Force on Cancer Prevention, Early Detection and Treatment in New Jersey" established pursuant to this act.

138. Section 2 of P.L.2011, c.155 (C.26:2-184.2) is amended to read as follows:

C.26:2-184.2 Establishment of public awareness campaign.

2. a. The Commissioner of Health shall establish a public awareness campaign to inform the general public about the clinical significance of ovarian cancer and its public health implications. The campaign shall include, at a minimum, risk factors, symptoms, the need for early detection, and methods of treatment.

b. The commissioner shall, at a minimum:

(1) provide for the development of printed educational materials and public service announcements in English and Spanish; and

(2) disseminate information for distribution to the public, through a variety of entities, including, but not limited to, local health agencies and clinics, physicians, health care facilities, county offices on aging, pharmacies, libraries, senior citizen centers, other community-based outreach programs and organizations, and the Department of Health’s official website.

139. Section 2 of P.L.2007, c.170 (C.26:2-186) is amended to read as follows:

C.26:2-186 Reporting diagnosis to Department of Health.

2. a. A physician, psychologist, and any other health care professional licensed pursuant to Title 45 of the Revised Statutes who is qualified by training to make the diagnosis and who then makes the diagnosis that a child has an autism spectrum disorder shall report this diagnosis to the Department of Health in a form and manner prescribed by the Commissioner of Health.

b. The report shall be in writing and shall include the name and address of the person submitting the report, the name, age, place of birth, and address of the child diagnosed as having an autism spectrum disorder, and other pertinent information as may be required by the commissioner; except that, if the child's parent or guardian objects to the reporting of the child's diagnosis for any reason, the report shall not include any information that could be used to identify the child.

c. The commissioner shall specify procedures for the health care professional to inform the child's parent or guardian of the requirements of subsections a. and b. of this section and the purpose served by including this information in the registry established pursuant to section 3 of P.L.2007, c.170 (C.26:2-187), as well as the parent's or guardian's right to refuse to permit the reporting of any information that could be used to identify the child.

140. Section 4 of P.L.2009, c.204 (C.26:2-186.1) is amended to read as follows:

C.26:2-186.1 Reporting adult diagnosis of autism spectrum disorder.

4. a. An adult who has been diagnosed as having an autism spectrum disorder by a physician, psychologist, or any other health care professional licensed pursuant to Title 45 of

the Revised Statutes who is qualified by training to make the diagnosis, and whose diagnosis has not been reported pursuant to section 2 of P.L.2007, c.170 (C.26:2-186), may, at his discretion, report this diagnosis, or request that a health care professional on his behalf report this diagnosis, to the Department of Health in a form and manner prescribed by the Commissioner of Health.

b. The report shall be in writing and shall include the name and address of the person submitting the report, the name, age, place of birth, and address of the adult diagnosed as having an autism spectrum disorder, and other pertinent information as may be required by the commissioner.

c. The commissioner shall specify procedures for the health care professional to inform the adult of the provisions of subsections a. and b. of this section and the purpose served by including this information in the registry established pursuant to section 3 of P.L.2007, c.170 (C.26:2-187).

141. Section 3 of P.L.2007, c.170 (C.26:2-187) is amended to read as follows:

C.26:2-187 Maintenance of up-to-date registry.

3. The Department of Health, in consultation with the Department of Human Services, shall maintain an up-to-date registry which shall include a record of: all reported cases of an autism spectrum disorder that occur in New Jersey, including those reported pursuant to section 2 of P.L.2007, c.170 (C.26:2-186) and section 4 of P.L.2009, c.204 (C.26:2-186.1); each reported case of an autism spectrum disorder that occurs in New Jersey in which the initial diagnosis is changed, lost, or considered misdiagnosed; and any other information it deems relevant and appropriate in order to conduct thorough and complete epidemiologic surveys of autism spectrum disorders, to enable analysis of this problem and to plan for and provide services to children and adults with an autism spectrum disorder and their families.

142. Section 4 of P.L.2007, c.170 (C.26:2-188) is amended to read as follows:

C.26:2-188 Use of reports; immunity for professionals.

4. a. The reports made pursuant to P.L.2007, c.170 (C.26:2-185 et seq.) and section 4 of P.L.2009, c.204 (C.26:2-186.1) are to be used only by the Department of Health and other agencies as may be designated by the Commissioner of Health, including the Department of Human Services, and shall not otherwise be divulged or made public so as to disclose the identity of any person to whom they relate; and, to that end, the reports shall not be included under materials available to public inspections pursuant to P.L.1963, c.73 (C.47:1A-1 et seq.) or P.L.2001, c.404 (C.47:1A-5 et al.).

b. A physician, psychologist, or health care professional providing information to the department in accordance with P.L.2007, c.170 (C.26:2-185 et seq.) or section 4 of P.L.2009, c.204 (C.26:2-186.1) shall not be deemed to be, or held liable for, divulging confidential information.

c. Nothing in P.L.2007, c.170 (C.26:2-185 et seq.) or section 4 of P.L.2009, c.204 (C.26:2-186.1) shall be construed to compel a child or adult who has been reported as having an autism spectrum disorder to submit to medical or health examination or supervision by the department.

143. Section 2 of P.L.2008, c.80 (C.26:2-190) is amended to read as follows:

C.26:2-190 Development of training curriculum; rules, regulations.

2. a. The Commissioner of Health and the Commissioner of Human Services, in consultation with the New Jersey Fire and Emergency Medical Services Institute and the New Jersey State First Aid Council, shall develop a training curriculum with the purpose of informing emergency responders of the risks associated with autism or an intellectual or other developmental disability, as well as providing instruction in appropriate recognition and response techniques concerning these disabilities. The curriculum shall be incorporated into existing time requirements for training and continuing education of emergency responders.

b. Prior to certification by the Department of Health, each emergency medical technician trained in basic life support services as defined in section 1 of P.L.1985, c.351 (C.26:2K-21) shall be required to satisfactorily complete the training developed under subsection a. of this section. Every emergency medical technician certified prior to the effective date of this act shall, within 36 months of the effective date of this act, satisfactorily complete the training in recognition and response techniques concerning these disabilities, through existing continuing education requirements.

c. The Commissioner of Health shall adopt rules and regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), to effectuate the purposes of this act.

144. Section 3 of P.L.2007, c.255 (C.26:2AA-3) is amended to read as follows:

C.26:2AA-3 Definitions relative to RSDS.

3. As used in this act:

"Commissioner" means the Commissioner of Health; and

"Reflex sympathetic dystrophy syndrome" or "RSDS" means a debilitating and progressively chronic condition characterized by severe burning pain, pathological changes in bone and skin, excessive sweating, tissue swelling, and extreme sensitivity to touch.

145. Section 4 of P.L.2007, c.255 (C.26:2AA-4) is amended to read as follows:

C.26:2AA-4 Establishment of education and research program.

4. The commissioner shall establish a reflex sympathetic dystrophy syndrome education and research program in the Department of Health. The purpose of the program is to promote public awareness of the causes of RSDS, the value of early detection and the diagnosis of and possible treatments for the syndrome, and to promote research, through public and private sources, to accurately identify, diagnose, and treat RSDS.

146. Section 5 of P.L.2007, c.255 (C.26:2AA-5) is amended to read as follows:

C.26:2AA-5 Responsibilities of Department of Health.

5. The Department of Health shall:

a. establish a public education program through the department's website, to promote RSDS education, which will enable individuals to make informed decisions about their health, including, but not limited to the following elements:

(1) the cause and nature of RSDS;

(2) the risk factors that contribute to the manifestation of RSDS;

(3) available treatment options, including risks and benefits of those options;

(4) environmental safety and injury prevention;

(5) rest and use of appropriate body mechanics;

(6) the availability of RSDS diagnostic, treatment, and outreach services in the community; and

(7) any other factors or elements that might mitigate the effects of RSDS;

b. notify local health departments, hospitals, clinics, and other health care providers about the availability of information concerning RSDS on the department's website;

c. within the limits of funds available to the department for this purpose, coordinate, promote, and offer professional education programs, through institutions of higher education, for health care providers and health-related community-based organizations, which may include, but are not limited to the following elements:

(1) research findings;

(2) the cause and nature of RSDS;

(3) the risk factors, including, but not limited to, lifestyle, heredity, and drug interactions;

(4) the diagnostic procedures and appropriate indications for their use;

(5) medical and surgical treatment options, including experimental and established drug therapies and the risks and benefits of each option;

(6) environmental safety and injury prevention; and

(7) the availability of RSDS diagnosis and treatment and support services in the community; and

d. promote research, through both private and public funding sources, to accurately identify, diagnose, and treat RSDS.

147. Section 1 of P.L.2006, c.48 (C.26:2D-82.1) is amended to read as follows:

C.26:2D-82.1 Restrictions on use of tanning facilities by minors.

1. a. A tanning facility operator shall not permit a person who is under 14 years of age to use a tanning facility.

b. A tanning facility operator shall not permit a person who is at least 14 but less than 18 years of age to use a tanning facility without written authorization of the person's parent or legal guardian indicating that such parent or guardian has read and understood the safety standards and warnings required pursuant to section 3 of P.L.1989, c.234 (C.26:2D-83). An emancipated minor shall be exempt from the authorization requirement of this subsection upon legal proof documenting said emancipation.

c. The Commissioner of Health shall establish by regulation:

(1) the contents required in the authorization form;

(2) the method for maintaining a record of the forms; and

(3) the frequency with which the forms shall be authorized or reauthorized.

d. The penalties for violating the provisions of this section shall be as provided in section 7 of P.L.1989, c.234 (C.26:2D-87).

148. Section 3 of P.L.1989, c.234 (C.26:2D-83) is amended to read as follows:

C.26:2D-83 Minimum safety standards for tanning facilities established.

3. The Commissioner of Health, in consultation with the Commissioner of Environmental Protection, shall, by regulation, establish minimum safety standards for tanning facilities. The standards shall include, but not be limited to:

a. Establishment of a maximum safe time of exposure to radiation and a maximum safe temperature at which tanning devices may be operated;

b. A requirement that a patron at a tanning facility wear protective eye glasses when using tanning equipment and that a patron be supervised as to the length of time the patron uses tanning equipment at the facility;

c. A requirement that the facility operator post easily legible, permanent warning signs near the tanning equipment which state: "DANGER-ULTRAVIOLET RADIATION FOLLOW ALL INSTRUCTIONS";

d. A requirement that the facility have protective shielding for tanning equipment in the facility; and

e. A requirement that the facility operator post a sign in conspicuous view at or near the reception area which states: "PERSONS UNDER AGE 14 SHALL NOT BE PERMITTED TO USE THIS TANNING FACILITY. PERSONS BETWEEN 14 AND 18 YEARS OF AGE SHALL NOT BE PERMITTED TO USE THIS TANNING FACILITY WITHOUT WRITTEN AUTHORIZATION OF A PARENT OR LEGAL GUARDIAN."

149. Section 5 of P.L.1989, c.234 (C.26:2D-85) is amended to read as follows:

C.26:2D-85 “Non-Ionizing Radiation Fund.”

5. There is established in the Department of Health a nonlapsing revolving fund known as the "Non-Ionizing Radiation Fund." The fund shall be credited with all fees collected pursuant to this act. Interest on monies in the fund shall be credited to the fund, and all monies in the fund are appropriated for the purposes of this act.

150. Section 6 of P.L.1989, c.234 (C.26:2D-86) is amended to read as follows:

C.26:2D-86 Tanning facility; annual registration, fee.

6. a. A tanning facility shall register annually with the Department of Health on forms provided by the department and shall pay to the department an annual registration fee.

b. The Department of Health shall establish a registration fee schedule, by regulation, to cover the costs of implementing the provisions of this act, including the costs incurred by local boards of health pursuant to section 4 of this act.

151. Section 7 of P.L.1989, c.234 (C.26:2D-87) is amended to read as follows:

C.26:2D-87 Violations, penalties.

7. A person who violates the provisions of this act is subject to a penalty of $100 for the first offense and $200 for each subsequent offense. The penalty shall be sued for and collected in a court of competent jurisdiction in a summary proceeding in accordance with the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

A penalty recovered under the provisions of this act shall be recovered by and in the name of the Commissioner of Health or by and in the name of the local board of health. When the plaintiff is the Commissioner of Health the penalty recovered shall be paid by the commissioner into the treasury of the State. When the plaintiff is a local board of health, the penalty recovered shall be paid by the local board of health into the treasury of the municipality where the violation occurred.

152. Section 8 of P.L.1989, c.234 (C.26:2D-88) is amended to read as follows:

C.26:2D-88 Rules, regulations.

8. In accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), the Commissioner of Health, in consultation with the Commissioner of Environmental Protection, shall promulgate rules and regulations necessary to carry out the purposes of this act.

153. Section 2 of P.L.1971, c.136 (C.26:2H-2) is amended to read as follows:

C.26:2H-2 Definitions.

2. The following words or phrases, as used in this act, shall have the following meanings, unless the context otherwise requires:

a. "Health care facility" means the facility or institution whether public or private, engaged principally in providing services for health maintenance organizations, diagnosis, or treatment of human disease, pain, injury, deformity, or physical condition, including, but not limited to, a general hospital, special hospital, mental hospital, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled nursing home, nursing home, intermediate care facility, tuberculosis hospital, chronic disease hospital, maternity hospital, outpatient clinic, dispensary, home health care agency, residential health care facility, and bioanalytical laboratory (except as specifically excluded hereunder) or central services facility serving one or more such institutions but excluding institutions that provide healing solely by prayer and excluding such bioanalytical laboratories as are independently owned and operated, and are not owned, operated, managed, or controlled, in whole or in part, directly or indirectly by any one or more health care facilities, and the predominant source of business of which is not by contract with health care facilities within the State of New Jersey and which solicit or accept specimens and operate predominantly in interstate commerce.

b. "Health care service" means the preadmission, outpatient, inpatient, and postdischarge care provided in or by a health care facility, and such other items or services as are necessary for such care, which are provided by or under the supervision of a physician for the purpose of health maintenance organizations, diagnosis, or treatment of human disease, pain, injury, disability, deformity, or physical condition, including, but not limited to, nursing service, home care nursing, and other paramedical service, ambulance service, service provided by an intern, resident in training or physician whose compensation is provided through agreement with a health care facility, laboratory service, medical social service, drugs, biologicals, supplies, appliances, equipment, bed and board, but excluding services provided by a physician in his private practice, except as provided in sections 7 and 12 of P.L.1971, c.136 (C.26:2H-7 and 26:2H-12), or by practitioners of healing solely by prayer, and services provided by first aid, rescue and ambulance squads as defined in the "New Jersey Highway Safety Act of 1971," P.L.1971, c.351 (C.27:5F-1 et seq.).

c. "Construction" means the erection, building, or substantial acquisition, alteration, reconstruction, improvement, renovation, extension, or modification of a health care facility, including its equipment, the inspection and supervision thereof; and the studies, surveys, designs, plans, working drawings, specifications, procedures, and other actions necessary thereto.

d. "Board" means the Health Care Administration Board established pursuant to this act.

e. (Deleted by amendment, P.L.1998, c.43).

f. "Government agency" means a department, board, bureau, division, office, agency, public benefit, or other corporation, or any other unit, however described, of the State or political subdivision thereof.

g. (Deleted by amendment, P.L.1991, c.187).

h. (Deleted by amendment, P.L.1991, c.187).

i. "Department" means the Department of Health.

j. "Commissioner" means the Commissioner of Health.

k. "Preliminary cost base" means that proportion of a hospital's current cost which may reasonably be required to be reimbursed to a properly utilized hospital for the efficient and effective delivery of appropriate and necessary health care services of high quality required by such hospital's mix of patients. The preliminary cost base initially may include costs identified by the commissioner and approved or adjusted by the commission as being in excess of that proportion of a hospital's current costs identified above, which excess costs shall be eliminated in a timely and reasonable manner prior to certification of the revenue base. The preliminary cost base shall be established in accordance with regulations proposed by the commissioner and approved by the board.

l. (Deleted by amendment, P.L.1992, c.160).

m. "Provider of health care" means an individual (1) who is a direct provider of health care service in that the individual's primary activity is the provision of health care services to individuals or the administration of health care facilities in which such care is provided and, when required by State law, the individual has received professional training in the provision of such services or in such administration and is licensed or certified for such provision or administration; or (2) who is an indirect provider of health care in that the individual (a) holds a fiduciary position with, or has a fiduciary interest in, any entity described in subparagraph b(ii) or subparagraph b(iv); provided, however, that a member of the governing body of a county or any elected official shall not be deemed to be a provider of health care unless he is a member of the board of trustees of a health care facility or a member of a board, committee or body with authority similar to that of a board of trustees, or unless he participates in the direct administration of a health care facility; or (b) received, either directly or through his spouse, more than one-tenth of his gross annual income for any one or more of the following:

(i) Fees or other compensation for research into or instruction in the provision of health care services;

(ii) Entities engaged in the provision of health care services or in research or instruction in the provision of health care services;

(iii) Producing or supplying drugs or other articles for individuals or entities for use in the provision of or in research into or instruction in the provision of health care services;

(iv) Entities engaged in producing drugs or such other articles.

n. "Private long-term health care facility" means a nursing home, skilled nursing home, or intermediate care facility presently in operation and licensed as such prior to the adoption of the 1967 Life Safety Code by the Department of Health in 1972 and which has a maximum 50-bed capacity and which does not accommodate Medicare or Medicaid patients.

o. (Deleted by amendment, P.L.1998, c.43).

p. "State Health Planning Board" means the board established pursuant to section 33 of P.L.1991, c.187 (C.26:2H-5.7) to conduct certificate of need review activities.

154. Section 1 of P.L.2000, c.62 (C.26:2H-5b) is amended to read as follows:

C.26:2H-5b Routine monitoring of pain as fifth vital sign required.

1. a. The Commissioner of Health shall prescribe, by regulation, requirements to be adopted by health care facilities licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) for the routine monitoring of pain as a fifth vital sign in patients, in addition to blood pressure, pulse, respiration, and temperature.

For the purpose of this subsection, the commissioner shall require health care facilities to:

(1) routinely inquire whether a patient is in pain;

(2) maintain policies and procedures as prescribed by the commissioner for asking patients to rate their degree of pain for a specified period of time and to record their responses; and

(3) routinely record levels of pain intensity on patient charts.

b. The requirements to be adopted pursuant to subsection a. of this section shall take effect no later than the 180th day after the effective date of this act.

155. Section 2 of P.L.2000, c.62 (C.26:2H-5c) is amended to read as follows:

C.26:2H-5c Rules, regulations.

2. The Commissioner of Health, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this act, for which purpose the commissioner shall consult, at a minimum, with: the State Board of Medical Examiners, the New Jersey Board of Nursing, the Board of Pharmacy, the New Jersey Hospital Association, the New Jersey Association of Health Care Facilities, the Medical Society of New Jersey, the New Jersey Association of Osteopathic Physicians and Surgeons, the New Jersey State Nurses Association, the Home Health Assembly of New Jersey, and the New Jersey Hospice and Palliative Care Organization.

156. Section 1 of P.L.2002, c.81 (C.26:2H-5d) is amended to read as follows:

C.26:2H-5d Provision of information by home health agency to patient.

1. a. The Commissioner of Health, in consultation with the Director of the Division of Consumer Affairs in the Department of Law and Public Safety, shall require that, no later than the 180th day after the date of enactment of this act, each home health agency licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall provide the following information to each patient receiving home-based services from that agency, or to a person designated by the patient:

(1) the name and certification or licensure title, as applicable, of the homemaker-home health aide or other health care professional whose practice is regulated pursuant to Title 45 of the Revised Statutes, to be displayed on an identification tag as required for homemaker-home health aides by regulation of the New Jersey Board of Nursing, or as otherwise to be prescribed by regulation of the commissioner for other health care professionals, that the homemaker-home health aide or other health care professional shall wear at all times while examining, observing, or caring for the patient; and

(2) a copy of the most current edition of the consumer guide to homemaker-home health aides published by the New Jersey Board of Nursing.

b. The consumer guide required pursuant to subsection a. of this section shall be provided:

(1) in advance of the provision of services to the patient, whenever possible; and

(2) otherwise upon the homemaker-home health aide's initial visit to the patient's home.

c. Beginning on the first day of the 13th month after the date of enactment of this act, the identification tag required pursuant to subsection a. of this section shall include a photograph of the homemaker-home health aide or other health care professional.

d. The commissioner, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this section.

157. Section 1 of P.L.2004, c.90 (C.26:2H-5e) is amended to read as follows:

C.26:2H-5e Adoption of policies for notifying family members of patient deaths by health care facilities.

1. A general or special hospital, nursing home or assisted living residence licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall, commencing no later than the 180th day after the effective date of this act and as prescribed by regulation of the Commissioner of Health, adopt and maintain written policies and procedures to delineate the responsibilities of its staff for prompt notification of a family member, guardian, or other designated person about a patient's death and confirmation and written documentation of that notification.

158. Section 3 of P.L.2005, c.21 (C.26:2H-5h) is amended to read as follows:

C.26:2H-5h Rules, regulations.

3. The Commissioner of Health, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this act, in consultation with the Quality Improvement Advisory Committee established by the commissioner. The regulations shall include, but not be limited to, procedures for standardizing the reporting of information by general hospitals and nursing homes that is required pursuant to subsection d. of section 2 of this act.

159. Section 2 of P.L.2008, c.58 (C.26:2H-5.1a) is amended to read as follows:

C.26:2H-5.1a Regulations prescribed by commissioner relative to appointment of monitor.

2. a. The Commissioner of Health shall prescribe, by regulation: (1) specific indicators by which a general hospital may be evaluated for financial soundness, and the thresholds at which it may be considered to be in financial distress or at risk of being in financial distress; and (2) the progressive levels of monitoring and department participation in the development and oversight of corrective measures to resolve a general hospital's financial or potential financial difficulties, including the various levels of involvement by an appointed monitor. The indicators and progressive levels of monitoring and intervention shall be guided by the indicators and levels of monitoring and intervention identified in the final report of the New Jersey Commission on Rationalizing Health Care Resources, issued on January 24, 2008.

b. The thresholds of specified financial indicators and corresponding Department of Health involvement that may be triggered by them shall include, but are not limited to, measures relating to:

(1) days cash-on-hand;
(2) cushion ratio;
(3) days in accounts receivable;
(4) average payment period;
(5) total margin;

(6) earnings before depreciation; and

(7) any other factor which the commissioner deems appropriate, including failure to provide required or requested financial information.

c. If the commissioner determines that a hospital is in financial distress or at risk of being in financial distress after considering the specified financial indicators set forth in subsection b. of this section, then the commissioner may appoint, in consultation with the hospital, a monitor to prevent further financial deterioration. Payment for the monitor shall be determined through a contingency contract established between the hospital and the monitor. The contract shall be subject to approval by the department with regard to the monitor's responsibilities. In no case shall a hospital bear financial liability if no savings result from measures undertaken pursuant to the contract.

The appointed monitor shall have demonstrated expertise in hospital administration, management, or operations. A monitor: (1) shall be authorized to attend all hospital board meetings, executive committee meetings, finance committee meetings, steering committee meetings, turnaround committee meetings, or any other meetings concerning the hospital's fiscal matters; (2) may be authorized to have voting and veto powers over actions taken in the above mentioned meetings; (3) shall report to the commissioner and the full hospital board of trustees in a manner prescribed by the commissioner; and (4) shall serve for such period of time as may be determined by the commissioner in consultation with the hospital.

The commissioner shall maintain continuing oversight of the actions and recommendations of the monitor to ensure that the public interest is protected.

160. Section 3 of P.L.2008, c.58 (C.26:2H-5.1b) is amended to read as follows:

C.26:2H-5.1b Conditions for licensure of general hospital.

3. As a condition of licensure under P.L.1971, c.136 (C.26:2H-1 et al.), a general hospital shall:

a. provide monthly unaudited financial information and annual audited financial statements to the Department of Health, and such other financial information as the department may request; and

b. permit the Commissioner of Health, or a monitor appointed by the commissioner, as applicable, to oversee its financial operations, and, if the commissioner determines that the hospital is at risk of being in financial distress or is in financial distress based on criteria specified by regulation, participate in the development and implementation of a corrective plan to resolve the hospital's financial difficulties, pursuant to section 2 of P.L.2008, c.58 (C.26:2H-5.1a).

161. Section 1 of P.L.2009, c.263 (C.26:2H-5.1c) is amended to read as follows:

C.26:2H-5.1c Ambulatory care facility to use common billing form.

1. An ambulatory care facility licensed to provide surgical services pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall use a common billing form, designated by the Commissioner of Health, for each patient when billing for health care services. The information provided on the billing form shall, to the extent applicable, be the same as that required of hospitals.

162. Section 3 of P.L.2009, c.263 (C.26:2H-5.1e) is amended to read as follows:

C.26:2H-5.1e Quarterly report from ambulatory care facility; required information.

3. a. An ambulatory care facility licensed to provide surgical services pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall be required to report quarterly to the Department of Health, in a form and manner prescribed by the commissioner:

(1) process quality indicators of infection control as selected by the commissioner in consultation with the Quality Improvement Advisory Committee within the department; and

(2) beginning 30 days after the adoption of regulations pursuant to this act, data on infection rates for the major site categories that define facility-associated infection locations, multiple infections, and device-related and non-device related infections, as selected by the commissioner in consultation with the Quality Improvement Advisory Committee within the department.

b. The information reported pursuant to this section shall be transmitted in such a manner as to not include identifying information about patients.

c. The commissioner shall promptly advise an ambulatory care facility in the event that the commissioner determines, based on information reported by the facility, that a change in facility practices or policy is necessary to improve performance in the prevention of facility-associated infection and quality of care provided at the facility.

d. The commissioner shall make available to members of the public, on the official Internet website of the department, the information reported pursuant to this section, in such a format as the commissioner deems appropriate to enable comparison among ambulatory care facilities with respect to the information.

e. In order to effectuate the purposes of this section, the commissioner, in consultation with the Quality Improvement Advisory Committee in the department, shall, by regulation: establish standard methods for identifying and reporting facility-associated infections; identify the major site categories for which infections shall be reported, taking into account the categories most likely to improve the delivery and outcome of health care in the State; and specify the methodology for presenting the data to the public, including procedures to adjust for differences in case mix and severity of infections among facilities.

163. Section 4 of P.L.2009, c.263 (C.26:2H-5.1f) is amended to read as follows:

C.26:2H-5.1f Rules, regulations.

4. The Commissioner of Health, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this act.

164. Section 33 of P.L.1991, c.187 (C.26:2H-5.7) is amended to read as follows:

C.26:2H-5.7 State Health Planning Board established.

33. There is established in the Department of Health a State Health Planning Board. The members of the board shall include: the Commissioners of Health, Children and Families, and Human Services, or their designees, who shall serve as ex officio, nonvoting members; the chairmen of the Health Care Administration Board and the Public Health Council, or their designees, who shall serve as ex officio members; and nine public members appointed by the Governor with the advice and consent of the Senate, five of whom are consumers of health care services who are neither providers of health care services or persons with a fiduciary interest in a health care service.

Of the additional public members first appointed pursuant to P.L.1998, c.43, two shall serve for a term of two years and two shall serve for a term of three years. Following the expiration of the original terms, the public members shall serve for a term of four years and are eligible for reappointment. Public members serving on the board on the effective date of P.L.1998, c.43 shall continue to serve for the term of their appointment. Any vacancy shall be filled in the same manner as the original appointment, for the unexpired term. Public members shall continue to serve until their successors are appointed. The public members shall serve without compensation but may be reimbursed for reasonable expenses incurred in the performance of their duties, within the limits of funds available to the board.

a. A member or employee of the State Health Planning Board shall not, by reason of his performance of any duty, function, or activity required of, or authorized to be undertaken by the board, be held civilly or criminally liable if that person acted within the scope of his duty, function, or activity as a member or employee of the board, without gross negligence or malice toward any person affected thereby.

b. A member of the State Health Planning Board shall not vote on any matter before the board concerning an individual or entity with which the member has, or within the last 12 months has had, any substantial ownership, employment, medical staff, fiduciary, contractual, creditor, or consultative relationship. A member who has or has had such a relationship with an individual or entity involved in any matter before the board shall make a written disclosure of the relationship before any action is taken by the board with respect to the matter and shall make the relationship public in any meeting in which action on the matter is to be taken.

165. Section 34 of P.L.1991, c.187 (C.26:2H-5.8) is amended to read as follows:

C.26:2H-5.8 Review of application for certificate of need.

34. a. (Deleted by amendment, P.L.1998, c.43).

b. The State Health Planning Board shall review applications for certificates of need and make recommendations to the Commissioner of Health.

c. In the case of an application for a certificate of need to transfer ownership of an existing general acute care hospital or to close or eliminate a health care facility or service that is subject to review by the State Health Planning Board, the State Health Planning Board shall hold at least one public hearing in the service area of the health care facility or service; except that, in the event the Attorney General or the Department of Health is required by State law to hold a public hearing on the transfer of ownership of the hospital, the State Health Planning Board shall not be required to hold a public hearing on the application for a certificate of need to transfer ownership of the hospital. The public hearing shall be held no later than 30 days after an application is deemed complete by the Commissioner of Health. Public notice of the hearing shall be provided at least two weeks in advance of the date of the hearing.

Notwithstanding the provisions of this subsection to the contrary, in the event that the commissioner determines that a proposed closure or elimination of a health care facility or service should be considered on an expedited basis in order to preserve the quality of health care provided to the community, the commissioner may reduce the period of time required for public notice of the hearing.

166. Section 2 of P.L.1999, c.311 (C.26:2H-5.11) is amended to read as follows:

C.26:2H-5.11 Definitions relative to use of needles, sharp devices in health care facilities.

2. As used in this act:

"Commissioner" means the Commissioner of Health.

"Department" means the Department of Health.

"Needle stick injury" means the parenteral introduction into the body of a health care worker of blood or other potentially infectious material by a needle or other sharp device during the worker's performance of health care duties in a health care facility.

167. Section 6 of P.L.2007, c.236 (C.26:2H-5.22) is amended to read as follows:

C.26:2H-5.22 Violations, penalties.

6. A covered health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et al.) that is in violation of the provisions of this act shall be subject to such penalties as the Commissioner of Health may determine pursuant to sections 13 and 14 of P.L.1971, c.136 (C.26:2H-13 and 26:2H-14).

168. Section 7 of P.L.2007, c.236 (C.26:2H-5.23) is amended to read as follows:

C.26:2H-5.23 Rules, regulations.

7. The Commissioners of Health and Human Services shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to carry out the purposes of this act.

169. Section 7 of P.L.1971, c.136 (C.26:2H-7) is amended to read as follows:

C.26:2H-7 Certificate of need required for construction, expansion of health care facility.

7. No health care facility shall be constructed or expanded, and no new health care service shall be instituted after the effective date of P.L.1971, c.136 (C.26:2H-1 et seq.) except upon application for and receipt of a certificate of need as provided by P.L.1971, c.136 (C.26:2H-1 et seq.). No agency of the State or of any county or municipal government shall approve any grant of funds for, or issue any license to, a health care facility which is constructed or expanded, or which institutes a new health care service, in violation of the provisions of P.L.1971, c.136 (C.26:2H-1 et seq.).

Except as provided in section 19 of P.L.1992, c.160 (C.26:2H-7a) and section 16 of P.L.1998, c.43 (C.26:2H-7c), the provisions of this section shall apply to:

a. The initiation of any health care service as provided in section 2 of P.L.1971, c.136 (C.26:2H-2);

b. The initiation by any person of a health care service which is the subject of a health planning regulation adopted by the Department of Health;

c. The purchase by any person of major moveable equipment whose total cost is over $2 million;

d. The expenditure by a licensed health care facility of over $2 million for construction of a new health care facility; and

e. The construction of a facility by any person, whose total project cost exceeds $2 million, if the facility-type is the subject of a health planning regulation adopted by the Department of Health.

The commissioner may periodically increase the monetary thresholds established in this section, by regulation, to reflect inflationary increases in the costs of health care equipment or construction.

For the purposes of this section, "health care service" shall include any service which is the subject of a health planning regulation adopted by the Department of Health, and "person" shall include a corporation, company, association, society, firm, partnership, and joint stock company, as well as an individual.

A physician who initiates a health care service which is the subject of a health planning regulation or purchases major moveable equipment pursuant to subsection b. or c. of this section, may apply to the commissioner for a waiver of the certificate of need requirement if: the equipment or health care service is such an essential, fundamental, and integral component of the physician's practice specialty, that the physician would be unable to practice his specialty according to the acceptable medical standards of that specialty without the health care service or equipment; the physician bills at least 75% of his total amount of charges in the practice specialty which uses the health care service or equipment; and the health care service or equipment is not otherwise available and accessible to patients, pursuant to standards established by the commissioner, by regulation. The commissioner shall make a determination about whether to grant or deny the waiver, within 120 days from the date the request for the waiver is received by the commissioner and shall so notify the physician who requested the waiver. If the request is denied, the commissioner shall include in that notification the reason for the denial. If the request is denied, the initiation of a health care service or the purchase of major moveable equipment shall be subject to the certificate of need requirements pursuant to this section.

A health maintenance organization which furnishes at least basic comprehensive care health services on a prepaid basis to enrollees either through providers employed by the health maintenance organization or through a medical group or groups which contract directly with the health maintenance organization, which initiates a health care service, or constructs a health care facility pursuant to subsection a., b., d., or e. of this section, may apply to the commissioner for a waiver of the certificate of need requirement if: the initiation of the health care service or the construction is in the best interests of State health planning; and the health maintenance organization is in compliance with the provisions of P.L.1973, c.337 (C.26:2J-1 et seq.) and complies with the provisions of subsection d. of section 3 of P.L.1973, c.337 (C.26:2J-3) regarding notification to the commissioner. The commissioner shall make a determination about whether to grant or deny the waiver within 45 days from the date the request for the waiver is received by the commissioner and shall so notify the health maintenance organization. If the request for a waiver is denied on the basis that the request would not be in the best interests of State health planning, the commissioner shall state in that notification the reason why the request would not be in the best interests of State health planning. If the request for a waiver is denied, the health maintenance organization's initiation of a health care service or construction project shall be subject to the certificate of need requirements pursuant to this section.

The requirement to obtain a certificate of need for major moveable equipment pursuant to subsection c. of this section shall not apply if a contract to purchase that equipment was entered into prior to July 1, 1991.

170. Section 16 of P.L.1998, c.43 (C.26:2H-7c) is amended to read as follows:

C.26:2H-7c Exemptions from certificate of need requirement.

16. a. Notwithstanding the provisions of section 7 of P.L.1971, c.136 (C.26:2H-7) to the contrary, 20 months after the effective date of P.L.1998, c.43 the following shall be exempt from the certificate of need requirement:

Extracorporeal shock wave lithotripter;

Hyperbaric chamber;

Positron emission tomography;

Residential drug and alcohol services;

Ambulatory surgical facilities;

Basic obstetric and pediatric services and birth centers, including additions of basic obstetric and pediatric beds in hospitals; and

Linear accelerator, including Cobalt 60 unit.

b. Notwithstanding the provisions of subsection a. of this section to the contrary, if the Commissioner of Health determines that Department of Health licensing standards for a health care service or facility listed in subsection a. of this section have been adopted by regulation of the department pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), the commissioner may exempt the health care service or facility from the provisions of section 7 of P.L.1971, c.136 (C.26:2H-7) prior to the 20-month period established in subsection a. of this section.

The commissioner shall publish notice of any exemptions established pursuant to this subsection in the New Jersey Register and provide for 45 days' public notice prior to the effective date of the exemption.

c. In the case of any health care service or facility that is not exempted from the provisions of section 7 of P.L.1971, c.136 (C.26:2H-7) pursuant to this section or section 19 of P.L.1992, c.160 (C.26:2H-7a) and is not subject to expedited review, the commissioner shall publish a call schedule for the initiation of the services or facilities within 90 days of the date of enactment of this act. In the event that the commissioner determines that there is insufficient need to support the initiation of the service or facility, the commissioner is authorized to cancel the call. The commissioner shall provide public notice of the cancellation at least 45 days prior to the scheduled call date.

171. Section 18 of P.L.1998, c.43 (C.26:2H-7d) is amended to read as follows:

C.26:2H-7d Certain health care equipment exempt.

18. Notwithstanding the provisions of P.L.1971, c.136 (C.26:2H-1 et seq.) to the contrary, health care equipment which involves new technology that is not identified in N.J.A.C.8:33 et seq., shall not be subject to certificate of need requirements and may be initiated in the State in accordance with the requirements of this section.

a. The new technology shall be directly related to a health care service for which the provider is already licensed and has obtained a certificate of need, when required.

b. The provider shall notify the Commissioner of Health about the intent to initiate the new technology at least 60 days prior to the date the provider will begin use of the technology.

c. The new technology shall have pre-market approval from the federal Food and Drug Administration.

d. The provider shall use the new technology in accordance with guidelines approved by The Joint Commission until such time as the Department of Health has adopted licensing standards for the new technology. The provider shall be required to comply with the department's licensing standards for the new technology upon adoption of the standards.

e. The provider shall agree to submit to the department appropriate patient information and other data concerning use of the new technology to assist the department in establishing licensing standards. The provider shall submit the information and other data on a quarterly basis until such time as licensing standards are adopted for the new technology.

f. The commissioner may suspend a provider's use of the new technology if he determines that the provider is not in compliance with the requirements of this section.

172. Section 3 of P.L.1996, c.102 (C.26:2H-7.6) is amended to read as follows:

C.26:2H-7.6 Requirements for subacute care unit.

3. a. A hospital which proposes to utilize a portion of its licensed bed capacity for the purpose of establishing a subacute care unit shall be subject to the following requirements:

(1) the subacute care unit's beds shall be licensed by the Department of Health as long-term care beds and shall meet all applicable State licensing and federal certification requirements, including the physical requirements for skilled nursing beds under the federal Medicare program established pursuant to Pub.L.89-97 (42 U.S.C.s.1395 et seq.), with reasonable waiver provisions as determined by the commissioner or the federal Centers for Medicare & Medicaid Services, as appropriate;

(2) the maximum length of stay in the unit shall not exceed eight days;

(3) the unit shall be certified to participate in the Medicare program as a skilled nursing facility;

(4) the unit shall be comprised of not more than 7% of the hospital's licensed medical-surgical bed capacity or 12 beds, whichever is greater;

(5) the hospital's licensed medical-surgical bed capacity shall be reduced, by the commissioner, by the number of beds used to establish a subacute care unit under the provisions of this section. Long-term care beds in a hospital's subacute care unit shall not be transferred to, or combined with, a subacute care unit in another hospital. Bed limitations for a hospital shall include both conversions of existing acute care beds and any purchases or other acquisitions or rentals of beds to be used by a hospital for the provision of subacute care under this act;

(6) (Deleted by amendment, P.L.1998, c.43).

(7) the hospital shall be subject to the fee for the filing of an application for a license for long-term care beds and any renewal thereof as established by the Department of Health pursuant to section 12 of P.L.1971, c.136 (C.26:2H-12).

b. Subacute care shall not be covered by the Medicaid program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.). The long-term care beds in a subacute care unit shall not be included in long-term care bed inventories for certificate of need review purposes.

173. Section 2 of P.L.2000, c.143 (C.26:2H-7.11) is amended to read as follows:

C.26:2H-7.11 Additional requirements for nonprofit hospitals relative to acquisitions; exemptions; procedures.

2. In addition to the requirements of P.L.1971, c.136 (C.26:2H-1 et seq.) concerning certificate of need and licensure requirements, a nonprofit hospital licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall satisfy the requirements of this act before applying to the Superior Court of New Jersey for approval prior to entering into a transaction that results in the acquisition of the hospital as defined in this act. The proposed acquisition shall be subject to the prior review of the Attorney General, in consultation with the

Commissioner of Health, pursuant to the provisions of this section. The Attorney General shall review the application in furtherance of his common law responsibilities as protector, supervisor, and enforcer of charitable trusts and charitable corporations.

For the purposes of sections 2 and 3 of this act, "acquisition" means the purchase, lease, exchange, conversion, restructuring, merger, division, consolidation, transfer of control, or other disposition of a substantial amount of assets or operations, whether through a single transaction or series of transactions, with one or more persons or entities.

This act shall not apply to a nonprofit hospital if the proposed acquisition is in the usual and regular course of its activities and the Attorney General has given the nonprofit hospital a written waiver as to the proposed acquisition. As used in this section, a proposed acquisition is not in the usual and regular course of a nonprofit hospital's activities if it effects a fundamental corporate change that involves transfer of ownership or control of charitable assets or a change of the nonprofit hospital's mission or purpose.

a. (1) Within five working days of submitting an application pursuant to this section, the nonprofit hospital shall publish a notice of the proposed acquisition, in a form approved by the Attorney General, in a newspaper of general circulation in the service area of the hospital once per week for three weeks. The notice shall state the names of the parties to the agreement, describe the contents of the application to the Attorney General, and state the date by which a person may submit written comments about the application to the Attorney General.

(2) Within 30 days after receipt of an initial application, the Attorney General shall advise the applicant in writing whether the application is complete, and, if not, shall specify what additional information is required.

(3) The Attorney General shall, upon receipt of the information requested, notify the applicant in writing of the date of completion of the application.

b. Within 90 days of the date of completion of the application, the Attorney General, in consultation with the Commissioner of Health, shall review the application and support the proposed acquisition, with or without any specific modifications, or, if the Attorney General finds that it is not in the public interest, oppose the proposed acquisition. The Attorney General or commissioner may, for good cause, extend the time for review of an application submitted pursuant to this section.

The proposed acquisition shall not be considered to be in the public interest unless the Attorney General determines that appropriate steps have been taken to safeguard the value of the charitable assets of the hospital and to ensure that any proceeds from the proposed acquisition are irrevocably dedicated for appropriate charitable health care purposes; and the Commissioner of Health determines that the proposed transaction is not likely to result in the deterioration of the quality, availability or accessibility of health care services in the affected communities.

c. In determining whether the acquisition meets the criteria of subsection b. of this section, the Attorney General shall consider:

(1) Whether the acquisition is permitted under the "New Jersey Nonprofit Corporation Act," Title 15A of the New Jersey Statutes, and other applicable State statutes governing nonprofit entities, trusts, or charities;

(2) Whether the nonprofit hospital exercised due diligence in deciding to effectuate the acquisition, selecting the other party to the acquisition and negotiating the terms and conditions of the acquisition;

(3) The procedures used by the nonprofit hospital in making its decision, including whether appropriate expert assistance was used;

(4) Whether conflict of interest was disclosed, including, but not limited to, conflicts of interest related to board members of, executives of and experts retained by the nonprofit hospital, purchaser, or other parties to the acquisition;

(5) Whether any management contract under the acquisition is for reasonable fair value;

(6) Whether the acquisition proceeds will be used for appropriate charitable health care purposes consistent with the nonprofit hospital's original purpose or for the support and promotion of health care and whether the proceeds will be controlled as charitable funds independently of the purchaser or parties to the acquisition; and

(7) Any other criteria the Attorney General establishes by regulation to determine whether the proposed acquisition is in the public interest.

d. In determining whether an acquisition by any person or entity other than a corporation organized in this State for charitable purposes under Title 15A of the New Jersey Statutes meets the criteria of subsection b. of this section, the Attorney General shall consider, in addition to the criteria set forth in subsection c., the following criteria:

(1) Whether the nonprofit hospital will receive full and fair market value for its assets. The Attorney General may employ, at the nonprofit hospital's expense, reasonably necessary expert assistance in making this determination;

(2) Whether charitable funds are placed at unreasonable risk, if the acquisition is financed in part by the nonprofit hospital;

(3) Whether a right of first refusal has been retained to repurchase the assets by a successor nonprofit corporation or foundation if, following the acquisition, the hospital is subsequently sold to, acquired by or merged with another entity;

(4) Whether the nonprofit hospital established appropriate criteria in deciding to pursue a conversion in relation to carrying out its mission and purposes;

(5) Whether the nonprofit hospital considered the proposed conversion as the only alternative or as the best alternative in carrying out its mission and purposes;

(6) Whether the nonprofit hospital exercised due care in assigning a value to the existing hospital and its charitable assets in proceeding to negotiate the proposed conversion;

(7) Whether officers, directors, board members, or senior management will receive future contracts in existing, new, or affiliated hospitals or foundations; and

(8) Any other criteria the Attorney General establishes by regulation to determine whether a proposed acquisition by any person or entity other than a corporation organized in this State for charitable purposes under Title 15A of the New Jersey Statutes is in the public interest.

e. In the Attorney General’s review of the proposed acquisition, the Attorney General may assess the entity proposing to acquire the nonprofit hospital for reasonable costs related to the review, as determined by the Attorney General to be necessary. Reasonable costs may include expert review of the acquisition and a process for educating the public about the acquisition and obtaining public input.

f. The Attorney General and the Commissioner of Health shall, during the course of the review pursuant to this section, hold at least one public hearing in which any person may file written comments and exhibits or appear and make a statement. The public hearing may, if the Attorney General and commissioner so agree, be conducted jointly. The commissioner may satisfy the requirements of this subsection by conducting a public hearing in conjunction with the certificate of need review process pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.). The Attorney General or the commissioner may subpoena additional information or witnesses, including, but not limited to, information about any transaction that is collateral to the proposed acquisition and any related documents, require and administer oaths, require

sworn statements, take depositions and use related discovery procedures for purposes of the hearing and at any time prior to completing the review of the proposed acquisition.

The Attorney General shall make the information received pursuant to this section, and the Department of Health shall make any information in its records relating to the proposed acquisition, available for inspection at no cost to the public.

The public hearing shall be held no later than 60 days after the date that an application from a nonprofit hospital is deemed complete by the Attorney General. Public notice of the hearing shall be provided at least two weeks in advance of the date of the hearing.

g. In a proposed acquisition subject to review under subsection d. of this section, the Attorney General, after consultation with the principal parties to the transaction, shall make a determination as to the amount of assets which the nonprofit hospital shall set aside as a charitable obligation, based on the full and fair market value of the hospital at the time of the proposed acquisition as determined by the Attorney General.

h. Upon execution of a proposed acquisition subject to review under subsection d. of this section, the amount determined by the Attorney General to be set aside as a charitable obligation shall be placed in a nonprofit charitable trust or one or more existing or newly established tax-exempt charitable organizations operating pursuant to 26 U.S.C. s. 501(c)(3). The charitable mission and grant-making functions of any charitable entity that receives assets pursuant to subsection g. of this section shall be dedicated to serving the health care needs of the community historically served by the predecessor nonprofit hospital. Any charitable entity that receives assets pursuant to subsection g. of this section, the directors, officers, and trustees of any such charitable entity, and the assets of any such charitable entity, including any stock involved in the acquisition, shall be independent of any influence or control by the acquiring entity, its directors, officers, trustees, subsidiaries, or affiliates.

(1) The governance of the charitable trust that results from the acquisition or of any newly established charitable organization that is to receive charitable assets pursuant to subsection g. of this section shall be subject to review and approval by the Attorney General. The governance of any existing charitable organization that is to receive charitable assets pursuant to subsection g. of this section shall be subject to review by the Attorney General. The governance of the charitable trust or the charitable organization shall be broadly based, and neither the trust or organization nor any officer, director, or senior manager of the trust or organization shall be affiliated with the acquiring entity and no officer, director, or senior manager of the trust or organization shall be a full-time employee of State government. No officer, director, or senior manager of the trust or organization shall have been a director, officer, agent, trustee, or employee of the nonprofit hospital during the three years immediately preceding the effective date of the acquisition, unless that person can demonstrate to the satisfaction of the Attorney General that the person's assumption of the position of officer, director, or senior manager of the trust or organization would not constitute a breach of fiduciary duty or other conflict of interest.

(2) The governing body of the charitable trust or organization shall establish or demonstrate that it has in place, as the case may be, a mechanism to avoid conflicts of interest and to prohibit grants that benefit the board of directors and management of the acquiring entity or its affiliates or subsidiaries.

(3) The governing body of the charitable trust or organization shall provide the Attorney General with an annual report which shall include an audited financial statement and a detailed description of its grant-making and other charitable activities related to its use of the charitable assets received pursuant to this act. The annual report shall be made available to the public at both the Attorney General's office and the office of the charitable trust or

organization. Nothing contained in this act shall affect the obligations of an entity possessing endowment funds under P.L.1975, c.26 (C.15:18-15 et seq.).

i. (1) The entity acquiring the nonprofit hospital, if determined to be necessary by the Commissioner of Health, shall provide funds, in an amount determined by the Commissioner of Health, for the hiring by the Department of Health of an independent health care access monitor to monitor and report quarterly to the Department of Health on community health care access by the entity, including levels of uncompensated care for indigent persons provided by the entity. The funding shall be provided for three years after the date of the acquisition. The entity acquiring the hospital shall provide the monitor with appropriate access to the entity's records in order to enable the monitor to fulfill this function.

To prevent the duplication of any information already reported by the entity, the monitor shall, to the extent possible, utilize data already provided by the entity to the Department of Health.

No personal identifiers shall be attached to any of the records obtained by the monitor, and all such records shall be subject to the privacy and confidentiality provisions of medical records provided by law.

(2) Following the monitoring period, or in the event that no monitoring period is established, if the Commissioner of Health receives information indicating that the acquiring entity is not fulfilling its commitment to the affected service area pursuant to this act and determines that the information is true, the commissioner shall order the acquiring entity to comply with a corrective action plan. The commissioner shall retain oversight of the acquiring entity's obligations under the corrective action plan for as long as necessary to ensure compliance with this act.

j. The trustees and senior managers of the nonprofit hospital are prohibited from investing in the acquiring entity for a period of three years following the acquisition.

k. No director, officer, agent, trustee, or employee of the nonprofit hospital shall benefit directly or indirectly from the acquisition, including the receipt of any compensation directly related to the proposed acquisition.

l. Upon completion by the Attorney General of the review of the application required by this act, the nonprofit hospital shall apply to the Superior Court for approval of the proposed acquisition. In that proceeding, the Attorney General shall advise the court as to whether the Attorney General supports or opposes the proposed acquisition, with or without any specific modifications, and the basis for that position. Any person who filed a written comment or exhibit or appeared and made a statement in the public hearing held by the Attorney General pursuant to subsection f. of this section shall be considered a party to the proceeding, including consumers or community groups representing the citizens of the State.

m. Notwithstanding the provisions of subsections a. and f. of this section to the contrary, in the event that the Attorney General or the Commissioner of Health determines that a proposed acquisition should be considered on an expedited basis in order to preserve the quality of health care provided to the community, the Attorney General and the commissioner may combine the public notice about the acquisition with the notice for a public hearing as required in subsections a. and f., respectively, and may reduce the period of time required for notice, as necessary. In considering a proposed acquisition on an expedited basis, the Attorney General and commissioner may agree to reduce the period of time for review of a completed application to less than 90 days.

n. The Attorney General, in consultation with the Commissioner of Health, shall adopt regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410, (C.52:14B-1 et seq.) to carry out the purposes of this act.

174. Section 5 of P.L.2000, c.143 (C.26:2H-7.14) is amended to read as follows:

C.26:2H-7.14 Construction of act.

5. Nothing in this act shall be construed to limit the existing authority of the Attorney General, the Commissioner of Health, or any other government official or entity or the court to review, approve or disapprove conditions related to an acquisition, transaction, or disposition under current law.

175. Section 1 of P.L.2002, c.25 (C.26:2H-7.15) is amended to read as follows:

C.26:2H-7.15 Definitions relative to assisted living.

1. As used in this act:

"Assisted living" means a coordinated array of supportive personal and health services, available 24 hours per day, which promote resident self-direction and participation in decisions that emphasize independence, individuality, privacy, dignity, and homelike surroundings to residents who have been assessed to need these services, including residents who require formal long-term care.

"Assisted living program" means the provision of or arrangement for meals and assisted living services, when needed, to the residents of publicly subsidized housing, which because of any federal, State, or local housing laws, rules, regulations, or requirements cannot become licensed as an assisted living residence.

"Assisted living residence" means a facility licensed by the Department of Health to provide apartment-style housing and congregate dining and to assure that assisted living services are available when needed, for four or more adult persons unrelated to the proprietor. Apartment units shall offer, at a minimum, one unfurnished room, a private bathroom, a kitchenette, and a lockable door on the unit entrance.

"Commissioner" means the Commissioner of Health.

176. Section 8 of P.L.2002, c.25 (C.26:2H-7.21) is amended to read as follows:

C.26:2H-7.21 Rules, regulations.

8. The Commissioner of Health, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) shall adopt rules and regulations to effectuate the purposes of this act.

177. Section 1 of P.L.1982, c.149 (C.26:2H-11.1) is amended to read as follows:

C.26:2H-11.1 Requirements for applicants for certificate of need, initial licensure for certain facilities.

1. In the case of an application for a certificate of need or initial licensure, as applicable, for a narcotic and drug abuse treatment center to be located within 500 feet from any building in this State used for the instruction of children between the ages of five and 18 years, the applicant shall notify the governing body of the municipality within which the applicant proposes to locate the treatment center of the applicant’s intention to apply for the certificate of need or licensure and the proposed location of the center. Documentation of the notice shall be filed with the certificate of need or license application. The Commissioner of

Health is hereby authorized to adopt reasonable rules and regulations, in accordance with the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), to effectuate the purposes of this act. For the purposes of this act, the definition of "narcotic and drug abuse treatment center" shall be identical to the definition in subsection (a) of section 2 of P.L.1970, c.334 (C.26:2G-22). This act shall not apply to any narcotic and drug abuse treatment center for which an application was filed prior to the effective date of this act.

178. Section 3 of P.L.1989, c.300 (C.26:2H-12.2a) is amended to read as follows:

C.26:2H-12.2a Maintenance of records of complaints, disciplinary actions.

3. a. A health care entity shall maintain all records of all documented complaints of events related to patient care about, and disciplinary proceedings or actions against, a health care professional who is employed by or has an affiliation with the health care entity. The health care entity shall retain the information for a period of seven years and make the records, including any information the health care entity has pertaining to records maintained on the health care professional prior to the effective date of P.L.1989, c.300 (C.45:9-19.4 et al.), available to the division, the board which licenses or otherwise authorizes the health care professional to practice, the Medical Practitioner Review Panel established pursuant to section 8 of P.L.1989, c.300 (C.45:9-19.8), and the Department of Health, as applicable, upon request.

b. A health care entity shall maintain for a period of four years all records and source data relating to its mortality, morbidity, complication, infection, and readmission and shall make the records available to the division, the board which licenses, or otherwise authorizes the health care professional, the review panel and the Department of Health, as applicable, upon request.

c. A health care entity which fails to maintain the records required pursuant to this section shall be subject to such penalties as the Department of Health shall determine pursuant to sections 13 and 14 of P.L.1971, c.136 (C.26:2H-13 and 26:2H-14) and section 16 of P.L.1997, c.192 (C.26:2S-16), or the director shall determine pursuant to P.L.1989, c.331 (C.34:8-43 et seq.), as applicable.

179. Section 2 of P.L.2005, c.83 (C.26:2H-12.2b) is amended to read as follows:

C.26:2H-12.2b Notification relative to certain impairments of health care professionals; definitions.

2. a. A health care entity shall notify the division in writing if a health care professional who is employed by, under contract to render professional services to, or has privileges granted by, that health care entity, or who provides such services pursuant to an agreement with a health care services firm or staffing registry:

(1) for reasons relating to the health care professional's impairment, incompetency, or professional misconduct, which incompetency or professional misconduct relates adversely to patient care or safety: (a) has full or partial privileges summarily or temporarily revoked or suspended, or permanently reduced, suspended, or revoked; (b) has been removed from the list of eligible employees of a health services firm or staffing registry; (c) has been discharged from the staff; or (d) has had a contract to render professional services terminated or rescinded;

(2) has conditions or limitations placed on the exercise of clinical privileges or practice within the health care entity for reasons relating to the health care professional's impairment, incompetency, or professional misconduct or, which incompetency or professional misconduct relates adversely to patient care or safety, including, but not limited to, second opinion requirements, non-routine concurrent or retrospective review of admissions or care, non-routine supervision by one or more members of the staff, or the completion of remedial education or training;

(3) voluntarily resigns from the staff if: (a) the health care entity is reviewing the health care professional's patient care or reviewing whether, based upon its reasonable belief, the health care professional's conduct demonstrates an impairment or incompetence or is unprofessional, which incompetence or unprofessional conduct relates adversely to patient care or safety; or (b) the health care entity, through any member of the medical or administrative staff, has expressed an intention to do such a review;

(4) voluntarily relinquishes any partial privilege or authorization to perform a specific procedure if: (a) the health care entity is reviewing the health care professional's patient care or reviewing whether, based upon its reasonable belief, the health care professional's conduct demonstrates an impairment or incompetence or is unprofessional, which incompetence or unprofessional conduct relates adversely to patient care or safety; or (b) the health care entity, through any member of the medical or administrative staff, has expressed an intention to do such a review;

(5) while under, or subsequent to, a review by the health care entity of the health care professional's patient care or professional conduct is granted a leave of absence for reasons relating to a physical, mental, or emotional condition or drug or alcohol use which impairs the health care professional's ability to practice with reasonable skill and safety, except that no report is required for pregnancy-related leaves of absence or if the health care professional has sought assistance from a professional assistance or intervention program approved or designated by the division or a board to provide confidential oversight of the health care professional and is following the treatment regimen or monitoring as that program requires; or

(6) is a party to a medical malpractice liability suit, to which the health care entity is also a party, and in which there is a settlement, judgment, or arbitration award.

As used in this subsection, incompetence, professional misconduct, and unprofessional conduct shall not include personal conduct, such as tardiness, insubordination, or other similar behavior, which does not relate to patient care or safety.

b. A health care entity shall notify the division in writing if it is in possession of information that indicates that a health care professional has failed to comply with a request to seek assistance from a professional assistance or intervention program approved or designated by the division or a board to provide confidential oversight of the health care professional, or has failed to follow the treatment regimen or monitoring program required by that program to assure that the health care professional's physical, mental, or emotional condition or drug or alcohol use does not impair the health care professional's ability to practice with reasonable skill and safety.

c. A health care entity shall notify the division in writing if any health care professional who has been the subject of a report pursuant to this section, has had conditions or limitations on the exercise of clinical privileges or practice within the health care entity altered, or privileges restored, or has resumed exercising clinical privileges that had been voluntarily relinquished.

d. In the case of a health care professional who is providing services at a health care entity pursuant to an agreement with a health care services firm or staffing agency and is the subject of a notice pursuant to this section, the health care entity shall, when it submits a notice to the division concerning that health care professional, provide a copy of the notice to the health care services firm or staffing agency.

e. The form of notification shall be prescribed by the Commissioner of Health, in consultation with the Commissioner of Human Services in the case of psychiatric facilities and developmental centers, and shall contain such information as may be required by the division and shall be made within seven days of the date of the action, settlement, judgment, or award.

f. A health care entity which fails to provide such notice to the division or fails to cooperate with a request for information by the division, the board or the Medical Practitioner Review Panel established pursuant to section 8 of P.L.1989, c.300 (C.45:9-19.8) shall be subject to such penalties as the Department of Health may determine pursuant to sections 13 and 14 of P.L.1971, c.136 (C.26:2H-13 and 26:2H-14).

g. A health care entity, or any employee thereof, which provides information to the division, the board, the Medical Practitioner Review Panel, a health care services firm or staffing agency, or the Department of Health, in good faith and without malice, regarding a health care professional pursuant to the provisions of this section or section 3 of P.L.1989, c.300 (C.26:2H-12.2a), is not liable for civil damages in any cause of action arising out of the provision or reporting of the information.

h. A health care entity shall provide the health care professional who is the subject of a notice pursuant to paragraphs (1), (2), (4), and (5) of subsection a. of this section and subsection c. of this section with a copy of the notice provided to the division, when the health care entity submits the notice to the division.

i. For the purposes of this section, section 3 of P.L.1989, c.300 (C.26:2H-12.2a) and section 15 of P.L.2005, c.83 (C.26:2H-12.2c):

"Board" means a professional and occupational licensing board within the Division of Consumer Affairs in the Department of Law and Public Safety which licenses or otherwise authorizes a health care professional to practice a health care profession.

"Division" means the Division of Consumer Affairs in the Department of Law and Public Safety.

"Health care entity" means a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.), a health maintenance organization authorized to operate pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.), a carrier which offers a managed care plan regulated pursuant to P.L.1997, c.192 (C.26:2S-1 et seq.), a State or county psychiatric hospital, a State developmental center, a staffing registry, and a home care services agency as defined in section 1 of P.L.1947, c.262 (C.45:11-23).

"Health care professional" means a person licensed or otherwise authorized pursuant to Title 45 or Title 52 of the Revised Statutes to practice a health care profession that is regulated by the Director of the Division of Consumer Affairs or by one of the following boards: the State Board of Medical Examiners, the New Jersey Board of Nursing, the New Jersey State Board of Dentistry, the New Jersey State Board of Optometrists, the New Jersey State Board of Pharmacy, the State Board of Chiropractic Examiners, the Acupuncture Examining Board, the State Board of Physical Therapy, the State Board of Respiratory Care, the Orthotics and Prosthetics Board of Examiners, the State Board of Psychological Examiners, the State Board of Social Work Examiners, the State Board of Veterinary Medical Examiners, the State Board of Examiners of Ophthalmic Dispensers and Ophthalmic

Technicians, the Audiology and Speech-Language Pathology Advisory Committee, the State Board of Marriage and Family Therapy Examiners, the Occupational Therapy Advisory Council and the Certified Psychoanalysts Advisory Committee. "Health care professional" also includes a nurse aide and a personal care assistant certified by the Department of Health.

180. Section 15 of P.L.2005, c.83 (C.26:2H-12.2c) is amended to read as follows:

C.26:2H-12.2c Disclosure of information by health care entity.

15. a. A health care entity, upon the inquiry of another health care entity, shall truthfully:

(1) disclose whether, within the seven years preceding the inquiry, it provided any notice to the division pursuant to section 2 of P.L.2005, c.83 (C.26:2H-12.2b), or to the review panel, as required by section 3 of P.L.1989, c.300 (C.26:2H-12.2a), with respect to the health care professional about whom the inquiry has been made, providing a copy of the form of notification and any supporting documentation that was provided to the division, a professional or occupational licensing board in the Division of Consumer Affairs in the Department of Law and Public Safety, or the review panel; and

(2) provide information about a current or former employee's job performance as it relates to patient care, as provided in this section, and, in the case of a former employee, the reason for the employee's separation.

b. For the purposes of this section, "job performance" shall relate to the suitability of the employee for re-employment at a health care entity, and the employee's skills and abilities as they relate to suitability for future employment at a health care entity. Information about a current or former employee's job performance pursuant to this paragraph shall be based on the employee's performance evaluation, and provided to another health care entity only if: (1) the evaluation has been signed by the evaluator and shared with the employee; (2) the employee has had the opportunity to respond; and (3) the employee's response, if any, has been taken into consideration when providing the information to another health care entity.

Job performance as it relates to patient care shall not include the current or former employee's participation in labor activities pursuant to the "National Labor Relations Act," 29 U.S.C. s.151 et seq.

c. A health care entity, or any employee designated by the entity, which, pursuant to this section, provides information in good faith and without malice to another health care entity concerning a health care professional, including information about a current or former employee's job performance as it relates to patient care, is not liable for civil damages in any cause of action arising out of the provision or reporting of the information.

d. A health care entity which fails to truthfully disclose information to another health care entity making an inquiry pursuant to this section or fails to cooperate with such request for information by the other health care entity shall be subject to such penalties as the Department of Health may determine pursuant to sections 13 and 14 of P.L.1971, c.136 (C.26:2H-13 and 26:2H-14) and section 16 of P.L.1997, c.192 (C.26:2S-16), or the director shall determine pursuant to P.L.1989, c.331 (C.34:8-43 et seq.), as applicable.

181. Section 1 of P.L.1998, c.136 (C.26:2H-12.6a) is amended to read as follows:

C.26:2H-12.6a Preparation, distribution of resource guide providing information on child abuse, neglect.

1. a. The Department of Children and Families, in consultation with the Department of Health, shall prepare a resource guide in both English and Spanish which provides

information on child abuse and neglect to all parents of newborn infants born in this State. The resource guide shall be distributed to each parent present during the infant's birth, by the personnel at a hospital or birthing facility, prior to the mother's discharge, as part of the hospital or birthing facility's discharge procedures.

b. The resource guide shall include information on the signs of child abuse and neglect, the services provided by the State which help in preventing child abuse and neglect, including the availability of home visitation resources, the legal ramifications of abusing or neglecting a child, and tips on child safety.

c. The department shall distribute the resource guide, at no charge, to all the hospitals and birthing facilities in the State. The department shall update the resource guide as necessary, and shall make additional copies of the resource guide available to health care providers upon request.

d. In addition to the resource guide prepared pursuant to subsection a. of this section, the department, in consultation with the Department of Health, shall prepare a pamphlet in both English and Spanish that includes information on the prevention of shaken baby syndrome and detailed suggestions for how to cope with a crying baby. The pamphlet shall be distributed to each parent present during the infant's birth, by the personnel at a hospital or birthing facility, prior to the mother's discharge, as part of the hospital or birthing facility's discharge procedures. The department shall: distribute the pamphlet, at no charge, to all hospitals and birthing facilities in the State; update the pamphlet as necessary; and make additional copies of the pamphlet available to health care providers upon request.

182. Section 1 of P.L.2005, c.50 (C.26:2H-12.6b) is amended to read as follows:

C.26:2H-12.6b Definitions relative to emergency contraception for sexual assault victims.

1. As used in P.L.2005, c.50 (C.26:2H-2.6b et seq.):

"Commissioner" means the Commissioner of Health.

"Division on Women" means the Division on Women in the Department of Children and Families.

"Emergency care to sexual assault victims" means a medical examination, procedure, or service provided by an emergency health care facility to a sexual assault victim following an alleged sexual offense.

"Emergency contraception" means one or more prescription drugs to prevent pregnancy, used separately or in combination, administered to or self-administered by a patient within a medically recommended time after sexual intercourse, dispensed for that purpose in accordance with professional standards of practice and determined to be safe by the United States Food and Drug Administration.

"Emergency health care facility" means a general hospital or satellite emergency department licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.).

"Medically and factually accurate and objective" means verified or supported by the weight of research conducted in compliance with accepted scientific methods and standards, published in peer-reviewed journals and recognized as accurate and objective by leading professional organizations and agencies with relevant expertise in the field of obstetrics and gynecology.

"Sexual Assault Nurse Examiner program" means the Statewide Sexual Assault Nurse Examiner program in the Division of Criminal Justice in the Department of Law and Public Safety, established pursuant to P.L.2001, c.81 (C.52:4B-50 et seq.).

"Sexual assault victim" means a female who alleges or is alleged to have suffered a personal, physical, or psychological injury as a result of a sexual offense.

"Sexual offense" means sexual assault and aggravated sexual assault as set forth in N.J.S.2C:14-2, criminal sexual contact and aggravated criminal sexual contact as set forth in N.J.S.2C:14-3, fourth degree lewdness as set forth in subsection b. of N.J.S.2C:14-4 and endangering the welfare of a child by engaging in sexual conduct which would impair or debauch the morals of the child as set forth in N.J.S.2C:24-4.

183. Section 2 of P.L.1989, c.170 (C.26:2H-12.8) is amended to read as follows:

C.26:2H-12.8 Rights of persons admitted to a general hospital.

2. Every person admitted to a general hospital as licensed by the Department of Health pursuant to P.L.1971, c.136 (C.26:2H-1 et al.) shall have the right:

a. To considerate and respectful care consistent with sound nursing and medical practices, which shall include being informed of the name and licensure status of a student nurse or facility staff member who examines, observes, or treats the patient and the right to expect and receive appropriate assessment, management, and treatment of pain as an integral component of that person's care;

b. To be informed of the name of the physician responsible for coordinating his care;

c. To obtain from the physician complete, current information concerning his diagnosis, treatment, and prognosis in terms he can reasonably be expected to understand. When it is not medically advisable to give this information to the patient, it shall be made available to another person designated by the patient on his behalf;

d. To receive from the physician information necessary to give informed consent prior to the start of any procedure or treatment and which, except for those emergency situations not requiring an informed consent, shall include as a minimum the specific procedure or treatment, the medically significant risks involved, and the possible duration of incapacitation, if any, as well as an explanation of the significance of the patient's informed consent. The patient shall be advised of any medically significant alternatives for care or treatment, however, this does not include experimental treatments that are not yet accepted by the medical establishment;

e. To refuse treatment to the extent permitted by law and to be informed of the medical consequences of this act;

f. To privacy to the extent consistent with providing adequate medical care to the patient. This shall not preclude discussion of a patient's case or examination of a patient by appropriate health care personnel;

g. To privacy and confidentiality of all records pertaining to the patient’s treatment, except as otherwise provided by law or third party payment contract, and to access to those records, including receipt of a copy thereof at reasonable cost, upon request, unless the patient’s physician states in writing that access by the patient is not medically advisable;

h. To expect that within its capacity, the hospital will make reasonable response to the patient’s request for services, including the services of an interpreter in a language other than English if 10% or more of the population in the hospital's service area speaks that language;

i. To be informed by the patient’s physician of any continuing health care requirements which may follow discharge and to receive assistance from the physician and appropriate hospital staff in arranging for required follow-up care after discharge;

j. To be informed by the hospital of the necessity of transfer to another facility prior to the transfer and of any alternatives to it which may exist, which transfer shall not be effected unless it is determined by the physician to be medically necessary;

k. To be informed, upon request, of other health care and educational institutions that the hospital has authorized to participate in his treatment;

l. To be advised if the hospital proposes to engage in or perform human research or experimentation and to refuse to participate in these projects. For the purposes of this subsection "human research" does not include the mere collecting of statistical data;

m. To examine and receive an explanation of the patient’s bill, regardless of source of payment, and to receive information or be advised on the availability of sources of financial assistance to help pay for the patient's care, as necessary;

n. To expect reasonable continuity of care;

o. To be advised of the hospital rules and regulations that apply to his conduct as a patient;

p. To treatment without discrimination as to race, age, religion, sex, national origin, or source of payment; and

q. To contract directly with a New Jersey licensed registered professional nurse of the patient's choosing for private professional nursing care during his hospitalization. A registered professional nurse so contracted shall adhere to hospital policies and procedures in regard to treatment protocols and policies and procedures so long as those policies and procedures are the same for private duty and regularly employed nurses. The registered professional nurse shall not be considered an agent or employee of the hospital for purposes of any financial liabilities, including, but not limited to, State or federal employee taxes, worker's compensation payments or coverage for professional liability.

The hospital, upon a patient's or the patient’s designee's request for private professional nursing care, shall provide the patient or the patient’s designee with a list of local nonprofit professional nurses association registries that refer nurses for private professional nursing care.

184. Section 14 of P.L.1999, c.154 (C.26:2H-12.12) is amended to read as follows:

C.26:2H-12.12 Responsibility of health care facilities for filing claims.

14. Effective 12 months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) is responsible for filing all claims for third party payment, including claims filed on behalf of the health care facility's patient for any health care service provided by the health care facility that is eligible for third party payment, except that at the patient's option, the patient may file the claim for third party payment.

a. In the case of a claim filed on behalf of the health care facility's patient, the health care facility shall file the claim within 60 days of the last date of service for a course of treatment, on the standard claim form adopted by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23).

b. In the case of a claim in which the patient has assigned the patient’s benefits to the health care facility, the health care facility shall file the claim within 180 days of the last date of service for a course of treatment, on the standard claim form adopted by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23). If the health care facility does not file the claim within 180 days of the last date of

service for a course of treatment, the third party payer shall reserve the right to deny payment of the claim, in accordance with regulations established by the Commissioner of Banking and Insurance, and the health care facility shall be prohibited from seeking any payment directly from the patient.

(1) In establishing the standards for denial of payment, the Commissioner of Banking and Insurance shall consider the length of delay in filing the claim, the good faith use of information provided by the patient to the health care facility with respect to the identity of the patient's third party payer, delays in filing a claim related to coordination of benefits between third party payers and any other factors the commissioner deems appropriate, and, accordingly, shall define specific instances where the sanctions permitted pursuant to this subsection shall not apply.

(2) A health care facility which fails to file a claim within 180 days and whose claim for payment has been denied by the third party payer in accordance with this subsection may, in the discretion of a judge of the Superior Court, be permitted to refile the claim if the third party payer has not been substantially prejudiced thereby. Application to the court for permission to refile a claim shall be made within 14 days of notification of denial of payment and shall be made upon motion based upon affidavits showing sufficient reasons for the failure to file the claim with the third party payer within 180 days.

c. The provisions of this section shall not apply to any claims filed pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.).

d. A health care facility which violates the provisions of subsection a. of this section may be subject to a civil penalty of $250 for each violation plus $50 for each day after the 60th day that the health care facility fails to submit a claim. The penalty shall be sued for and collected by the Department of Health pursuant to the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

185. Section 3 of P.L.1999, c.362 (C.26:2H-12.13) is amended to read as follows:

C.26:2H-12.13 Posting of drinking water test reports by general hospitals.

3. a. The owner or operator of a general hospital who is required to prepare a Consumer Confidence Report pursuant to the "Safe Drinking Water Act Amendments of 1996," (42 U.S.C.s.300f et al.), or who receives a Consumer Confidence Report from the owner or operator of a public community water system, shall post each Consumer Confidence Report it prepares or receives in the area of each major entrance and in each admitting room in the hospital.

b. The owner or operator of a general hospital who is a supplier of water but is not required to prepare a Consumer Confidence Report pursuant to the "Safe Drinking Water Act Amendments of 1996," and who is required to conduct tests of its drinking water by the Department of Environmental Protection, shall post a chart setting forth the results of the water tests, including the level of detection and, as appropriate for each contaminant, the maximum contaminant level, highest level allowed, action level, treatment technique, or other expression of an acceptable level, for each contaminant, in the area of each major entrance and in each admitting room in the general hospital. The chart also shall include in bold print the statement required to be included in a Consumer Confidence Report pursuant to 40 CFR s.141.154(a). The chart shall not include contaminants that are not detected.

c. As used in this section, "general hospital" shall mean any general hospital licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.).

d. The provisions of this section shall be enforced by the Department of Health. The Department of Health shall not be required to conduct on-site inspections to determine compliance with this section more frequently than any on-site inspections of general hospitals are conducted by the department pursuant to any other law.

186. Section 4 of P.L.1999, c.362 (C.26:2H-12.14) is amended to read as follows:

C.26:2H-12.14 Posting of drinking water test reports by rehabilitation centers, extended care facilities, nursing homes.

4. a. The owner or operator of a rehabilitation center, extended care facility, skilled nursing home, or nursing home who is required to prepare a Consumer Confidence Report pursuant to the "Safe Drinking Water Act Amendments of 1996," (42 U.S.C.s.300f et al.), or who receives a Consumer Confidence Report from the owner or operator of a public community water system, shall post each Consumer Confidence Report it prepares or receives in at least one conspicuous location in the rehabilitation center, extended care facility, skilled nursing home, or nursing home.

b. The owner or operator of a rehabilitation center, extended care facility, skilled nursing home, or nursing home who is a supplier of water but is not required to prepare a Consumer Confidence Report pursuant to the "Safe Drinking Water Act Amendments of 1996," and who is required to conduct tests of its drinking water by the Department of Environmental Protection, shall post a chart setting forth the results of the water tests, including the level of detection and, as appropriate for each contaminant, the maximum contaminant level, highest level allowed, action level, treatment technique, or other expression of an acceptable level, for each contaminant, in at least one conspicuous location in the rehabilitation center, extended care facility, skilled nursing home, or nursing home. The chart also shall include in bold print the statement required to be included in a Consumer Confidence Report pursuant to 40 CFR s.141.154(a). The chart shall not include contaminants that are not detected.

c. As used in this section, "rehabilitation center," "extended care facility," "skilled nursing home," and "nursing home" shall mean a rehabilitation center, extended care facility, skilled nursing home, or nursing home licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.).

d. The provisions of this section shall be enforced by the Department of Health. The Department of Health shall not be required to conduct on-site inspections to determine compliance with this section more frequently than any on-site inspections of rehabilitation centers, extended care facilities, skilled nursing homes, or nursing homes are conducted by the department pursuant to any other law.

187. Section 2 of P.L.1999, c.436 (C.26:2H-12.15) is amended to read as follows:

C.26:2H-12.15 Regulations on use of unlicensed assistive personnel.

2. a. The Commissioner of Health, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt regulations governing the use of unlicensed assistive personnel in licensed health care facilities, in consultation with at least the following: the Director of the Division of Consumer Affairs in the Department of Law and Public Safety, the New Jersey Hospital Association, the New Jersey Association of Health Care Facilities, the Medical Society of New Jersey, and the New Jersey State Nurses Association.

As used in this section, "unlicensed assistive personnel" means any unlicensed or uncertified personnel employed by a licensed health care facility that perform nursing tasks which do not require the skill or judgment of a registered professional nurse and which are assigned to them by, and carried out under the supervision of, a registered professional nurse.

b. The regulations adopted pursuant to subsection a. of this section, shall require, at a minimum, that:

(1) unlicensed assistive personnel employed by a health care facility meet the standards and requirements for education and competency evaluation prescribed by the New Jersey Board of Nursing pursuant to paragraph (26) of subsection d. of section 2 of P.L.1947, c.262 (C.45:11-24); and

(2) a health care facility, prior to implementing the use of unlicensed assistive personnel, establish a multidisciplinary committee, including representation from registered professional nurses, physicians, administrative staff, and unlicensed assistive personnel, to evaluate the need for using these personnel, formulate and adopt a plan to implement their use, and monitor the implementation of the plan.

c. The plan for implementing the use of unlicensed assistive personnel pursuant to paragraph (2) of subsection b. of this section shall, at a minimum:

(1) require the use and specify the composition of multidisciplinary patient care teams operating under the plan;

(2) prescribe materials and protocols for the orientation and training of health care facility staff with respect to implementing the plan;

(3) provide for the periodic monitoring and evaluation of the use of unlicensed assistive personnel by the multidisciplinary committee established pursuant to subsection b. of this section; and

(4) require in-service training and educational programming for both registered professional nurses and unlicensed assistive personnel which include subject matter relating to the delegation of nursing tasks to unlicensed assistive personnel and the supervision of these personnel by registered professional nurses.

188. Section 2 of P.L.2001, c.234 (C.26:2H-12.17) is amended to read as follows:

C.26:2H-12.17 Waiver of utilization requirement.

2. The Commissioner of Health may waive the 10% utilization requirement or reduce the required percentage by regulation for specific regions of the State or Statewide if the commissioner determines that sufficient numbers of assisted living beds are available in the State to meet the needs of Medicaid-eligible persons within the limits of the federal waiver to provide assisted living services through the Medicaid program.

189. Section 6 of P.L.2001, c.234 (C.26:2H-12.21) is amended to read as follows:

C.26:2H-12.21 Rules, regulations.

6. The Commissioner of Health shall adopt regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) necessary to carry out the purposes of this act.

190. Section 3 of P.L.2004, c.9 (C.26:2H-12.25) is amended to read as follows:

C.26:2H-12.25 Definitions relative to patient safety; plans; reports; documentation, notification of adverse effects, etc.

3. a. As used in this act:

"Adverse event" means an event that is a negative consequence of care that results in unintended injury or illness, which may or may not have been preventable.

"Anonymous" means that information is presented in a form and manner that prevents the identification of the person filing the report.

"Commissioner" means the Commissioner of Health.

"Department" means the Department of Health.

"Event" means a discrete, auditable, and clearly defined occurrence.

"Health care facility" or "facility" means a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) and a State psychiatric hospital operated by the Department of Human Services and listed in R.S.30:1-7.

"Health care professional" means an individual who, acting within the scope of the individual’s licensure or certification, provides health care services, and includes, but is not limited to, a physician, dentist, nurse, pharmacist, or other health care professional whose professional practice is regulated pursuant to Title 45 of the Revised Statutes.

"Near-miss" means an occurrence that could have resulted in an averse event but the adverse event was prevented.

"Preventable event" means an event that could have been anticipated and prepared against, but occurs because of an error or other system failure.

"Serious preventable adverse event" means an adverse event that is a preventable event and results in death or loss of a body part, or disability or loss of bodily function lasting more than seven days or still present at the time of discharge from a health care facility.

b. In accordance with the requirements established by the commissioner by regulation, pursuant to this act, a health care facility shall develop and implement a patient safety plan for the purpose of improving the health and safety of patients at the facility.

The patient safety plan shall, at a minimum, include:

(1) a patient safety committee, as prescribed by regulation;

(2) a process for teams of facility staff, which teams are comprised of personnel who are representative of the facility's various disciplines and have appropriate competencies, to conduct ongoing analysis and application of evidence-based patient safety practices in order to reduce the probability of adverse events resulting from exposure to the health care system across a range of diseases and procedures;

(3) a process for teams of facility staff, which teams are comprised of personnel who are representative of the facility's various disciplines and have appropriate competencies, to conduct analyses of near-misses, with particular attention to serious preventable adverse events and adverse events; and

(4) a process for the provision of ongoing patient safety training for facility personnel.

The provisions of this subsection shall not be construed to eliminate or lessen a hospital's obligation under current law or regulation to have a continuous quality improvement program.

c. A health care facility shall report to the department or, in the case of a State psychiatric hospital, to the Department of Human Services, in a form and manner established by the commissioner, every serious preventable adverse event that occurs in that facility.

d. A health care facility shall assure that the patient affected by a serious preventable adverse event or an adverse event specifically related to an allergic reaction, or, in the case of a minor or a patient who is incapacitated, the patient's parent or guardian or other family

member, as appropriate, is informed of the serious preventable adverse event or adverse event specifically related to an allergic reaction, no later than the end of the episode of care, or, if discovery occurs after the end of the episode of care, in a timely fashion as established by the commissioner by regulation. The time, date, participants, and content of the notification shall be documented in the patient's medical record in accordance with rules and regulations adopted by the commissioner. The content of the documentation shall be determined in accordance with the rules and regulations of the commissioner. If the patient's physician determines that the disclosure would seriously and adversely affect the patient's health, then the facility shall assure that the family member, if available, is notified in accordance with rules and regulations adopted by the commissioner. In the event that an adult patient is not informed of the serious preventable adverse event or adverse event specifically related to an allergic reaction, the facility shall assure that the physician includes a statement in the patient's medical record that provides the reason for not informing the patient pursuant to this section.

e. (1) A health care professional or other employee of a health care facility is encouraged to make anonymous reports to the department or, in the case of a State psychiatric hospital, to the Department of Human Services, in a form and manner established by the commissioner, regarding near-misses, preventable events, and adverse events that are otherwise not subject to mandatory reporting pursuant to subsection c. of this section.

(2) The commissioner shall establish procedures for and a system to collect, store, and analyze information voluntarily reported to the department pursuant to this subsection. The repository shall function as a clearinghouse for trend analysis of the information collected pursuant to this subsection.

f. Any documents, materials, or information received by the department, or the Department of Human Services, as applicable, pursuant to the provisions of subsections c. and e. of this section concerning serious preventable adverse events, near-misses, preventable events, and adverse events that are otherwise not subject to mandatory reporting pursuant to subsection c. of this section, shall not be:

(1) subject to discovery or admissible as evidence or otherwise disclosed in any civil, criminal, or administrative action or proceeding;

(2) considered a public record under P.L.1963, c.73 (C.47:1A-1 et seq.) or P.L.2001, c.404 (C.47:1A-5 et al.); or

(3) used in an adverse employment action or in the evaluation of decisions made in relation to accreditation, certification, credentialing, or licensing of an individual, which is based on the individual's participation in the development, collection, reporting or storage of information in accordance with this section. The provisions of this paragraph shall not be construed to limit a health care facility from taking disciplinary action against a health care professional in a case in which the professional has displayed recklessness, gross negligence, or willful misconduct, or in which there is evidence, based on other similar cases known to the facility, of a pattern of significant substandard performance that resulted in serious preventable adverse events.

The information received by the department, or the Department of Human Services, as applicable, shall be shared with the Attorney General in accordance with rules and regulations adopted pursuant to subsection j. of this section, and may be used by the department, the Department of Human Services, and the Attorney General for the purposes of this act and for oversight of facilities and health care professionals; however, the departments and the Attorney General shall not use the information for any other purpose.

In using the information to exercise oversight, the department, Department of Human Services, and Attorney General, as applicable, shall place primary emphasis on assuring effective corrective action by the facility or health care professional, reserving punitive enforcement or disciplinary action for those cases in which the facility or the professional has displayed recklessness, gross negligence, or willful misconduct, or in which there is evidence, based on other similar cases known to the department, Department of Human Services or the Attorney General, of a pattern of significant substandard performance that has the potential for or actually results in harm to patients.

g. Any documents, materials, or information developed by a health care facility as part of a process of self-critical analysis conducted pursuant to subsection b. of this section concerning preventable events, near-misses, and adverse events, including serious preventable adverse events, and any document or oral statement that constitutes the disclosure provided to a patient or the patient's family member or guardian pursuant to subsection d. of this section, shall not be:

(1) subject to discovery or admissible as evidence or otherwise disclosed in any civil, criminal, or administrative action or proceeding; or

(2) used in an adverse employment action or in the evaluation of decisions made in relation to accreditation, certification, credentialing, or licensing of an individual, which is based on the individual's participation in the development, collection, reporting, or storage of information in accordance with subsection b. of this section. The provisions of this paragraph shall not be construed to limit a health care facility from taking disciplinary action against a health care professional in a case in which the professional has displayed recklessness, gross negligence or willful misconduct, or in which there is evidence, based on other similar cases known to the facility, of a pattern of significant substandard performance that resulted in serious preventable adverse events.

h. Notwithstanding the fact that documents, materials, or information may have been considered in the process of self-critical analysis conducted pursuant to subsection b. of this section, or received by the department or the Department of Human Services pursuant to the provisions of subsection c. or e. of this section, the provisions of this act shall not be construed to increase or decrease, in any way, the availability, discoverability, admissibility, or use of any such documents, materials, or information if obtained from any source or context other than those specified in this act.

i. The investigative and disciplinary powers conferred on the boards and commissions established pursuant to Title 45 of the Revised Statutes, the Director of the Division of Consumer Affairs in the Department of Law and Public Safety and the Attorney General under the provisions of P.L.1978, c.73 (C.45:1-14 et seq.) or any other law, rule, or regulation, as well as the investigative and enforcement powers conferred on the department and the commissioner under the provisions of Title 26 of the Revised Statutes or any other law, rule or regulation, shall not be exercised in such a manner so as to unduly interfere with a health care facility's implementation of its patient safety plan established pursuant to this section. However, this act shall not be construed to otherwise affect, in any way, the exercise of such investigative, disciplinary, and enforcement powers.

j. The commissioner shall, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), adopt such rules and regulations necessary to carry out the provisions of this act. The regulations shall establish: criteria for a health care facility's patient safety plan and patient safety committee; the time frame and format for mandatory reporting of serious preventable adverse events at a health care facility; the types of events that qualify as serious preventable adverse events and adverse events specifically related to

an allergic reaction; the circumstances under which a health care facility is not required to inform a patient or the patient's family about a serious preventable adverse event or adverse event specifically related to an allergic reaction; and a system for the sharing of information received by the department and the Department of Human Services pursuant to subsections c. and e. of this section with the Attorney General. In establishing the criteria for reporting serious preventable adverse events, the commissioner shall, to the extent feasible, use criteria for these events that have been or are developed by organizations engaged in the development of nationally recognized standards.

The commissioner shall consult with the Commissioner of Human Services with respect to rules and regulations affecting the State psychiatric hospitals and with the Attorney General with respect to rules and regulations regarding the establishment of a system for the sharing of information received by the department and the Department of Human Services pursuant to subsections c. and e. of this section with the Attorney General.

k. Nothing in this act shall be construed to increase or decrease the discoverability, in accordance with Christy v. Salem, No. A-6448-02T3 (Superior Court of New Jersey, Appellate Division, February 17, 2004)(2004 WL291160), of any documents, materials or information if obtained from any source or context other than those specified in this act.

191. Section 8 of P.L.2007, c.196 (C.26:2H-12.25a) is amended to read as follows:

C.26:2H-12.25a Compilation of findings on patient safety; annual reports.

8. The Commissioner of Health and the Commissioner of Human Services shall compile their findings and recommendations for operational changes related to patient safety in health care facilities, based on information reported to the commissioners pursuant to the "Patient Safety Act," P.L.2004, c.9 (C.26:2H-12.23 et seq.).

The commissioners shall jointly issue an annual report of their findings and recommendations to the Governor, and to the Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), to be made available on the official Internet website of the Department of Health.

192. Section 1 of P.L.2009, c.122 (C.26:2H-12.25b) is amended to read as follows:

C.26:2H-12.25b Certain data included in New Jersey Hospital Performance Report; rules, regulations.

1. a. The Department of Health shall include in the New Jersey Hospital Performance Report issued annually by the department hospital-specific data from hospital procedure and diagnosis codes concerning the following patient safety indicators:

(1) Foreign body left during procedure (PSI 05);
(2) Iatrogenic pneumothorax (PSI 06);
(3) Postoperative hip fracture (PSI 08);
(4) Postoperative hemorrhage or hematoma (PSI 09);
(5) Postoperative deep vein thrombosis (DVT) or pulmonary embolism (PE) (PSI 12);
(6) Postoperative sepsis (PSI 13);
(7) Postoperative wound dehiscence (PSI 14);
(8) Accidental puncture or laceration (PSI 15);
(9) Transfusion reaction (PSI 16);
(10) Birth trauma (PSI 17);
(11) Obstetric trauma-vaginal delivery with instrument (PSI 18);

(12) Obstetric trauma-vaginal delivery without instrument (PSI 19);

(13) Air embolism; and

(14) Surgery on the wrong side, wrong body part, or wrong person, or wrong surgery performed on a patient.

b. The Commissioner of Health, in consultation with the Quality Improvement Advisory Committee in the Department of Health, may include additional patient safety indicators in the annual report, by regulation. The commissioner shall consider indicators that: (1) are recommended by the federal Agency for Healthcare Research and Quality or the Centers for Medicare & Medicaid Services; (2) are suitable for comparative reporting and public accountability, and are risk adjusted; (3) have a strong evidence base with no substantial evidence against their use for comparative reporting; and (4) can be measured through data that are available through hospital procedure and diagnosis codes.

c. The commissioner shall request the Quality Improvement Advisory Committee to study and make recommendations to the commissioner on how to expand public reporting by the department of patient pressure ulcers, patient infections due to hospital care, and falls by patients in general hospitals.

d. The commissioner shall, in accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), adopt such rules and regulations as the commissioner deems necessary to carry out the provisions of this act.

193. Section 2 of P.L.2004, c.136 (C.26:2H-12.28) is amended to read as follows:

C.26:2H-12.28 Designation of hospitals as stroke centers.

2. The Commissioner of Health shall designate hospitals that meet the criteria set forth in this act as primary or comprehensive stroke centers.

a. A hospital shall apply to the commissioner for designation and shall demonstrate to the satisfaction of the commissioner that the hospital meets the criteria set forth in section 3 or 4 of this act for a primary or comprehensive stroke center, respectively.

b. The commissioner shall designate as many hospitals as primary stroke centers as apply for the designation, provided that the hospital meets the criteria set forth in section 3 of this act. In addition to the criteria set forth in section 3 of this act, the commissioner is encouraged to take into consideration whether the hospital contracts with carriers that provide coverage through the State Medicaid program, established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.) and the NJ FamilyCare Program, established pursuant to P.L.2005, c.156 (C.30:4J-8 et al.).

c. The commissioner shall designate as many hospitals as comprehensive stroke centers as apply for the designation, provided that the hospital meets the criteria set forth in section 4 of this act.

d. The commissioner may suspend or revoke a hospital's designation as a stroke center, after notice and hearing, if the commissioner determines that the hospital is not in compliance with the requirements of this act.

194. Section 4 of P.L.2004, c.136 (C.26:2H-12.30) is amended to read as follows:

C.26:2H-12.30 Minimum criteria for comprehensive stroke centers.

4. A hospital designated as a comprehensive stroke center shall use proven state-of-the-art technology and medical techniques and, at a minimum, meet the criteria set forth in this section.

a. The hospital shall meet all of the criteria required for a primary stroke center pursuant to section 3 of this act.

b. With respect to patient care, the hospital shall:

(1) maintain a neurosurgical team that is capable of assessing and treating complex stroke and stroke-like syndromes;

(2) maintain on staff a neuro-radiologist with Certificate of Added Qualifications and a physician with neuro-interventional angiographic training and skills;

(3) provide comprehensive rehabilitation services either on site or by transfer agreement with another health care facility; and

(4) enter into and maintain written transfer agreements with primary stroke centers to accept transfer of patients with complex strokes when clinically warranted.

c. With respect to support services, the hospital shall:

(1) have magnetic resonance imaging and computed tomography angiography capabilities;

(2) have digital subtraction angiography and a suite equipped for neuro-interventional procedures;

(3) develop and maintain sophisticated outcomes assessment and performance improvement capability that incorporates data from affiliated primary stroke centers and integrates regional, State, and national data;

(4) provide guidance and continuing medical education to primary stroke centers;

(5) provide graduate medical education in stroke; and

(6) conduct research on stroke-related topics.

d. If the Commissioner of Health determines that a new drug, device, technique, or technology has become available for the treatment of stroke that provides a diagnostic or therapeutic advantage over existing elements included in the criteria established in this section or in section 3 of this act, the commissioner may, by regulation, revise or update the criteria accordingly.

195. Section 5 of P.L.2004, c.136 (C.26:2H-12.31) is amended to read as follows:

C.26:2H-12.31 Awarding of matching grants to designated stroke centers.

5. a. In order to encourage and ensure the establishment of stroke centers throughout the State, the Commissioner of Health shall award matching grants to hospitals that seek designation as stroke centers and demonstrate a need for financial assistance to develop the necessary infrastructure, including personnel and equipment, in order to satisfy the criteria for designation provided pursuant to this act. The matching grants shall not exceed $250,000 or 50% of the hospital's cost for developing the necessary infrastructure, whichever is less.

b. A hospital seeking designation as a stroke center shall apply to the commissioner for a matching grant, in a manner and on a form required by the commissioner, and provide such information as the commissioner deems necessary to determine if the hospital is eligible for the grant.

c. The commissioner may provide matching grants to as many hospitals as the commissioner deems appropriate, except that:

(1) Matching grant awards shall be made to at least two applicant hospitals in the northern region of this State (comprising Bergen, Hudson, Essex, Passaic, Morris, Sussex, and Warren counties), at least two applicant hospitals in the central region of this State (comprising Union, Somerset, Hunterdon, Mercer, Middlesex, and Monmouth counties) and at least two applicant hospitals in the southern region of this State (comprising Burlington,

Camden, Gloucester, Salem, Cumberland, Cape May, Atlantic, and Ocean counties), provided in the case of each region that the applicant hospitals receiving the awards must be eligible therefor under the provisions of this act; and

(2) No more than 20% of the funds appropriated pursuant to this act shall be allocated to hospitals that seek designation as comprehensive stroke centers.

196. Section 6 of P.L.2004, c.136 (C.26:2H-12.32) is amended to read as follows:

C.26:2H-12.32 Report to Governor, Legislature.

6. The Commissioner of Health shall, not later than September 1, 2005, prepare and submit to the Governor, the President of the Senate, and the Speaker of the General Assembly a report indicating, as of June 30, 2005, the total number of hospitals that shall have applied for grants under section 5 of this act and the number of those applicants that shall have been found to be eligible for such grants, the total number of grants awarded, the name and address of each grantee hospital and the amount of the award to each, and the amount of each award that shall have been paid to the grantee.

197. Section 1 of P.L.2007, c.65 (C.26:2H-12.33) is amended to read as follows:

C.26:2H-12.33 Availability of certain information on departmental website.

1. a. The Department of Health shall make available to the public, through its official department website, information regarding:

(1) the ownership of each long-term care facility and adult day health services facility licensed by the department; and

(2) any violation of statutory standards or rules and regulations of the department pertaining to the care of patients or physical plant standards found at any such facility by the department.

b. The information made available to the public pursuant to subsection a. of this section shall be provided in a manner that would enable a member of the public to search the website by name of a facility or its owner in order to access the information. The department shall also make the information available in writing, upon request.

c. The information regarding the ownership of a long-term care or adult day health services facility that is made available to the public pursuant to subsection a. of this section shall provide, at a minimum: the name of the owner of a facility as listed on the facility's license and, if there is more than one owner or the facility is owned by a corporation, the name of each person who holds at least a 10% interest in the facility; the name of any other licensed long-term care or adult day health services facility in the State owned by this owner, corporation, and each person who holds at least a 10% interest in the facility, as applicable; and the address and contact information for the facility.

d. The information that is displayed on the official department website pursuant to subsection a. of this section shall include Internet web links to the New Jersey Report Card for Nursing Homes maintained by the department and the Medicare Nursing Home Compare database maintained by the federal Centers for Medicare & Medicaid Services.

198. Section 1 of P.L.2007, c.74 (C.26:2H-12.34) is amended to read as follows:

C.26:2H-12.34 Training required for service as trustee of general hospital, conditions.

1. a. (1) As a condition of serving as a member of the board of trustees of a general hospital licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et al.), a person shall be required to complete a training program approved by the Commissioner of Health that is designed to clarify the roles and duties of a hospital trustee and is at least one day in length.

(2) The training shall be completed no later than six months after the date that the person is appointed as a member of the board, except that a person who is appointed as a member of a hospital board of trustees on or after the date of enactment of this act but prior to the effective date thereof shall complete the training no later than six months after the effective date.

(3) A person who was appointed as a member of a hospital board of trustees prior to the date of enactment of P.L.2007, c.74 shall complete the training no later than six months after the effective date of P.L.2008, c.57.

b. The commissioner shall, in consultation with the New Jersey Hospital Association, the Hospital Alliance of New Jersey, and the New Jersey Council of Teaching Hospitals:

(1) prescribe the subject matter of the training, which shall include, but need not be limited to, a review of the types of financial, organizational, legal, regulatory, and ethical issues that a hospital trustee may be required to consider in the course of discharging the trustee's governance responsibilities;

(2) arrange for, or specify, the entity or entities to provide the training;

(3) specify the timeframe within which the training is to be completed;

(4) certify completion of the training for each trustee upon receipt of documentation thereof, as provided on a form and in a manner prescribed by the commissioner, or otherwise arrange for certification by the training entity; and

(5) take such other actions as the commissioner determines appropriate to effectuate the purposes of this act.

199. Section 2 of P.L.2007, c.120 (C.26:2H-12.36) is amended to read as follows:

C.26:2H-12.36 Hospitals required to implement an infection program, reporting of cases of MRSA.

2. a. Within one month after the effective date of this act, all general hospitals licensed by the Department of Health pursuant to P.L.1971, c.136 (C.26:2H-1 et al.) shall implement an infection prevention program in their intensive care unit or units, as applicable, and if the hospital has no intensive care unit, then in another high-risk unit such as a surgical unit, or other unit where there is significant risk of facility-acquired infections.

Ultimately, the hospital shall expand the infection prevention program to all areas of the hospital, with the exception of an inpatient psychiatric unit, if applicable. The expansion of the infection prevention program shall be completed as quickly as feasible, taking into account the hospital's patient population, physical plant, and other facility-specific circumstances.

b. In addition to any other best practices and effective strategies, the hospital shall incorporate the following strategies:

(1) identification and isolation of both colonized and infected patients by screening patients upon admission in order to break the chain of transmission;

(2) contact precautions for patients found to be MRSA positive, as "contact precautions" is defined by the Centers for Disease Control and Prevention;

(3) patient cultures for MRSA upon discharge or transfer from the unit where the infection prevention program has been implemented, and flagging of patients who are readmitted to the hospital;

(4) strict adherence to hygiene guidelines;

(5) a written infections prevention and control policy with input from frontline caregivers; and

(6) a worker education requirement regarding modes of transmission of MRSA, use of protective equipment, disinfection policies and procedures, and other preventive measures.

c. A general hospital shall report to the Department of Health, in a manner and according to a schedule prescribed by the Commissioner of Health, the number of cases of hospital-acquired MRSA that occur in its facility.

200. Section 3 of P.L.2007, c.120 (C.26:2H-12.37) is amended to read as follows:

C.26:2H-12.37 Violations, penalties.

3. A general hospital that is in violation of the provisions of this act shall be subject to such penalties as the Commissioner of Health may determine pursuant to sections 13 and 14 of P.L.1971, c.136 (C.26:2H-13 and 26:2H-14).

201. Section 2 of P.L.2007, c.196 (C.26:2H-12.40) is amended to read as follows:

C.26:2H-12.40 Findings, declarations relative to reporting of infection rates by hospitals.

2. The Legislature finds and declares:

a. Health care facility-associated infections constitute a major public health problem in this country, affecting from 5% to 10% of hospitalized patients annually, resulting in an estimated two million infections, and 90,000 deaths, and adding an estimated $4.5 to $5.7 billion in health care costs;

b. Many health care facility-associated infections can be prevented, and a goal of zero health care facility-associated infections is desirable. There are many simple and effective practices in hospitals that can dramatically reduce the incidence of health care facility-associated infections, such as hand washing, using gloves and properly sterilized equipment, and following the same established best practices, every time, for procedures such as the insertion of an intravenous tube to deliver fluids and medication;

c. The uniform reporting of health care facility-associated infections to the State, and the review and analysis of this data by the Department of Health, will provide a measurable means to assist hospitals in improving patient outcomes;

d. The federal Centers for Disease Control and Prevention recommends that states establishing public reporting systems for health care facility-associated infections focus on major site categories to report rates of health care facility-associated infections related to procedures and conditions including, but not limited to, urinary tract infections, surgical site infections, ventilator-associated pneumonia, and central line-related bloodstream infections. A focus on major site categories helps ensure that data collection is concentrated in populations where health care facility-associated infections are more prevalent, and that the infection rates reported are most useful for targeting prevention practices and making comparisons among hospitals and within hospitals, over time;

e. The Department of Health currently provides comparative hospital performance data in its annual New Jersey Hospital Performance Report, and including information about

hospital infection rates will further enhance the value of the report to the public and health care providers; and

f. Therefore, it is a matter of public health and fiscal policy that patients in New Jersey's hospitals receive health care that incorporates best practices in infection control, not only to protect their health and lives, but also to ensure the economic viability of New Jersey's hospitals.

202. Section 3 of P.L.2007, c.196 (C.26:2H-12.41) is amended to read as follows:

C.26:2H-12.41 Quarterly reports by general hospital to Department of Health.

3. A general hospital licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et al.) shall be required to report quarterly to the Department of Health, in a form and manner prescribed by the Commissioner of Health:

a. process quality indicators of hospital infection control that have been identified by the federal Centers for Medicare & Medicaid Services, as selected by the commissioner in consultation with the Quality Improvement Advisory Committee within the department; and

b. beginning 30 days after the adoption of regulations pursuant to this act, data on infection rates for the major site categories that define health care facility-associated infection locations, multiple infections, and device-related and non-device related infections, identified by the federal Centers for Disease Control and Prevention, as selected by the commissioner in consultation with the Quality Improvement Advisory Committee within the department.

203. Section 5 of P.L.2007, c.196 (C.26:2H-12.43) is amended to read as follows:

C.26:2H-12.43 Information available to public on Internet website.

5. The commissioner shall make available to members of the public, on the official Internet website of the Department of Health, the information reported pursuant to this act, in such a format as the commissioner deems appropriate to enable comparison among hospitals, with respect to the information, and shall include information in the New Jersey Hospital Performance Report annually issued by the commissioner that measures the performance of general hospitals in the State with respect to process quality indicators and health care facility-associated infection among patients.

204. Section 3 of P.L.2007, c.247 (C.26:2H-12.48) is amended to read as follows:

C.26:2H-12.48 Provision of copy of brochure to pregnant patients.

3. A health care professional shall provide to each patient to whom that individual is providing prenatal care, as early as practicable in the health care professional's therapeutic relationship with the patient, preferably in the first trimester, a copy of the brochure prepared by the Division of Family Health Services in the Department of Health that may be downloaded from the website of the department, which is designed to answer common questions about umbilical cord and placental blood donation and storage, including the NMDP-affiliated public umbilical cord blood bank and private umbilical cord blood bank options and the differences between and benefits of these options. The health care professional shall offer to discuss the information contained in the brochure with the patient.

205. Section 2 of P.L.2008, c.59 (C.26:2H-12.51) is amended to read as follows:

C.26:2H-12.51 Notice of meeting on department’s website.

2. The Department of Health shall post the notice of a hospital's annual public meeting on the department's website.

206. Section 1 of P.L.2008, c.60 (C.26:2H-12.52) is amended to read as follows:

C.26:2H-12.52 Limitation on charges for certain uninsured patients.

1. A hospital licensed by the Department of Health pursuant to P.L.1971, c.136 (C.26:2H-1 et al.) shall charge a patient who is an uninsured resident of this State, and whose family gross income is less than 500% of the federal poverty level, an amount no greater than 115% of the applicable payment rate under the federal Medicare program, established pursuant to Pub.L.89-97 (42 U.S.C.s.1395 et seq.), for the health care services rendered to the patient. The amount shall be in accordance with the sliding scale based on income developed by the department pursuant to this act.

207. Section 2 of P.L.2008, c.60 (C.26:2H-12.53) is amended to read as follows:

C.26:2H-12.53 Sliding scale for certain hospital charges.

2. The Department of Health shall establish a sliding scale based on income which stipulates the percentage of a hospital charge that an uninsured resident of this State whose family gross income is less than 500% of the federal poverty level is required to pay for health care services rendered at a hospital.

208. Section 2 of P.L.2009, c.61 (C.26:2H-12.57) is amended to read as follows:

C.26:2H-12.57 Written informational sheet for assisted living facilities.

2. The Department of Health, in consultation with the Division of Medical Assistance and Health Services in the Department of Human Services, shall prepare a written informational sheet for assisted living facilities that explains eligibility for participation in a federally approved 1915(c) Medicaid waiver program that provides assisted living services. The informational sheets shall be available on the website of the Department of Health and shall be updated by the Department of Health as necessary to reflect a change in eligibility for the programs.

209. Section 3 of P.L.2009, c.61 (C.26:2H-12.58) is amended to read as follows:

C.26:2H-12.58 Distribution of informational sheets.

3. The Department of Health shall distribute the applicable informational sheets, prepared and updated pursuant to section 2 of this act, to all licensed assisted living facilities in the State.

210. Section 1 of P.L.2010, c.61 (C.26:2H-12.59) is amended to read as follows:

C.26:2H-12.59 Online brochure relative to bone marrow donation.

1. a. The Commissioner of Health shall prepare an online brochure for display on the Internet website of the Department of Health, based upon information derived from the National Marrow Donor Program, or NMDP, which may be downloaded by physicians and

utilized by the commissioner for the purposes of subsection c. of this section, and shall be designed to inform patients of the option to become a bone marrow or peripheral blood stem cell, or PBSC, donor by registering with the NMDP and to answer common questions about bone marrow and peripheral blood stem cell, or PBSC, donation.

b. The brochure shall describe:

(1) the health benefits to the community from making a bone marrow or PBSC donation through the NMDP;

(2) how to register with the NMDP;

(3) the procedures for making a bone marrow or PBSC donation through the NMDP, including notice that there is no charge to the donor or the donor's family for making the donation;

(4) the circumstances and procedures by which a patient may receive a transfusion of the patient's previously donated blood; and

(5) any other aspects of bone marrow or PBSC donation that the commissioner deems appropriate for the purposes of this act.

c. The commissioner, within the limits of resources available to the Department of Health for this purpose, shall seek to promote awareness among physicians and the general public in this State about the option to become a bone marrow or PBSC donor. In doing so, the commissioner shall consult with at least the following: the Medical Society of New Jersey, the Institute of Medicine and Public Health of New Jersey, the NMDP, and other organizations that are seeking to increase bone marrow and PBSC donation among various ethnic groups within the State in need of these donations.

211. Section 1 of P.L.2011, c.16 (C.26:2H-12.61) is amended to read as follows:

C.26:2H-12.61 Discharge of patients from certain residences; provision for care in alternate facility.

1. a. If a facility licensed to operate as an assisted living residence or comprehensive personal care home pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) opts to surrender its license and has promised a resident of the facility or the resident's responsible party, in writing through a resident agreement or other instrument, or through a condition of licensure or certificate of need with the Department of Health, that it will not discharge a resident who becomes Medicaid-eligible, as that term is defined in section 1 of P.L.2001, c.234 (C.26:2H-12.16), the facility shall escrow sufficient funds, as determined by the Commissioner of Health, to cover the cost of providing a resident with care in an alternate State-licensed assisted living residence or comprehensive personal care home for as long as the resident shall require care.

b. The facility shall cover any costs necessary to utilize actuarial services as the Department of Health may require to determine the amount to be escrowed pursuant to subsection a. of this section.

c. In the event of a facility bankruptcy, any monies left over after all creditors have been paid shall be used, to the maximum extent practicable, to cover the cost of care provided to a resident in an alternate State-licensed assisted living residence or comprehensive personal care home pursuant to subsection a. of this section.

212. Section 7 of P.L.2007, c.225 (C.26:2H-14.14) is amended to read as follows:

C.26:2H-14.14 Violations, penalties.

7. A covered health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et al.) that is in violation of the provisions of this act shall be subject to such penalties as the Department of Health may determine pursuant to sections 13 and 14 of P.L.1971, c.136 (C.26:2H-13 and 26:2H-14).

213. Section 8 of P.L.2007, c.225 (C.26:2H-14.15) is amended to read as follows:

C.26:2H-14.15 Rules, regulations.

8. The Commissioner of Health shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), within 12 months of the date of enactment of this act, to carry out the purposes of this act.

214. Section 3 of P.L.1987, c.299 (C.26:2H-18c) is amended to read as follows:

C.26:2H-18c Designation of specialty acute care children’s hospital for southern New Jersey.

3. a. The Commissioner of Health, subject to the provisions of subsection b. of this section, shall designate Cooper University Hospital in the City of Camden as the State's specialty acute care children's hospital in southern New Jersey for the counties of Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, and Salem.

b. The designation by the Commissioner of Health pursuant to subsection a. of this section shall be made subsequent to, and shall be contingent upon, the execution of a written agreement between Cooper University Hospital and a majority of the acute care hospitals providing inpatient pediatric services which are located in the counties listed in subsection a. of this section.

The written agreement shall state that the other facility recognizes Cooper University Hospital as the State's specialty acute care children's hospital for the counties listed in subsection a. of this section and shall set forth the basis on which the other facility shall make referrals to Cooper University Hospital.

215. Section 1 of P.L.1992, c.181 (C.26:2H-18d) is amended to read as follows:

C.26:2H-18d Designation of specialty acute care children’s hospital for central New Jersey.

1. a. The Commissioner of Health, subject to the provisions of subsection b. of this section, shall designate Robert Wood Johnson University Hospital/St. Peter's University Hospital in the City of New Brunswick as the State's specialty acute care children's hospital in central New Jersey for the counties of Hunterdon, Mercer, Middlesex, and Somerset.

b. The designation by the Commissioner of Health pursuant to subsection a. of this section shall be made subsequent to, and shall be contingent upon, the execution of a written agreement between Robert Wood Johnson University Hospital/St. Peter's University Hospital and a majority of the acute care hospitals providing inpatient pediatric services which are located in the counties listed in subsection a. of this section.

The written agreement shall state that the other facility recognizes Robert Wood Johnson University Hospital/St. Peter's University Hospital as the State's specialty acute care children's hospital for the counties listed in subsection a. of this section and shall set forth the basis on which the other facility shall make referrals to Robert Wood Johnson University Hospital/St. Peter's University Hospital.

216. Section 1 of P.L.1993, c.374 (C.26:2H-18e) is amended to read as follows:

C.26:2H-18e Designation of specialty acute care children’s hospital for Bergen, Passaic, Sussex, and Warren counties.

1. a. The Commissioner of Health, subject to the provisions of subsection b. of this section, shall designate St. Joseph's Hospital and Medical Center in the City of Paterson as the State's specialty acute care children's hospital for the counties of Bergen, Passaic, Sussex, and Warren.

b. The designation by the Commissioner of Health pursuant to subsection a. of this section shall be made subsequent to, and shall be contingent upon, the execution of a written agreement between St. Joseph's Hospital and Medical Center and a majority of the acute care hospitals providing inpatient pediatric services which are located in the counties listed in subsection a. of this section.

The written agreement shall state that the other facility recognizes St. Joseph's Hospital and Medical Center as the State's specialty acute care children's hospital for the counties listed in subsection a. of this section and shall set forth the basis on which the other facility shall make referrals to St. Joseph's Hospital and Medical Center.

217. Section 2 of P.L.2003, c.98 (C.26:2H-18f) is amended to read as follows:

C.26:2H-18f Designation of specialty acute care children’s hospital for Morris and Union counties.

2. a. The Commissioner of Health, subject to the provisions of subsection b. of this section, shall designate Morristown Memorial Hospital as the State's specialty acute care children's hospital for Morris and Union counties.

b. The designation by the Commissioner of Health pursuant to subsection a. of this section shall be made subsequent to, and shall be contingent upon, the execution of written transfer agreements between Morristown Memorial Hospital and a majority of the acute care hospitals providing inpatient pediatric services which are located in Morris and Union counties.

The written agreement shall state that the other facility recognizes Morristown Memorial Hospital as the State's specialty acute care children's hospital for Morris and Union counties and shall set forth the basis on which the other facility shall make referrals to Morristown Memorial Hospital.

218. Section 1 of P.L.2005, c.116 (C.26:2H-18g) is amended to read as follows:

C.26:2H-18g Designation of acute care children’s hospitals for Monmouth and Ocean counties.

1. a. The Commissioner of Health, subject to the provisions of subsection b. of this section, shall designate Jersey Shore University Medical Center and Monmouth Medical Center, each, as the State's specialty acute care children's hospitals for Monmouth and Ocean counties, subject to the commissioner's determination that each hospital meets all of the licensure criteria that apply to a children's hospital and has met and complied with all of the requirements to obtain State authorization to offer the component services that constitute a children's hospital. The commissioner's determination and the designation pursuant thereto shall be made separately for each hospital; and the commissioner's decision on the

designation of each hospital shall be made independently of, and shall not be contingent upon, the decision on the designation of the other hospital.

b. The designation of each hospital by the Commissioner of Health pursuant to subsection a. of this section shall be made subsequent to, and shall be contingent upon, the execution of written transfer agreements, respectively, between: Jersey Shore University Medical Center and a majority of the acute care hospitals providing inpatient pediatric services located in Monmouth and Ocean counties; and Monmouth Medical Center and a majority of the acute care hospitals providing inpatient pediatric services located in Monmouth and Ocean counties.

The written agreement shall state that the other facility recognizes Jersey Shore University Medical Center and Monmouth Medical Center, as applicable, as the State's specialty acute care children's hospitals for Monmouth and Ocean counties and shall set forth the basis on which the other facility shall make referrals to Jersey Shore University Medical Center or Monmouth Medical Center, as applicable.

219. Section 1 of P.L.2011, c.208 (C.26:2H-18h) is amended to read as follows:

C.26:2H-18h Specialized care facilities for Huntington’s Disease; rules, regulations.

1. a. The Commissioner of Health may issue a nursing facility license for a facility that provides care for Huntington's Disease.

b. The commissioner, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), may adopt rules and regulations to effectuate the purposes of this act.

220. Section 2 of P.L.1992, c.160 (C.26:2H-18.52) is amended to read as follows:

C.26:2H-18.52 Definitions relative to provision of health care services to low income persons.

2. As used in sections 1 through 17 of P.L.1992, c.160 (C.26:2H-18.51 through 26:2H-18.67), sections 12 through 15 of P.L.1995, c.133 (C.26:2H-18.59a through C.26:2H-18.59d), sections 7 through 12 of P.L.1996, c.28 (C.26:2H-18.59e et al.) and sections 6, 8, 10 and 11 of P.L.1997, c.263 (C.26:2H-18.58e, C.26:2H-18.58f, C.26:2H-18.58d and C.26:2H-18.59h):

"Administrator" means the administrator of the Health Care Subsidy Fund appointed by the commissioner.

"Charity care" means care provided at disproportionate share hospitals that may be eligible for a charity care subsidy pursuant to this act.

"Charity care subsidy" means the component of the disproportionate share payment that is attributable to care provided at a disproportionate share hospital to persons unable to pay for that care, as provided in this act.

"Commission" means the New Jersey Essential Health Services Commission established pursuant to section 4 of this act.

"Commissioner" means the Commissioner of Health.

"Department" means the Department of Health.

"Disproportionate share hospital" means a hospital designated by the Commissioner of Human Services pursuant to Pub.L.89-97 (42 U.S.C. s.1396a et seq.) and Pub.L.102-234.

"Disproportionate share payment" means those payments made by the Division of Medical Assistance and Health Services in the Department of Human Services to hospitals defined as disproportionate share hospitals by the Commissioner of Human Services in accordance with

federal laws and regulations applicable to hospitals serving a disproportionate number of low income patients.

"Fund" means the Health Care Subsidy Fund established pursuant to section 8 of this act.

"Hospital" means an acute care hospital licensed by the Department of Health pursuant to P.L.1971, c.136 (C.26:2H-1 et al.).

"Medicaid" means the New Jersey Medical Assistance and Health Services Program in the Department of Human Services established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

"Medicare" means the program established pursuant to Pub.L.89-97 (42 U.S.C. s.1395 et seq.).

221. Section 2 of P.L.2006, c.87 (C.26:2H-18.55a) is amended to read as follows:

C.26:2H-18.55a Compilation of information relative to employed recipients of charity care.

2. a. The Commissioner of Health shall compile, to the extent data are available, the following information about recipients of charity care who are employed:

(1) the employer's name and address;

(2) the number of recipients of charity care who are employed by the employer; and

(3) the cost to the State of providing charity care for the employer's employees and their dependents.

b. In order to compile the information required pursuant to this section, the commissioner may require hospitals and other health care facilities to submit such information as may be necessary for this purpose.

c. The commissioner may include comparable information about recipients of other public health care coverage programs, and other information as the commissioner deems appropriate regarding employer-based coverage for persons covered under public insurance programs.

d. The information compiled by the commissioner shall not include the name of any charity care recipient or any family member of a recipient.

e. The commissioner shall provide the information required pursuant to this section to the Commissioner of Human Services for inclusion in the annual report on Access to Employer-Based Health Insurance, as provided in section 1 of P.L.2006, c.87 (C.30:4J-17).

222. Section 7 of P.L.1992, c.160 (C.26:2H-18.57) is amended to read as follows:

C.26:2H-18.57 Assessment of per adjusted admission charge.

7. a. Effective January 1, 1994, the Department of Health shall assess each hospital a per adjusted admission charge of $10.

Of the revenues raised by the hospital per adjusted admission charge, $5 per adjusted admission shall be used by the department to carry out its duties pursuant to P.L.1992, c.160 (C.26:2H-18.51 et al.) and $5 per adjusted admission shall be used by the department for administrative costs related to health planning.

b. Effective July 1, 2004, the department shall assess each licensed ambulatory care facility that is licensed to provide one or more of the following ambulatory care services: ambulatory surgery, computerized axial tomography, comprehensive outpatient rehabilitation, extracorporeal shock wave lithotripsy, magnetic resonance imaging, megavoltage radiation oncology, positron emission tomography, orthotripsy, and sleep disorder services. The Commissioner of Health may, by regulation, add additional categories of ambulatory care services that shall be subject to the assessment if such services are added

to the list of services provided in N.J.A.C.8:43A-2.2(b) after the effective date of P.L.2004, c.54.

The assessment established in this subsection shall not apply to an ambulatory care facility that is licensed to a hospital in this State as an off-site ambulatory care service facility.

(1) For Fiscal Year 2005, the assessment on an ambulatory care facility providing one or more of the services listed in this subsection shall be based on gross receipts for the 2003 tax year as follows:

(a) a facility with less than $300,000 in gross receipts shall not pay an assessment; and

(b) a facility with at least $300,000 in gross receipts shall pay an assessment equal to 3.5% of its gross receipts or $200,000, whichever amount is less.

The commissioner shall provide notice no later than August 15, 2004 to all facilities that are subject to the assessment that the first payment of the assessment is due October 1, 2004 and that proof of gross receipts for the facility's tax year ending in calendar year 2003 shall be provided by the facility to the commissioner no later than September 15, 2004. If a facility fails to provide proof of gross receipts by September 15, 2004, the facility shall be assessed the maximum rate of $200,000 for Fiscal Year 2005.

The Fiscal Year 2005 assessment shall be payable to the department in four installments, with payments due October 1, 2004, January 1, 2005, March 15, 2005 and June 15, 2005.

(2) For Fiscal Year 2006, the commissioner shall use the calendar year 2004 data submitted in accordance with subsection c. of this section to calculate a uniform gross receipts assessment rate for each facility with gross receipts over $300,000 that is subject to the assessment, except that no facility shall pay an assessment greater than $200,000. The rate shall be calculated so as to raise the same amount in the aggregate as was assessed in Fiscal Year 2005. A facility shall pay its assessment to the department in four payments in accordance with a timetable prescribed by the commissioner.

(3) Beginning in Fiscal Year 2007 and for each fiscal year thereafter through Fiscal Year 2010, the uniform gross receipts assessment rate calculated in accordance with paragraph (2) of this subsection shall be applied to each facility subject to the assessment with gross receipts over $300,000, as those gross receipts are documented in the facility's most recent annual report to the department, except that no facility shall pay an assessment greater than $200,000. A facility shall pay its annual assessment to the department in four payments in accordance with a timetable prescribed by the commissioner.

(4) Beginning in Fiscal Year 2011 and for each fiscal year thereafter, the uniform gross receipts assessment shall be applied at the rate of 2.95% to each facility subject to the assessment with gross receipts over $300,000, as those gross receipts are documented in the facility's most recent annual report submitted to the department pursuant to subsection c. of this section, except that no facility shall pay an assessment greater than $350,000. A facility shall pay its annual assessment to the department in four payments in accordance with a timetable prescribed by the commissioner.

c. Each ambulatory care facility that is subject to the assessment provided in subsection b. of this section shall submit an annual report including, at a minimum, data on volume of patient visits, charges, and gross revenues, by payer type, for patient services, beginning with calendar year 2004 data. The annual report shall be submitted to the department according to a timetable and in a form and manner prescribed by the commissioner.

The department may audit selected annual reports in order to determine their accuracy.

d. (1) If, upon audit as provided for in subsection c. of this section, it is determined that an ambulatory care facility understated its gross receipts in its annual report to the

department, the facility's assessment for the fiscal year that was based on the defective report shall be retroactively increased to the appropriate amount and the facility shall be liable for a penalty in the amount of the difference between the original and corrected assessment.

(2) A facility that fails to provide the information required pursuant to subsection c. of this section shall be liable for a civil penalty not to exceed $500 for each day in which the facility is not in compliance.

(3) A facility that is operating one or more of the ambulatory care services listed in subsection b. of this section without a license from the department, on or after July 1, 2004, shall be liable for double the amount of the assessment provided for in subsection b. of this section, in addition to such other penalties as the department may impose for operating an ambulatory care facility without a license.

(4) The commissioner shall recover any penalties provided for in this subsection in an administrative proceeding in accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

e. The revenues raised by the ambulatory care facility assessment pursuant to this section shall be deposited in the Health Care Subsidy Fund established pursuant to section 8 of P.L.1992, c.160 (C.26:2H-18.58).

223. Section 8 of P.L.1992, c.160 (C.26:2H-18.58) is amended to read as follows:

C.26:2H-18.58 Health Care Subsidy Fund.

8. There is established the Health Care Subsidy Fund in the Department of Health.

a. The fund shall be comprised of revenues from employee and employer contributions made pursuant to section 29 of P.L.1992, c.160 (C.43:21-7b), revenues from the hospital assessment made pursuant to section 12 of P.L.1992, c.160 (C.26:2H-18.62), revenues pursuant to section 11 of P.L.1996, c.28 (C.26:2H-18.58c), revenues from interest and penalties collected pursuant to this act and revenues from other sources as the Legislature shall determine. Interest earned on the monies in the fund shall be credited to the fund. The fund shall be a nonlapsing fund dedicated for use by the State to: (1) distribute charity care and other uncompensated care disproportionate share payments to hospitals, and other eligible providers pursuant to section 8 of P.L.1996, c.28 (C.26:2H-18.59f), provide subsidies for the Health Access New Jersey program established pursuant to section 15 of P.L.1992, c.160 (C.26:2H-18.65), and provide funding for children's health care coverage in the NJ FamilyCare Program pursuant to P.L.2005, c.156 (C.30:4J-8 et al.); (2) provide funding for federally qualified health centers pursuant to section 12 of P.L.1992, c.160 (C.26:2H-18.62); and (3) provide for the payment in State fiscal year 2002 of appropriate Medicaid expenses, subject to the approval of the Director of the Division of Budget and Accounting.

b. The fund shall be administered by a person appointed by the commissioner.

The administrator of the fund is responsible for overseeing and coordinating the collection and reimbursement of fund monies. The administrator is responsible for promptly informing the commissioner if monies are not or are not reasonably expected to be collected or disbursed.

c. The commissioner shall adopt rules and regulations to ensure the integrity of the fund, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

d. The administrator shall establish separate accounts for the charity care component of the disproportionate share hospital subsidy, other uncompensated care component of the disproportionate share hospital subsidy, federally qualified health centers funding, and the

payments for subsidies for insurance premiums to provide care in disproportionate share hospitals, known as the Health Access New Jersey subsidy account, respectively.

e. In the event that the charity care component of the disproportionate share hospital subsidy account has a surplus in a given year after payments are distributed pursuant to the methodology established in section 13 of P.L.1995, c.133 (C.26:2H-18.59b) and section 7 of P.L.1996, c.28 (C.26:2H-18.59e) and within the limitations provided in subsection e. of section 9 of P.L.1992, c.160 (C.26:2H-18.59), the surplus monies in calendar years 2002, 2003 and 2004 shall lapse to the unemployment compensation fund established pursuant to R.S.43:21-9, and each year thereafter shall lapse to the charity care component of the disproportionate share hospital subsidy account for distribution in subsequent years.

224. Section 6 of P.L.1997, c.263 (C.26:2H-18.58e) is amended to read as follows:

C.26:2H-18.58e Transfer of funds to Hospital Relief Fund.

6. a. The Commissioner of Health shall transfer to the Hospital Health Care Subsidy account, known as the Hospital Relief Fund, in the Division of Medical Assistance and Health Services in the Department of Human Services from the Health Care Subsidy Fund, $50.75 million in fiscal year 1998 and $101.5 million each fiscal year thereafter, according to a schedule to be determined by the Commissioner of Health in consultation with the Commissioner of Human Services. These funds shall be distributed to eligible disproportionate share hospitals according to a methodology adopted by the Commissioner of Human Services pursuant to N.J.A.C.10:52-8.2, using hospital expenditure data for the most recent calendar year available for reimbursements from these funds.

b. In fiscal year 1998 and each fiscal year thereafter, the Governor shall recommend and the Legislature shall appropriate to the Hospital Health Care Subsidy account for distribution to disproportionate share hospitals which are eligible for reimbursement pursuant to subsection a. of this section, those federal funds received in connection with the provision of hospital reimbursements from that account.

225. Section 8 of P.L.1997, c.263 (C.26:2H-18.58f) is amended to read as follows:

C.26:2H-18.58f Transfer of funds to Division of Medical Assistance and Health Services.

8. a. The Commissioner of Health shall transfer to the Division of Medical Assistance and Health Services in the Department of Human Services from the Health Care Subsidy Fund, $23.8 million in fiscal year 1998, $47.6 million in fiscal year 1999, and an amount in each succeeding fiscal year that is necessary to obtain the maximum amount of federal funds to which the State is entitled in order to provide children's health care coverage in the NJ FamilyCare Program pursuant to P.L.2005, c.156 (C.30:4J-8 et al.), according to a schedule to be determined by the Commissioner of Health in consultation with the Commissioner of Human Services. These funds shall be expended to provide children's health care coverage in the NJ FamilyCare Program pursuant to P.L.2005, c.156.

b. In fiscal year 1999 and each fiscal year thereafter, the Governor shall recommend and the Legislature shall appropriate to the Division of Medical Assistance and Health Services for the purposes of subsection a. of this section, those federal funds received in connection with the provision of children's health care coverage in the NJ FamilyCare Program pursuant to P.L.2005, c.156.

226. Section 4 of P.L.1997, c.264 (C.26:2H-18.58g) is amended to read as follows:

C.26:2H-18.58g Disposition of revenue collected from cigarette tax.

4. Notwithstanding the provisions of any other law to the contrary,

a. commencing July 1, 1998 and ending June 30, 2006: after the deposit required pursuant to section 5 of P.L.1982, c.40 (C.54:40A-37.1), the first $150,000,000 of revenue collected annually from the cigarette tax imposed pursuant to P.L.1948, c.65 (C.54:40A-1 et seq.) and the first $5,000,000 of revenue collected annually from the "Tobacco Products Wholesale Sales and Use Tax Act," P.L.1990, c.39 (C.54:40B-1 et seq.), shall be deposited into the Health Care Subsidy Fund established pursuant to section 8 of P.L.1992, c.160 (C.26:2H-18.58); and the next $390,000,000 of revenue collected annually from the cigarette tax imposed pursuant to P.L.1948, c.65 (C.54:40A-1 et seq.) shall be appropriated annually for health programs, and the next $50,000,000 of revenue collected annually from the cigarette tax imposed pursuant to P.L.1948, c.65 (C.54:40A-1 et seq.) shall be appropriated annually to the New Jersey Economic Development Authority for payment of debt service incurred by the authority for school facilities projects and in fiscal years commencing July 1, 2002 and July 1, 2003, the next $30,000,000 of revenue collected annually from the cigarette tax imposed pursuant to P.L.1948, c.65 (C.54:40A-1 et seq.) shall be directed to the Department of Health to fund anti-smoking initiatives, except that the amount shall be $40,000,000 in the fiscal year commencing July 1, 2004 and $45,000,000 in the fiscal year commencing July 1, 2005; and

b. commencing with fiscal years beginning on and after July 1, 2006, after the deposit required pursuant to section 5 of P.L.1982, c.40 (C.54:40A-37.1), the first $150,000,000 of revenue collected annually from the cigarette tax imposed pursuant to P.L.1948, c.65 (C.54:40A-1 et seq.) and the first $5,000,000 of revenue collected annually from the "Tobacco Products Wholesale Sales and Use Tax Act," P.L.1990, c.39 (C.54:40B-1 et seq.), shall be deposited into the Health Care Subsidy Fund established pursuant to section 8 of P.L.1992, c.160 (C.26:2H-18.58). In addition, commencing with fiscal years beginning on and after July 1, 2006 but before July 1, 2009, there shall be deposited $215,000,000 of revenue collected annually from the cigarette tax imposed pursuant to P.L.1948, c.65 (C.54:40A-1 et seq.) in accordance with the provisions of section 5 of P.L.2004, c.68 (C.34:1B-21.20), and, commencing with fiscal years beginning on and after July 1, 2009, there shall be deposited $241,500,000 of revenue collected annually from the cigarette tax imposed pursuant to P.L.1948, c.65 (C.54:40A-1 et seq.) in accordance with the provisions of section 5 of P.L.2004, c.68 (C.34:1B-21.20).

227. Section 9 of P.L.1997, c.263 (C.26:2H-18.59) is amended to read as follows:

C.26:2H-18.59 Allocation of funds.

9. a. The commissioner shall allocate such funds as specified in subsection e. of this section to the charity care component of the disproportionate share hospital subsidy account. In a given year, the department shall transfer from the fund to the Division of Medical Assistance and Health Services in the Department of Human Services such funds as may be necessary for the total approved charity care disproportionate share payments to hospitals for that year.

b. For the period January 1, 1993 to December 31, 1993, the commission shall allocate $500 million to the charity care component of the disproportionate share hospital subsidy account. The Department of Health shall recommend the amount that the Division of Medical Assistance and Health Services shall pay to an eligible hospital on a provisional,

monthly basis pursuant to paragraphs (1) and (2) of this subsection. The department shall also advise the commission and each eligible hospital of the amount a hospital is entitled to receive.

(1) The department shall determine if a hospital is eligible to receive a charity care subsidy in 1993 based on the following:

$$\frac{\text{Hospital Specific Approved Uncompensated Care-1991}}{\text{Hospital Specific Preliminary Cost Base-1992}} = \text{Hospital Specific \% Uncompensated Care (\%UC)}$$

A hospital is eligible for a charity care subsidy in 1993 if, upon establishing a rank order of the %UC for all hospitals, the hospital is among the 80% of hospitals with the highest %UC.

(2) The maximum amount of the charity care subsidy an eligible hospital may receive in 1993 shall be based on the following:

$$\frac{\text{Hospital Specific Approved Uncompensated Care-1991}}{\text{Total approved Uncompensated Care All Eligible Hospitals-1991}} \times \$500 \text{ million} = \text{Maximum Amount of Hospital Specific Charity Care Subsidy for 1993}$$

(3) A hospital shall be required to submit all claims for charity care cost reimbursement, as well as demographic information about the persons who qualify for charity care, to the department in a manner and time frame specified by the Commissioner of Health, in order to continue to be eligible for a charity care subsidy in 1993 and in subsequent years.

The demographic information shall include the recipient's age, sex, marital status, employment status, type of health insurance coverage, if any, and if the recipient is a child under 18 years of age who does not have health insurance coverage or a married person who does not have health insurance coverage, whether the child's parent or the married person's spouse, as the case may be, has health insurance.

(4) A hospital shall be reimbursed for the cost of eligible charity care at the same rate paid to that hospital by the Medicaid program; except that charity care services provided to emergency room patients who do not require those services on an emergency basis shall be reimbursed at a rate appropriate for primary care, according to a schedule of payments developed by the commission.

(5) The department shall provide for an audit of a hospital's charity care for 1993 within a time frame established by the department.

c. For the period January 1, 1994 to December 31, 1994, a hospital shall receive disproportionate share payments from the Division of Medical Assistance and Health Services based on the amount of charity care submitted to the commission or its designated agent, in a form and manner specified by the commission. The commission or its designated

agent shall review and price all charity care claims and notify the Division of Medical Assistance and Health Services of the amount it shall pay to each hospital on a monthly basis based on actual services rendered.

(1) (Deleted by amendment, P.L.1995, c.133.)

(2) If the commission is not able to fully implement the charity care claims pricing system by January 1, 1994, the commission shall continue to make provisional disproportionate share payments to eligible hospitals, through the Division of Medical Assistance and Health Services, based on the charity care costs incurred by all hospitals in 1993, until such time as the commission is able to implement the claims pricing system.

If there are additional charity care balances available after the 1994 distribution based on 1993 charity care costs, the department shall transfer these available balances from the fund to the Division of Medical Assistance and Health Services for an approved one-time additional disproportionate share payment to hospitals according to the methodology provided in section 12 of P.L.1995, c.133 (C.26:2H-18.59a). The total payment for all hospitals shall not exceed $75.5 million.

(3) A hospital shall be reimbursed for the cost of eligible charity care at the same rate paid to that hospital by the Medicaid program; except that charity care services provided to emergency room patients who do not require those services on an emergency basis shall be reimbursed at a rate appropriate for primary care, according to a schedule of payments developed by the commission.

(4) (Deleted by amendment, P.L.1995, c.133.)

d. (Deleted by amendment, P.L.1995, c.133.)

e. The total amount allocated for charity care subsidy payments shall be: in 1994, $450 million; in 1995, $400 million; in 1996, $310 million; in 1997, $300 million; for the period January 1, 1998 through June 30, 1998, $160 million; and in fiscal year 1999 and each fiscal year thereafter through fiscal year 2004, $320 million. Total payments to hospitals shall not exceed the amount allocated for each given year.

f. Beginning January 1, 1995:

(1) The charity care subsidy shall be determined pursuant to section 13 of P.L.1995, c.133 (C.26:2H-18.59b).

(2) A charity care claim shall be valued at the same rate paid to that hospital by the Medicaid program, except that charity care services provided to emergency room patients who do not require those services on an emergency basis shall be valued at a rate appropriate for primary care according to a schedule of payments adopted by the commissioner.

(3) The department shall provide for an audit of a hospital's charity care within a time frame established by the commissioner.

228. Section 9 of P.L.1996, c.28 (C.26:2H-18.59g) is amended to read as follows:

C.26:2H-18.59g Establishment of technology infrastructure to support the provision of charity care.

9. The Commissioner of Health, in consultation with the State Treasurer, shall establish a technology infrastructure to support the provision of charity care pursuant to P.L.1992, c.160 (C.26:2H-18.51 et al.).

The State Treasurer, in consultation with the Commissioners of Health and Human Services may, if deemed to be in the State's best interests, include system features and provisions in the technology infrastructure to satisfy the requirements of multiple programs and purposes, including, but not limited to, programs such as, Medicaid, food stamps, public

assistance, and purposes such as the exchange and consolidation of health care information permitted by law, eligibility and identity verification, claims processing, the use of electronic patient identification technology, and electronic data interchange.

229. Section 3 of P.L.2004, c.113 (C.26:2H-18.59i) is amended to read as follows:

C.26:2H-18.59i Reimbursed documented charity care; charity care subsidy formula after July 1, 2004.

3. a. Beginning July 1, 2004 and each year thereafter:

(1) Reimbursed documented charity care shall be equal to the Medicaid-priced amounts of charity care claims submitted to the Department of Health for the most recent calendar year, adjusted, as necessary, to reflect the annual audit results. These amounts shall be augmented to reflect payments to hospitals by the Medicaid program for Graduate Medical Education and Indirect Medical Education based on the most recent Graduate Medical Education and Indirect Medical Education formulas utilized by the federal Medicare program.

(2) Hospital-specific reimbursed documented charity care shall be equal to the Medicaid-priced dollar amount of charity care provided by a hospital as submitted to the Department of Health for the most recent calendar year. A sample of the claims submitted by the hospital to the department shall be subject to an annual audit conducted pursuant to applicable charity care eligibility criteria.

b. Beginning July 1, 2004 and each year thereafter, the charity care subsidy shall be determined according to the following methodology:

(1) Each hospital shall be ranked in order of its hospital-specific, relative charity care percentage, or RCCP, by dividing the amount of hospital-specific gross revenue for charity care patients by the hospital's total gross revenue for all patients.

(2) The nine hospitals with the highest RCCPs shall receive a charity care payment equal to 96% of each hospital's hospital-specific reimbursed documented charity care. The hospital ranked number 10 shall receive a charity care payment equal to 94% of its hospital-specific reimbursed documented charity care, and each hospital ranked number 11 and below shall receive two percentage points less than the hospital ranked immediately above that hospital.

(3) Notwithstanding the provisions of paragraph (2) of this subsection to the contrary, each of the hospitals located in the 10 municipalities in the State with the lowest median annual household income according to the most recent census data, shall be ranked from the hospital with the highest hospital-specific reimbursed documented charity care to the hospital with the lowest hospital-specific reimbursed documented charity care. The hospital in each of the 10 municipalities, if any, with the highest documented hospital-specific charity care shall receive a charity care payment equal to 96% of its hospital-specific reimbursed documented charity care.

(4) Notwithstanding the provisions of this subsection to the contrary, no hospital shall receive reimbursement for less than 43% of its hospital-specific reimbursed documented charity care.

c. To ensure that charity care subsidy payments remain viable and appropriate, the State shall maintain the charity care subsidy at an amount not less than 75% of the Medicaid-priced amounts of charity care provided by hospitals in the State. In addition, these amounts shall be augmented to reflect payments to hospitals by the Medicaid program for Graduate Medical Education and Indirect Medical Education based on the most recent Graduate

Medical Education and Indirect Medical Education formulas utilized by the federal Medicare program.

d. Notwithstanding any other provisions of this section to the contrary, in the event that the change from the charity care subsidy formula in effect for fiscal year 2004 to the formula established pursuant to this section in effect for fiscal year 2005, reduces, for any reason, the amount of the charity care subsidy payment to a hospital below the amount that the hospital received under the formula in effect in fiscal year 2004, the hospital shall receive a payment equal to the amount it would have received under the formula in effect for fiscal year 2004.

230. Section 6 of P.L.2008, c.38 (C.26:2H-18.59j) is amended to read as follows:

C.26:2H-18.59j Charity claims by hospital, eligibility.

6. Notwithstanding the provisions of section 3 of P.L.2004, c.113 (C.26:2H-18.59i) to the contrary, a hospital shall not submit charity care claims to the Department of Health for health care services provided to a child under 19 years of age who presents at a hospital for emergency care and who may be deemed presumptively eligible for NJ FamilyCare coverage pursuant to P.L.2005, c.156 (C.30:4J-8 et al.) or Medicaid coverage pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

231. Section 3 of P.L.2007, c.217 (C.26:2H-18.60c) is amended to read as follows:

C.26:2H-18.60c Required procedures by hospitals for charity care.

3. The Commissioner of Health shall require the use of procedures by hospitals to ensure their uniform collection from applicants for charity care pursuant to section 10 of P.L.1992, c.160 (C.26:2H-18.60) and the transmission to the Department of Health of demographic and financial information as the commissioner requires pursuant to section 14 of P.L.1995, c.133 (C.26:2H-18.59c) and any other information that the commissioner determines necessary to ensure the efficient, cost-effective operation of the hospital charity care subsidy program and to prevent and detect fraudulent charity care claims.

232. Section 4 of P.L.2007, c.217 (C.26:2H-18.60d) is amended to read as follows:

C.26:2H-18.60d Interagency agreement with Medicaid Inspector General.

4. a. The Commissioner of Health and the Medicaid Inspector General shall establish an inter-agency agreement under which the staff and resources of the Office of the Medicaid Inspector General are utilized to:

(1) investigate charity care claims, which that office or the Department of Health reasonably suspects may be fraudulent, with the same authority as that granted to the Medicaid Inspector General to investigate complaints related to Medicaid integrity, fraud, and abuse pursuant to P.L.2007, c.58 (C.30:4D-53 et al.); and

(2) recover monies from third party payers that were paid as charity care subsidies based upon fraudulent charity care claims.

b. The commissioner and the Medicaid Inspector General shall take such actions as are necessary to ensure that any monies recovered pursuant to subsection a. of this section are deposited in the Health Care Subsidy Fund and used for the purposes of providing charity care subsidies pursuant to P.L.1992, c.160 (C.26:2H-18.51 et al.).

233. Section 5 of P.L.2007, c.217 (C.26:2H-18.60e) is amended to read as follows:

C.26:2H-18.60e Inter-agency agreement with State Treasurer.

5. The Commissioner of Health and the State Treasurer shall establish an inter-agency agreement under which the staff and resources of the Division of Taxation in the Department of the Treasury are utilized to conduct random checks of personal State income tax returns filed by persons determined eligible for charity care pursuant to section 10 of P.L.1992, c.160 (C.26:2H-18.60), in consultation with the commissioner, and with the Medicaid Inspector General pursuant to section 4 of P.L.2007, c.217 (C.26:2H-18.60d), for the purposes of determining the validity of charity care claims for health care services provided to those persons.

234. Section 7 of P.L.2007, c.217 (C.26:2H-18.60f) is amended to read as follows:

C.26:2H-18.60f Reporting system established.

7. The Commissioner of Health shall establish a mechanism, by means of a toll-free telephone hotline or electronic mail, through which persons may confidentially report suspected incidents of fraudulent charity care claims to the Department of Health.

235. Section 12 of P.L.1992, c.160 (C.26:2H-18.62) is amended to read as follows:

C.26:2H-18.62 Monies designated for Health Care Subsidy Fund; allocation of monies.

12. a. (Deleted by amendment, P.L.2005, c.237).

b. (Deleted by amendment, P.L.2005, c.237).

c. (1) Notwithstanding any law to the contrary, each general hospital and each specialty heart hospital shall pay .53% of its total operating revenue to the department for deposit in the Health Care Subsidy Fund. The hospital shall make monthly payments to the department beginning July 1, 1993. The commissioner shall determine the manner in which the payments shall be made.

For the purposes of this subsection, "total operating revenue" shall be defined by the department in accordance with financial reporting requirements established pursuant to N.J.A.C.8:31B-3.3 and shall include revenue from any ambulatory care facility that is licensed to a general hospital as an off-site ambulatory care service facility.

(2) The commissioner shall allocate the monies paid by hospitals pursuant to paragraph (1) of this subsection as follows:

(a) In State fiscal years 2006 and 2007, $35 million of those monies shall be allocated to the support of federally qualified health centers in this State, and the remainder shall be allocated to the support of (i) the infant mortality reduction program in the Department of Health, (ii) the primary care physician and dentist loan redemption program established in the Higher Education Student Assistance Authority by article 3 of P.L.1999, c.46 (C.18A:71C-32 et seq.), and (iii) the development and use of health information electronic data interchange technology pursuant to P.L.1999, c.154 (C.17B:30-23 et al.); and

(b) In State fiscal year 2008 and thereafter, $40 million of those monies shall be allocated to the support of federally qualified health centers in this State.

Monies allocated to the support of federally qualified health centers in the State under this paragraph shall be used for the purpose of compensating them for health care services provided to uninsured patients.

d. The monies paid by the hospitals and allocated under subsection c. of this section for the support of federally qualified health centers shall be credited to the federally qualified health centers account.

e. (1) Monies paid by hospitals under subsection c. of this section in excess of $40 million, federal matching funds received on account of such monies, and interest received on such payments and funds shall be allocated exclusively to support funding to hospitals.

(2) In the event that any approval, application, or other condition necessary for the implementation of this subsection and the distribution of funds pursuant thereto consistent with the Fiscal Year 2011 annual appropriations act is not obtained, granted, or satisfied, the Departments of Health and Human Services shall jointly prepare a plan concerning charity care and related hospital funding, which shall be subject to the approval of the Joint Budget Oversight Committee.

236. Section 3 of P.L.2008, c.33 (C.26:2H-18.76) is amended to read as follows:

C.26:2H-18.76 Health Care Stabilization Fund.

3. a. The Health Care Stabilization Fund is established as a nonlapsing, revolving fund in the Department of Health. The fund shall be administered by the Department of Health in consultation with the Department of the Treasury. The fund shall be comprised of revenues as are appropriated by the Legislature from time to time, along with any interest earned on monies in the fund.

b. Monies from the fund shall be disbursed solely as grants to qualifying licensed health care facilities pursuant to eligibility criteria, and subject to conditions, prescribed by the Commissioner of Health in accordance with the requirements of this act.

237. Section 4 of P.L.2008, c.33 (C.26:2H-18.77) is amended to read as follows:

C.26:2H-18.77 Awarding of grant to health care facility; factors considered.

4. The Commissioner of Health, in consultation with the State Treasurer and the New Jersey Health Care Facilities Financing Authority, may award a grant to a hospital or other licensed health care facility from the fund if the commissioner determines that, due to extraordinary circumstances, the grant is necessary to maintain access to essential health care services or referral sources, as appropriate. In determining whether to award a grant to a licensed health care facility, the commissioner shall consider whether, at a minimum, the following factors are present:

a. Extraordinary circumstances threaten access to essential health services for residents in a community;

b. Persons in a community will be without ready access to essential health care services in the absence of the award of a grant from the fund;

c. Funding is unavailable from other sources to preserve or provide essential health care services;

d. A grant from the fund is likely to stabilize access to the essential health care services;

e. There is a reasonable likelihood that the essential health care services will be sustainable upon the termination of the grant;

f. The proposed recipient of the grant agrees to conditions established by the commissioner for receipt of a grant; and

g. The hospital or other licensed health care facility serves a significant number of uninsured and underinsured persons.

238. Section 5 of P.L.2008, c.33 (C.26:2H-18.78) is amended to read as follows:

C.26:2H-18.78 Conditions for receipt of grant; rules, regulations; annual report.

5. a. The Commissioner of Health shall set reasonable conditions for the receipt of a grant by a general hospital or other licensed health care facility, which conditions may include, but need not be limited to, requirements to assure the efficient and effective delivery of health care services.

The facility shall agree to: the provision of essential health care services to the community as determined by the commissioner; facilitating the enrollment of individuals in appropriate government insurance programs; and providing the Department of Health with quality of care, utilization, and financial information as determined by the commissioner to be reasonable and necessary. In the case of a facility whose financial condition created or contributed to the extraordinary circumstances necessitating the award of the grant, the facility shall agree to such corrective steps to its governance, management, and business operations as the commissioner deems reasonable and appropriate in light of the facility's circumstances and the health care needs of the community.

b. Within one year of the award of a grant from the fund, the commissioner, in consultation with the State Comptroller, shall cause to be conducted an audit to evaluate:

(1) whether a grantee's use of the funds was consistent with the provisions of this act, the commissioner's regulations, and any conditions imposed upon the award of the grant; and

(2) whether a grantee's use of the funds furthered the purposes of this act.

c. The commissioner, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt such rules and regulations as are necessary to effectuate the purposes of this act. The regulations shall specify eligibility criteria for, and conditions that must be met by, a health care facility to receive a grant from the fund.

Notwithstanding any provision of P.L.1968, c.410 (C.52:14B-1 et seq.) to the contrary, the commissioner may adopt immediately upon filing with the Office of Administrative Law such regulations as the commissioner deems necessary to implement the provisions of this act, which shall be effective for a period not to exceed 270 days following enactment of this act and may thereafter be amended, adopted, or readopted by the department in accordance with the requirements of P.L.1968, c.410.

d. The commissioner shall annually, by March 1 of each year, submit a report on the Health Care Stabilization Fund to the Governor, and to the Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1). The commissioner shall include a copy of the report on the department's website.

The report shall identify the health care facilities that received grants during the reporting period, the purpose for which the grant was allocated to the facility, and the extent to which the awarding of the grant furthered the purposes of this act. The report shall include a copy of any audits conducted pursuant to subsection b. of this section.

239. Section 3 of P.L.1997, c.78 (C.26:2H-81) is amended to read as follows:

C.26:2H-81 Rules, regulations.

3. The Commissioner of Health shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) necessary to carry out the provisions of this act.

240. Section 2 of P.L.1997, c.100 (C.26:2H-83) is amended to read as follows:

C.26:2H-83 Background checks for nurse aid, personal care assistant certification.

2. a. The Department of Health shall not issue a nurse aide or personal care assistant certification to any applicant, except on a conditional basis as provided for in subsection d. of section 3 of P.L.1997, c.100 (C.26:2H-84), unless the Commissioner of Health first determines, consistent with the requirements of sections 2 through 6 of P.L.1997, c.100 (C.26:2H-83 through 87), that no criminal history record information exists on file in the Federal Bureau of Investigation, Identification Division, or in the State Bureau of Identification in the Division of State Police, which would disqualify that person from being certified. A nurse aide or personal care assistant certified by the department prior to the effective date of P.L.2000, c.20 upon whom a criminal history record background check has not been conducted pursuant to sections 2 through 6 of P.L.1997, c.100 (C.26:2H-83 through 87), shall be required to undergo that criminal history record background check as a condition of that individual's initial recertification following the effective date of P.L.2000, c.20.

In addition, a follow-up criminal history record background check of federal records shall be conducted at least once every two years as a condition of recertification for every certified nurse aide and personal care assistant; except that the commissioner, in lieu of conducting follow-up criminal history record background checks for purposes of recertification, may provide for an alternative means of determining whether a certified nurse aide or personal care assistant has been convicted of a crime or disorderly persons offense which would disqualify that person from certification, including, but not limited to, a match of a person's Social Security number or other identifying information with records of criminal proceedings in this and other states. If the commissioner elects to implement this alternative means of determining whether a certified nurse aide or personal care assistant has been convicted of a crime or disorderly persons offense which would disqualify that person from certification, the commissioner shall report to the Governor and the Legislature prior to its implementation on the projected costs and procedures to be followed with respect to its implementation and setting forth the rationale therefor.

A person shall be disqualified from certification if that person's criminal history record background check reveals a record of conviction of any of the following crimes and offenses:

(1) In New Jersey, any crime or disorderly persons offense:

(a) involving danger to the person, meaning those crimes and disorderly persons offenses set forth in N.J.S.2C:11-1 et seq., N.J.S.2C:12-1 et seq., N.J.S.2C:13-1 et seq., N.J.S.2C:14-1 et seq. or N.J.S.2C:15-1 et seq.; or

(b) against the family, children, or incompetents, meaning those crimes and disorderly persons offenses set forth in N.J.S.2C:24-1 et seq.; or

(c) involving theft as set forth in chapter 20 of Title 2C of the New Jersey Statutes; or

(d) involving any controlled dangerous substance or controlled substance analog as set forth in chapter 35 of Title 2C of the New Jersey Statutes except paragraph (4) of subsection a. of N.J.S.2C:35-10.

(2) In any other state or jurisdiction, of conduct which, if committed in New Jersey, would constitute any of the crimes or disorderly persons offenses described in paragraph (1) of this subsection.

b. Notwithstanding the provisions of subsection a. of this section, no person shall be disqualified from certification on the basis of any conviction disclosed by a criminal history record background check performed pursuant to sections 2 through 6 and section 14 of

P.L.1997, c.100 (C.26:2H-83 through 87 and C.53:1-20.9a) if the person has affirmatively demonstrated to the Commissioner of Health clear and convincing evidence of the person's rehabilitation. In determining whether a person has affirmatively demonstrated rehabilitation, the following factors shall be considered:

(1) the nature and responsibility of the position which the convicted person would hold, has held or currently holds, as the case may be;

(2) the nature and seriousness of the offense;

(3) the circumstances under which the offense occurred;

(4) the date of the offense;

(5) the age of the person when the offense was committed;

(6) whether the offense was an isolated or repeated incident;

(7) any social conditions which may have contributed to the offense; and

(8) any evidence of rehabilitation, including good conduct in prison or in the community, counseling or psychiatric treatment received, acquisition of additional academic or vocational schooling, successful participation in correctional work-release programs, or the recommendation of those who have had the person under their supervision.

c. If a person subject to the provisions of sections 2 through 6 of P.L.1997, c.100 (C.26:2H-83 through 87) refuses to consent to, or cooperate in, the securing of a criminal history record background check, the commissioner shall, as applicable:

(1) not issue a nurse aide or personal care assistant certification and shall notify the applicant, and the applicant's employer if the applicant is conditionally employed as provided in subsection d. of section 3 of P.L.1997, c.100 (C.26:2H-84) or the applicant's prospective employer if known, of that denial; or

(2) revoke the person's current nurse aide or personal care assistant certification and notify the person, and the person's employer, if known, of that revocation.

241. Section 3 of P.L.1997, c.100 (C.26:2H-84) is amended to read as follows:

C.26:2H-84 Qualification, disqualification for certification; petition for hearing.

3. a. An applicant for certification, or a certified nurse aide or personal care assistant who is required to undergo a criminal history record background check pursuant to section 2 of P.L.1997, c.100 (C.26:2H-83), shall submit to the Commissioner of Health that individual's name, address, and fingerprints taken on standard fingerprint cards by a State or municipal law enforcement agency. The commissioner is authorized to exchange fingerprint data with and receive criminal history record information from the Federal Bureau of Investigation and the Division of State Police for use in making the determinations required by sections 2 through 6 of P.L.1997, c.100 (C.26:2H-83 through 87).

b. Upon receipt of the criminal history record information for a person from the Federal Bureau of Investigation or the Division of State Police, the commissioner shall immediately notify, in writing, the applicant, and the applicant's employer if the applicant is conditionally employed as provided in subsection d. of this section or the applicant's prospective employer if known, or a certified nurse aide or personal care assistant who is required to undergo a criminal history record background check pursuant to section 2 of P.L.1997, c.100 (C.26:2H-83) and that person's employer, as applicable, of the person's qualification or disqualification for certification under sections 2 through 6 of P.L.1997, c.100 (C.26:2H-83 through 87). If the person is disqualified, the conviction or convictions which constitute the basis for the disqualification shall be identified in the notice to the person, but shall not be identified in the notice to the person's employer or prospective employer.

c. The person who is the subject of the background check shall have 30 days from the date of the written notice of disqualification to petition the commissioner for a hearing on the accuracy of the person's criminal history record information or to establish the person's rehabilitation under subsection b. of section 2 of P.L.1997, c.100 (C.26:2H-83). The commissioner shall notify the person's employer or prospective employer of the person's petition for a hearing within five days following the receipt of the petition from the person. Upon the issuance of a final decision upon a petition to the commissioner pursuant to this subsection, the commissioner shall notify the person and the person's employer or prospective employer as to whether the person remains disqualified from certification under sections 2 through 6 of P.L.1997, c.100 (C.26:2H-83 through 87).

d. An applicant for certification may be issued conditional certification and may be employed as a nurse aide or a personal care assistant conditionally for a period not to exceed 60 days, pending completion of a criminal history record background check required under sections 2 through 6 of P.L.1997, c.100 (C.26:2H-83 through 87) by the Division of State Police in the Department of Law and Public Safety based upon an examination of its own files in accordance with section 14 of P.L.1997, c.100 (C.53:1-20.9a), and for an additional period not to exceed 60 days pending completion of a criminal history record background check by federal authorities as arranged for by the Division of State Police pursuant to section 14 of P.L.1997, c.100 (C.53:1-20.9a), if the person submits to the commissioner a sworn statement attesting that the person has not been convicted of any crime or disorderly persons offense as described in section 2 of P.L.1997, c.100 (C.26:2H-83). A person who submits a false sworn statement shall be disqualified from certification as a nurse aide or a personal care assistant, as the case may be, and shall not have an opportunity to establish rehabilitation pursuant to subsection b. of section 2 of P.L.1997, c.100 (C.26:2H-83).

A conditionally employed person, or an employed person certified as a nurse aide or a personal care assistant, who disputes the accuracy of the criminal history record information and who files a petition requesting a hearing pursuant to subsection c. of this section may remain employed by that person's employer until the commissioner rules on the person's petition but, pending the commissioner's ruling, the employer shall not permit the person to have unsupervised contact with patients, residents, or clients, as the case may be, who are 60 years of age or older.

e. (1) A licensed health care facility or other entity that has received an application from or conditionally employs an applicant for nurse aide or personal care assistant certification, or employs a certified nurse aide or personal care assistant, and:

(a) receives notice from the Commissioner of Health that the applicant or certified nurse aide or personal care assistant, as applicable, has been determined by the commissioner to be disqualified from certification as a nurse aide or personal care assistant pursuant to sections 2 through 6 of P.L.1997, c.100 (C.26:2H-83 through 87); or

(b) terminates its employment of a conditionally employed applicant for nurse aide or personal care assistant certification or a certified nurse aide or personal care assistant because the person was disqualified from employment at the health care facility or other entity on the basis of a conviction of a crime or disorderly persons offense as described in section 2 of P.L.1997, c.100 (C.26:2H-83) after commencing employment at the health care facility or other entity;

shall be immune from liability for disclosing that disqualification or termination in good faith to another licensed health care facility or other entity that is qualified by statute or regulation to employ the person as a nurse aide or personal care assistant.

(2) A licensed health care facility or other entity which discloses information pursuant to paragraph (1) of this subsection shall be presumed to be acting in good faith unless it is shown by clear and convincing evidence that the health care facility or other entity acted with actual malice toward the person who is the subject of the information.

f. (1) A licensed health care facility or other entity, upon receiving notice from the Commissioner of Health that a person employed by it as a nurse aide or personal care assistant, including a conditionally employed person, has been convicted of a crime or disorderly persons offense as described in section 2 of P.L.1997, c.100 (C.26:2H-83) after commencing employment at the health care facility or other entity, shall:

(a) immediately terminate the person's employment as a nurse aide or personal care assistant; and

(b) report information about the termination to the Commissioner of Health in a manner prescribed by the commissioner, who shall thereupon deem the person to be disqualified from certification as a nurse aide or personal care assistant, subject to the provisions of paragraph (3) of this subsection.

(2) A licensed health care facility or other entity shall be immune from liability for any actions taken in good faith pursuant to paragraph (1) of this subsection and shall be presumed to be acting in good faith unless it is shown by clear and convincing evidence that the health care facility or other entity acted with actual malice toward the employee.

(3) The person terminated from employment pursuant to paragraph (1) of this subsection shall have 30 days from the date of the termination to petition the commissioner for a hearing on the accuracy of the information about the conviction reported to the commissioner or to establish why the person should not be terminated from employment, and disqualified from certification, as a nurse aide or personal care assistant. The commissioner shall notify the person's employer of the person's petition for a hearing within five days following the receipt of the petition from the person. Upon the issuance of a final decision upon a petition to the commissioner pursuant to this paragraph, the commissioner shall notify the person and the person's employer as to whether:

(a) the person is to be reinstated in the person’s employment as a nurse aide or personal care assistant and retain the person’s certification; or

(b) the person's termination from employment as a nurse aide or personal care assistant stands and the person remains disqualified from certification.

g. The commissioner shall provide for a registry of all persons who have successfully completed all training and competency evaluation requirements for certification as a nurse aide or personal care assistant and shall provide for the inclusion in the registry of information about the disqualification of any person from certification pursuant to sections 2 through 6 of P.L.1997, c.100 (C.26:2H-83 through 87); for which purposes, the commissioner may use an existing registry established pursuant to statute or regulation, subject to the requirements of federal law. The registry shall include the specific documented findings constituting the basis for that disqualification, except that the information shall indicate that the person was convicted of a crime or disorderly persons offense as described in section 2 of P.L.1997, c.100 (C.26:2H-83), but shall not identify the conviction or convictions which constitute the basis for the disqualification.

242. Section 4 of P.L.1997, c.100 (C.26:2H-85) is amended to read as follows:

C.26:2H-85 Assumption of cost of background checks.

4. The Department of Health shall assume the cost of the criminal history record background check conducted on an applicant for nurse aide or personal care assistant certification, or a certified nurse aide or personal care assistant, as the case may be, pursuant to sections 2 through 6 and section 14 of P.L.1997, c.100 (C.26:2H-83 through 87 and C.53:1-20.9a).

243. Section 5 of P.L.1997, c.100 (C.26:2H-86) is amended to read as follows:

C.26:2H-86 Rules, regulations.

5. In accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), the Commissioner of Health shall adopt rules and regulations necessary to implement the provisions of sections 1 through 4 and section 6 of P.L.1997, c.100 (C.26:2H-82 through C.26:2H-85 and C.26:2H-87).

244. Section 6 of P.L.1997, c.100 (C.26:2H-87) is amended to read as follows:

C.26:2H-87 False statement; fine.

6. Any person submitting a false sworn statement pursuant to section 3 of P.L.1997, c.100 (C.26:2H-84) shall be subject to a fine of not more than $1,000, which may be assessed by the Commissioner of Health.

245. Section 2 of P.L.1997, c.296 (C.26:2H-89) is amended to read as follows:

C.26:2H-89 PACE, pre-PACE program operation.

2. A PACE or Pre-PACE program shall operate in the State only in accordance with a contract with the Department of Human Services pursuant to the provisions of this act.

The programs shall not be subject to the requirements of P.L.1973, c.337 (C.26:2J-1 et seq.).

246. Section 3 of P.L.2003, c.105 (C.26:2H-94) is amended to read as follows:

C.26:2H-94 Definitions relative to nursing home quality of care.

3. As used in this act:

"Commissioner" means the Commissioner of Human Services.

"Department" means the Department of Human Services.

"Director" means the Director of the Division of Taxation in the Department of the Treasury.

"Fund" means the "Nursing Home Quality of Care Improvement Fund" established pursuant to this act.

"Medicaid" means the Medicaid program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

"Nursing home" means a long-term care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.), as well as the distinct part of another health care facility or continuing care retirement community that is licensed to provide skilled nursing care services pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.). For the purposes of this act, nursing home shall not include: an acute care hospital; assisted living facility; comprehensive personal care home; residential health care facility; adult day health care facility; alternate family care program; adult family care program; home health care agency; State psychiatric hospital; county health

care facility, including, but not limited to, county geriatric center, county nursing home or other county long-term care facility; the New Jersey Firemen's Home; or a health care facility operated by the Department of Military and Veterans' Affairs.

247. Section 4 of P.L.2003, c.105 (C.26:2H-95) is amended to read as follows:

C.26:2H-95 “Nursing Home Quality of Care Improvement Fund.”

4. The "Nursing Home Quality of Care Improvement Fund" is established as a nonlapsing fund in the Department of the Treasury. The fund shall be administered by the State Treasurer, in consultation with the Commissioner of Human Services or the commissioner’s designee, who shall be responsible for the oversight, coordination, and disbursement of fund monies, and shall be credited with monies received pursuant to section 6 of this act, except for those monies which are deposited into the General Fund in accordance with the provisions of that section.

a. The fund shall be comprised of:

(1) revenues from assessments paid by nursing homes pursuant to section 5 of this act;

(2) matching federal funds received pursuant to Title XIX of the federal Social Security Act (42 U.S.C. s.1396 et seq.) that result from the expenditure of revenues from assessments collected pursuant to section 5 of this act;

(3) General Fund revenues, as necessary, to allow for the per diem add-on payments pursuant to subsection d. of section 6 of this act until the revenue from the assessment has been collected. Upon collection of the revenue from the assessment, the General Fund shall be repaid within 90 days; and

(4) any interest or other income earned on monies deposited into the fund.

b. Any disbursement of monies from the fund shall be used solely for Medicaid nursing home add-ons as provided for under section 6 of this act, which shall not in any manner render the assessment mechanism set forth in section 5 of this act to be in violation of the hold harmless provisions of 42 C.F.R. s.433.68(f).

c. The State Treasurer shall provide by regulation for such measures as are required to ensure the integrity of the fund.

d. The State Treasurer shall establish separate accounts within the fund as are needed to efficiently manage and disburse fund monies.

e. Monies in the fund shall not be used to supplant appropriations from the General Fund to the department for use in securing matching federal funds not otherwise provided for in this act.

f. The Director of the Division of Taxation shall be responsible for collecting the assessments.

248. Section 3 of P.L.2005, c.233 (C.26:2H-104) is amended to read as follows:

C.26:2H-104 Definitions relative to advance directives for mental health care.

3. As used in this act:

"Adult" means an individual 18 years of age or older.

"Advance directive for mental health care" or "advance directive" means a writing executed in accordance with the requirements of this act. An "advance directive" may include a proxy directive or an instruction directive, or both.

"Decision-making capacity" means a patient's ability to understand and appreciate the nature and consequences of mental health care decisions, including the benefits and risks of

each, and alternatives to any proposed mental health care, and to reach an informed decision. A patient's decision-making capacity is evaluated relative to the demands of a particular mental health care decision.

"Declarant" means a competent adult who executes an advance directive for mental health care.

"Domestic partner" means a domestic partner as defined in section 3 of P.L.2003, c.246 (C.26:8A-3).

"Instruction directive" means a writing which provides instructions and direction regarding the declarant's wishes for mental health care in the event that the declarant subsequently lacks decision-making capacity.

"Mental health care decision" means a decision to accept or refuse any treatment, service, or procedure used to diagnose, treat, or care for a patient's mental condition. "Mental health care decision" also means a decision to accept or refuse the services of a particular mental health care professional or psychiatric facility, including a decision to accept or to refuse a transfer of care.

"Mental health care professional" means an individual licensed or certified by this State to provide or administer mental health care in the ordinary course of business or practice of a profession.

"Mental health care representative" means the individual designated by a declarant pursuant to the proxy directive part of an advance directive for mental health care for the purpose of making mental health care decisions on the declarant's behalf, and includes an individual designated as an alternate mental health care representative who is acting as the declarant's mental health care representative in accordance with the terms and order of priority stated in an advance directive for mental health care.

"Patient" means an individual who is under the care of a mental health care professional.

"Proxy directive" means a writing which designates a mental health care representative in the event that the declarant subsequently lacks decision-making capacity.

"Psychiatric facility" means a State psychiatric facility listed in R.S.30:1-7, a county psychiatric hospital or the psychiatric unit of a county hospital, a short-term care facility, special psychiatric hospital or psychiatric unit of a general hospital or other health care facility licensed by the Department of Health pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.), or a hospital or community-based mental health center or other entity licensed or funded by the Department of Human Services to provide community-based mental health services.

"Responsible mental health care professional" means a person licensed or certified by the State to provide or administer mental health care who is selected by, or assigned to, the patient and has primary responsibility for the care and treatment of the patient.

"State" means a state, territory, or possession of the United States, the District of Columbia, or the Commonwealth of Puerto Rico.

249. Section 16 of P.L.2005, c.233 (C.26:2H-117) is amended to read as follows:

C.26:2H-117 Rules, regulations relative to psychiatric facilities operated by the Department of Health.

16. In accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), the Commissioner of Health, in consultation with the Commissioner of Human Services, shall adopt rules and regulations, with respect to psychiatric facilities licensed by the Department of Health, to:

a. provide for the annual reporting by those psychiatric facilities to the Department of Health, and the gathering of such additional data, as is reasonably necessary to oversee and evaluate the implementation of this act; except that the commissioner shall seek to minimize the burdens of record-keeping imposed by the rules and regulations and ensure the appropriate confidentiality of patient records; and

b. require those psychiatric facilities to adopt policies and practices designed to:

(1) make routine inquiry, at the time of admission and at such other times as are appropriate under the circumstances, concerning the existence and location of an advance directive for mental health care;

(2) provide appropriate informational materials concerning advance directives for mental health care, including information about the registry of advance directives for mental health care established or designated pursuant to section 17 of this act, to all interested patients and their families and mental health care representatives, and to assist patients interested in discussing and executing an advance directive for mental health care, as well as to encourage declarants to periodically review their advance directives for mental health care as needed;

(3) inform mental health care professionals of their rights and responsibilities under this act, to assure that the rights and responsibilities are understood, and to provide a forum for discussion and consultation regarding the requirements of this act; and

(4) otherwise comply with the provisions of this act.

250. Section 18 of P.L.2005, c.233 (C.26:2H-118) is amended to read as follows:

C.26:2H-118 Joint evaluation, report to Governor, Legislature.

18. The Department of Health and the Department of Human Services shall jointly evaluate the implementation of this act and report to the Governor and the Legislature, including recommendations for any changes deemed necessary, within five years after the effective date of this act.

251. Section 19 of P.L.2005, c.233 (C.26:2H-119) is amended to read as follows:

C.26:2H-119 Immunity from criminal, civil liability.

19. a. A mental health care representative shall not be subject to criminal or civil liability for any actions performed in good faith and in accordance with the provisions of this act to carry out the terms of an advance directive for mental health care.

b. A mental health care professional shall not be subject to criminal or civil liability, or to discipline by the psychiatric facility or the respective State licensing board for professional misconduct, for any actions performed to carry out the terms of an advance directive for mental health care in good faith and in accordance with: the provisions of this act; any rules and regulations adopted by the Commissioner of Health or the Commissioner of Human Services pursuant to this act; and accepted professional standards.

c. A psychiatric facility shall not be subject to criminal or civil liability for any actions performed in good faith and in accordance with the provisions of this act to carry out the terms of an advance directive for mental health care.

252. Section 1 of P.L.2006, c.75 (C.26:2H-126) is amended to read as follows:

C.26:2H-126 Notification to residents of closing, relocation of nursing home, assisted living facility; exceptions.

1. a. Except as provided in subsection b. of this section, at least 60 days prior to the proposed date of the closing or relocation of a nursing home or assisted living residence licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.), the nursing home or assisted living administrator shall notify, in writing, a resident of the facility, the resident's legal representative, if applicable, and the Department of Health of the closing or relocation of the facility.

b. The Commissioner of Health may waive the 60-day notice requirement in subsection a. of this section if the commissioner determines that an emergency situation warrants a more immediate closure or relocation of the nursing home or assisted living residence. In the case of such an emergency situation, the administrator of the facility shall notify, in writing, a resident, the resident's legal representative, if applicable, and the Department of Health of the closure or relocation as soon as practicable.

As used in this section, an "emergency situation" may include: the suspension or revocation of the facility license by the commissioner; decertification of the facility by the federal Medicare program established pursuant to Title XVIII of the "Social Security Act," Pub.L.89-97 (42 U.S.C. s.1395 et seq.), or the Medicaid program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.); or any other event as prescribed by regulation of the commissioner.

253. Section 1 of P.L.2009, c.55 (C.26:2H-127) is amended to read as follows:

C.26:2H-127 Assisted living facility, refund of deposit, certain circumstances.

1. a. An assisted living facility licensed by the Department of Health pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) that requires a new resident, as a condition of admission to the facility, to pay a one-time security deposit, which is in addition to the regular monthly rental and services charges, shall provide that the deposit plus interest earned on the deposit is refundable to the resident or other designated person upon the resident's vacating the facility if the resident provides the facility with 30 days' notice that the resident intends to vacate the facility.

b. The facility may deduct an amount not to exceed one percent per annum of the amount of the invested or deposited security deposit for the cost of servicing and processing an account containing a security deposit.

254. Section 1 of P.L.2011, c.58 (C.26:2H-128) is amended to read as follows:

C.26:2H-128 Rights of residents of assisted living facilities, comprehensive personal care homes.

1. a. Each assisted living facility and comprehensive personal care home provider licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall distribute to each resident and post in a conspicuous, public place in the facility or home, as applicable, a statement of resident rights. The statement of rights shall include, at a minimum, the rights set forth in subsection b. of this section. Each resident, resident family member, and legally appointed guardian, as applicable, shall be informed of the resident rights, and provided with explanations if needed. The provider shall ensure that each resident, or the resident's legally appointed guardian, as applicable, signs a copy of the statement of rights.

b. Every resident of an assisted living facility or comprehensive personal care home that is licensed in the State shall have the right to:

(1) receive personalized services and care in accordance with the resident's individualized general service or health service plan;

(2) receive a level of care and services that address the resident's changing physical and psychosocial status;

(3) have the resident’s independence and individuality;

(4) be treated with respect, courtesy, consideration, and dignity;

(5) make choices with respect to services and lifestyle;

(6) privacy;

(7) have or not to have families' and friends' participation in resident service planning and implementation;

(8) receive pain management as needed, in accordance with Department of Health regulations;

(9) choose a physician, advanced practice nurse, or physician assistant;

(10) appeal an involuntary discharge as specified in department regulations;

(11) receive written documentation that fee increases based on a higher level of care are based on reassessment of the resident and in accordance with department regulations;

(12) receive a written explanation of fee increases that are not related to increased services, upon request by the resident;

(13) participate, to the fullest extent that the resident is able, in planning the resident’s own medical treatment and care;

(14) refuse medication and treatment after the resident has been informed, in language that the resident understands, of the possible consequences of this decision;

(15) refuse to participate in experimental research, including the investigations of new drugs and medical devices, and to be included in experimental research only when the resident gives informed, written consent to such participation;

(16) be free from physical and mental abuse and neglect;

(17) be free from chemical and physical restraints, unless a physician, advanced practice nurse, or physician assistant authorizes the use for a limited period of time to protect the resident or others from injury. Under no circumstances shall a resident be confined in a locked room, or restrained, including with the use of excessive drugs, for punishment or for the convenience of staff;

(18) manage the resident's own finances, and to delegate that responsibility to a family member, assigned guardian, facility administrator, or some other individual with power of attorney. The resident's authorization delegating such authority shall be witnessed and in writing;

(19) receive prior to or at the time of admission, and afterwards through addenda, an admission agreement that complies with all applicable State and federal laws, describes the services provided and the related charges, and includes the policies for payment of fees, deposits, and refunds;

(20) receive a quarterly written account of the resident's funds, the itemized property deposited with the facility for the resident's use and safekeeping, and all financial transactions with the resident, next-of-kin, or guardian, which account shall show the amount of property in the account at the beginning and end of the accounting period, as well as a list of all deposits and withdrawals, substantiated by receipts given to the resident or the resident's guardian;

(21) have daily access during specified hours to the money and property that the resident has deposited with the facility, and to delegate, in writing, this right of access to a representative;

(22) live in safe and clean conditions that do not admit more residents than can safely be accommodated;

(23) not be arbitrarily and capriciously moved to a different bed or room;

(24) wear the resident's own clothes;

(25) keep and use the resident's personal property, unless doing so would be unsafe, impractical, or an infringement on the rights of other residents;

(26) reasonable opportunities for private and intimate physical and social interaction with other people, including the opportunity to share a room with another individual unless it is medically inadvisable;

(27) confidential treatment with regard to information about the resident, subject to the requirements of law;

(28) receive and send mail in unopened envelopes, unless the resident requests otherwise, and the right to request and receive assistance in reading and writing correspondence unless medically contraindicated;

(29) have a private telephone in the resident's living quarters at the resident's own expense;

(30) meet with any visitors of the resident's choice, at any time, in accordance with facility policies and procedures;

(31) take part in activities, and to meet with and participate in the activities of any social, religious, and community groups, as long as these activities do not disrupt the lives of other residents;

(32) refuse to perform services for the facility;

(33) request visits at any time by representatives of the religion of the resident's choice and, upon the resident's request, to attend outside religious services at the resident's own expense;

(34) participate in meals, recreation, and social activities without being subjected to discrimination based on age, race, religion, sex, marital status, nationality, or disability;

(35) organize and participate in a resident council that presents residents' concerns to the administrator of the facility;

(36) be transferred or discharged only in accordance with the terms of the admission agreement and with N.J.A.C. 8:36-5.1(d);

(37) receive written notice at least 30 days in advance when the facility requests the resident's transfer or discharge, except in an emergency, which notice shall include the name and contact information for the New Jersey Office of the Ombudsman for the Institutionalized Elderly;

(38) receive a written statement of resident rights and any regulations established by the facility involving resident rights and responsibilities;

(39) retain and exercise all constitutional, civil, and legal rights to which the resident is entitled by law;

(40) voice complaints without fear of interference, discharge, reprisal, and obtain contact information respecting government agencies to which residents can complain and ask questions, which information also shall be posted in a conspicuous place in the facility;

(41) hire a private caregiver or companion at the resident's expense and responsibility, as long as the caregiver or companion complies with the facility's policies and procedures; and

(42) obtain medications from a pharmacy of the resident's choosing, as long as the pharmacy complies with the facility's medication administration system, if applicable.

255. Section 3 of P.L.2011, c.145 (C.26:2H-131) is amended to read as follows:

C.26:2H-131 Definitions relative to POLST form.

3. As used in sections 1 through 12 of this act:

"Advance directive" means an advance directive for health care as defined in section 3 of P.L.1991, c.201 (C.26:2H-55).

"Advanced practice nurse" or "APN" means a person who is certified as an advanced practice nurse pursuant to P.L.1991, c.377 (C.45:11-45 et seq.).

"Commissioner" means the Commissioner of Health.

"Decision-making capacity" means a patient's ability to understand and appreciate the nature and consequences of a particular health care decision, including the benefits and risks of that decision, and alternatives to any proposed health care, and to reach an informed decision.

"Department" means the Department of Health.

"Emergency care" means the use of resuscitative measures and other immediate treatment provided in response to a sudden, acute, and unanticipated medical crisis in order to avoid injury, impairment, or death.

"Emergency care provider" means an emergency medical technician, paramedic, or member of a first aid, ambulance, or rescue squad.

"Health care decision" means a decision to accept, withdraw, or refuse a treatment, service, or procedure used to diagnose, treat, or care for a person's physical or mental condition, including life-sustaining treatment.

"Health care institution" means a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.), a psychiatric facility as defined in section 2 of P.L.1987, c.116 (C.30:4-27.2), or a State developmental center listed in R.S.30:1-7.

"Health care professional" means a health care professional who is licensed or otherwise authorized to practice a health care profession pursuant to Title 45 or 52 of the Revised Statutes and is currently engaged in that practice.

"Life-sustaining treatment" means the use of any medical device or procedure, artificially provided fluids and nutrition, drugs, surgery, or therapy that uses mechanical or other artificial means to sustain, restore, or supplant a vital bodily function, and thereby increase the expected life span of a patient.

"Patient" means a person who is under the care of a physician or APN.

"Patient's representative" means an individual who is designated by a patient or otherwise authorized under law to make health care decisions on the patient's behalf if the patient lacks decision-making capacity.

"Physician" means a person who is licensed to practice medicine and surgery pursuant to chapter 9 of Title 45 of the Revised Statutes.

"Physician Orders for Life-Sustaining Treatment form" or "POLST form" means a standardized printed document that is uniquely identifiable and has a uniform color, which:

a. is recommended for use on a voluntary basis by patients who have advanced chronic progressive illness or a life expectancy of less than five years, or who otherwise wish to further define their preferences for health care;

b. does not qualify as an advance directive;

c. is not valid unless it meets the requirements for a completed POLST form as set forth in this act;

d. provides a means by which to indicate whether the patient has made an anatomical gift pursuant to P.L.2008, c.50 (C.26:6-77 et al.);

e. is intended to provide direction to emergency care personnel regarding the use of emergency care, and to a health care professional regarding the use of life-sustaining treatment, with respect to the patient, by indicating the patient's preference concerning the use of specified interventions and the intensity of treatment for each intervention;

f. is intended to accompany the patient, and to be honored by all personnel attending the patient, across the full range of possible health care settings, including the patient's home, a health care institution, or otherwise at the scene of a medical emergency; and

g. may be modified or revoked at any time by a patient with decision-making capacity or the patient's representative in accordance with the provisions of section 7 of this act.

"Resuscitative measures" means cardiopulmonary resuscitation provided in the event that a patient suffers a cardiac or respiratory arrest.

256. Section 5 of P.L.2011, c.145 (C.26:2H-133) is amended to read as follows:

C.26:2H-133 Designation of patient safety organization; responsibilities.

5. The Commissioner of Health shall designate a patient safety organization (PSO) operating in this State pursuant to the federal "Patient Safety and Quality Improvement Act of 2005," Pub.L.109-41, to carry out the following responsibilities, by mutual written agreement of the commissioner and that PSO:

a. prescribe a POLST form and the procedures for completion, modification, and revocation of the form;

b. seek to promote awareness among health care professionals, emergency care providers, and the general public in this State about the option to complete a POLST form;

c. provide ongoing training of health care professionals and emergency care providers about the use of the POLST form, in consultation with organizations representing, and educational programs serving, health care professionals and emergency care providers, respectively, in this State;

d. prescribe additional requirements for the completion of a POLST form that may be applicable in the case of a patient with mental illness or a developmental disability in consultation with organizations that represent persons with mental illness and developmental disabilities, respectively;

e. provide for ongoing evaluation of the design and use of POLST forms through the use of such data as the PSO determines reasonably necessary for that purpose, subject to the commissioner's written approval; and

f. seek to minimize any record-keeping burden imposed on a health care institution pursuant to this act and take such actions as are necessary to ensure the confidentiality of any data furnished to the PSO that may contain patient-specific information.

257. Section 11 of P.L.2011, c.145 (C.26:2H-139) is amended to read as follows:

C.26:2H-139 Intentional failure to act, penalties, degree of crime.

11. a. A health care professional who intentionally fails to act in accordance with the requirements of this act is subject to discipline for professional misconduct pursuant to section 8 of P.L.1978, c.73 (C.45:1-21).

b. A health care institution that intentionally fails to act in accordance with the requirements of this act shall be liable to a civil penalty of not more than $1,000 for each offense. For the purposes of this subsection, each violation shall constitute a separate offense. The civil penalty shall be collected in a summary proceeding, brought in the name

of the State in a court of competent jurisdiction pursuant to the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

c. An emergency care provider subject to regulation by the Department of Health who intentionally fails to act in accordance with the requirements of this act is subject to such disciplinary measures as the commissioner deems necessary and within his statutory authority to impose.

d. A person who commits any of the following acts is guilty of a crime of the fourth degree:

(1) willfully concealing, canceling, defacing, obliterating, or withholding personal knowledge of a completed POLST form or a modification or revocation thereof, without the patient's consent;

(2) falsifying or forging a completed POLST form or a modification or revocation thereof of another person;

(3) coercing or fraudulently inducing the completion of a POLST form or a modification or revocation thereof; or

(4) requiring or prohibiting the completion of a POLST form or a modification or revocation thereof as a condition of coverage under any policy of health or life insurance or an annuity, or a public benefits program, or as a condition of the provision of health care.

e. The commission of an act identified in paragraph (1), (2), or (3) of subsection d. of this section, which results in the involuntary earlier death of a patient, shall constitute a crime of the first degree.

f. The provisions of this section shall not be construed to repeal any sanctions applicable under any other law.

258. Section 3 of P.L.1972, c.29 (C.26:2I-3) is amended to read as follows:

C.26:2I-3 Terms defined.

3. As used in this act, the following words and terms shall have the following meanings, unless the context indicates or requires another or different meaning or intent:

"Authority" means the New Jersey Health Care Facilities Financing Authority created by this act or any board, body, commission, department, or officer succeeding to the principal functions thereof or to whom the powers conferred upon the authority by this act shall be given by law.

"Bond" means bonds, notes, or other evidences of indebtedness of the authority issued pursuant to this act.

"Commissioner" means the Commissioner of Health.

"Credit agreement" means a loan agreement, revolving credit agreement, agreement establishing a line of credit, letter of credit, reimbursement agreement, interest exchange agreement, insurance contract, surety bond, commitment to purchase bonds, purchase or sale agreement, or commitment or other contract or agreement authorized and approved by the authority in connection with the authorization, issuance, security or payment of bonds.

"Health care organization" means an organization located in this State which is authorized or permitted by law, whether directly or indirectly through a holding corporation, partnership, or other entity, to provide health care-related services, including, but not limited to, hospital, outpatient, public health, home health care, residential care, assisted living, hospice, health maintenance organization, blood bank, alcohol or drug abuse, half-way house, diagnostic, treatment, rehabilitation, extended care, skilled nursing care, nursing care, intermediate care, tuberculosis care, chronic disease care, maternity, mental health, boarding

or sheltered care or day care, services provided by a physician in his office, or any other service offered in connection with health care services or by an entity affiliated with a health care organization or an integrated delivery system.

"Hospital asset transformation program" means the hospital asset transformation program established pursuant to subsection g. of section 7 of P.L.1972, c.29 (C.26:2I-7).

"Integrated delivery system" means a group of legally affiliated health care organizations.

"Public health care organization" means a State, county, or municipal health care organization.

"Project" or "health care organization project" means the acquisition, construction, improvement, renovation, or rehabilitation of lands, buildings, fixtures, equipment, and articles of personal property, or other tangible or intangible assets that are necessary or useful in the development, establishment, or operation of a health care organization pursuant to this act, and "project" or "health care organization project" may include: the financing, refinancing, or consolidation of secured or unsecured debt, borrowings, or obligations, or the provision of financing for any other expense incurred in the ordinary course of business, all of which lands, buildings, fixtures, equipment, and articles of personal property are to be used or occupied by any person in the health care organization; the acquisition of an entity interest, including capital stock, in a corporation; or any combination thereof; and may include any combination of the foregoing undertaken jointly by any health care organization with one or more other health care organizations.

"Project cost" or "health care organization project cost" means the sum total of all or any part of costs incurred or estimated to be incurred by the authority or by a health care organization which are reasonable and necessary for carrying out all works and undertakings and providing all necessary equipment for the development of a project, exclusive of the amount of any private or federal, State, or local financial assistance for and received by a health care organization for the payment of such project cost. Such costs shall include, but are not necessarily limited to: interest prior to, during and for a reasonable period after such development; start-up costs and costs of operation and maintenance during the construction period and for a reasonable additional period thereafter; organization, administration, operation, and other expenses of the health care organization prior to and during construction; the cost of necessary studies, surveys, plans, and specifications, architectural, engineering, legal, or other special services; the cost of acquisition of land, buildings, and improvements thereon (including payments for the relocation of persons displaced by such acquisition), site preparation and development, construction, reconstruction, equipment, including fixtures, equipment, and cost of demolition and removal, and articles of personal property required; the reasonable cost of financing incurred by a health care organization or the authority in the course of the development of the project; reserves for debt service; the fees imposed upon a health care organization by the commissioner and by the authority; other fees charged, and necessary expenses incurred in connection with the initial occupancy of the project; and the cost of such other items as may be reasonable and necessary for the development of a project; as well as provision or reserves for working capital, operating or maintenance or replacement expenses, or for payment or security of principal of, or interest on, bonds.

259. Section 4 of P.L.1972, c.29 (C.26:2I-4) is amended to read as follows:

C.26:2I-4 “New Jersey Health Care Facilities Financing Authority.”

4. a. There is hereby established in the Department of Health, a public body corporate and politic, with corporate succession, to be known as the "New Jersey Health Care Facilities Financing Authority." The authority shall constitute a political subdivision of the State established as an instrumentality exercising public and essential governmental functions, and the exercise by the authority of the powers conferred by this act shall be deemed and held to be an essential governmental function.

b. The authority shall consist of seven members, three of whom shall be the commissioner, who shall be the chairman, the Commissioner of Banking and Insurance, and the Commissioner of Human Services, who shall serve during their terms of office, or when so designated by them, their deputies or other representatives, who shall serve at their pleasure, and four public members who are citizens of the State to be appointed by the Governor, with the advice and consent of the Senate for terms of four years; provided that the four members first appointed by the Governor shall serve terms expiring on the first, second, third, and fourth, respectively, April 30 ensuing after the enactment of this act. Each member shall hold office for the term of the member's appointment and until the member's successor shall have been appointed and qualified. Any vacancy among the public members shall be filled by appointment for the unexpired term only.

c. Any member of the authority appointed by the Governor may be removed from office by the Governor for cause after a public hearing.

d. The members of the authority shall serve without compensation, but the authority may reimburse its members for necessary expenses incurred in the discharge of their official duties.

e. The authority, upon the first appointment of its members and thereafter on or after April 30 in each year, shall annually elect from among its members a vice chairman who shall hold office until April 30 next ensuing and shall continue to serve during the term of his successor and until his successor shall have been appointed and qualified. The authority may also appoint, retain, and employ, without regard to the provisions of Title 11A, Civil Service, of the New Jersey Statutes, such officers, agents, and employees as it may require, and it shall determine their qualifications, terms of office, duties, services, and compensation.

f. The powers of the authority shall be vested in the members thereof in office from time to time and a majority of the total authorized membership of the authority shall constitute a quorum at any meeting thereof. Action may be taken and motions and resolutions adopted by the authority at any meeting thereof by the affirmative vote of a majority of the members present, unless in any case the bylaws of the authority shall require a larger number. No vacancy in the membership of the authority shall impair the right of a quorum to exercise all the rights and perform all the duties of the authority.

g. Each member and the treasurer of the authority shall execute a bond to be conditioned upon the faithful performance of the duties of such member or treasurer, as the case may be, in such form and amount as may be prescribed by the Attorney General. Such bonds shall be filed in the office of the Secretary of State. At all times thereafter the members and treasurer of the authority shall maintain such bonds in full force and effect. All costs of such bonds shall be borne by the authority.

h. No trustee, director, officer, or employee of a health care organization may serve as a member of the authority.

i. At least two true copies of the minutes of every meeting of the authority shall be forthwith delivered by and under the certification of the secretary thereof, to the Governor. No action taken at such meeting by the authority shall have force or effect until 10 days, exclusive of Saturdays, Sundays, and public holidays, after such copies of the minutes shall

have been so delivered or at such earlier time as the Governor shall sign a statement of approval thereof. If, in said 10-day period, the Governor returns a copy of the minutes with veto of any action taken by the authority or any member thereof at such meeting, such action shall be null and of no effect. If the Governor shall not return the minutes within said 10-day period, any action therein recited shall have force and effect according to the wording thereof. At any time prior to the expiration of the said 10-day period, the Governor may sign a statement of approval of all or any such action of the authority.

The powers conferred in this subsection upon the Governor shall be exercised with due regard for the rights of the holders of bonds of the authority at any time outstanding.

260. Section 5 of P.L.1972, c.29 (C.26:2I-5) is amended to read as follows:

C.26:2I-5 Powers of authority.

5. Powers of authority. The authority shall have power:

a. To adopt bylaws for the regulation of its affairs and the conduct of its business and to alter and revise such bylaws from time to time at its discretion.

b. To adopt and have an official seal and alter the same at pleasure.

c. To maintain an office at such place or places within the State as it may designate.

d. To sue and be sued in its own name.

e. To borrow money and to issue bonds of the authority and to provide for the rights of the holders thereof as provided in this act.

f. To acquire, lease as lessee or lessor, hold and dispose of real and personal property or any interest therein, in the exercise of its powers and the performance of its duties under this act.

g. To acquire in the name of the authority by purchase or otherwise, on such terms and conditions and in such manner as it may deem proper, any land or interest therein and other property which it may determine is reasonably necessary for any project; and to hold and use the same and to sell, convey, lease, or otherwise dispose of property so acquired, no longer necessary for the authority's purposes, for fair consideration after public notice.

h. To receive and accept, from any federal or other public agency or governmental entity directly or through the Department of Health or any other agency of the State or any health care organization, grants or loans for or in aid of the acquisition or construction of any project, and to receive and accept aid or contributions from any other source, of either money, property, labor or other things of value, to be held, used, and applied only for the purposes for which such grants, loans and, contributions may be made.

i. To prepare or cause to be prepared plans, specifications, designs, and estimates of costs for the construction and equipment of health care organization projects for health care organizations under the provisions of this act, and from time to time to modify such plans, specifications, designs, or estimates.

j. By contract or contracts with and for health care organizations only, to construct, acquire, reconstruct, rehabilitate and improve, and furnish and equip health care organization projects. The authority, in the exercise of its authority to make and enter into contracts and agreements necessary or incidental to the performance of its duties and the execution of its powers, shall adopt standing rules and procedures providing that, except as hereinafter provided, no contract on behalf of the authority shall be entered into for the doing of any work, or for the hiring of equipment or vehicles, where the sum to be expended exceeds the sum of $7,500 or the amount determined as provided in this subsection, unless the authority shall first publicly advertise for bids therefor, and shall award the contract to the lowest

responsible bidder; provided, however, that such advertising shall not be required where the contract to be entered into is one for the furnishing or performing of services of a professional nature or for the supplying of any product or the rendering of any service by a public utility subject to the jurisdiction of the Board of Public Utilities, and tariffs and schedules of the charges, made, charged, or exacted by the public utility for any such products to be supplied or services to be rendered are filed with said board. The Governor, in consultation with the Department of the Treasury, shall, no later than March 1 of each odd-numbered year, adjust the threshold amount set forth in this subsection, or subsequent to 1985 the threshold amount resulting from any adjustment under this subsection or section 17 of P.L.1985, c.469, in direct proportion to the rise or fall of the Consumer Price Index for all urban consumers in the New York City and the Philadelphia areas as reported by the United States Department of Labor. The Governor shall, no later than June 1 of each odd-numbered year, notify the authority of the adjustment. The adjustment shall become effective July 1 of each odd-numbered year.

k. To determine the location and character of any project to be undertaken, subject to the provisions of this act, and subject to State health and environmental laws, to construct, reconstruct, maintain, repair, lease as lessee or lessor, and regulate the same and operate the same in the event of default by a health care organization of its obligations and agreements with the authority; to enter into contracts for any or all such purposes; and to enter into contracts for the management and operation of a project in the event of default as herein provided. The authority shall use its best efforts to conclude its position as an operator as herein provided as soon as is practicable.

l. To establish rules and regulations for the use of a project or any portion thereof and to designate a health care organization as its agent to establish rules and regulations for the use of a project undertaken by such a health care organization.

m. Generally to fix and revise from time to time and to charge and collect rates, rents, fees, and other charges for the use of and for the services furnished or to be furnished by a project or any portion thereof and to contract with holders of its bonds and with any other person, party, association, corporation or other body, public or private, in respect thereof.

n. To enter into agreements, credit agreements or contracts, execute any and all instruments, and do and perform any and all acts or things necessary, convenient or desirable for the purposes of the authority or to carry out any power expressly given in this act.

o. To invest any moneys held in reserve or sinking funds, or any moneys not required for immediate use or disbursement, at the discretion of the authority, in such obligations as are authorized by resolution of the authority.

p. To obtain, or aid in obtaining, from any department or agency of the United States any insurance or guarantee as to, or of, or for the payment or repayment of interest or principal, or both, or any part thereof, on any loan or any instrument evidencing or securing the same, made or entered into pursuant to the provisions of this act; and notwithstanding any other provisions of this act, to enter into agreement, contract, or any other instrument whatsoever with respect to any such insurance or guarantee, and accept payment in such manner and form as provided therein in the event of default by the borrower.

q. To obtain from any department or agency of the United States or a private insurance company any insurance or guarantee as to, or of, or for the payment or repayment of interest or principal, or both, or any part thereof, on any bonds issued by the authority pursuant to the provisions of this act; and notwithstanding any other provisions of this act, to enter into any agreement, contract, or any other instrument whatsoever with respect to any such insurance or guarantee, except to the extent that such action would in any way impair or interfere with

the authority's ability to perform and fulfill the terms of any agreement made with the holders of the bonds of the authority.

r. To receive and accept, from any department or agency of the United States or of the State or from any other entity, any grant, appropriation, or other moneys to be used for or applied to any corporate purpose of the authority, including without limitation the meeting of debt service obligations of the authority in respect of its bonds.

s. Subject to the approval of the State Treasurer, to grant or loan all or any portion of the funds received pursuant to subsection g. of section 7 of P.L.1972, c.29 (C.26:2I-7) in connection with the hospital asset transformation program.

261. Section 21 of P.L.1972, c.29 (C.26:2I-21) is amended to read as follows:

C.26:2I-21 Department may visit, examine, inspect authority, require reports.

21. The Department of Health, or the commissioner or their representatives, may visit, examine into, and inspect, the authority and may require, as often as desired, duly verified reports therefrom giving such information and in such form as the department or commissioner shall prescribe.

262. Section 23 of P.L.1972, c.29 (C.26:2I-23) is amended to read as follows:

C.26:2I-23 Powers of State departments, agencies.

23. In order to provide new health care organizations and to enable the construction and financing thereof, to refinance indebtedness hereafter created by the authority for the purpose of providing one or more health care organizations or additions or improvements thereto or modernization thereof or for any one or more of said purposes but for no other purpose unless authorized by law, each of the following bodies shall have the powers hereafter enumerated to be exercised upon such terms and conditions, including the fixing of fair consideration or rental to be paid or received, as it shall determine by resolution as to such property and each shall be subject to the performance of the duties hereafter enumerated, that is to say, the Department of Health as to such as are located on land owned by, or owned by the State and held for, any State institution or on lands of the institutions under the jurisdiction of the Department of Health or of the Department of Human Services, or by the authority, the Commissioner of Human Services as to State institutions operated by that department, the board of trustees or governing body of any public health care organization, the board of trustees of the University of Medicine and Dentistry of New Jersey, as to such as are located on land owned by the university, or by the State for the university, the State or by the particular public health care organization, respectively, namely:

a. The power to sell and to convey to the authority title in fee simple in any such land and any existing health care facility thereon owned by the State and held for any department thereof or of any of the institutions under the jurisdiction of the Department of Health or the power to sell and to convey to the authority such title as the State or the public health care organization, respectively, may have in any such land and any existing health care facility thereon.

b. The power to lease to the authority any land and any existing health care facility thereon so owned for a term or terms not exceeding 50 years each.

c. The power to lease or sublease from the authority, and to make available, any such land and existing health care facility conveyed or leased to the authority under subsections a.

and b. of this section, and any new health care facility erected upon such land or upon any other land owned by the authority.

d. The power and duty, upon receipt of notice of any assignment by the authority of any lease or sublease made under subsection c. of this section, or of any of its rights under any such lease or sublease, to recognize and give effect to such assignment, and to pay to the assignee thereof rentals or other payments then due or which may become due under any such lease or sublease which has been so assigned by the authority.

263. Section 6 of P.L.1991, c.279 (C.26:2J-4.4) is amended to read as follows:

C.26:2J-4.4 Health maintenance organization, mammogram examination benefits.

6. Notwithstanding any provision of law to the contrary, a certificate of authority to establish and operate a health maintenance organization in this State shall not be issued or continued by the Commissioner of Banking and Insurance on or after the effective date of this act unless the health maintenance organization provides health care services to any enrollee for the conduct of: one baseline mammogram examination for women who are at least 35 but less than 40 years of age; a mammogram examination every year for women age 40 and over; and, in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider.

These health care services shall be provided to the same extent as for any other sickness under the enrollee agreement.

The provisions of this section shall apply to all enrollee agreements in which the health maintenance organization has reserved the right to change the schedule of charges.

264. Section 8 of P.L.1993, c.327 (C.26:2J-4.6) is amended to read as follows:

C.26:2J-4.6 Health maintenance organization, benefits for health promotion.

8. a. Notwithstanding any provision of this act or any other law to the contrary, a certificate of authority to establish and operate a health maintenance organization in this State shall not be issued or continued by the Commissioner of Health on or after the effective date of this act unless the health maintenance organization provides health care services to any enrollee which include a health promotion program providing health wellness examinations and counseling, which program shall include, but not be limited to, the following tests and services:

(1) For all persons 20 years of age and older, annual tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level or, alternatively, low-density lipoprotein (LDL) level, and blood high-density lipoprotein (HDL) level;

(2) For all persons 35 years of age or older, a glaucoma eye test every five years;

(3) For all persons 40 years of age or older, an annual stool examination for presence of blood;

(4) For all persons 45 years of age or older, a left-sided colon examination of 35 to 60 centimeters every five years;

(5) For all women 20 years of age or older, a pap smear pursuant to the provisions of section 5 of P.L.1995, c.415 (C.26:2J-4.12);

(6) For all women 40 years of age or older, a mammogram examination pursuant to the provisions of section 6 of P.L.1991, c.279 (C.26:2J-4.4);

(7) For all adults, recommended immunizations; and

(8) For all persons 20 years of age or older, an annual consultation with a health care provider to discuss lifestyle behaviors that promote health and well-being including, but not limited to, smoking control, nutrition and diet recommendations, exercise plans, lower back protection, weight control, immunization practices, breast self-examination, testicular self-examination, and seat belt usage in motor vehicles.

Notwithstanding the provisions of this subsection to the contrary, if a physician or other health care provider recommends that it would be medically appropriate for an enrollee to receive a different schedule of tests and services than that provided for under this subsection, the health maintenance organization shall provide coverage for the tests or services actually provided, within the limits of the amounts listed in subsection b. of this section.

b. A health maintenance organization shall not be required to offer services to enrollees set forth in subsection a. of this section for which the value exceeds: $125 a year for each person between the ages of 20 to 39, inclusive; $145 a year for each man age 40 and over; and $235 a year for each woman age 40 and over; except that for persons 45 years of age or older, the value of a left-sided colon examination shall not be included in the above amount; however, no health maintenance organization shall be required to provide services to enrollees for a left-sided colon examination with a value in excess of $150.

c. The Commissioner of Health, in consultation with the Department of the Treasury, shall annually adjust the threshold amounts provided by subsection b. of this section in direct proportion to the increase or decrease in the consumer price index for all urban consumers in the New York City and Philadelphia areas as reported by the United States Department of Labor. The adjustment shall become effective on July 1 of the year in which it is reported.

d. Nothing in this act shall be construed to require that a health maintenance organization take any actions which conflict with the health benefits, underwriting and rating standards established by the federal government pursuant to subchapter XI of Pub.L.93-222 (42 U.S.C. s.300e et seq.).

e. This section shall apply to all health maintenance organization contracts in which the right to change the enrollee charge has been reserved.

f. The provisions of this section shall not apply to a health benefits plan subject to the provisions of P.L.1992, c.161 (C.17B:27A-2 et seq.) or P.L.1992, c.162 (C.17B:27A-17 et seq.).

265. Section 4 of P.L.1995, c.316 (C.26:2J-4.10) is amended to read as follows:

C.26:2J-4.10 Health maintenance organization, child screening, blood lead, hearing loss; immunizations.

4. A certificate of authority to establish and operate a health maintenance organization in this State shall not be issued or continued by the Commissioner of Banking and Insurance on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.) unless the health maintenance organization offers health care services to any enrollee which include:

a. Screening by blood lead measurement for lead poisoning for children, including confirmatory blood lead testing as specified by the Department of Health pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1); and medical evaluation and any necessary medical follow-up and treatment for lead poisoned children.

b. All childhood immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Service and the Department of Health pursuant to section 7 of P.L.1995, c.316 (C.26:2-137.1). A health maintenance organization shall notify its enrollees, in writing, of any change in the health care services

provided with respect to childhood immunizations and any related changes in premium. The notification shall be in a form and manner to be determined by the Commissioner of Banking and Insurance.

c. Screening for newborn hearing loss by appropriate electrophysiologic screening measures and periodic monitoring of infants for delayed onset hearing loss, pursuant to P.L.2001, c.373 (C.26:2-103.1 et al.). Payment for this screening service shall be separate and distinct from payment for routine new baby care in the form of a newborn hearing screening fee as negotiated with the provider and facility.

The health care services provided pursuant to this section shall be provided to the same extent as for any other medical condition under the contract, except that a deductible shall not be applied for services provided pursuant to this section; however, with respect to a contract that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), a deductible shall not be applied for any services provided pursuant to this section that represent preventive care as permitted by that federal law, and shall not be applied as provided pursuant to section 12 of P.L.2005, c.248 (C.26:2J-4.29). This section shall apply to all contracts under which the health maintenance organization has reserved the right to change the schedule of charges for enrollee coverage.

266. Section 5 of P.L.1995, c.415 (C.26:2J-4.12) is amended to read as follows:

C.26:2J-4.12 HMO contracts, Pap smear benefits.

5. A certificate of authority to establish and operate a health maintenance organization in this State shall not be issued or continued by the Commissioner of Banking and Insurance on or after the effective date of this act unless the health maintenance organization offers health care services to any enrollee or other person covered thereunder which include a Pap smear. The health care services shall be provided to the same extent as for any other medical condition under the contract.

As used in this section, and notwithstanding the provisions of this section to the contrary, "Pap smear" means an initial Pap smear and any confirmatory test when medically necessary and as ordered by the covered person's physician and includes all laboratory costs associated with the initial Pap smear and any confirmatory test.

The provisions of this section shall apply to all contracts for health care services by health maintenance organizations under which the right to change the schedule of charges for enrollee coverage is reserved.

267. Section 6 of P.L.1997, c.75 (C.26:2J-4.14) is amended to read as follows:

C.26:2J-4.14 HMO to provide benefits for reconstructive breast surgery.

6. A certificate of authority to establish and operate a health maintenance organization in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.) shall not be issued or continued by the Commissioner of Banking and Insurance on or after the effective date of P.L.1997, c.75 unless the health maintenance organization provides health care services to any enrollee, following a mastectomy on one breast or both breasts, for reconstructive breast surgery, surgery to restore and achieve symmetry between the two breasts, and prostheses and, under any contract for health care services providing outpatient x-ray or radiation therapy, outpatient chemotherapy following surgical procedures in connection with the treatment of breast cancer shall be included as a part of the outpatient x-ray or radiation therapy.

The health care services shall be provided to the same extent as for any other medical condition under the contract for health care services.

The provisions of this section shall apply to all contracts for health care services by health maintenance organizations under which the right to change the schedule of charges for enrollee coverage is reserved.

268. Section 8 of P.L.1997, c.149 (C.26:2J-4.15) is amended to read as follows:

C.26:2J-4.15 Coverage for minimum inpatient care following mastectomy by HMO.

8. a. Every enrollee agreement that provides hospital or medical expense benefits and is delivered, issued, executed, or renewed in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.) or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this act shall provide health care services for a minimum of 72 hours of inpatient care following a modified radical mastectomy and a minimum of 48 hours of inpatient care following a simple mastectomy. The enrollee agreement shall not require a health care provider to obtain authorization from the health maintenance organization for prescribing 72 or 48 hours, as appropriate, of inpatient care as provided for in this section.

The provisions of this section shall not be construed to: require a patient to receive inpatient care for 72 or 48 hours, as appropriate, if the patient in consultation with the patient's physician determines that a shorter length of stay is medically appropriate; or relieve a patient or a patient's physician, if appropriate, of any notification requirements to the health maintenance organization under the enrollee agreement.

The health care services shall be provided to the same extent as for any other sickness under the enrollee agreement.

The provisions of this section shall apply to enrollee agreements in which the health maintenance organization has reserved the right to change the schedule of charges.

b. The Commissioner of Banking and Insurance shall adopt regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to implement the provisions of this section.

269. Section 8 of P.L.1997, c.338 (C.26:2J-4.17) is amended to read as follows:

C.26:2J-4.17 Coverage for treatment of inherited metabolic diseases by health maintenance organization.

8. Notwithstanding any provision of law to the contrary, a certificate of authority to establish and operate a health maintenance organization in this State shall not be issued or continued by the Commissioner of Banking and Insurance on or after the effective date of this act unless the health maintenance organization provides health care services to each enrollee for the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods and low protein modified food products, when diagnosed and determined to be medically necessary by the enrollee's physician.

For the purposes of this section, "inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry for which testing is mandated pursuant to P.L.1977, c.321 (C.26:2-110 et seq.); "low protein modified food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease, but does not include a natural food that is naturally low in

protein; and "medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered enterally under direction of a physician.

The health care services shall be provided to the same extent as for any other medical condition under the contract.

The provisions of this section shall apply to all contracts for health care services by health maintenance organizations under which the right to change the schedule of charges for enrollee coverage is reserved.

270. Section 6 of P.L.1999, c.49 (C.26:2J-4.19) is amended to read as follows:

C.26:2J-4.19 Coverage for certain dental procedures for the severely disabled or child age five or under by HMO.

6. a. A certificate of authority to establish and operate a health maintenance organization in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.), shall not be issued or continued by the Commissioner of Banking and Insurance on or after the effective date of this amendatory and supplementary act unless the health maintenance organization provides health care services to an enrollee who is severely disabled or a child age five or under for: (1) general anesthesia and hospitalization for dental services; or (2) a medical condition covered by the enrollee agreement which requires hospitalization or general anesthesia for dental services rendered by a participating dentist regardless of where the dental services are provided.

b. A health maintenance organization may require prior authorization of hospitalization for dental services in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

c. This section shall apply to all contracts for health care services in which the health maintenance organization has reserved the right to change the schedule of charges.

271. Section 8 of P.L.1999, c.108 (C.26:2J-4.20) is amended to read as follows:

C.26:2J-4.20 HMO to provide coverage for biologically based mental illness.

8. a. Every enrollee agreement delivered, issued, executed, or renewed in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.) or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act shall provide health care services for biologically-based mental illness under the same terms and conditions as provided for any other sickness under the agreement. "Biologically-based mental illness" means a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder, or autism. "Same terms and conditions" means that the health maintenance organization cannot apply different copayments, deductibles, or health care services limits to biologically-based mental health care services than those applied to other medical or surgical health care services.

b. Nothing in this section shall be construed to change the manner in which a health maintenance organization determines:

(1) whether a mental health care service meets the medical necessity standard as established by the health maintenance organization; or

(2) which providers shall be entitled to reimbursement or to be participating providers, as appropriate, for mental health services under the enrollee agreement.

c. The provisions of this section shall apply to enrollee agreements in which the health maintenance organization has reserved the right to change the premium.

272. Section 1 of P.L.1999, c.332 (C.26:2J-4.21) is amended to read as follows:

C.26:2J-4.21 HMO to provide continuing nursing home care, certain.

1. a. A certificate of authority to establish and operate a health maintenance organization in this State shall not be issued or continued by the Commissioner of Banking and Insurance on or after the effective date of this act unless the health maintenance organization offers health care services in conformance with the provisions of subsection b. of this section.

b. If an enrollee is a resident of a skilled nursing facility, continuing care retirement community, or a retirement community which operates a skilled nursing facility on the premises of the community, regardless of whether the health maintenance organization is under contract with the skilled nursing facility or the skilled nursing facility at the continuing care retirement community or retirement community, the enrollee's primary care physician shall refer the enrollee to the skilled nursing facility or the community's Medicare-certified skilled nursing unit, as applicable, rather than to a skilled nursing facility separate from the facility or the community of origin, if:

(1) the skilled nursing facility or the continuing care retirement community or retirement community with a skilled nursing facility has the capacity to provide the services the enrollee needs;

(2) the primary care physician, in consultation with the enrollee or a representative of the enrollee's family, determines that the referral is in the best interest of the enrollee;

(3) the skilled nursing facility or the continuing care retirement community or retirement community with a skilled nursing facility agrees to be reimbursed at the same contract rate negotiated by the health maintenance organization with similar providers for the same services and supplies in the same geographic area; and

(4) the skilled nursing facility or the continuing care retirement community or retirement community with a skilled nursing facility meets all applicable State licensing and certification requirements.

c. For the purposes of this act, "continuing care retirement community" means a continuing care facility operating under a certificate of authority issued by the Department of Community Affairs pursuant to P.L.1986, c.103 (C.52:27D-330 et seq.), and "retirement community" means a retirement community which is registered with the Department of Community Affairs pursuant to P.L.1977, c.419 (C.45:22A-21 et seq.).

273. Section 8 of P.L.2001, c.295 (C.26:2J-4.24) is amended to read as follows:

C.26:2J-4.24 HMO agreement to provide coverage for colorectal cancer screening.

8. Every enrollee agreement that provides hospital or medical expense benefits and is delivered, issued, executed, or renewed in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance on or after the effective date of this act, shall provide health care services to any enrollee or other person covered thereunder for expenses incurred in conducting

colorectal cancer screening at regular intervals for persons age 50 and over and for persons of any age who are considered to be at high risk for colorectal cancer. The methods of screening for which benefits shall be provided shall include: a screening fecal occult blood test, flexible sigmoidoscopy, colonoscopy, barium enema, or any combination thereof; or the most reliable, medically recognized screening test available. The method and frequency of screening to be utilized shall be in accordance with the most recent published guidelines of the American Cancer Society and as determined medically necessary by the covered person's physician, in consultation with the covered person.

As used in this section, "high risk for colorectal cancer" means a person has:

a. a family history of: familial adenomatous polyposis; hereditary non-polyposis colon cancer; or breast, ovarian, endometrial, or colon cancer or polyps;

b. chronic inflammatory bowel disease; or

c. a background, ethnicity, or lifestyle that the physician believes puts the person at elevated risk for colorectal cancer.

The health care services shall be provided to the same extent as for any other medical condition under the enrollee agreement.

The provisions of this section shall apply to all enrollee agreements in which the health maintenance organization has reserved the right to change the schedule of charges.

274. Section 11 of P.L.2005, c.248 (C.26:2J-4.28) is amended to read as follows:

C.26:2J-4.28 HMO, high deductible, coverage for preventive care.

11. A certificate of authority to establish and operate a health maintenance organization, which organization offers a contract that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), shall not be issued or continued by the Commissioner of Banking and Insurance on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), unless the health maintenance organization offers health care services to any enrollee which include services provided in-network which represent medically necessary preventive care as permitted by that federal law.

The services provided pursuant to this section shall be provided to the same extent as for any other medical condition under the contract, except that a deductible shall not be applied for services provided pursuant to this section. This section shall apply to all contracts under which the health maintenance organization has reserved the right to change the schedule of charges for enrollee coverage.

275. Section 12 of P.L.2005, c.248 (C.26:2J-4.29) is amended to read as follows:

C.26:2J-4.29 Health service corporation, coverage for prescription female contraceptives.

12. Notwithstanding the provisions of section 4 of P.L.1995, c.316 (C.26:2J-4.10) regarding deductibles for a high deductible health plan, a contract offered by a health maintenance organization, which certificate of authority to establish and operate is issued or continued by the Commissioner of Banking and Insurance on or after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.), that qualifies as a high deductible health plan for which qualified medical expenses are paid using a health savings account established pursuant to section 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.223), shall not apply a deductible for any benefits in which a deductible is not applicable pursuant to any law enacted after the effective date of P.L.2005, c.248 (C.17:48E-35.27 et al.).

This section shall apply to all contracts under which the health maintenance organization has reserved the right to change the schedule of charges for enrollee coverage.

276. Section 8 of P.L.2007, c.345 (C.26:2J-4.31) is amended to read as follows:

C.26:2J-4.31 HMOs to provide benefits for orthotic and prosthetic appliances.

8. a. A certificate of authority to establish and operate a health maintenance organization in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.) shall not be issued or continued by the Commissioner of Banking and Insurance on or after the effective date of this act unless the health maintenance organization provides health care services for any person covered thereunder for expenses incurred in obtaining an orthotic or prosthetic appliance from any licensed orthotist or prosthetist, or any certified pedorthist, as determined medically necessary by the covered person's physician.

As used in this section, "orthotic appliance," "prosthetic appliance," "licensed orthotist," and "licensed prosthetist" have the meaning assigned to them in section 3 of P.L.1991, c.512 (C.45:12B-3) and "certified pedorthist" has the meaning assigned to it in subsection j. of section 18 of P.L.1991, c.512 (C.45:12B-18).

b. On and after the effective date of this act, a health maintenance organization shall reimburse for orthotic and prosthetic appliances at the same rate as reimbursement for such appliances under the federal Medicare reimbursement schedule.

c. The benefits shall be provided to the same extent as for any other medical condition under the enrollee agreement.

d. The provisions of this section shall apply to all enrollee agreements in which the health maintenance organization has reserved the right to change the schedule of charges.

277. Section 23 of P.L.1973, c.337 (C.26:2J-23) is amended to read as follows:

C.26:2J-23 Fees.

23. Every health maintenance organization subject to this act shall pay to the commissioner the following fees:

a. for filing an application for a certificate of authority or amendment thereto, $100.00;

b. for filing each annual report, $10.00; and

c. for the purpose of supporting the activities of the Department of Banking and Insurance associated with the regulation of health maintenance organizations, $1.50 per life per year, with payment being made annually no later than July 15 for the preceding calendar year. Payments made by a health maintenance organization pursuant to this act shall not in any way reduce payments that may be owed by a health maintenance organization pursuant to P.L.1995, c.156 (C.17:1C-19 et seq.) and subsequent amendments thereto. No such payment shall be required for any per life per year that is funded through the Medicaid program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.) or the NJ FamilyCare Program established pursuant to P.L.2005, c.156 (C.30:4J-8 et al.).

In accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), the commissioner may promulgate rules and regulations directing that additional fees be paid.

From fees collected under the provisions of subsection c. of this section, the Legislature shall in each fiscal year appropriate to the community health law project the sum of $100,000 to fund a grant in support of a program to provide any senior citizen resident of this State who is covered as an enrollee in or beneficiary of a health plan administered by a health

maintenance organization with information concerning the person's rights under the program and assistance with the procedures for receiving the benefits to which the person is entitled under the program.

278. Section 1 of P.L.1986, c.106 (C.26:2K-35) is amended to read as follows:

C.26:2K-35 Definitions.

1. As used in this act:

a. "Commissioner" means the Commissioner of Health.

b. "Dispatch" means the coordinated request for and dispatch of the emergency medical service helicopter response unit by a central communications center located in the service area, following protocols developed by the mobile intensive care hospital, the regional trauma or critical care center, the commissioner, and the superintendent.

c. "Emergency medical service helicopter response unit" means a specially equipped hospital-based emergency medical service helicopter staffed by advanced life support personnel and operated for the provision of advanced life support services under the medical direction of a mobile intensive care program and the regional trauma or critical care center authorized by the commissioner.

d. "Emergency medical transportation" means the prehospital or interhospital transportation of an acutely ill or injured patient by a dedicated emergency medical service helicopter response unit operated, maintained and piloted by the Division of State Police of the Department of Law and Public Safety, pursuant to regulations adopted by the commissioner under chapter 40 of Title 8 of the New Jersey Administrative Code.

e. "Medical direction" means the medical control and medical orders transmitted from the physician of the mobile intensive care hospital or from the physician at the regional trauma or critical care center to the staff of the helicopter. The mobile intensive care unit coordinating center and regional trauma or critical care center shall have the ability to cross patch and consult with each other as approved by the commissioner.

f. "Mobile intensive care hospital" means a hospital authorized by the commissioner to develop and maintain a mobile intensive care unit to provide advanced life support services in accordance with P.L.1984, c.146 (C.26:2K-7 et al.).

g. "Regional trauma center" means a State designated level one hospital-based trauma center equipped and staffed to provide emergency medical services to an accident or trauma victim, including, but not limited to, the level one trauma centers at the University of Medicine and Dentistry of New Jersey-University Hospital in Newark, known as the "Eric Munoz Trauma Center," and at the Cooper Hospital/University Medical Center in Camden.

h. "Critical care center" means a hospital authorized by the commissioner to provide regional critical care services, such as trauma, burn, spinal cord, cardiac, poison, or neonatal care.

i. "Superintendent" means the Superintendent of the Division of State Police of the Department of Law and Public Safety.

279. Section 1 of P.L.2003, c.1 (C.26:2K-47.1) is amended to read as follows:

C.26:2K-47.1 Definitions relative to administration of epinephrine.

1. As used in this act:

"Commissioner" means the Commissioner of Health;

"Emergency medical service" means a program in a hospital staffed 24 hours-a-day by a licensed physician trained in emergency medicine;

"Emergency medical technician" means a person trained in basic life support services as defined in section 1 of P.L.1985, c.351 (C.26:2K-21) and who is certified by the Department of Health to provide that level of care.

280. Section 2 of P.L.2003, c.1 (C.26:2K-47.2) is amended to read as follows:

C.26:2K-47.2 Administration, maintenance, disposal of auto-injector device; certification; training; fee.

2. a. An emergency medical technician who has been certified by the commissioner pursuant to subsection b. of this section to administer an epinephrine auto-injector device shall administer, maintain and dispose of the device in accordance with rules and regulations adopted by the commissioner.

Each administration of an auto-injector device pursuant to this act shall be reported to the Department of Health in a manner determined by the commissioner.

b. The commissioner shall establish written standards and application procedures which an emergency medical technician shall meet in order to obtain certification. The commissioner shall certify a candidate who: provides evidence of satisfactory completion of an educational program which is approved by the commissioner and includes training in the administration of epinephrine auto-injector devices; and passes an examination in the administration of the devices which is approved by the commissioner.

c. The commissioner shall maintain a registry of all persons certified pursuant to this section, which shall include, but not be limited to:

(1) the person's name and residence; and

(2) the date that certification was granted.

d. The commissioner shall annually compile a list of emergency medical technicians who have obtained certification to administer an epinephrine auto-injector device pursuant to this section, which shall be available to the public.

e. A fee may be charged to a person enrolled in an educational program approved by the department which includes training in the administration of an epinephrine auto-injector device in order to cover the cost of training and testing for certification pursuant to this section, if the entity that provides the educational program is not reimbursed for the cost of that training and testing from the "Emergency Medical Technician Training Fund" established pursuant to section 3 of P.L.1992, c.143 (C.26:2K-56).

281. Section 10 of P.L.2003, c.1 (C.26:2K-47.9) is amended to read as follows:

C.26:2K-47.9 Rules, regulations.

10. Pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), the Commissioner of Health shall adopt rules and regulations to effectuate the purposes of this act, including medical protocols for the administration of epinephrine auto-injector devices, in consultation with the State mobile intensive care advisory council and the New Jersey State First Aid Council, Inc. The rules and regulations shall address age appropriateness in the administration of epinephrine.

282. Section 1 of P.L.2009, c.174 (C.26:2K-63) is amended to read as follows:

C.26:2K-63 Certification as EMT valid for five years.

1. Certification of a person as an emergency medical technician by the Commissioner of Health, when that person meets the requirements therefor as prescribed by regulation of the commissioner, shall be valid for a period of five years.

283. Section 2 of P.L.2009, c.174 (C.26:2K-64) is amended to read as follows:

C.26:2K-64 Rules, regulations.

2. The Commissioner of Health, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this act.

284. Section 1 of P.L.2003, c.269 (C.26:2M-7.2) is amended to read as follows:

C.26:2M-7.2 Training for long-term care facility staff relative to Alzheimer’s Disease.

1. a. The Commissioner of Health shall establish a mandatory training program for long-term care facility staff, as described in subsection b. of this section, in the specialized care of patients who are diagnosed by a physician as having Alzheimer's disease or a related disorder. The training program shall include the causes and progression of Alzheimer's disease and related disorders and methods to deal with the specific problems encountered in the care of patients with Alzheimer's disease and related disorders, including, but not limited to: communicating with patients with Alzheimer's disease and related disorders; psychological, social and physical needs of patients with Alzheimer's disease and related disorders; and safety measures which need to be taken for a patient with Alzheimer's disease and related disorders.

b. A long-term care facility shall annually provide training, under the training program established pursuant to subsection a. of this section, to a certified nurse aide, licensed practical nurse, registered professional nurse, and other health care professionals, as appropriate, who provide direct care to a patient in the facility who is diagnosed as having Alzheimer's disease or a related disorder.

285. Section 2 of P.L.1988, c.114 (C.26:2M-10) is amended to read as follows:

C.26:2M-10 Definitions.

2. As used in this act:

a. "Adult day care" means a community-based group program designed to meet the needs of functionally or cognitively impaired adults through an individual plan of care structured to provide a variety of health, social, and related support services in a protective setting during any part of a day but less than 24 hours.

b. "Alzheimer's Disease and related disorders" means forms of dementia characterized by a general loss of intellectual abilities of sufficient severity to interfere with social or occupational functioning.

c. "Care needs or behavioral problems" means the manifestations of dementia which may include, but need not be limited to, progressive memory loss, confusion, inability to communicate, extreme personality change, and eventual inability to perform the most basic tasks.

d. "Commissioner" means the Commissioner of Human Services.

e. "Department" means the Department of Human Services.

f. "Grantee" means a public agency, private for profit agency, or private nonprofit agency selected by the department to establish an adult day care program for participants pursuant to this act.

g. "Participant" means an individual with Alzheimer's disease or a related disorder, particularly those in the moderate to severe stages. To be eligible for services, a participant shall have documentation from a physician that the participant has Alzheimer's disease or a related disorder.

286. Section 2 of P.L.2011, c.76 (C.26:2M-17) is amended to read as follows:

C.26:2M-17 New Jersey Alzheimer’s Disease Study Commission.

2. a. There is established the New Jersey Alzheimer's Disease Study Commission in the Department of Human Services.

b. The commission shall consist of 15 members as follows:

(1) the Commissioners of Health and Human Services, or their designees, who shall serve ex officio;

(2) two members of the Senate, to be appointed by the President of the Senate, who shall not be of the same political party;

(3) two members of the General Assembly, to be appointed by the Speaker of the General Assembly, who shall not be of the same political party; and

(4) nine members appointed by the Governor, as follows: two persons recommended by the Alzheimer's Association, one of whom shall be a representative of the Greater New Jersey Chapter and one of whom shall be a representative of the Alzheimer's Association Delaware Valley Chapter; three health care professionals who are currently involved in the provision of direct services, one of whom shall be a representative of an agency that provides home care services to persons with dementia, one of whom shall be a representative of an assisted living facility that provides specialized services to persons with dementia, and one of whom shall be a representative of a licensed nursing home that provides specialized services to persons with dementia; one representative from the clergy who has experience providing emotional and spiritual care and support for persons with Alzheimer's disease and their families; two persons who by reason of family relationship or legal guardianship bear or have borne responsibility in caring for a person with Alzheimer's disease; and one attorney who is currently licensed and practicing in New Jersey, has expertise in legal and financial planning and elder care issues, and has extensive community-based experience working with persons with Alzheimer's disease and their families.

c. Vacancies in the membership of the commission shall be filled in the same manner provided for the original appointments.

d. The commission shall organize as soon as practicable following the appointment of its members and shall select a chairperson from among the members. The chairperson shall appoint a secretary who need not be a member of the commission.

e. Members of the commission shall serve without compensation, but shall be reimbursed for necessary expenses incurred in the performance of their duties as members of the commission, within the limits of funds appropriated or otherwise made available to the commission for its purposes.

f. The commission shall be entitled to call to its assistance and avail itself of the services of the employees of any State, county, or municipal department, board, bureau, commission, or agency as it may require and as may be available to it for its purposes.

g. The Department of Human Services shall provide staff support to the commission, as necessary.

287. Section 2 of P.L.2003, c.257 (C.26:2N-9) is amended to read as follows:

C.26:2N-9 Administration of antibody titer prior to second dose of MMR vaccine.

2. a. Prior to administering a second dose of the measles-mumps-rubella (MMR) vaccine to a child, a health care provider may give the child's parent or guardian the option of consenting to the administration of an antibody titer to determine whether or not the child has already developed immunity to MMR in response to a previously administered dose of the vaccine and would not require the second dose.

b. Documented laboratory evidence of immunity from MMR shall exempt a child from further vaccination for MMR, as may be required pursuant to Department of Health regulations.

288. Section 3 of P.L.2003, c.257 (C.26:2N-10) is amended to read as follows:

C.26:2N-10 Pamphlet explaining nature, purpose of MMR vaccine and anti-body titer.

3. The Commissioner of Health shall prepare and make available to all health care providers in the State a pamphlet that explains the nature and purpose of the MMR vaccine and the antibody titer used to determine immunity pursuant to section 2 of this act.

The commissioner shall send a copy of the pamphlet to every licensed health care provider in the State who administers the MMR vaccine, with a cover letter advising the health care provider that the pamphlet was prepared in accordance with the requirements of P.L.2003, c. 257 (C.26:2N-8 et seq.), known as "Holly's Law," and how the health care provider can obtain additional copies of the pamphlet from the Department of Health.

289. Section 4 of P.L.2003, c.257 (C.26:2N-11) is amended to read as follows:

C.26:2N-11 Rules, regulations.

4. The Commissioner of Health shall adopt rules and regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), necessary to carry out the provisions of this act.

290. Section 2 of P.L.1993, c.288 (C.26:2Q-2) is amended to read as follows:

C.26:2Q-2 Definitions.

2. As used in sections 1 through 12 of P.L.1993, c.288 (C.26:2Q-1 through C.26:2Q-12):

"Commissioner" means the Commissioner of Health.

"Department" means the Department of Health.

"Interim controls" means a set of measures designed to reduce temporarily human exposure or likely exposure to lead-based paint hazards, including specialized cleaning, repairs, maintenance, painting, temporary containment, ongoing monitoring of lead-based paint hazards or potential hazards, and the establishment and operation of management and resident education programs, or as the term is defined under 42 U.S.C.s.4851b.

"Lead abatement" means a set of measures designed to permanently eliminate lead-based paint hazards in accordance with standards established by the Commissioner of Community

Affairs in compliance with standards promulgated by the appropriate federal agencies. Such term includes:

a. the removal of lead-based paint and lead-contaminated dust, the permanent containment or encapsulation of lead-based paint, the replacement of lead-painted surfaces or fixtures, and the removal or covering of lead contaminated soil; and

b. all preparation, cleanup, disposal, and post-abatement clearance testing activities associated with such measures.

"Lead evaluation" means a surface-by-surface investigation to determine the presence of lead-based paint and the provision of a report explaining the results of the investigation.

"Lead hazard control work" means work to make housing lead-safe, or to mitigate, through the use of interim controls as permitted under federal law and as defined in 42 U.S.C.s.4851b, or to eliminate permanently lead-based paint hazards by abatement on a premises by a person certified to perform lead abatement work pursuant to sections 1 through 12 of P.L.1993, c.288 (C.26:2Q-1 et seq.) and sections 14 through 24 of P.L.1993, c.288 (C.52:27D-427 et seq.).

"Lead-based paint" means paint or other surface coating material that contains lead in excess of 1.0 milligrams per centimeter squared or in excess of 0.5% by weight, or such other level as may be established by federal law.

"Lead-based paint hazard" means any condition that causes exposure to lead from lead-contaminated dust or soil or lead-contaminated paint that is deteriorated or present in surfaces, that would result in adverse human health effects.

"Lead-based paint hazard inspection" means an inspection of residential housing and the structure's interior common areas and exterior surface for the presence of lead-based paint hazards.

"Lead safe maintenance work" means those maintenance activities which are necessary to maintain surfaces in a lead safe condition and to prevent lead-based paint hazards from occurring or reoccurring.

"Surface" means an area such as an interior or exterior wall, ceiling, floor, door, door frame, window sill, window frame, porch, stair, handrail and spindle, or other abradable surface, soil, furniture, a carpet, a radiator or a water pipe.

291. Section 2 of P.L.1997, c.191 (C.26:2R-2) is amended to read as follows:

C.26:2R-2 Definitions relative to “Osteoporosis Prevention and Education Program Act.”

2. As used in this act:

"Commissioner" means the Commissioner of Human Services.

"Council" means the Interagency Council on Osteoporosis established pursuant to this act.

"Department" means the Department of Human Services.

"Program" means the osteoporosis prevention and education program established pursuant to this act.

292. Section 3 of P.L.1997, c.191 (C.26:2R-3) is amended to read as follows:

C.26:2R-3 Establishment of osteoporosis prevention and education program.

3. a. The Commissioner of Human Services shall establish an osteoporosis prevention and education program in the Department of Human Services. The purpose of the program is to promote: public awareness of the causes of osteoporosis; options for prevention; the value of early detection; and possible treatments, including the benefits and risks of those treatments.

The department may accept, for that purpose, any special grant of money, services, or property from the federal government or any of its agencies, or from any foundation, organization, or medical school.

b. The program shall include the following:

(1) Development of a public education and outreach campaign to promote osteoporosis prevention and education, including, but not limited to, the following subjects:

(a) The cause and nature of the disease;

(b) Risk factors;

(c) The role of hysterectomy;

(d) Prevention of osteoporosis, including nutrition, diet, and physical exercise;

(e) Diagnostic procedures and appropriate indications for their use;

(f) Hormone replacement, including the benefits and risks;

(g) Environmental safety and injury prevention; and

(h) Availability of osteoporosis diagnostic treatment services in the community.

(2) Development of educational materials to be made available for consumers, particularly targeted to high-risk groups, through local boards of health, physicians, other health care providers, including, but not limited to, health maintenance organizations, hospitals, and clinics, and women's organizations.

(3) Development of professional education programs for health care providers to assist them in understanding research findings and the subjects set forth in paragraph (1) of this subsection.

(4) Development and maintenance of a list of current providers of specialized services for the prevention and treatment of osteoporosis. Dissemination of the list shall be accompanied by a description of diagnostic procedures, appropriate indications for their use, and a cautionary statement about the current status of osteoporosis research, prevention, and treatment. The statement shall also indicate that the department does not license, certify, or in any other way approve osteoporosis programs or centers in this State.

293. Section 1 of P.L.1999, c.330 (C.26:2R-3.1) is amended to read as follows:

C.26:2R-3.1 Preparation, distribution of informational pamphlet on osteoporosis.

1. The Department of Human Services shall prepare an informational pamphlet which describes the causes and nature of osteoporosis as well as methods which may be used to prevent and treat osteoporosis, including nutrition, diet, physical exercise, and medications. The department shall make a supply of these pamphlets available to all pharmacies registered with the New Jersey Board of Pharmacy for distribution to the public.

294. Section 2 of P.L.1997, c.192 (C.26:2S-2) is amended to read as follows:

C.26:2S-2 Definitions relative to health care quality.

2. As used in sections 2 through 19 of this act:

"Behavioral health care services" means procedures or services rendered by a health care provider for the treatment of mental illness, emotional disorders, or drug or alcohol abuse. "Behavioral health care services" does not include: any quality assurance or utilization management activities or treatment plan reviews conducted by a carrier, or a private entity on behalf of the carrier, pertaining to these services, whether administrative or clinical in nature; or any other administrative functions, including, but not limited to, accounting and financial reporting, billing and collection, data processing, debt or debt service, legal services, promotion and marketing, or provider credentialing.

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation, or health maintenance organization authorized to issue health benefits plans in this State.

"Commissioner" means the Commissioner of Banking and Insurance.

"Contract holder" means an employer or organization that purchases a contract for services.

"Covered person" means a person on whose behalf a carrier offering the plan is obligated to pay benefits or provide services pursuant to the health benefits plan.

"Covered service" means a health care service provided to a covered person under a health benefits plan for which the carrier is obligated to pay benefits or provide services.

"Department" means the Department of Banking and Insurance.

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. Health benefits plan includes, but is not limited to, Medicare supplement coverage and risk contracts to the extent not otherwise prohibited by federal law. For the purposes of this act, health benefits plan shall not include the following plans, policies, or contracts: accident only, credit, disability, long-term care, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), or hospital confinement indemnity coverage.

"Health care provider" means an individual or entity which, acting within the scope of its licensure or certification, provides a covered service defined by the health benefits plan. Health care provider includes, but is not limited to, a physician and other health care professionals licensed pursuant to Title 45 of the Revised Statutes, and a hospital and other health care facilities licensed pursuant to Title 26 of the Revised Statutes.

"Independent utilization review organization" means an independent entity comprised of physicians and other health care professionals who are representative of the active practitioners in the area in which the organization will operate and which is under contract with the department to provide medical necessity or appropriateness of services appeal reviews pursuant to this act.

"Managed behavioral health care organization" means an entity, other than a carrier, which contracts with a carrier to provide, undertake to arrange, or administer behavioral health care services to covered persons through health care providers employed by the managed behavioral health care organization or otherwise make behavioral health care services available to covered persons through contracts with health care providers. "Managed b services on a discounted fee-for-service basis.

"Managed care plan" means a health benefits plan that integrates the financing and delivery of appropriate health care services to covered persons by arrangements with participating providers, who are selected to participate on the basis of explicit standards, to furnish a comprehensive set of health care services and financial incentives for covered persons to use the participating providers and procedures provided for in the plan.

"Subscriber" means, in the case of a group contract, a person whose employment or other status, except family status, is the basis for eligibility for enrollment by the carrier or, in the case of an individual contract, the person in whose name the contract is issued.

"Utilization management" means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines, in order to recommend or determine whether, or to what extent, a health care service given or proposed to be given to a covered person should or will be reimbursed,

covered, paid for, or otherwise provided under the health benefits plan. The system may include: preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory care procedures, and retrospective review.

295. Section 1 of P.L.2001, c.88 (C.26:2S-7.1) is amended to read as follows:

C.26:2S-7.1 Universal application for credentialing physicians for a carrier’s provider network.

1. The Commissioner of Banking and Insurance, in consultation with the New Jersey Association of Health Plans, the Health Insurance Association of America, the Medical Society of New Jersey, the New Jersey Hospital Association, and such other representatives of managed care plans as the commissioner deems appropriate, shall adopt by regulation, a universal physician application for participation form for use by carriers which offer managed care plans for the purpose of credentialing physicians who seek to participate in a carrier's provider network and for the purpose of credentialing physicians who are employed by hospitals or other health care facilities which seek to participate in a carrier's provider network.

The commissioner, in consultation with the New Jersey Association of Health Plans, the Health Insurance Association of America, the Medical Society of New Jersey, the New Jersey Hospital Association and such other representatives of managed care plans as the commissioner deems appropriate, shall also adopt by regulation a form for renewal of credentialing, which shall be an abbreviated version of the universal application form. The renewal form shall be designed to enable a physician to indicate changes in the information provided in the application form.

The commissioner shall revise the universal application and renewal forms, as necessary, to conform with industry-wide, national standards for credentialing.

In developing the forms, the commissioner shall consult with the Commissioner of Human Services to ensure that the credentialing requirements for participation in the Medicaid program, established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), and the NJ FamilyCare Program established pursuant to P.L.2005, c.156 (C.30:4J-8 et al.) are adequately reflected on the application and renewal forms.

296. Section 3 of P.L.2001, c.88 (C.26:2S-7.3) is amended to read as follows:

C.26:2S-7.3 Rules, regulations.

3. The Commissioner of Banking and Insurance shall adopt regulations within 180 days of the date of enactment of this act, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), necessary to carry out the purposes of this act.

297. Section 1 of P.L.2000, c.121 (C.26:2S-10.1) is amended to read as follows:

C.26:2S-10.1 Home treatment for bleeding episodes associated with hemophilia, required coverage.

1. A carrier which offers a managed care plan that provides benefits or health care services, as applicable, for the home treatment of bleeding episodes associated with hemophilia, including the purchase of blood products and blood infusion equipment, shall comply with the provisions of this section.

a. For the purpose of providing home treatment services for bleeding episodes associated with hemophilia, the carrier shall be required to contract with, and exclusively use, providers that comply with standards adopted by regulation of the Department of Banking and Insurance in consultation with the Hemophilia Association of New Jersey. At a minimum, the standards shall require that each provider:

(1) provide services pursuant to a prescription from the covered person's attending physician and not make any substitutions of blood products without prior approval of the attending physician;

(2) provide all brands of clotting factor products in low, medium and high-assay range levels to execute treatment regimens as prescribed by a covered person's attending physician, and all needed ancillary supplies for the treatment or prevention of bleeding episodes, including, but not limited to, needles, syringes, and cold compression packs;

(3) have the ability to deliver prescribed blood products, medications, and nursing services within three hours after receipt of a prescription for an emergent situation, and maintain 24-hour on-call service to accommodate this requirement;

(4) demonstrate experience with and knowledge of bleeding disorders and the management thereof;

(5) demonstrate the ability for appropriate and necessary record keeping and documentation, including the ability to expedite product recall or notification systems and the ability to assist covered persons in obtaining third party reimbursement;

(6) provide for proper removal and disposal of hazardous waste pursuant to State and federal law;

(7) provide covered persons with a written copy of the agency's policy regarding discontinuation of services related to loss of health benefits plan coverage or inability to pay; and

(8) provide covered persons, upon request, with information about the expected costs for medications and services provided by the agency that are not otherwise covered by the covered person's health benefits plan.

b. The Department of Banking and Insurance shall compile a list of providers who meet the minimum standards established pursuant to this section and shall make the list available to carriers and covered persons, upon request.

c. As used in this section: "blood product" includes, but is not limited to, Factor VIII, Factor IX and cryoprecipitate; and "blood infusion equipment" includes, but is not limited to, syringes and needles.

298. Section 11 of P.L.2000, c.121 (C.26:2S-10.3) is amended to read as follows:

C.26:2S-10.3 Regulations by department.

11. The Department of Banking and Insurance, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt regulations to carry out the provisions of sections 1 and 2 of this act.

299. Section 1 of P.L.2011, c.190 (C.26:2S-14.1) is amended to read as follows:

C.26:2S-14.1 General hospital to provide information concerning the Independent Health Care Appeals Program.

1. A general hospital licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall be required, as prescribed by regulation of the Commissioner of Health, to:

(1) post, in a conspicuous place in each of its waiting rooms for members of the general public, a notice, as prescribed pursuant to section 3 of P.L.2011, c.190 (C.26:2S-14.2), which provides information about the operation of, and how to apply for, the Independent Health Care Appeals Program established pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11); and

(2) ensure that appropriate hospital staff, including direct patient care providers, staff that are concerned with billing for hospital services or provide financial counseling to patients, and staff otherwise engaged in providing patient advocacy or patient relations services, are made aware of the program and are able to provide information to patients and their family members, or other persons on the patient's behalf, about how to contact the program.

300. Section 3 of P.L.2011, c.190 (C.26:2S-14.2) is amended to read as follows:

C.26:2S-14.2 Size, content, format of notice.

3. The Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and the State Board of Medical Examiners, shall prescribe the size, content, and format of the notice about the Independent Health Care Appeals Program to be posted in general hospitals pursuant to section 1 of P.L.2011, c.190 (C.26:2S-14.1) and in physicians' medical offices pursuant to section 2 of P.L.2011, c.190 (C.45:9-22.26), and shall make the notice available to general hospitals and physicians, and to members of the general public, by posting it on the Internet website of the Department of Banking and Insurance.

301. Section 4 of P.L.2011, c.190 (C.26:2S-14.3) is amended to read as follows:

C.26:2S-14.3 Rules, regulations.

4. The Commissioner of Health and the State Board of Medical Examiners, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) and in consultation with each other and the Commissioner of Banking and Insurance, shall adopt rules and regulations to effectuate the purposes of this act.

302. Section 2 of P.L.2001, c.14 (C.26:2S-20) is amended to read as follows:

C.26:2S-20 Definitions relative to Managed Health Care Consumer Assistance Program.

2. As used in this act:

"Carrier" means a carrier as defined in section 2 of P.L.1997, c.192 (C.26:2S-2).

"Commissioner" means the Commissioner of Banking and Insurance.

"Department" means the Department of Banking and Insurance.

"Managed care plan" means a managed care plan as defined in section 2 of P.L.1997, c.192 (C.26:2S-2).

"Medicaid" means the Medicaid program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

"Medicare" means the federal Medicare program established pursuant to the federal Social Security Act, Pub.L.89-97 (42 U.S.C. s.1395 et seq.).

"NJ FamilyCare" means the FamilyCare Health Coverage Program established pursuant to P.L.2005, c.156 (C.30:4J-8 et al.).

"Program" means the Managed Health Care Consumer Assistance Program established pursuant to this act.

303. Section 3 of P.L.2001, c.14 (C.26:2S-21) is amended to read as follows:

C.26:2S-21 Managed Health Care Consumer Assistance Program.

3. a. There is established the Managed Health Care Consumer Assistance Program in the Department of Banking and Insurance. The commissioner shall make agreements to operate the program as necessary, in consultation with the Commissioner of Human Services, to assure that citizens have reasonable access to services in all regions of the State.

b. The program shall:

(1) create and provide educational materials and training to consumers regarding their rights and responsibilities as enrollees in managed care plans, including materials and training specific to Medicaid, NJ FamilyCare, Medicare, and commercial managed care plans;

(2) assist and educate individual enrollees about the functions of the State and federal agencies that regulate managed care products, assist and educate enrollees about the various complaint, grievance, and appeal processes, including State fair hearings, provide assistance to individuals in determining which process is most appropriate for the individual to pursue when necessary, maintain and provide to individual enrollees the forms that may be necessary to submit a complaint, grievance or appeal with the State or federal agencies, and provide assistance to individual enrollees in completion of the forms, if necessary;

(3) maintain and provide information to individuals upon request about advocacy groups, including legal services programs Statewide and in each county that may be available to assist individuals, and maintain lists of State and Congressional representatives and the means by which to contact representatives, for distribution upon request;

(4) maintain a toll-free telephone number for consumers to call for information and assistance. The number shall be accessible to the deaf and hard of hearing, and staff or translation services shall be available to assist non-English proficient individuals who are members of language groups that meet population thresholds established by the department;

(5) ensure that individuals have timely access to the services of, and receive timely responses from, the program;

(6) provide feedback to managed care plans, beneficiary advisory groups and employers regarding enrollees' concerns and problems;

(7) provide nonpartisan information about federal and State activities relative to managed care, and provide assistance to individuals in obtaining copies of pending legislation, statutes, and regulations; and

(8) develop and maintain a data base monitoring the degree of each type of service provided by the program to individual enrollees, the types of concerns and complaints brought to the program and the entities about which complaints and concerns are brought.

c. In order to meet its objectives, the program shall have access to:

(1) the medical and other records of an individual enrollee maintained by a managed care plan, upon the specific written authorization of the enrollee or his legal representative;

(2) the administrative records, policies, and documents of managed care plans to which individuals or the general public have access; and

(3) all licensing, certification, and data reporting records maintained by the State or reported to the federal government by the State that are not proprietary information or otherwise protected by law, with copies thereof to be supplied to the program by the State upon the request of the program.

d. The program shall take such actions as are necessary to protect the identity and confidentiality of any complainant or other individual with respect to whom the program

maintains files or records. Any medical or personally identifying information received or in the possession of the program shall be considered confidential and shall be used only by the department, the program and such other agencies as the commissioner designates and shall not be subject to public access, inspection or copying under P.L.1963, c.73 (C.47:1A-1 et seq.) or the common law concerning access to public records. This subsection shall not be construed to limit the ability of the program to compile and report non-identifying data pursuant to paragraph (8) of subsection b. of this section.

e. The program shall seek to coordinate its activities with consumer advocacy organizations, legal assistance providers serving low-income and other vulnerable health care consumers, managed care and health insurance counseling assistance programs, and relevant federal and State agencies to assure that the information and assistance provided by the program are current and accurate.

f. Until such time as the program is developed, the commissioner shall make agreements with two independent, private nonprofit consumer advocacy organizations, which shall be the Community Health Law Project and New Jersey Protection and Advocacy, Inc. to operate the program on an interim basis. The interim program shall be in effect for one year from the effective date of this act. Any appropriation in this act for the program may be allocated for the interim program.

304. Section 8 of P.L.2001, c.14 (C.26:2S-25) is amended to read as follows:

C.26:2S-25 Rules, regulations.

8. The Commissioner of Banking and Insurance, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this act.

305. Section 1 of P.L.1998, c.116 (C.26:2T-1) is amended to read as follows:

C.26:2T-1 Newly diagnosed Hepatitis C cases; information, reports.

1. The Commissioner of Health shall provide for the inclusion of all newly diagnosed cases of hepatitis C among those communicable diseases which are required to be reported by health care providers or other designated persons to the Department of Health pursuant to N.J.A.C.8:57-1.4 and 8:57-1.5. The commissioner shall require that such information be reported directly to the department, rather than to local health departments, as the commissioner determines necessary to assist the department to develop hepatitis C disease control measures, and shall revise these requirements as necessary to reflect technological advances which improve the ability to diagnose and treat the disease.

306. Section 2 of P.L.1998, c.116 (C.26:2T-2) is amended to read as follows:

C.26:2T-2 Written guidance for screening.

2. The Commissioner of Health shall provide written guidance regarding screening for the hepatitis C virus to licensed physicians and public health officers which reflects current and accepted standards of medical and public health practice, consistent with the recommendations of the federal Centers for Disease Control and Prevention, and encourages appropriate screening and diagnosis of all persons at high risk for hepatitis C infection as defined by the federal centers, including, but not limited to:

(1) veterans of the United States armed forces;

(2) women who underwent a caesarian section or a premature delivery prior to 1990;

(3) persons who received blood or blood products prior to 1992;

(4) persons who received an organ or tissue transplant prior to 1990;

(5) persons who have received invasive cosmetic procedures, including body piercing and tattooing;

(6) persons who have a history of multiple sexually transmitted diseases or multiple partners;

(7) persons with a history of intravenous drug use; and

(8) such other categories of persons at high risk for hepatitis C infection as may be determined by the commissioner.

307. Section 3 of P.L.1998, c.116 (C.26:2T-3) is amended to read as follows:

C.26:2T-3 Provision of information materials to physicians, public health officers.

3. The Commissioner of Health shall make available to licensed physicians and public health officers, in printed and electronic format, hepatitis C education and prevention information materials which reflect the recommendations of the federal Centers for Disease Control and Prevention and other relevant entities, including, but not limited to, the American Liver Foundation, for distribution to persons at high risk for hepatitis C infection as described in section 2 of this act.

308. Section 4 of P.L.1998, c.116 (C.26:2T-4) is amended to read as follows:

C.26:2T-4 Rules, regulations.

4. The Commissioner of Health, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this act.

309. Section 2 of P.L.2001, c.357 (C.26:2T-6) is amended to read as follows:

C.26:2T-6 Definitions relative to hepatitis C.

2. As used in this act:

"Commissioner" means the Commissioner of Health.

"HCV" means the hepatitis C virus.

"Program" means the hepatitis C education, prevention, and screening program established pursuant to this act.

310. Section 3 of P.L.2001, c.357 (C.26:2T-7) is amended to read as follows:

C.26:2T-7 Hepatitis C education, prevention and screening program.

3. In consultation with the hepatitis C advisory board established pursuant to section 4 of this act, the Commissioner of Health shall establish a hepatitis C education, prevention, and screening program that includes, but is not limited to, measures directed to physicians and other health care workers, police officers, correctional officers, firefighters, emergency services personnel, employees of the State's developmental centers, and the general public. The program shall be established in accordance with accepted public health practice and recommendations of the federal Centers for Disease Control and Prevention, the Surgeon General of the United States, the American Association for the Study of Liver Diseases, the

National Institutes of Health and the American Liver Foundation and within the limits of resources available for the purposes thereof.

a. For the purposes of this program, the commissioner shall develop and implement the following:

(1) public education and outreach to raise awareness of hepatitis C among persons at high risk for hepatitis C as described in section 2 of P.L.1998, c.116 (C.26:2T-2), which includes police officers, firefighters, persons employed by correctional facilities, emergency response personnel, and other high-risk groups, including, but not limited to, health care professionals and persons employed in primary care settings or health care facilities, which shall include, at a minimum, information on risk factors, the value of early detection and the options available for treating hepatitis C;

(2) measures to promote public awareness about the availability of hepatitis C screening, prevention and treatment services among persons at high risk for hepatitis C as determined by the commissioner based upon data provided by the federal Centers for Disease Control and Prevention, the Surgeon General of the United States, the American Association for the Study of Liver Diseases, the National Institutes of Health and the American Liver Foundation, and any other nationally recognized liver societies;

(3) educational activities for health care professionals in regard to the epidemiology, natural history, detection, and treatment of hepatitis C, which shall include information about coinfection with HCV and HIV and the implications of coinfection for HIV or AIDS treatment;

(4) educational and informational measures targeted at specific groups, including, but not limited to, activities designed to educate youth about the long-term consequences of infection with HCV;

(5) measures to prevent further transmission of HCV and to prevent onset of chronic liver disease caused by hepatitis C through outreach to detect and treat chronic HCV infection; and

(6) a collaborative effort with the Department of Corrections to develop screening services to identify inmates at risk for hepatitis C upon admission, and to provide education and counseling about treatment options to reduce the potential health risk to the community from these persons.

b. The commissioner shall evaluate existing hepatitis C support services in the community and assess the need for improving the quality and accessibility of these services.

c. The commissioner shall seek to establish public-private partnerships to promote outreach and increase awareness for the purposes of this act among employers, organized labor, health care providers, health insurers, and community-based organizations, and coalitions.

d. The commissioner shall take such actions as are reasonably necessary to ensure that the program established pursuant to this act provides clear, complete, and accurate hepatitis C education, information, and referral services in a multiculturally competent manner that is designed to provide appropriate linkages to health care services for persons in need thereof.

e. The commissioner shall seek to secure the use of such funds or other resources from private nonprofit or for-profit sources or the federal government to effectuate the purposes of this act as may be available therefor, which shall be used to supplement and shall not supplant State funds used to carry out the purposes of this act.

f. The commissioner shall seek, to the maximum extent practicable, to coordinate the activities of the program, as applicable, with services provided separately to specific populations, including, but not limited to, veterans of the United States armed forces, persons

participating in private or public drug abuse or alcohol treatment programs, and persons with HIV.

311. Section 1 of P.L.1999, c.366 (C.26:2U-1) is amended to read as follows:

C.26:2U-1 Chronic Fatigue Syndrome resources network established.

1. The Commissioner of Health shall establish a Statewide network of resources to provide the following services to persons with chronic fatigue syndrome, also known as chronic fatigue immune dysfunction syndrome: physician training and patient education programs, and a public awareness campaign.

312. Section 2 of P.L.1999, c.66 (C.26:2U-2) is amended to read as follows:

C.26:2U-2 Informational manual; preparation, availability.

2. The Department of Health, in consultation with the New Jersey Chronic Fatigue Syndrome Association, Inc., the Academy of Medicine of New Jersey, and the University of Medicine and Dentistry of New Jersey, shall prepare and make available to all health care providers in the State, upon request, a manual which provides information about the clinical significance, diagnosis and treatment of chronic fatigue syndrome. The manual may contain any other information which the Commissioner of Health deems necessary and may be revised by the department whenever new information about chronic fatigue syndrome becomes available. The department shall publicize and make available the manual to the maximum extent possible.

313. Section 3 of P.L.1999, c.66 (C.26:2U-3) is amended to read as follows:

C.26:2U-3 Rules, regulations.

3. The Commissioner of Health, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this act.

314. Section 3 of P.L.1999, c.72 (C.26:2V-3) is amended to read as follows:

C.26:2V-3 Definitions relative to arthritis quality of life initiative.

3. As used in this act:

"Commissioner" means the Commissioner of Human Services.

"Department" means the Department of Human Services.

"Initiative" means the arthritis quality of life initiative established pursuant to this act.

"Arthritis" means any of the more than 130 types of arthritis and rheumatic diseases.

315. Section 5 of P.L.1999, c.72 (C.26:2V-5) is amended to read as follows:

C.26:2V-5 Advisory Council on Arthritis.

5. There is established an Advisory Council on Arthritis in the department to advise the commissioner on the development and implementation of the initiative. The council shall include: two members of the Senate, to be appointed by the President of the Senate, who shall not be of the same political party; two members of the General Assembly, to be appointed by the Speaker of the General Assembly, who shall not be of the same political

party; the Senior Assistant Commissioner, Public Health Prevention and Protection and the Director of the Division of Aging Services in the Department of Human Services; the Director of the Division on Women in the Department of Children and Families, and a member of the Interagency Council on Osteoporosis, as ex officio members; and 15 public members to be appointed by the commissioner who may include representatives of persons with arthritis, arthritis health organizations, public health educators, experts in arthritis research, prevention, and treatment and health care strategic planning, and health care providers including physicians and nurses. The public members of the council shall serve without compensation and may be reimbursed for any expenses incurred by them in the performance of their duties.

Legislative members shall serve during their terms of office. Public members shall serve for a term of three years from the date of their appointment and until their successors are appointed and qualified; except that of the first appointments made: five shall be for a term of one year, five for two years, and five for three years.

Vacancies shall be filled in the same manner as the original appointments were made.

The advisory council shall organize as soon as may be practicable after the appointment of its members and shall select a chairman from among its members and a secretary who need not be a member of the council.

316. Section 1 of P.L.1999, c.361 (C.26:2W-1) is amended to read as follows:

C.26:2W-1 Cancer Awareness Education and Research Program.

1. The Commissioner of Health shall establish a Cancer Awareness, Education and Research Program to provide the following: support for cancer medical research; physician education and awareness; and patient education and screening services, particularly for members of minority groups.

317. Section 2 of P.L.1999, c.361 (C.26:2W-2) is amended to read as follows:

C.26:2W-2 Rules, regulations.

2. The Commissioner of Health, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this act.

318. Section 1 of P.L.2001, c.196 (C.26:2W-3) is amended to read as follows:

C.26:2W-3 Breast cancer public awareness campaign.

1. a. The Commissioner of Health shall establish a breast cancer public awareness campaign, as a component of the Cancer Awareness, Education and Research Program established pursuant to P.L.1999, c.361 (C.26:2W-1 et seq.), to promote awareness and outreach throughout the State in regard to breast cancer screening services. The public awareness campaign shall be established in accordance with accepted public health practice and recommendations of the federal Centers for Disease Control and Prevention, and within the limits of funds appropriated pursuant to this act and any other resources available for the purposes thereof.

b. For the purposes of this act, the commissioner shall, at a minimum:

(1) develop and implement a Statewide plan to promote public awareness among members of the public, community-based organizations, and health care providers, and encourage more referrals to breast cancer screening services;

(2) distribute promotional incentives for free or discounted items to be provided to women by local retail businesses that will encourage them to undergo mammography and become educated about breast cancer;

(3) provide for the use of public service announcements and printed materials in both English and Spanish;

(4) seek to disseminate information through a variety of entities, including, but not limited to, primary care sites, health care facilities, local health departments and clinics, county offices on the aging, pharmacies, libraries, YWCAs and YMCAs, senior centers, houses of worship, programs that serve victims of domestic violence, other community-based outreach programs and organizations, and the Internet;

(5) consult and seek to collaborate with at least the following entities to effectuate the public awareness campaign: the New Jersey Primary Care Association, the American Cancer Society, the Medical Society of New Jersey, the New Jersey Hospital Association, Planned Parenthood, AARP, the New Jersey Advisory Commission on the Status of Women, the New Jersey State Commission on Cancer Research, The Cancer Institute of New Jersey, the New Jersey Pharmacists Association, the Health Research and Educational Trust of New Jersey, and The Peer Review Organization of New Jersey, Inc.;

(6) establish and publicize the availability of a toll-free telephone number operated by the Department of Health to provide information and referral to members of the general public about breast screening services, with particular emphasis on facilitating free and reduced charge screening for low-income and uninsured women; and

(7) seek to secure the use of such funds or other resources from private nonprofit or for-profit sources or the federal government to effectuate the purposes of this act as may be available therefor, which shall be used to supplement and shall not supplant State funds used to carry out the purposes of this act.

319. Section 1 of P.L.2000, c.25 (C.26:2X-1) is amended to read as follows:

C.26:2X-1 Public awareness campaign relative to meningitis.

1. The Commissioner of Health shall establish a public awareness campaign to inform the general public about the clinical significance of meningitis and its public health implications, including its causes and the most effective means of prevention and treatment.

320. Section 3 of P.L.2000, c.25 (C.26:2X-2) is amended to read as follows:

C.26:2X-2 Rules, regulations.

3. The Commissioner of Health, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this act.

321. Section 1 of P.L.2006, c.64 (C.26:2X-3) is amended to read as follows:

C.26:2X-3 Development of educational fact sheet concerning meningococcal meningitis.

1. The Commissioner of Health, in consultation with the Commissioner of Education, shall develop an educational fact sheet concerning meningococcal meningitis for distribution

to parents or guardians of students in grades 6 through 12, pursuant to section 2 of P.L.2006, c.64 (C.18A:40-21.2). The educational fact sheet shall include, but need not be limited to, the following information:

a. the causes, symptoms, and means of transmission of meningococcal meningitis;

b. the availability, effectiveness, and risks of the meningitis vaccine; and

c. where additional information concerning the disease can be obtained.

322. Section 2 of P.L.2001, c.304 (C.26:2Y-2) is amended to read as follows:

C.26:2Y-2 Findings, declarations relative to adult family care.

2. The Legislature finds and declares that:

a. In the absence of appropriate housing with supportive services, many elders or people with physical disabilities are often subject to inappropriate, premature, or overextended institutionalization. This results in the overutilization of costly services and the negative impact of the institutional environment on the individual's emotional and physical well-being. A need exists to fill this gap in the housing continuum between independent living and institutionalization for those elders and physically disabled citizens who are in need of shelter and services to remain in the community.

b. Adult family care has proven to be a successful and cost-effective means of fulfilling basic shelter and everyday service needs of elders and physically disabled adults, thereby enabling them to preserve their independence, choice and dignity in a secure environment.

c. Therefore, it is the policy of this State to promote the health, safety and welfare of its elderly and physically disabled citizens by encouraging the development of adult family care homes for elders and physically disabled adults and to provide for the licensing of caregivers and regulation of such adult family care homes by the Department of Health.

323. Section 3 of P.L.2001, c.304 (C.26:2Y-3) is amended to read as follows:

C.26:2Y-3 Definitions relative to adult family care.

3. As used in this act:

"Activities of daily living" or "ADL" means functions and tasks for self-care which are performed either independently or with supervision or assistance, which include, but are not limited to, mobility, transferring, walking, grooming, bathing, dressing and undressing, eating, and toileting.

"Adult family care" means a 24-hour per day living arrangement for persons who, because of age or physical disability, need assistance with activities of daily living, and for whom services designed to meet their individual needs are provided by licensed caregivers in approved adult family care homes.

"Adult family care caregiver" means a person licensed to provide care and services in the daily operation of an adult family care home, but does not include the owner or lessor of the building in which the adult family care home is situated unless the owner or lessor is also the provider of care and services in the adult family care home.

"Adult family care home" means a residence regulated by the department and housing no more than three clients, in which personal care and other supportive services are provided by an individual who has been licensed by the department as an adult family care caregiver. "Adult family care home" shall not include a rooming or boarding house used and operated under license of the Department of Community Affairs pursuant to P.L.1979, c.496 (C.55:13B-1 et seq.).

"Adult family care sponsor agency" means an entity licensed by the department to administer an adult family care program within a given area, which provides essential administrative and clerical support services to two or more caregivers, and which shall not be considered to be a health care facility as defined in section 2 of P.L.1971, c.136 (C.26:2H-2).

"Client" means an elder or person with physical disabilities enrolled in adult family care.

"Commissioner" means the Commissioner of Health.

"Department" means the Department of Health.

"Elder" means a person sixty years of age or older.

324. Section 13 of P.L.2001, c.304 (C.26:2Y-11) is amended to read as follows:

C.26:2Y-11 Rules, regulations.

13. The Commissioner of Health, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this act.

325. Section 2 of P.L.2005, c.274 (C.26:2MM-2) is amended to read as follows:

C.26:2MM-2 Definitions relative to elderly person suicide prevention.

2. As used in this act:

"Alcohol and drug counselor" means a person who is a certified alcohol and drug counselor or a licensed clinical alcohol and drug counselor pursuant to P.L.1997, c.331 (C.45:2D-1 et seq.).

"Attempted suicide" means destructive behavior intended by the actor to result in the actor's harm or death.

"Completed suicide" means a death that is known or reasonably suspected to have resulted from an intentional act of the deceased, regardless of whether it has been ruled a suicide by a medical examiner.

"Council" means the New Jersey Elderly Person Suicide Prevention Advisory Council established pursuant to section 3 of this act.

"Department" means the Department of Human Services.

"Elderly person" means a person 65 years of age and older.

"Licensed clinical social worker" means a person who holds a current, valid license issued pursuant to subsection a. of section 6 or subsection a. or d. of section 8 of P.L.1991, c.134 (C.45:15BB-1 et seq.).

326. Section 3 of P.L.2005, c.274 (C.26:2MM-3) is amended to read as follows:

C.26:2MM-3 New Jersey Elderly Person Suicide Prevention Advisory Council.

3. There is established in the Department of Human Services the New Jersey Elderly Person Suicide Prevention Advisory Council.

a. The purpose of the council shall be to examine existing needs of and services for elderly persons at risk of suicide and make recommendations to the department for suicide prevention and intervention strategies to help reduce the incidence of attempted and completed suicides among elderly persons.

b. The council shall consist of nine members as follows:

(1) the Commissioners of Health and Human Services and the chairman of the Community Mental Health Citizens Advisory Board established pursuant to P.L.1957, c.146 (C.30:9A-1 et seq.), or their designees, who shall serve ex officio;

(2) two public members appointed by the Governor, one of whom shall be a person with personal or family experience with suicide of an elderly person and one of whom shall be an alcohol and drug counselor;

(3) two public members appointed by the Speaker of the General Assembly, who are not members of the same political party, one of whom shall be a registered professional nurse and one of whom shall be a licensed clinical social worker; and

(4) two public members appointed by the President of the Senate, who are not members of the same political party, one of whom shall be a physician who has been specially trained in caring for elderly persons and has a certificate of added qualifications in geriatrics and one of whom shall be a geropsychiatrist.

c. The public members shall be appointed no later than 60 days after the enactment of this act.

d. The public members shall serve for a term of five years; but, of the members first appointed, two shall serve for a term of three years, two shall serve for a term of four years and two shall serve for a term of five years. Members are eligible for reappointment upon the expiration of their terms. Vacancies in the membership of the council shall be filled in the same manner provided for the original appointments.

e. The council shall organize as soon as practicable following the appointment of its members and shall select a chairperson and vice-chairperson from among the members. The chairperson shall appoint a secretary who need not be a member of the council.

f. The public members shall serve without compensation, but shall be reimbursed for necessary expenses incurred in the performance of their duties and within the limits of funds available to the council.

g. The council shall be entitled to call to its assistance and avail itself of the services of the employees of any State, county, or municipal department, board, bureau, commission, or agency as it may require and as may be available to it for its purposes.

h. The Department of Human Services shall provide staff support to the council.

327. Section 115 of P.L.2008, c.29 (C.26:2NN-1) is amended to read as follows:

C.26:2NN-1 “Law Enforcement Officer Crisis Intervention Services” telephone hotline.

115. a. The Department of Human Services shall maintain a toll-free information "Law Enforcement Officer Crisis Intervention Services" telephone hotline on a 24-hour basis.

The hotline shall receive and respond to calls from law enforcement officers and sheriff's officers who have been involved in any event or incident which has produced personal or job-related depression, anxiety, stress, or other psychological or emotional tension, trauma, or disorder for the officer and officers who have been wounded in the line of duty. The operators of the hotline shall seek to identify those officers who should be referred to further debriefing, and counseling services, and to provide such referrals. In the case of wounded officers, those services may include peer counseling, diffusing, debriefing, group therapy and individual therapy as part of a coordinated assistance program, to be known as the "Blue Heart Law Enforcement Assistance Program," designed and implemented by the University of Medicine and Dentistry of New Jersey's University Behavioral Healthcare Unit.

b. The operators of the hotline shall be trained by the Department of Human Services and, to the greatest extent possible, shall be persons, who by experience or education, are:

(1) familiar with post trauma disorders and the emotional and psychological tensions, depressions, and anxieties unique to law enforcement officers and sheriff's officers; or (2) trained to provide counseling services involving marriage and family life, substance abuse, personal stress management, and other emotional or psychological disorders or conditions which may be likely to adversely affect the personal and professional well-being of a law enforcement officer and a sheriff's officer.

c. To ensure the integrity of the telephone hotline and to encourage officers to utilize it, the commissioner shall provide for the confidentiality of the names of the officers calling, the information discussed by that officer and the operator, and any referrals for further debriefing or counseling; provided, however, the commissioner may, by rule and regulation, (1) establish guidelines providing for the tracking of any officer who exhibits a severe emotional or psychological disorder or condition which the operator handling the call reasonably believes might result in harm to the officer or others and (2) establish a confidential registry of wounded New Jersey law enforcement officers.

328. Section 16 of P.L.2008, c.39 (C.26:2NN-2) is amended to read as follows:

C.26:2NN-2 List of counseling resources available to law enforcement, sheriff’s officers.

116. The Commissioner of Human Services shall prepare a list of appropriately licensed or certified psychiatrists, psychologists, and social workers; other appropriately trained and qualified counselors; and experienced former law enforcement officers who are willing to accept referrals and to participate in the debriefing and counseling offered law enforcement officers and sheriff's officers under the provisions of sections 115 to 116 of P.L.2008, c.29 (C.26:2NN-1 to C.26:2NN-2).

329. Section 2 of P.L.2005, c.3 (C.26:3A2-36) is amended to read as follows:

C.26:3A2-36 Plan for standardization, coordination of hazardous materials emergency response programs.

2. a. The Department of Environmental Protection, with the concurrence of the Department of Health and the State Office of Emergency Management in the Division of State Police in the Department of Law and Public Safety, shall develop a comprehensive plan for the standardization and coordination of county hazardous material response programs to effectively address all incidents involving hazardous materials, including, but not limited to, chemical, biological, radiological, nuclear, or explosive incidents.

The plan shall include procedures for State, county, and local response to incidents involving hazardous materials, including, but not limited to, chemical, biological, radiological, nuclear, or explosive incidents, and planning, training, exercising, and equipment requirements designed to assure that local responders have the capacity, competency and capability to protect the public from exposure to those materials, and shall include the adoption of environmental health performance standards and standards of administrative procedures for county hazardous materials response.

b. The certified local health agency in each county shall develop, in consultation with their county office of emergency management, a comprehensive, coordinated county-wide emergency response program for incidents involving hazardous materials, including, but not limited to, chemical, biological, radiological, nuclear, or explosive incidents for the county that is consistent with the plan developed by the department pursuant to subsection a. of this section.

c. In any county in which there is no certified local health agency, the board of chosen freeholders shall designate a local health agency from the county to develop, in consultation with the county office of emergency management and the Department of Health, a comprehensive, coordinated county-wide emergency response program for incidents involving hazardous materials, including, but not limited to, chemical, biological, radiological, nuclear, or explosive incidents for the county that is consistent with the plan developed by the department pursuant to subsection a. of this section.

330. Section 4 of P.L.2005, c.3 (C.26:3A2-38) is amended to read as follows:

C.26:3A2-38 Rules, regulations relative to grant awards, performance standards, interlocal agreements.

4. a. The Department of Environmental Protection, with the concurrence of the Department of Health and the State Office of Emergency Management in the Division of State Police in the Department of Law and Public Safety, and in consultation with representatives of certified local health agencies, shall adopt, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), rules and regulations that:

(1) establish criteria and procedures for the award of grants to certified local health agencies, or local health agencies, as appropriate, pursuant to section 3 of P.L.2005, c.3 (C.26:3A2-37);

(2) establish environmental health performance standards and standards of administrative procedures for county hazardous materials response for incidents involving hazardous materials, including, but not limited to, chemical, biological, radiological, nuclear, or explosive incidents; and

(3) establish criteria and procedures for the development of inter-local agreements to facilitate the creation of a Statewide mutual aid network for responding to incidents involving hazardous materials, including, but not limited to, chemical, biological, radiological, nuclear, or explosive incidents

b. Prior to the adoption of rules and regulations pursuant to subsection a. of this section, and notwithstanding the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to the contrary, the Commissioner of Environmental Protection may, immediately upon filing the proper notice with the Office of Administrative Law, adopt such temporary rules and regulations as the commissioner determines are necessary to implement the provisions of P.L.2005, c.3 (C.26:3A2-36 et al.). The temporary rules and regulations shall be in effect for a period not to exceed 270 days after the date of the filing, except that in no case shall the temporary rules and regulations be in effect one year after the effective date of P.L.2005, c.3 (C.26:3A2-36 et al.). The temporary rules and regulations shall thereafter be amended, adopted or readopted by the commissioner as the commissioner determines is necessary in accordance with the requirements of the "Administrative Procedure Act."

331. Section 8 of P.L.2005, c.383 (C.26:3D-62) is amended to read as follows:

C.26:3D-62 Violations, fines, penalties; enforcement.

8. a. The person having control of an indoor public place or workplace shall order any person smoking in violation of this act to comply with the provisions of this act. A person, after being so ordered, who smokes in violation of this act is subject to a fine of not less than $250 for the first offense, $500 for the second offense and $1,000 for each subsequent

offense. A penalty shall be recovered in accordance with the provisions of subsections c. and d. of this section.

b. The Department of Health or the local board of health or the board, body, or officers exercising the functions of the local board of health according to law, upon written complaint or having reason to suspect that an indoor public place or workplace covered by the provisions of this act is or may be in violation of the provisions of this act, shall, by written notification, advise the person having control of the place accordingly, and order appropriate action to be taken. A person receiving that notice who fails or refuses to comply with the order is subject to a fine of not less than $250 for the first offense, $500 for the second offense, and $1,000 for each subsequent offense. In addition to the penalty provided herein, the court may order immediate compliance with the provisions of this act.

c. A penalty recovered under the provisions of this act shall be recovered by and in the name of the Commissioner of Health or by and in the name of the local board of health. When the plaintiff is the Commissioner of Health, the penalty recovered shall be paid by the commissioner into the treasury of the State. When the plaintiff is a local board of health, the penalty recovered shall be paid by the local board into the treasury of the municipality where the violation occurred.

d. A municipal court shall have jurisdiction over proceedings to enforce and collect any penalty imposed because of a violation of this act if the violation has occurred within the territorial jurisdiction of the court. The proceedings shall be summary and in accordance with the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.). Process shall be in the nature of a summons or warrant and shall issue only at the suit of the Commissioner of Health, or the local board of health, as the case may be, as plaintiff.

e. The penalties provided in subsections a. and b. of this section shall be the only civil remedy for a violation of this act, and there shall be no private right of action against a party for failure to comply with the provisions of this act.

332. Section 10 of P.L.2005, c.383 (C.26:3D-64) is amended to read as follows:

C.26:3D-64 Rules, regulations.

10. The Commissioner of Health, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this act.

333. Section 1 of P.L.2005, c.26 (C.26:3E-14) is amended to read as follows:

C.26:3E-14 Fact sheet distributed to restaurants relative to nut allergies; definitions.

1. The Commissioner of Health, in consultation with the New Jersey Restaurant Association, shall prepare a fact sheet, to be directed to restaurant managers and staff, which is designed to explain nut allergies and the health-related consequences to persons with nut allergies who are exposed to food items that contain or are prepared with nut products, and includes a recommendation that restaurants identify such food items on their menus. The commissioner shall make this fact sheet available to local boards of health by electronic or other means of distribution, and local health officers shall furnish this information to restaurants at the time of inspection.

As used in this section:

"Nut" means peanuts and tree nuts, including, but not limited to, almonds, brazil nuts, cashews, hazelnuts, filberts, macadamia nuts, pecans, pistachios, and walnuts; and

"Restaurant" means an establishment in which the principal business is the sale of food for consumption on the premises.

334. Section 2 of P.L.2005, c.26 (C.26:3E-15) is amended to read as follows:

C.26:3E-15 “Ask Before You Eat” public information campaign.

2. The Commissioner of Health shall conduct, within the limits of monies appropriated pursuant to this act, a public information campaign regarding food allergies, to be known as "Ask Before You Eat." The public information campaign shall be designed to inform the public about food allergies and the health-related consequences, including anaphylaxis, to persons with such allergies who are exposed to food items that contain or are prepared with ingredients that trigger severe allergic reactions, such as peanuts, tree nuts, and seafood.

335. Section 2 of P.L.2009, c.306 (C.26:3E-17) is amended to read as follows:

C.26:3E-17 Requirements for certain retail food establishments.

2. Notwithstanding any provision of law to the contrary:

a. (1) A retail food establishment using a standard printed menu shall list next to each food or beverage item on the menu, the total number of calories for that item as usually prepared and offered for sale;

(2) A retail food establishment using a menu board system or similar signage shall list next to each food or beverage item on the board or sign, the total number of calories for that item as usually prepared and offered for sale;

(3) A retail food establishment that has a drive-through window shall display calorie content values either on the drive-through menu board or on an adjacent stanchion visible at the point of ordering, and the calorie content values shall be posted adjacent to their respective menu item names as clearly and conspicuously as the price or menu item is on the drive-through menu board; and

(4) A retail food establishment which offers alcoholic beverages for sale may, as an alternative to listing calorie information for each individual alcoholic beverage, list the average caloric value for beers, wines, and spirits as established by the United States Department of Agriculture, Agriculture Research Service in the National Nutrient Database for Standard Reference.

A retail food establishment that lists the average caloric values for alcoholic beverages pursuant to this paragraph shall add to the labeling the following statement: "Signature drinks or liqueurs with added ingredients may increase calorie content."

b. The calorie information listed pursuant to paragraphs (1) and (2) of subsection a. of this section shall be posted clearly and conspicuously adjacent or in close proximity to the applicable menu item using a font and format that is at least as prominent, in size and appearance, as that used to post either the name or price of the menu item.

The calorie content values required by this act shall be based upon a verifiable analysis of the menu item, which may include the use of nutrient databases, laboratory testing, or other reliable methods of analysis, and shall be rounded to the nearest 10 calories for calorie content values above 50 calories and to the nearest five calories for calorie content values 50 calories and below.

c. The provisions of this section shall apply to each menu item that is served in portions the size and content of which are standardized.

d. For menu items that come in different flavors and varieties but that are listed as a single menu item, the minimum to maximum numbers of calories for all flavors and varieties of that item shall be listed on the menu, menu board, or stanchion, as applicable, for each size offered for sale.

e. (1) The disclosure of calorie information on a menu, menu board, or stanchion next to a standard menu item that is a combination of at least two standard menu items on the menu, menu board, or stanchion, shall, based upon all possible combinations for that standard menu item, include both the minimum and the maximum amount of calories. If there is only one possible total amount of calories, that total shall be disclosed.

(2) The disclosure of calorie information on a menu, menu board, or stanchion next to a standard menu item that is not an appetizer or dessert, but is intended to serve more than one individual, shall include both:

(a) the number of individuals intended to be served by the standard menu item; and

(b) the calorie information per individual serving.

If the standard menu item is a combination of at least two standard menu items, the disclosure shall, based upon all possible combinations for that standard menu item, include both the minimum and the maximum amount of calories. If there is only one possible total amount of calories, that total shall be disclosed.

f. Nothing in this section shall prohibit a retail food establishment from providing additional nutrition information to its customers for each food or beverage item listed on its menu.

g. The provisions of this section shall not apply to any:

(1) item not listed on a standard printed menu or menu board system or similar signage, including, but not limited to, condiments or other products placed on a table or counter for general use; or

(2) daily specials, temporary menu items appearing on the menu for less than 60 days per calendar year, customized orders, or food or beverage items from a consumer self-serve salad bar or buffet.

h. (1) The Department of Health or the local board of health or the board, body, or officers exercising the functions of the local board of health according to law, upon written complaint or having reason to suspect that a violation of this act has occurred, shall, by written notification, advise the proprietor of the retail food establishment accordingly and order appropriate action to be taken.

(2) A proprietor of a retail food establishment who violates the provisions of this section by failing to provide the information about food and beverage items as required in this section, or knowingly misstating the number of calories in a food or beverage item, shall be subject to a penalty of not less than $50 or more than $100 for the first offense, and not less than $250 or more than $500 for the second or any subsequent offense. A municipal court shall have jurisdiction over proceedings to enforce and collect any penalty imposed because of a violation of this act, if the violation has occurred within the territorial jurisdiction of the court. The proceedings shall be summary and in accordance with the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.). Process shall be in the nature of a summons or warrant and shall issue only at the suit of the Commissioner of Health, or the local board of health, as the case may be, as plaintiff.

When the plaintiff is the Commissioner of Health, the penalty recovered shall be paid by the commissioner into the treasury of the State. When the plaintiff is a local board of health, the penalty recovered shall be paid by the local board into the treasury of the municipality where the violation occurred.

i. The provisions of this section shall not be construed to create or enhance any claim, right of action, or civil liability that did not previously exist under State law or limit any claim, right of action, or civil liability that otherwise exists under State law.

j. There shall be no private right of action against the proprietor of a retail food establishment for failure to comply with the provisions of this section.

k. To the extent consistent with federal law, the provisions of this section, as well as any other State law that regulates the disclosure of caloric information, shall be a matter of Statewide concern and shall occupy the entire field of regulation regarding the disclosure of caloric information by a retail food establishment, as well as content required to be posted on menus, menu board systems or similar signage, or stanchions, as applicable. No ordinance or regulation of a local government or local board of health shall regulate the dissemination of caloric information or the content required to be placed on menus, menu board systems or similar signage, or stanchions by a retail food establishment. Any local government or local board of health ordinance or regulation that violates this prohibition is void and shall have no force or effect.

l. As used in this section, "retail food establishment" means a fixed restaurant or any similar place that is part of a chain with 20 or more locations nationally and doing business

(1) under the same trade name or under common ownership or control or

(2) as franchised outlets of a parent business,

the principal activity of which consists of preparing for consumption within the establishment a meal or food to be eaten on the premises or picked up at a drive-through window.

336. Section 3 of P.L.2009, c.306 (C.26:3E-18) is amended to read as follows:

C.26:3E-18 Rules, regulations.

3. The Commissioner of Health shall adopt rules and regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), to effectuate the purposes of this act.

337. R.S.26:4-2 is amended to read as follows:

Powers of State department and local board.

26:4-2. In order to prevent the spread of disease affecting humans, the Department of Health, and the local boards of health within their respective jurisdictions and subject to the State sanitary code, shall have power to:

a. Declare what diseases are communicable.

b. Declare when any communicable disease has become epidemic.

c. Require the reporting of communicable diseases.

d. Maintain and enforce proper and sufficient quarantine, wherever deemed necessary.

e. Remove any person infected with a communicable disease to a suitable place, if in its judgment removal is necessary and can be accomplished without any undue risk to the person infected.

f. Disinfect any premises when deemed necessary.

g. Remove to a proper place to be designated by it all articles within its jurisdiction, which, in its opinion, shall be infected with any matter likely to communicate disease and to destroy such articles, when in its opinion the safety of the public health requires it.

In the event the Governor declares a public health emergency, the department shall oversee the uniform exercise of these powers in the State and the local board of health shall be subject to the department's exercise of authority under this section.

338. Section 3 of P.L.2007, c.134 (C.26:4-95.4) is amended to read as follows:

C.26:4-95.4 Public awareness campaign about HPV.

3. a. The Commissioner of Health, in consultation with the Commissioner of Education and the Director of the Division on Women in the Department of Children and Families, shall establish a public awareness campaign to inform the general public about the clinical significance and public health implications of the human papillomavirus, including its causes and the most effective means of prevention and treatment. The public awareness campaign shall be established in accordance with accepted public health practice and recommendations of the federal Centers for Disease Control and Prevention, and within the limits of available funds and any other resources available for the purposes thereof.

b. The commissioner shall prepare a patient information brochure regarding the human papillomavirus, including its causes and the most effective means of prevention and treatment. The department shall distribute the pamphlet, at no charge, to all pediatricians in the State. The department shall update the pamphlet as necessary, and shall make additional copies of the pamphlet available to other health care providers upon request.

339. Section 3 of P.L.2004, c.138 (C.26:4-133) is amended to read as follows:

C.26:4-133 Definitions relative to Statewide automated and electronic immunization registry.

3. As used in this act:

"Commissioner" means the Commissioner of Health.

"Department" means the Department of Health.

"Health care provider" means a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) or a health care professional whose practice is regulated pursuant to Title 45 of the Revised Statutes.

"Registry" means the New Jersey Immunization Information System established pursuant to this act.

340. Section 4 of P.L.2004, c.138 (C.26:4-134) is amended to read as follows:

C.26:4-134 Statewide automated and electronic immunization registry.

4. a. There is established a Statewide automated and electronic immunization registry, to be designated as the New Jersey Immunization Information System, in the Department of Health. The registry shall be designed to serve as a single repository of immunization records to aid, coordinate, and help promote effective and cost-efficient disease screening, prevention, and control efforts in the State.

b. A newborn infant in New Jersey, who is born on or after January 1, 1998, shall be enrolled in the registry immediately following birth unless the parent or legal guardian of the infant provides a written request to not participate in the registry.

A child born prior to January 1, 1998 may be enrolled in the registry at the parent's or legal guardian's written request.

c. Access to the information in the registry shall be limited to: health care providers, schools, colleges, licensed child care centers, and public agencies, and private organizations as determined by regulation of the commissioner. A registrant, or the registrant's parent or legal guardian if the registrant is a minor, shall have access to the registrant's immunization and other preventive health screening information in the registry.

d. The information contained in the registry shall be used for the following purposes:

(1) to help ensure that registrants receive all recommended immunizations in a timely manner by providing access to the registrants' immunization records;

(2) to help improve immunization rates by providing notice to registrants of overdue or upcoming immunizations; and

(3) to help control communicable diseases by assisting in the identification of persons who require immediate immunization in the event of a vaccine-preventable disease outbreak.

e. The authentic immunization and other preventive health screening record of a child, which shall consist of a paper or electronic copy of the registry entry that is a true and accurate representation of the information contained therein, obtained from the registry shall be accepted as a valid immunization and preventive health screening record of the registrant for the purpose of meeting immunization and preventive health screening documentation requirements for admission to a school, college, or licensed child care center.

f. A health care provider shall not discriminate in any way against a person solely because the person elects not to participate in the registry.

g. An authorized user granted access as provided in subsection c. of this section shall only access information in the registry on a specific patient or client who is presently receiving services, is under the user's care or is within the applicable governmental health authority's jurisdiction.

h. An agency, organization, or other entity authorized to access information in the registry shall not use any report made by a health care provider pursuant to this act in any punitive manner against the provider.

i. The commissioner, in consultation with the Public Health Council, shall adopt rules and regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), to effectuate the purposes of this act, including, but not limited to:

(1) the establishment and maintenance of the registry;

(2) the methods for submitting, and the content of, reports of immunizations to the registry, for which purpose the commissioner shall provide, to the maximum extent practicable, for reporting options to facilitate compliance with the requirements of subsection b. of this section;

(3) procedures for the birth hospital of a newborn infant or health care provider, as applicable, to inform the parent or legal guardian of a newborn infant or minor of the purpose of the registry and its potential uses by parties having authorized access to registry information, and the content of that information;

(4) procedures for a registrant, or the registrant's parent or legal guardian if the registrant is a minor, to review and correct information contained in the registry;

(5) procedures for the parent or legal guardian of a newborn infant or minor, or a person over 18 years of age, to request to not participate in the registry at any time and to remove or inactivate information from the registry;

(6) limits on, and methods of, access to the registry by those authorized pursuant to subsection c. of this section;

(7) procedures for health insurers to obtain immunization information from the registry concerning only their covered persons, as well as summary statistics, which information or statistics shall not be used or disclosed for any other purpose than to:

(a) improve patient care;

(b) provide quality assurance to employers purchasing group coverage and to health care providers;

(c) improve outreach and education efforts with respect to their covered persons and health care providers; and

(d) monitor and improve quality of care standards as developed by professional organizations, accreditation agencies and government agencies in collaboration with the department; and

(8) procedures for the department to disseminate statistical information and supporting commentary.

341. Section 10 of P.L.2011, c.210 (C.26:5B-6) is amended to read as follows:

C.26:5B-6 Availability of information about sickle cell anemia.

10. a. The Department of Health, in consultation with the Medical Society of New Jersey and the University of Medicine and Dentistry of New Jersey, shall prepare, and make available on its Internet website, information in English and Spanish, which is designed to be easily understandable by the general public, about the genetic risk factors associated with, and the symptoms and treatment of, sickle cell anemia, in addition to any other information that the Commissioner of Health deems necessary for the purposes of this act. The department shall revise this information whenever new information about sickle cell anemia becomes available.

b. The department shall prepare an informational booklet in English and Spanish that contains the information posted on its website pursuant to subsection a. of this section, as funds become available for that purpose. The department shall make a supply of booklets available to all licensed health care facilities engaged in the diagnosis or treatment of sickle cell anemia, as well as to health care professionals, community health centers, members of the public, and social services agencies upon their request.

342. Section 1 of P.L.1995, c.174 (C.26:5C-15) is amended to read as follows:

C.26:5C-15 Definitions.

1. As used in this act:

"AIDS" means acquired immune deficiency syndrome as defined by the Centers for Disease Control and Prevention of the United States Public Health Service.

"Commissioner" means the Commissioner of Health.

"Department" means the Department of Health.

"HIV" means the human immunodeficiency virus or any other related virus identified as a probable causative agent of AIDS.

343. Section 2 of P.L.1997, c.246 (C.26:5C-22) is amended to read as follows:

C.26:5C-22 HIV test on potential semen donor; consent; payment; notification.

2. a. A semen bank shall perform an HIV test on a potential donor prior to that person donating semen and shall freeze all donated semen for a waiting period of at least six

months, in accordance with standards adopted by the United States Centers for Disease Control and Prevention.

b. A semen bank shall perform the HIV test only after the donor has provided written informed consent according to standards adopted by the Commissioner of Health. A donor who refuses to provide written informed consent to an HIV test or tests positive for HIV shall not be permitted to donate semen.

c. The cost of the HIV test shall be borne by the recipient of the donation.

d. The Commissioner of Health shall establish procedures for notification by a semen bank to donors of screening results and referrals to appropriate counseling and health care services as necessary.

344. Section 4 of P.L.1997, c.246 (C.26:5C-24) is amended to read as follows:

C.26:5C-24 Rules, regulations.

4. The Commissioner of Health, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this act.

345. Section 3 of P.L.2006, c.99 (C.26:5C-27) is amended to read as follows:

C.26:5C-27 Demonstration program for operation of sterile syringe access programs.

3. The Commissioner of Health shall establish a demonstration program to permit up to six municipalities to operate a sterile syringe access program in accordance with the provisions of this act. For the purposes of the demonstration program, the commissioner shall prescribe by regulation requirements for a municipality to establish, or otherwise authorize the operation within that municipality of, a sterile syringe access program to provide for the exchange of hypodermic syringes and needles in accordance with the provisions of this act.

a. The commissioner shall:

(1) request an application, to be submitted on a form and in a manner to be prescribed by the commissioner, from any municipality that seeks to establish a sterile syringe access program, or from other entities authorized to operate a sterile syringe access program within that municipality as provided in paragraph (2) of subsection a. of section 4 of this act;

(2) approve those applications that meet the requirements established by regulation of the commissioner and contract with the municipalities or entities whose applications are approved to establish a sterile syringe access program as provided in paragraph (2) of subsection a. of section 4 of this act to operate a sterile syringe access program in any municipality in which the governing body has authorized the operation of sterile syringe access programs within that municipality by ordinance;

(3) support and facilitate, to the maximum extent practicable, the linkage of sterile syringe access programs to health care facilities and programs as may provide appropriate health care services, including mental health and substance abuse treatment, and to housing assistance, career employment-related counseling, and education counseling to consumers participating in a sterile syringe access program;

(4) provide for the adoption of a uniform identification card or other uniform Statewide means of identification for consumers, staff, and volunteers of a sterile syringe access program pursuant to paragraph (8) of subsection b. of section 4 of this act; and

(5) maintain a record of the data reported to the commissioner by sterile syringe access programs pursuant to paragraph (10) of subsection b. of section 4 of this act.

b. The commissioner shall be authorized to accept funding as may be made available from the private sector to effectuate the purposes of this act.

346. Section 3 of P.L.2008, c.49 (C.26:6-70) is amended to read as follows:

C.26:6-70 Definitions relative to anatomical gifts for educational and research use.

3. As used in this act:

"Anatomical research recovery organization" means a nonprofit corporation engaged in the recovery of a human body or part donated for education, research, or the advancement of medical, dental, or mortuary science pursuant to P.L.1969, c.161 (C.26:6-57 et seq.) or any subsequent statute adopted pursuant thereto, where part or all of the recovery takes place in this State. Anatomical research recovery organization shall not include an accredited institution of higher education in this State that uses an anatomical gift for its own educational or research purposes and is not engaged in the distribution of a human body or part to another person or entity.

"Commissioner" means the Commissioner of Health.

"Department" means the Department of Health.

"Distribution" means the removal of a human body or part from a storage location to any other location for educational or research use, or the advancement of medical, dental, or mortuary science.

"Education" means the use of the whole body or parts for purposes of teaching or training individuals, including medical or dental professionals and students, with regard to the anatomy and characteristics of the human body.

"Human body part" or "part" means organs, tissues, eyes, bones, blood vessels, and any other portions of a deceased human body which are subject to an anatomical gift pursuant to P.L.1969, c.161 (C.26:6-57) or any subsequent statute adopted pursuant thereto, but does not include blood collected pursuant to P.L.1945, c.301 (C.26:2A-1).

"Recovery" means the obtaining of a human body or part, including, but not limited to, determining or obtaining consent or authorization for donation of the human body or part, performing surgical or other technical procedures for recovering the body or part, and processing the body or part. Recovery does not include actions taken by a medical examiner or coroner as part of his professional duties.

"Research" means the conduct of scientific testing and observation designed to result in the acquisition of generalizable knowledge. Research does not include an autopsy or other investigation conducted for the purpose of obtaining information related to the decedent.

347. Section 4 of P.L.2008, c.49 (C.26:6-71) is amended to read as follows:

C.26:6-71 Registration as anatomical research recovery organization.

4. a. No person shall engage in the recovery of a human body or part donated in this State for education, research, or the advancement of medical, dental, or mortuary science pursuant to P.L.1969, c.161 (C.26:6-57 et seq.) or any subsequent statute adopted pursuant thereto, unless the person is registered as an anatomical research recovery organization with the Department of Health pursuant to this act.

The registration required pursuant to this act shall be in addition to any license or permit required by a local board of health, other local health agency, or any State or federal agency.

b. The registration shall be valid for a one-year period and may be renewed subject to compliance with the requirements of this act. The commissioner shall establish such registration and renewal fees as may be reasonable and necessary to carry out the purposes of this act.

c. The commissioner may enter and inspect the premises of any anatomical research recovery organization and the books and records as is reasonably necessary to carry out the provisions of this act.

348. Section 28 of P.L.2003, c.221 (C.26:8-21.1) is amended to read as follows:

C.26:8-21.1 Rules, regulations.

28. The Commissioner of Health, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this act.

349. R.S.26:8-23 is amended to read as follows:

Duty of the department; examination of records.

26:8-23. The Department of Health shall have charge of the registration of births, deaths, fetal deaths, marriages, civil unions, and domestic partnerships and shall procure the prompt and accurate registration of the same in each registration district and in the department. The department may promulgate any rule or regulation which it deems necessary for the uniform and thorough enforcement of this section.

The department may decline permission to examine any record except in the presence of an officer or employee of the department.

350. Section 17 of P.L.2003, c.221 (C.26:8-24.2) is amended to read as follows:

C.26:8-24.2 “New Jersey Electronic Death Registration Support Fund.”

17. a. There is established the "New Jersey Electronic Death Registration Support Fund" as a nonlapsing, revolving fund to be administered by the Commissioner of Health and credited with monies received pursuant to subsection c. of R.S.26:8-62.

b. The State Treasurer is the custodian of the fund and all disbursements from the fund shall be made by the treasurer upon vouchers signed by the commissioner. The monies in the fund shall be invested and reinvested by the Director of the Division of Investment in the Department of the Treasury as are other trust funds in the custody of the State Treasurer in the manner provided by law. Interest received on the monies in the fund shall be credited to the fund.

c. The monies in the fund and the interest earned thereon shall be used to meet the development and operational costs of the NJ-EDRS, including, but not limited to, costs associated with: personnel; hardware purchases and maintenance; software and communications infrastructure; website hosting; and licensing fees, royalties and transaction expenses incurred in the development, installation, maintenance and operation of electronic payment security, authentication and encryption systems, and user training and education.

d. The Commissioner of Health shall, no later than 30 months after the date of enactment of P.L.2003, c.221, report to the chairs of the Senate Health, Human Services and Senior Citizens Committee, the Senate Budget and Appropriations Committee, the Assembly Health and Human Services Committee and the Assembly Appropriations Committee, or

their successors, concerning the sources and uses of monies in the fund. The report shall include a description of the methodology used by the State registrar to set the fee imposed pursuant to subsection c. of R.S.26:8-62, a summary of the monies credited to the fund, and a summary of expenditures by category from the fund pursuant to the authority of this section and the requirements of section 16 of P.L.2003, c.221 (C.26:8-24.1), together with any recommendations by the State registrar or the commissioner for changes that either considers should be made in the law concerning the implementation of the NJ-EDRS or the fees imposed pursuant to subsection c. of R.S.26:8-62.

351. Section 2 of P.L.1983, c.291 (C.26:8-40.21) is amended to read as follows:

C.26:8-40.21 Birth defects, severe neonatal jaundice registry.

2. a. The Department of Health shall establish and maintain a birth defects and severe neonatal jaundice registry, which shall contain a confidential record of all birth defects and all cases of severe hyperbilirubinemia that occur in New Jersey and any other information that the department deems necessary and appropriate in order to conduct thorough and complete epidemiologic surveys of birth defects and cases of severe hyperbilirubinemia that occur in this State and plan for and provide services to children with birth defects and severe hyperbilirubinemia and their families.

b. The department shall make available electronically on its Internet website, in English and Spanish, information on the characteristics and effects of severe neonatal jaundice.

352. Section 3 of P.L.1983, c.291 (C.26:8-40.22) is amended to read as follows:

C.26:8-40.22 Confidential reports of abortions of fetus with or infant affected by birth defect or severe neonatal jaundice.

3. a. The Commissioner of Health, in consultation with the Public Health Council, shall require the confidential reporting to the Department of Health of all cases where an infant is diagnosed with severe hyperbilirubinemia, and where a pregnancy results in a naturally aborted fetus or infant affected by a birth defect, and an electively aborted fetus that exhibits or is known to have a birth defect after 15 weeks of gestation. The reporting requirement shall apply to all infants from birth through five years of age.

b. The Commissioner of Health shall determine the health care providers and facilities which shall be required to report all birth defects and all cases of severe hyperbilirubinemia, the types of conditions or defects that shall be reported, the type of information that shall be contained in the confidential report and the method for making the report. In reports concerning all fetuses with anomalies, the name of the mother shall not be submitted.

353. R.S.26:8-69 is amended to read as follows:

Penalties; recovery.

26:8-69. Except as otherwise specifically provided in this chapter and R.S.37:1-1 et seq., any person who shall:

a. Fail or refuse to furnish correctly any information in the person’s possession; or

b. Willfully and knowingly furnish false information affecting any certificate or record required by this chapter; or

c. Willfully alter, otherwise than is provided by R.S.26:8-48 et seq., or willfully or knowingly falsify, any certificate or record established by this chapter; or

d. Fail to fill out and transmit any certificate or record in the manner required by this chapter; or

e. Being a local registrar, deputy registrar, alternate deputy registrar or subregistrar, shall fail to perform the person’s duty as required by this chapter and by the directions of the State registrar thereunder; or

f. Violate any of the provisions of this chapter or fail to discharge any duty required by this chapter-

Shall be subject to a penalty of not less than $100 nor more than $250 for each first offense and not less than $250 nor more than $500 for each subsequent offense.

The penalties shall be recovered in a civil action in the name of the Department of Health or local board in any court of competent jurisdiction.

The Superior Court or municipal court shall have jurisdiction over proceedings to enforce and collect any such penalty, if the violation has occurred within the territorial jurisdiction of the court. The proceedings shall be summary and in accordance with the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

Notwithstanding the provisions of this section to the contrary, the State registrar may refer a violation of this chapter by a physician, nurse, or funeral director who is licensed pursuant to Title 45 of the Revised Statutes to the appropriate professional board in the Division of Consumer Affairs in the Department of Law and Public Safety, which shall, in accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), assess the penalty provided for in this subsection and assume enforcement responsibility on the same basis as it would for a violation of the statute or regulations governing the practice of those persons regulated by that board.

354. Section 3 of P.L.2003, c.246 (C.26:8A-3) is amended to read as follows:

C.26:8A-3 Definitions relative to domestic partners.

3. As used in sections 1 through 9 of P.L.2003, c.246 (C.26:8A-1 through C.26:8A-9) and in R.S.26:8-1 et seq.:

"Affidavit of Domestic Partnership" means an affidavit that sets forth each party's name and age, the parties' common mailing address, and a statement that, at the time the affidavit is signed, both parties meet the requirements of this act for entering into a domestic partnership and wish to enter into a domestic partnership with each other.

"Basic living expenses" means the cost of basic food and shelter, and any other cost, including, but not limited to, the cost of health care, if some or all of the cost is paid as a benefit because a person is another person's domestic partner.

"Certificate of Domestic Partnership" means a certificate that includes: the full names of the domestic partners, a statement that the two individuals are members of a registered domestic partnership recognized by the State of New Jersey, the date that the domestic partnership was entered into, and a statement that the partners are entitled to all the rights, privileges and responsibilities accorded to domestic partners under the law. The certificate shall bear the seal of the State of New Jersey.

"Commissioner" means the Commissioner of Health.

"Domestic partner" or "partner" means a person who is in a relationship that satisfies the definition of a domestic partnership as set forth in this act.

"Have a common residence" means that two persons share the same place to live in this State, or share the same place to live in another jurisdiction when at least one of the persons is a member of a State-administered retirement system, regardless of whether or not: the

legal right to possess the place is in both of their names; one or both persons have additional places to live; or one person temporarily leaves the shared place of residence to reside elsewhere, on either a short-term or long-term basis, for reasons that include, but are not limited to, medical care, incarceration, education, a sabbatical, or employment, but intends to return to the shared place of residence.

"Jointly responsible" means that each domestic partner agrees to provide for the other partner's basic living expenses if the other partner is unable to provide for himself.

"Notice of Rights and Obligations of Domestic Partners" means a form that advises domestic partners, or persons seeking to become domestic partners, of the procedural requirements for establishing, maintaining, and terminating a domestic partnership, and includes information about the rights and responsibilities of the partners.

355. Section 59 of P.L.2003, c.246 (C.26:8A-12) is amended to read as follows:

C.26:8A-12 Rules, regulations; responsible agencies.

59. a. The Commissioner of Health, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of sections 1 through 10 and 13 through 35 of this act.

b. The Commissioner of Banking and Insurance, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of sections 47 through 52, 55 and 56 of this act.

c. The New Jersey Individual Health Coverage Program Board, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of section 53 of this act.

d. The New Jersey Small Employer Health Benefits Program Board, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of section 54 of this act.

356. Section 2 of P.L.2005, c.222 (C.26:13-2) is amended to read as follows:

C.26:13-2 Definitions relative to emergency health powers.

2. As used in this act:

"Biological agent" means any microorganism, virus, bacterium, rickettsiae, fungus, toxin, infectious substance, or biological product that may be naturally occurring or engineered as a result of biotechnology, or any naturally occurring or bioengineered component of any such microorganism, virus, bacterium, rickettsiae, fungus, infectious substance, or biological product, capable of causing death, disease, or other biological malfunction in a human, an animal, a plant, or another living organism.

"Bioterrorism" means the intentional use or threat of use of any biological agent, to cause death, disease, or other biological malfunction in a human, animal, plant, or other living organism, or degrade the quality and safety of the food, air, or water supply.

"Chemical weapon" means a toxic chemical and its precursors, except where intended for a lawful purpose as long as the type and quantity is consistent with such a purpose. Chemical weapon includes, but is not limited to: nerve agents, choking agents, blood agents, and incapacitating agents.

"Commissioner" means the Commissioner of Health, or the commissioner's designee.

"Contagious disease" means an infectious disease that can be transmitted from person to person.

"Department" means the Department of Health.

"Health care facility" means any non-federal institution, building or agency, or portion thereof whether public or private for profit or nonprofit that is used, operated or designed to provide health services, medical or dental treatment or nursing, rehabilitative, or preventive care to any person. Health care facility includes, but is not limited to: an ambulatory surgical facility, home health agency, hospice, hospital, infirmary, intermediate care facility, dialysis center, long-term care facility, medical assistance facility, mental health center, paid and volunteer emergency medical services, outpatient facility, public health center, rehabilitation facility, residential treatment facility, skilled nursing facility, and adult day care center. Health care facility also includes, but is not limited to, the following related property when used for or in connection with the foregoing: a laboratory, research facility, pharmacy, laundry facility, health personnel training and lodging facility, patient, guest and health personnel food service facility, and the portion of an office or office building used by persons engaged in health care professions or services.

"Health care provider" means any person or entity who provides health care services including, but not limited to: a health care facility, bioanalytical laboratory director, perfusionist, physician, physician assistant, pharmacist, dentist, nurse, paramedic, respiratory care practitioner, medical or laboratory technician, and ambulance and emergency medical workers.

"Infectious disease" means a disease caused by a living organism or other pathogen, including a fungus, bacteria, parasite, protozoan, virus, or prion. An infectious disease may, or may not, be transmissible from person to person, animal to person, or insect to person.

"Isolation" means the physical separation and confinement of an individual or groups of individuals who are infected or reasonably believed to be infected, on the basis of signs, symptoms or laboratory analysis, with a contagious or possibly contagious disease from non-isolated individuals, to prevent or limit the transmission of the disease to non-isolated individuals.

"Local health agency" means a county, regional, municipal, or other governmental agency organized for the purpose of providing health services, administered by a full-time health officer and conducting a public health program pursuant to law.

"Local Information Network and Communications System Agency" or " LINCS agency" means the lead local public health agency in each county or identified city, as designated and determined by the commissioner pursuant to section 21 of this act, responsible for providing central planning, coordination, and delivery of specialized services within the designated county or city, in partnership with the other local health agencies within that jurisdiction, in order to prepare for and respond to acts of bioterrorism and other forms of terrorism or other public health emergencies or threats, and to discharge the activities as specified under this act.

"Microorganism" includes, but is not limited to, bacteria, viruses, fungi, rickettsiae, or protozoa.

"Nuclear or radiological device" means: any nuclear device which is an explosive device designed to cause a nuclear yield; an explosive radiological dispersal device used directly or indirectly to spread radioactive material; or a simple radiological dispersal device which is any act, container or any other device used to release radiological material for use as a weapon.

"Overlap agent or toxin" means: any microorganism or toxin that poses a risk to both human and animal health and includes:

Anthrax - Bacillus anthracis

Botulism - Clostridium botulinum toxin, Botulinum neurotoxins, Botulinum neurotoxin producing species of Clostridium
Plague - Yersinia pestis
Tularemia - Francisella tularensis
Viral Hemorrhagic Fevers - Ebola, Marburg, Lassa, Machupo
Brucellosis- Brucellosis species
Glanders - Burkholderia mallei
Melioidosis - Burkholderia pseudomallei
Psittacosis - Chlamydophila psittaci
Coccidiodomycosis - Coccidiodes immitis
Q Fever - Coxiella burnetii
Typhus Fever - Rickettsia prowazekii
Viral Encephalitis - VEE (Venezuelan equine encephalitis virus), EEE (Eastern equine encephalitis), WEE (Western equine encephalitis)
Toxins - Ricinus communis, Clostridium perfringens, Staph. Aureus, Staphylococcal enterotoxins, T-2 toxin, Shigatoxin
Nipah - Nipah virus
Hantavirus - Hantavirus
West Nile Fever - West Nile virus
Hendra - Hendra virus
Rift Valley Fever - Rift Valley Fever virus
Highly Pathogenic Avian Influenza

"Public health emergency" means an occurrence or imminent threat of an occurrence that:

a. is caused or is reasonably believed to be caused by any of the following: (1) bioterrorism or an accidental release of one or more biological agents; (2) the appearance of a novel or previously controlled or eradicated biological agent; (3) a natural disaster; (4) a chemical attack or accidental release of toxic chemicals; or (5) a nuclear attack or nuclear accident; and

b. poses a high probability of any of the following harms: (1) a large number of deaths, illness, or injury in the affected population; (2) a large number of serious or long-term impairments in the affected population; or (3) exposure to a biological agent or chemical that poses a significant risk of substantial future harm to a large number of people in the affected population.

"Quarantine" means the physical separation and confinement of an individual or groups of individuals, who are or may have been exposed to a contagious or possibly contagious disease and who do not show signs or symptoms of a contagious disease, from non-quarantined individuals, to prevent or limit the transmission of the disease to non-quarantined individuals.

"Toxin" means the toxic material of plants, animals, microorganisms, viruses, fungi, or infectious substances, or a recombinant molecule, whatever its origin or method of production, including:

a. any poisonous substance or biological product that may be engineered as a result of biotechnology or produced by a living organism; or

b. any poisonous isomer or biological product, homolog, or derivative of such a substance.

357. Section 24 of P.L.2005, c.222 (C.26:13-24) is amended to read as follows:

C.26:13-24 State Public Health Emergency Claim Reimbursement Board.

24. a. There is hereby established in the Department of Health a State Public Health Emergency Claim Reimbursement Board. The board shall include the following members: the Commissioner of Health, who shall be the presiding officer, the Attorney General, the Adjutant General of the Department of Military and Veterans' Affairs, the State Director of Emergency Management, the Secretary of Agriculture, the Commissioner of Banking and Insurance, the Commissioner of Environmental Protection, the Commissioner of Community Affairs, the State Medical Examiner, and the State Treasurer, or their designees. The members of the board shall serve without pay in connection with all such duties as are prescribed in this act.

b. The board shall meet at such times as may be necessary to fulfill the requirements set forth herein. The Commissioner of Health shall convene the board within 45 days of the filing of a complete petition. The concurrence of six members of the board shall be necessary for the validity of all acts of the board.

c. Subject to available appropriations, the board shall have the authority to award reasonable reimbursement, as determined by the board, for any services required of any person under the provisions of this act, which shall be paid at the prevailing established rate for services of a like or similar nature as determined by the board. Subject to available appropriations, the board shall have the authority to award reasonable reimbursement, as determined by the board, for any property employed, taken, or used under the provisions of this act.

d. All awards shall be paid from any funds appropriated by the State, any political subdivision of the State, or the federal government, for such purpose. In awarding reimbursement under this section, the board shall take into account any funds, or any other thing of value, received by a claimant from any other source, including but not limited to private donations, contributions, and insurance proceeds. The board shall not award reimbursement unless the claimant has demonstrated, to the satisfaction of the board, that the claimant has first sought reimbursement for any loss incurred due to the declaration of a public health emergency from any and all appropriate third party payers.

358. Section 25 of P.L.2005, c.222 (C.26:13-25) is amended to read as follows:

C.26:13-25 Claims for reimbursement.

25. a. Any person making a claim for reimbursement for private property or services employed, taken or used for a public purpose under this act shall, subsequent to the termination of the public health emergency, file a petition for an award with the State Public Health Emergency Claim Reimbursement Board, established pursuant to section 24 of this act, through the Commissioner of Health. The petition shall be signed by the claimant and shall set forth the following:

(1) a description of the services or property employed, taken, or used;

(2) the dates of the employment, taking, or usage;

(3) the person or entity ordering the employment, taking, or usage;

(4) such additional information as the petitioner deems relevant to a full consideration of the claim; and

(5) any additional information that the board may require.

b. The board may establish such forms, documents, and procedures as may be necessary to expedite the processing of claims, and all claimants shall utilize and follow the forms, documents, and procedures, if so established. Subsequent to the filing of an initial petition,

the board may request such additional information as it deems necessary from any claimant and may require the claimant, and any other person with knowledge of facts and circumstances relevant to the claim, to appear before the board for a hearing. No petition shall be filed with the board more than 180 days from the last date the services or property were employed, taken or used, except that this deadline may be extended by the board as is necessary to further the purposes of this act.

c. The board's determination concerning a claimant's petition for reimbursement shall be transmitted to the claimant in writing. The claimant may appeal the decision to the Superior Court subject to the Rules of Court regarding the review of State agency actions.

d. Any person seeking reimbursement under this act shall proceed in accordance with the provisions of this section unless the declaration of public health emergency which gives rise to the claim or petition for reimbursement is superseded by order of the Governor pursuant to P.L.1942, c.251 (C.App.A:9-33 et seq.). Upon the declaration of an emergency by the Governor pursuant to P.L.1942, c.251 which supersedes the declaration of a public health emergency, the person shall proceed in accordance with the provisions of P.L.1942, c.251 and the person's rights, remedies and entitlement to reimbursement shall be limited to that which is afforded in that act.

e. Notwithstanding the provisions of this section to the contrary, in the event funds are otherwise made available for reimbursement, a person shall not be required to file a petition for an award with the board pursuant to this section.

359. Section 6 of P.L.1968, c.413 (C.30:4D-6) is amended to read as follows:

C.30:4D-6 Basic medical care and services.

6. a. Subject to the requirements of Title XIX of the federal Social Security Act, the limitations imposed by this act and by the rules and regulations promulgated pursuant thereto, the department shall provide medical assistance to qualified applicants, including authorized services within each of the following classifications:

(1) Inpatient hospital services;

(2) Outpatient hospital services;

(3) Other laboratory and X-ray services;

(4) (a) Skilled nursing or intermediate care facility services;

(b) Early and periodic screening and diagnosis of individuals who are eligible under the program and are under age 21, to ascertain their physical or mental defects and the health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations of the Secretary of the federal Department of Health and Human Services and approved by the commissioner;

(5) Physician's services furnished in the office, the patient's home, a hospital, a skilled nursing, or intermediate care facility or elsewhere.

As used in this subsection, "laboratory and X-ray services" includes HIV drug resistance testing, including, but not limited to, genotype assays that have been cleared or approved by the federal Food and Drug Administration, laboratory developed genotype assays, phenotype assays, and other assays using phenotype prediction with genotype comparison, for persons diagnosed with HIV infection or AIDS.

b. Subject to the limitations imposed by federal law, by this act, and by the rules and regulations promulgated pursuant thereto, the medical assistance program may be expanded to include authorized services within each of the following classifications:

(1) Medical care not included in subsection a.(5) above, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice, as defined by State law;

(2) Home health care services;

(3) Clinic services;

(4) Dental services;

(5) Physical therapy and related services;

(6) Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(7) Optometric services;

(8) Podiatric services;

(9) Chiropractic services;

(10) Psychological services;

(11) Inpatient psychiatric hospital services for individuals under 21 years of age, or under age 22 if they are receiving such services immediately before attaining age 21;

(12) Other diagnostic, screening, preventive, and rehabilitative services, and other remedial care;

(13) Inpatient hospital services, nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for mental diseases;

(14) Intermediate care facility services;

(15) Transportation services;

(16) Services in connection with the inpatient or outpatient treatment or care of drug abuse, when the treatment is prescribed by a physician and provided in a licensed hospital or in a narcotic and drug abuse treatment center approved by the Department of Health pursuant to P.L.1970, c.334 (C.26:2G-21 et seq.) and whose staff includes a medical director, and limited to those services eligible for federal financial participation under Title XIX of the federal Social Security Act;

(17) Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary of the federal Department of Health and Human Services, and approved by the commissioner;

(18) Comprehensive maternity care, which may include: the basic number of prenatal and postpartum visits recommended by the American College of Obstetrics and Gynecology; additional prenatal and postpartum visits that are medically necessary; necessary laboratory, nutritional assessment and counseling, health education, personal counseling, managed care, outreach, and follow-up services; treatment of conditions which may complicate pregnancy; and physician or certified nurse-midwife delivery services;

(19) Comprehensive pediatric care, which may include: ambulatory, preventive, and primary care health services. The preventive services shall include, at a minimum, the basic number of preventive visits recommended by the American Academy of Pediatrics;

(20) Services provided by a hospice which is participating in the Medicare program established pursuant to Title XVIII of the Social Security Act, Pub.L.89-97 (42 U.S.C. s.1395 et seq.). Hospice services shall be provided subject to approval of the Secretary of the federal Department of Health and Human Services for federal reimbursement;

(21) Mammograms, subject to approval of the Secretary of the federal Department of Health and Human Services for federal reimbursement, including one baseline mammogram for women who are at least 35 but less than 40 years of age; one mammogram examination every two years or more frequently, if recommended by a physician, for women who are at

least 40 but less than 50 years of age; and one mammogram examination every year for women age 50 and over.

c. Payments for the foregoing services, goods, and supplies furnished pursuant to this act shall be made to the extent authorized by this act, the rules and regulations promulgated pursuant thereto and, where applicable, subject to the agreement of insurance provided for under this act. The payments shall constitute payment in full to the provider on behalf of the recipient. Every provider making a claim for payment pursuant to this act shall certify in writing on the claim submitted that no additional amount will be charged to the recipient, the recipient's family, the recipient's representative or others on the recipient's behalf for the services, goods, and supplies furnished pursuant to this act.

No provider whose claim for payment pursuant to this act has been denied because the services, goods, or supplies were determined to be medically unnecessary shall seek reimbursement from the recipient, his family, his representative or others on his behalf for such services, goods, and supplies provided pursuant to this act; provided, however, a provider may seek reimbursement from a recipient for services, goods, or supplies not authorized by this act, if the recipient elected to receive the services, goods or supplies with the knowledge that they were not authorized.

d. Any individual eligible for medical assistance (including drugs) may obtain such assistance from any person qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability on a prepayment basis), who undertakes to provide the individual such services.

No copayment or other form of cost-sharing shall be imposed on any individual eligible for medical assistance, except as mandated by federal law as a condition of federal financial participation.

e. Anything in this act to the contrary notwithstanding, no payments for medical assistance shall be made under this act with respect to care or services for any individual who:

(1) Is an inmate of a public institution (except as a patient in a medical institution); provided, however, that an individual who is otherwise eligible may continue to receive services for the month in which he becomes an inmate, should the commissioner determine to expand the scope of Medicaid eligibility to include such an individual, subject to the limitations imposed by federal law and regulations, or

(2) Has not attained 65 years of age and who is a patient in an institution for mental diseases, or

(3) Is over 21 years of age and who is receiving inpatient psychiatric hospital services in a psychiatric facility; provided, however, that an individual who was receiving such services immediately prior to attaining age 21 may continue to receive such services until the individual reaches age 22. Nothing in this subsection shall prohibit the commissioner from extending medical assistance to all eligible persons receiving inpatient psychiatric services; provided that there is federal financial participation available.

f. (1) A third party as defined in section 3 of P.L.1968, c.413 (C.30:4D-3) shall not consider a person's eligibility for Medicaid in this or another state when determining the person's eligibility for enrollment or the provision of benefits by that third party.

(2) In addition, any provision in a contract of insurance, health benefits plan, or other health care coverage document, will, trust, agreement, court order, or other instrument which reduces or excludes coverage or payment for health care-related goods and services to or for an individual because of that individual's actual or potential eligibility for or receipt of

Medicaid benefits shall be null and void, and no payments shall be made under this act as a result of any such provision.

(3) Notwithstanding any provision of law to the contrary, the provisions of paragraph (2) of this subsection shall not apply to a trust agreement that is established pursuant to 42 U.S.C. s.1396p(d)(4)(A) or (C) to supplement and augment assistance provided by government entities to a person who is disabled as defined in section 1614(a)(3) of the federal Social Security Act (42 U.S.C. s.1382c (a)(3)).

g. The following services shall be provided to eligible medically needy individuals as follows:

(1) Pregnant women shall be provided prenatal care and delivery services and postpartum care, including the services cited in subsection a.(1), (3), and (5) of this section and subsection b.(1)-(10), (12), (15), and (17) of this section, and nursing facility services cited in subsection b.(13) of this section.

(2) Dependent children shall be provided with services cited in subsection a.(3) and (5) of this section and subsection b.(1), (2), (3), (4), (5), (6), (7), (10), (12), (15), and (17) of this section, and nursing facility services cited in subsection b.(13) of this section.

(3) Individuals who are 65 years of age or older shall be provided with services cited in subsection a.(3) and (5) of this section and subsection b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10), (12), (15), and (17) of this section, and nursing facility services cited in subsection b.(13) of this section.

(4) Individuals who are blind or disabled shall be provided with services cited in subsection a.(3) and (5) of this section and subsection b.(1)-(5), (6) excluding prescribed drugs, (7), (8), (10), (12), (15), and (17) of this section, and nursing facility services cited in subsection b.(13) of this section.

(5) (a) Inpatient hospital services, subsection a.(1) of this section, shall only be provided to eligible medically needy individuals, other than pregnant women, if the federal Department of Health and Human Services discontinues the State's waiver to establish inpatient hospital reimbursement rates for the Medicare and Medicaid programs under the authority of section 601(c)(3) of the Social Security Act Amendments of 1983, Pub.L.98-21 (42 U.S.C. s.1395ww(c)(5)). Inpatient hospital services may be extended to other eligible medically needy individuals if the federal Department of Health and Human Services directs that these services be included.

(b) Outpatient hospital services, subsection a.(2) of this section, shall only be provided to eligible medically needy individuals if the federal Department of Health and Human Services discontinues the State's waiver to establish outpatient hospital reimbursement rates for the Medicare and Medicaid programs under the authority of section 601(c)(3) of the Social Security Amendments of 1983, Pub.L.98-21 (42 U.S.C. s.1395ww(c)(5)). Outpatient hospital services may be extended to all or to certain medically needy individuals if the federal Department of Health and Human Services directs that these services be included. However, the use of outpatient hospital services shall be limited to clinic services and to emergency room services for injuries and significant acute medical conditions.

(c) The division shall monitor the use of inpatient and outpatient hospital services by medically needy persons.

h. In the case of a qualified disabled and working individual pursuant to section 6408 of Pub.L.101-239 (42 U.S.C. s.1396d), the only medical assistance provided under this act shall be the payment of premiums for Medicare part A under 42 U.S.C. ss.1395i-2 and 1395r.

i. In the case of a specified low-income Medicare beneficiary pursuant to 42 U.S.C. s.1396a(a)10(E)iii, the only medical assistance provided under this act shall be the payment

of premiums for Medicare part B under 42 U.S.C. s.1395r as provided for in 42 U.S.C. s.1396d(p)(3)(A)(ii).

j. In the case of a qualified individual pursuant to 42 U.S.C. s.1396a(aa), the only medical assistance provided under this act shall be payment for authorized services provided during the period in which the individual requires treatment for breast or cervical cancer, in accordance with criteria established by the commissioner.

360. Section 3 of P.L.1981, c.134 (C.30:4D-6.4) is amended to read as follows:

C.30:4D-6.4 Minimum requirements, liability insurance, personnel; rules, regulations.

3. After consulting with the Commissioner of Human Services, the Commissioner of Health is authorized and empowered to issue and enforce, or cause to be issued and enforced through the division, all necessary rules, regulations, and administrative orders with respect to:

a. The development of minimum requirements concerning the equipment, supplies, and vehicles of providers of mobility assistance vehicle services;

b. The establishment of standards for the amount of liability insurance each provider must maintain in order to be eligible to provide mobility assistance vehicle services. Evidence of such insurance, including the name of the insurer and the policy number, shall be filed at the time of application for approval by the division and from time to time as the division shall deem necessary; and

c. The establishment of standards for certified trained personnel employed by providers of mobility assistance vehicle services.

361. Section 7 of P.L.1968, c.413 (C.30:4D-7) is amended to read as follows:

C.30:4D-7 Duties of commissioner.

7. Duties of commissioner. The commissioner is authorized and empowered to issue, or to cause to be issued through the Division of Medical Assistance and Health Services, all necessary rules and regulations and administrative orders, and to do or cause to be done all other acts and things necessary to secure for the State of New Jersey the maximum federal participation that is available with respect to a program of medical assistance, consistent with fiscal responsibility and within the limits of funds available for any fiscal year, and to the extent authorized by the medical assistance program plan; to adopt fee schedules with regard to medical assistance benefits and otherwise to accomplish the purposes of this act, including specifically the following:

a. Subject to the limits imposed by this act, to submit a plan for medical assistance, as required by Title XIX of the federal Social Security Act, to the federal Department of Health and Human Services for approval pursuant to the provisions of such law; to act for the State in making negotiations relative to the submission and approval of such plan, to make such arrangements, not inconsistent with the law, as may be required by or pursuant to federal law to obtain and retain such approval and to secure for the State the benefits of the provisions of such law;

b. Subject to the limits imposed by this act, to determine the amount and scope of services to be covered, that the amounts to be paid are reasonable, and the duration of medical assistance to be furnished; provided, however, that the department shall provide medical assistance on behalf of all recipients of categorical assistance and such other related groups as are mandatory under federal laws and rules and regulations, as they now are or as

they may be hereafter amended, in order to obtain federal matching funds for such purposes and, in addition, provide medical assistance for the resource family children specified in subsection i.(7) of section 3 of P.L.1968, c.413 (C.30:4D-3). The medical assistance provided for these groups shall not be less in scope, duration, or amount than is currently furnished these groups, and in addition, shall include at least the minimum services required under federal laws and rules and regulations to obtain federal matching funds for such purposes.

The commissioner is authorized and empowered, at such times as he may determine feasible, within the limits of appropriated funds for any fiscal year, to extend the scope, duration, and amount of medical assistance on behalf of these groups of categorical assistance recipients, related groups as are mandatory, and resource family children authorized pursuant to section 3i. (7) of this act, so as to include, in whole or in part, the optional medical services authorized under federal laws and rules and regulations, and the commissioner shall have the authority to establish and maintain the priorities given such optional medical services; provided, however, that medical assistance shall be provided to at least such groups and in such scope, duration, and amount as are required to obtain federal matching funds.

The commissioner is further authorized and empowered, at such times as he may determine feasible, within the limits of appropriated funds for any fiscal year, to issue, or cause to be issued through the Division of Medical Assistance and Health Services, all necessary rules, regulations and administrative orders, and to do or cause to be done all other acts and things necessary to implement and administer demonstration projects pursuant to Title XI, section 1115 of the federal Social Security Act, including, but not limited to waiving compliance with specific provisions of this act, to the extent and for the period of time the commissioner deems necessary, as well as contracting with any legal entity, including but not limited to corporations organized pursuant to Title 14A, New Jersey Statutes (N.J.S.14A:1-1 et seq.), Title 15, Revised Statutes (R.S.15:1-1 et seq.), and Title 15A, New Jersey Statutes (N.J.S.15A:1-1 et seq.) as well as boards, groups, agencies, persons, and other public or private entities;

c. To administer the provisions of this act;

d. To make reports to the federal Department of Health and Human Services as from time to time may be required by such federal department and to the New Jersey Legislature as hereinafter provided;

e. To assure that any applicant, qualified applicant or recipient shall be afforded the opportunity for a hearing should the person’s claim for medical assistance be denied, reduced, terminated, or not acted upon within a reasonable time;

f. To assure that providers shall be afforded the opportunity for an administrative hearing within a reasonable time on any valid complaint arising out of the claim payment process;

g. To provide safeguards to restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with administration of this act;

h. To take all necessary action to recover any and all payments incorrectly made to or illegally received by a provider from such provider or his estate or from any other person, firm, corporation, partnership, or entity responsible for or receiving the benefit or possession of the incorrect or illegal payments or their estates, successors or assigns, and to assess and collect such penalties as are provided for herein;

i. To take all necessary action to recover the cost of benefits incorrectly provided to or illegally obtained by a recipient, including those made after a voluntary divestiture of real or

personal property or any interest or estate in property for less than adequate consideration made for the purpose of qualifying for assistance. The division shall take action to recover the cost of benefits from a recipient, legally responsible relative, representative payee, or any other party or parties whose action or inaction resulted in the incorrect or illegal payments or who received the benefit of the divestiture, or from their respective estates, as the case may be and to assess and collect the penalties as are provided for herein, except that no lien shall be imposed against property of the recipient prior to his death except in accordance with section 17 of P.L.1968, c.413 (C.30:4D-17). No recovery action shall be initiated more than five years after an incorrect payment has been made to a recipient when the incorrect payment was due solely to an error on the part of the State or any agency, agent, or subdivision thereof;

j. To take all necessary action to recover the cost of benefits correctly provided to a recipient from the estate of said recipient in accordance with sections 6 through 12 of this amendatory and supplementary act;

k. To take all reasonable measures to ascertain the legal or equitable liability of third parties to pay for care and services (available under the plan) arising out of injury, disease, or disability; where it is known that a third party has a liability, to treat such liability as a resource of the individual on whose behalf the care and services are made available for purposes of determining eligibility; and in any case where such a liability is found to exist after medical assistance has been made available on behalf of the individual, to seek reimbursement for such assistance to the extent of such liability;

l. To compromise, waive, or settle and execute a release of any claim arising under this act including interest or other penalties, or designate another to compromise, waive, or settle and execute a release of any claim arising under this act. The commissioner or the commissioner's designee whose title shall be specified by regulation may compromise, settle or waive any such claim in whole or in part, either in the interest of the Medicaid program or for any other reason which the commissioner by regulation shall establish;

m. To pay or credit to a provider any net amount found by final audit as defined by regulation to be owing to the provider. Such payment, if it is not made within 45 days of the final audit, shall include interest on the amount due at the maximum legal rate in effect on the date the payment became due, except that such interest shall not be paid on any obligation for the period preceding September 15, 1976. This subsection shall not apply until federal financial participation is available for such interest payments;

n. To issue, or designate another to issue, subpoenas to compel the attendance of witnesses and the production of books, records, accounts, papers, and documents of any party, whether or not that party is a provider, which directly or indirectly relate to goods or services provided under this act, for the purpose of assisting in any investigation, examination, or inspection, or in any suspension, debarment, disqualification, recovery, or other proceeding arising under this act;

o. To solicit, receive, and review bids pursuant to the provisions of P.L.1954, c.48 (C.52:34-6 et seq.) and all amendments and supplements thereto, by any corporation doing business in the State of New Jersey, including nonprofit hospital service corporations, medical service corporations, health service corporations, or dental service corporations incorporated in New Jersey and authorized to do business pursuant to P.L.1938, c.366 (C.17:48-1 et seq.), P.L.1940, c.74 (C.17:48A-1 et seq.), P.L.1985, c.236 (C.17:48E-1 et seq.), or P.L.1968, c.305 (C.17:48C-1 et seq.), and to make recommendations in connection therewith to the State Medicaid Commission;

p. To contract, or otherwise provide as in this act provided, for the payment of claims in the manner approved by the State Medicaid Commission;

q. Where necessary, to advance funds to the underwriter or fiscal agent to enable such underwriter or fiscal agent, in accordance with terms of its contract, to make payments to providers;

r. To enter into contracts with federal, State, or local governmental agencies, or other appropriate parties, when necessary to carry out the provisions of this act;

s. To assure that the nature and quality of the medical assistance provided for under this act shall be uniform and equitable to all recipients;

t. To provide for the reimbursement of State and county-administered skilled nursing and intermediate care facilities through the use of a governmental peer grouping system, subject to federal approval and the availability of federal reimbursement.

(1) In establishing a governmental peer grouping system, the State's financial participation is limited to an amount equal to the nonfederal share of the reimbursement which would be due each facility if the governmental peer grouping system was not established, and each county's financial participation in this reimbursement system is equal to the nonfederal share of the increase in reimbursement for its facility or facilities which results from the establishment of the governmental peer grouping system.

(2) On or before December 1 of each year, the commissioner shall estimate and certify to the Director of the Division of Local Government Services in the Department of Community Affairs the amount of increased federal reimbursement a county may receive under the governmental peer grouping system. On or before December 15 of each year, the Director of the Division of Local Government Services shall certify the increased federal reimbursement to the chief financial officer of each county. If the amount of increased federal reimbursement to a county exceeds or is less than the amount certified, the certification for the next year shall account for the actual amount of federal reimbursement that the county received during the prior calendar year.

(3) The governing body of each county entitled to receive increased federal reimbursement under the provisions of this amendatory act shall, by March 31 of each year, submit a report to the commissioner on the intended use of the savings in county expenditures which result from the increased federal reimbursement. The governing body of each county, with the advice of agencies providing social and health related services, shall use not less than 10% and no more than 50% of the savings in county expenditures which result from the increased federal reimbursement for community-based social and health related programs for elderly and disabled persons who may otherwise require nursing home care. This percentage shall be negotiated annually between the governing body and the commissioner and shall take into account a county's social, demographic, and fiscal conditions, a county's social and health related expenditures and needs, and estimates of federal revenues to support county operations in the upcoming year, particularly in the areas of social and health related services.

(4) The commissioner, subject to approval by law, may terminate the governmental peer grouping system if federal reimbursement is significantly reduced or if the Medicaid program is significantly altered or changed by the federal government subsequent to the enactment of this amendatory act. The commissioner, prior to terminating the governmental peer grouping system, shall submit to the Legislature and to the governing body of each county a report as to the reasons for terminating the governmental peer grouping system;

u. The commissioner, in consultation with the Commissioner of Health, shall:

(1) Develop criteria and standards for comprehensive maternity or pediatric care providers and determine whether a provider who requests to become a comprehensive maternity or pediatric care provider meets the department's criteria and standards;

(2) Develop a program of comprehensive maternity care services which defines the type of services to be provided, the level of services to be provided, and the frequency with which qualified applicants are to receive services pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.);

(3) Develop a program of comprehensive pediatric care services which defines the type of services to be provided, the level of services to be provided, and the frequency with which qualified applicants are to receive services pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.);

(4) Develop and implement a system for monitoring the quality and delivery of comprehensive maternity and pediatric care services and a system for evaluating the effectiveness of the services programs in meeting their objectives;

(5) Establish provider reimbursement rates for the comprehensive maternity and pediatric care services;

v. The commissioner, jointly with the Commissioner of Health, shall report to the Governor and the Legislature no later than two years following the date of enactment of P.L.1987, c.115 (C.30:4D-2.1 et al.) and annually thereafter on the status of the comprehensive maternity and pediatric care services and their effectiveness in meeting the objectives set forth in section 1 of P.L.1987, c.115 (C.30:4D-2.1) accompanying the report with any recommendations for changes in the law governing the services that the commissioners deem necessary.

362. Section 2 of P.L.2009, c.268 (C.30:4D-7l) is amended to read as follows:

C.30:4D-71 Department to facilitate implementation of C.30:4D-7k.

2. The Department of Health shall adjust the Family Planning Services Grant-in-Aid appropriation and transfer the appropriate amount of State funds to the Division of Medical Assistance and Health Services in the Department of Human Services to facilitate the implementation of section 1 of this act. The Department of Health shall notify the Legislative Budget and Finance Officer as to the amount that is transferred.

363. Section 4 of P.L.2011, c.114 (C.30:4D-8.4) is amended to read as follows:

C.30:4D-8.4 Applications for certification as a Medicaid ACO.

4. a. The department shall accept applications for certification from demonstration project applicants beginning 60 days following the effective date of this act, and shall certify an applicant as a Medicaid ACO for participation in the demonstration project following its determination that the applicant meets the requirements specified in this section. The department may deny certification of any ACO applicant that the department determines does not meet the requirements of this act. The department may consider applications for approval, including revised applications submitted by an ACO not previously approved to participate in the demonstration project.

b. The department, in consultation with the Department of Health, may certify as many ACOs for participation in the demonstration project as it determines appropriate, but shall certify no more than one ACO for each designated area.

c. Prior to certification, a demonstration project applicant shall demonstrate that it meets the following minimum standards:

(1) The applicant has been formed as a nonprofit corporation pursuant to the "New Jersey Nonprofit Corporation Act," P.L.1983, c.127 (C.15A:1-1 et seq.), for the purposes described in this act;

(2) The applicant's governing board includes:

(a) individuals representing the interests of: health care providers, including, but not limited to, general hospitals, clinics, private practice offices, physicians, behavioral health care providers, and dentists, patients, and other social service agencies or organizations located in the designated area; and

(b) voting representation from at least two consumer organizations capable of advocating on behalf of patients residing within the designated area of the ACO. At least one of the organizations shall have extensive leadership involvement by individuals residing within the designated area of the ACO, and shall have a physical location within the designated area. Additionally, at least one of the individuals representing a consumer organization shall be an individual who resides within the designated area served by the ACO;

(3) The applicant has support of its application by: all of the general hospitals located in the designated area served by the ACO; no fewer than 75% of the qualified primary care providers located in the designated area; and at least four qualified behavioral health care providers located in the designated area;

(4) The applicant has a process for receipt of gainsharing payments from the department and any voluntarily participating Medicaid managed care organizations, and the subsequent distribution of such gainsharing payments in accordance with a quality improvement and gainsharing plan to be approved by the department, in consultation with the Department of Health;

(5) The applicant has a process for engaging members of the community and for receiving public comments with respect to its gainsharing plan;

(6) The applicant has a commitment to become accountable for the health outcomes, quality, cost, and access to care of Medicaid recipients residing in the designated area for a period of at least three years following certification; and

(7) The applicant has a commitment to ensure the use of electronic prescribing and electronic medical records by health care providers located in the designated area.

d. Nothing in this act shall be construed to prevent the department from certifying an applicant as a Medicaid ACO that also participates in a Medicare ACO demonstration project approved by the federal Centers for Medicare & Medicaid Services.

364. Section 5 of P.L.2011, c.114 (C.30:4D-8.5) is amended to read as follows:

C.30:4D-8.5 Eligibility to receive, distribute gainsharing payments.

5. a. A certified Medicaid ACO shall be eligible to receive and distribute gainsharing payments only after having received approval from the department of its gainsharing plan, which approval may be requested by the ACO at the time of certification or at any time within one year of certification. An ACO may seek to amend its gainsharing plan at any time following the plan's initial approval by submitting amendments to the department for approval.

b. The department, with input from the Department of Health and utilizing outcome evaluation data provided by the Rutgers Center for State Health Policy, shall approve only those gainsharing plans that promote: improvements in health outcomes and quality of care, as measured by objective benchmarks as well as patient experience of care; expanded access to primary and behavioral health care services; and the reduction of unnecessary and

inefficient costs associated with care rendered to Medicaid recipients residing in the ACO's designated area. The department and the Department of Health shall provide all data necessary to the Rutgers Center for State Health Policy for analysis in support of the department's review of gainsharing plans. Criteria to be considered by the department and the Department of Health in approving a gainsharing plan shall include, but are not limited to:

(1) whether the plan promotes: care coordination through multi-disciplinary teams, including care coordination of patients with chronic diseases and the elderly; expansion of the medical home and chronic care models; increased patient medication adherence and use of medication therapy management services; use of health information technology and sharing of health information; and use of open access scheduling in clinical and behavioral health care settings;

(2) whether the plan encourages services such as patient or family health education and health promotion, home-based services, telephonic communication, group care, and culturally and linguistically appropriate care;

(3) whether the gainsharing payment system is structured to reward quality and improved patient outcomes and experience of care;

(4) whether the plan funds interdisciplinary collaboration between behavioral health and primary care providers for patients with complex care needs likely to inappropriately access an emergency department and general hospital for preventable conditions;

(5) whether the plan funds improved access to dental services for high-risk patients likely to inappropriately access an emergency department and general hospital for untreated dental conditions; and

(6) whether the plan has been developed with community input and will be made available for inspection by members of the community served by the ACO.

c. The gainsharing plan shall include an appropriate proposed time period beginning and ending on specified dates prior to the commencement of the demonstration project, which shall be the benchmark period against which cost savings can be measured on an annual basis going forward. Savings shall be calculated in accordance with a methodology that:

(1) identifies expenditures per recipient by the Medicaid fee-for-service program during the benchmark period, adjusted for characteristics of recipients and local conditions that predict future Medicaid spending but are not amenable to the care coordination or management activities of an ACO which shall serve as the benchmark payment calculation;

(2) compares the benchmark payment calculation to amounts paid by the Medicaid fee-for-service program for all such resident recipients during subsequent periods; and

(3) provides that the benchmark payment calculation shall remain fixed for a period of three years following approval of the gainsharing plan.

d. The percentage of cost savings identified pursuant to subsection c. of this section to be distributed to the ACO, retained by any voluntarily participating Medicaid managed care organization, and retained by the State, shall be identified in the gainsharing plan and shall remain in effect for a period of three years following approval of the gainsharing plan. The percentages shall be designed to ensure that:

(1) the State can achieve meaningful savings and support the ongoing operation of the demonstration project, and

(2) the ACO receives a sufficient portion of the shared savings necessary to achieve its mission and expand its scope of activities.

e. Notwithstanding the provisions of this section to the contrary, the department shall not approve a gainsharing plan that provides direct or indirect financial incentives for the

reduction or limitation of medically necessary and appropriate items or services provided to patients under a health care provider's clinical care in violation of federal law.

f. Notwithstanding the provisions of this section to the contrary, a gainsharing plan that provides for shared savings between general hospitals and physicians related to acute care admissions utilizing the methodological component of the Physician-Hospital Collaboration Demonstration awarded by the federal Centers for Medicare & Medicaid Services to the New Jersey Care Integration Consortium, shall not be required to be approved by the department. The department shall not be under any obligation to participate in the Physician-Hospital Collaboration Demonstration.

g. The department shall consider using a portion of any savings generated to expand the nursing, primary care, behavioral health care, and dental workforces and services in the area served by the ACO.

h. A gainsharing plan submitted to the department for this ACO demonstration project shall contain an assessment of the expected impact of revenues on hospitals that agree to participate. The assessment shall include estimates for changes in both direct patient care reimbursement and indirect revenue, such as disproportionate share payments, graduate medical education payments, and other similar payments. The assessment shall include a review of whether participation in the demonstration project could significantly impact the financial stability of any hospital through rapid reductions in revenue and how this impact will be mitigated. The gainsharing plan shall include a letter of support from all participating hospitals in order to be accepted by the department.

365. Section 8 of P.L.2011, c.114 (C.30:4D-8.8) is amended to read as follows:

C.30:4D-8.8 Duties of the department; authorization to seek grants.

8. a. The department, in consultation with the Department of Health, shall:

(1) design and implement the application process for approval of participating ACOs in the demonstration project;

(2) collect data from participants in the demonstration project; and

(3) approve a methodology proposed by the Medicaid ACO applicant for calculation of cost savings and for monitoring of health outcomes and quality of care under the demonstration project.

b. The department and the Department of Health shall be authorized to jointly seek public and private grants to implement and operate the demonstration project.

366. Section 9 of P.L.2011, c.114 (C.30:4D-8.9) is amended to read as follows:

C.30:4D-8.9 Annual evaluation.

9. The department, in consultation with the Department of Health, shall evaluate the demonstration project annually to assess whether: cost savings, including, but not limited to, savings in administrative costs and savings due to improved health outcomes, are achieved through implementation of the demonstration project.

The department, in consultation with the Department of Health, and with the assistance of the Rutgers Center for State Health Policy, shall evaluate the demonstration project annually to assess whether there is improvement in the rates of health screening, the outcomes and hospitalization rates for persons with chronic illnesses, and the hospitalization and readmission rates for patients residing in the designated areas served by the ACOs. The

department and the Department of Health shall provide the Rutgers Center for State Health Policy with all data necessary to perform the annual evaluation of the demonstration project.

367. Section 12 of P.L.2011, c.114 (C.30:4D-8.12) is amended to read as follows:

C.30:4D-8.12 Continuation of payments for certain services.

12. a. Under the demonstration project, payment shall continue to be made to providers of services and suppliers participating in the Medicaid ACO for services provided to managed care recipients or individuals who receive services on a fee-for-service basis in the same manner as they would otherwise be made, except that the ACO is eligible to receive gainsharing payments under sections 5 and 6 of this act if it meets the requirements set forth therein.

b. Nothing in this act shall be construed to authorize the Department of Human Services or Health to waive or limit any provisions of federal or State law or reimbursement methodologies governing Medicaid reimbursement to federally qualified health centers, including, but not limited to, Medicaid prospective payment reimbursement and any supplemental payments made to a federally qualified health center providing services to Medicaid managed care recipients.

368. Section 14 of P.L.2001, c.114 (C.30:4D-8.14) is amended to read as follows:

C.30:4D-8.14 Report to Governor, Legislature.

14. Upon completion of the demonstration project, the Commissioners of Human Services and Health shall report to the Governor, and to the Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), on the demonstration project, and include in the report the findings of the evaluation carried out pursuant to section 9 of this act. The commissioners shall make such recommendations as they deem appropriate.

If, after three years following enactment of this act, the commissioners find the demonstration project was successful in reducing costs and improving health outcomes and the quality of care for Medicaid recipients, the commissioners may recommend that Medicaid ACOs be established on a permanent basis and in additional communities in which Medicaid recipients reside.

369. Section 15 of P.L.2011, c.114 (C.30:4D-8.15) is amended to read as follows:

C.30:4D-8.15 Rules, regulations.

15. The Commissioner of Human Services, in accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) and with input from the Commissioner of Health, shall, within 180 days of the effective date of this act, adopt rules and regulations establishing the standards for gainsharing plans submitted by Medicaid ACOs. The Commissioner of Human Services shall also adopt, with input from the Commissioner of Health such rules and regulations governing the ongoing oversight and monitoring of the quality of care delivered to Medicaid recipients in the designated areas served by the Medicaid ACOs, and such other requirements as the Commissioner of Human Services deems necessary to carry out the provisions of this act.

370. Section 2 of P.L.1998, c.41 (C.30:4D-17.17a) is amended to read as follows:

C.30:4D-17.17a Drug Utilization Review Board.

2. a. There is established the Drug Utilization Review Board in the department to advise the department on the implementation of a drug utilization review program pursuant to P.L.1993, c.16 (C.30:4D-17.16 et seq.) and this section. The board shall establish a Senior Drug Utilization Review Committee to address the specific prescribing needs of the elderly and an AIDS/HIV Drug Utilization Review Committee to address the specific prescribing needs of persons with AIDS/HIV, in addition to such other committees as it deems necessary. It shall be the responsibility of each committee to evaluate the specific prescribing needs of its beneficiary population, and to submit recommendations to the board in regard thereto.

The board shall consist of 17 members, including the Commissioners of Human Services and Health or their designees, who shall serve as nonvoting ex officio members, and 15 public members. The public members shall be appointed by the Governor with the advice and consent of the Senate. The appointments shall be made as follows: six persons licensed and actively engaged in the practice of medicine in this State, including one who is a psychiatrist and at least two who specialize in geriatric medicine and two who specialize in AIDS/HIV care, one of whom who is a pediatric AIDS/HIV specialist, four of whom shall be appointed upon the recommendation of the Medical Society of New Jersey and two upon the recommendation of the New Jersey Association of Osteopathic Physicians and Surgeons; one person licensed as a physician in this State who is actively engaged in academic medicine; four persons licensed in and actively practicing or teaching pharmacy in this State, who shall be appointed from a list of pharmacists recommended by the New Jersey Pharmacists Association, the New Jersey Council of Chain Drug Stores, the Garden State Pharmacy Owners, Inc., the New Jersey Society of Hospital Pharmacists, the Academy of Consultant Pharmacists and the College of Pharmacy of Rutgers, The State University; one additional health care professional; two persons certified as advanced practice nurses in this State, who shall be appointed upon the recommendation of the New Jersey State Nurses Association; and one member to be appointed upon the recommendation of the Pharmaceutical Research and Manufacturers of America.

Each member of the board shall have expertise in the clinically appropriate prescribing and dispensing of outpatient drugs.

b. All appointments to the board shall be made no later than the 60th day after the effective date of this act. The public members shall be appointed for two-year terms and shall serve until a successor is appointed and qualified, and are eligible for reappointment; except that of the public members first appointed, eight shall be appointed for a term of two years and five for a term of one year.

c. Vacancies in the membership of the board shall be filled in the same manner as the original appointments were made but for the unexpired term only. Members of the board shall serve with compensation for the time and expenses incurred in the performance of their duties as board members, as determined by the Commissioners of Human Services and Health, subject to the approval of the Director of the Division of Budget and Accounting in the Department of the Treasury.

d The board shall select a chairman from among the public members, who shall serve a one-year term, and a secretary. The chairman may serve consecutive terms. The board shall adopt bylaws. The board shall meet at least quarterly and may meet at other times at the call of the chairman. The board shall in all respects comply with the provisions of the "Senator Byron M. Baer Open Public Meetings Act," P.L.1975, c.231 (C.10:4-6 et seq.). No motion

to take any action by the board shall be valid except upon the affirmative vote of a majority of the authorized membership of the board.

e. The duties of the board shall include the development and application of the criteria and standards to be used in retrospective and prospective drug utilization review. The criteria and standards shall be based on the compendia and developed with professional input in a consensus fashion. There shall be provisions for timely reassessments and revisions as necessary and provisions for input by persons acting as patient advocates. The drug utilization review standards shall reflect the local practices of prescribers, in order to monitor:

(1) therapeutic appropriateness;

(2) overutilization or underutilization;

(3) therapeutic duplication;

(4) drug-disease contraindications;

(5) drug-drug interactions;

(6) incorrect drug dosage;

(7) duration of drug treatment; and

(8) clinical drug abuse or misuse.

The board shall recommend to the department criteria for denials of claims and establish standards for a medical exception process. The board shall also consider relevant information provided by interested parties outside of the board and, if appropriate, shall make revisions to the criteria and standards in a timely manner based upon this information.

f. The board, with the approval of the department, shall be responsible for the development, selection, application, and assessment of interventions or remedial strategies for prescribers, pharmacists, and beneficiaries that are educational and not punitive in nature to improve the quality of care, including:

(1) Information disseminated to prescribers and pharmacists to ensure that they are aware of the duties and powers of the board;

(2) Written, oral, or electronic reminders of patient-specific or drug-specific information that are designed to ensure prescriber, pharmacist, and beneficiary confidentiality, and suggested changes in the prescribing or dispensing practices designed to improve the quality of care;

(3) The development of an educational program, using data provided through drug utilization review as a part of active and ongoing educational outreach activities to improve prescribing and dispensing practices as provided in this section. These educational outreach activities shall include accurate, balanced, and timely information about drugs and their effect on a patient. If the board contracts with another entity to provide this program, that entity shall publicly disclose any financial interest or benefit that accrues to it from the products selected or used in this program;

(4) Use of face-to-face discussion between experts in drug therapy and the prescriber or pharmacist who has been designated by the board for educational intervention;

(5) Intensified reviews or monitoring of selected prescribers or pharmacists;

(6) The timely evaluation of interventions to determine whether the interventions have improved the quality of care; and

(7) The review of case profiles prior to the conducting of an intervention.

371. Section 3 of P.L.1993, c.163 (C.30:4D-17.18) is amended to read as follows:

C.30:4D-17.18 Responsibilities of department.

3. The department shall be responsible for:

a. (Deleted by amendment, P.L.1998, c.41).

b. The implementation of a drug utilization review program, subject to the approval of the Commissioner of Health, to ensure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes, including the approval of the provisions of any contractual agreement between the State pharmaceutical benefits program and other entities processing and reviewing drug claims and profiles for the drug utilization review program.

The program shall include both retrospective and prospective drug utilization review. Retrospective drug utilization review shall include an analysis of drug claims processing data in order to identify patterns of fraud, abuse, or gross overuse, and inappropriate or medically unnecessary care, and to assess data on drug use against standards that are based on the compendia and other sources. Prospective drug utilization review shall include a review conducted by the pharmacist at the point of sale.

c. (Deleted by amendment, P.L.1998, c.41).

d. (Deleted by amendment, P.L.1998, c.41).

e. The submission of an annual report, which shall be subject to public comment prior to its issuance, to the federal Department of Health and Human Services by December 1 of each year. The annual report shall also be submitted to the Governor, the Legislature, the New Jersey Pharmaceutical Association and the Medical Society of New Jersey by December 1 of each year. The report shall include the following information:

(1) An overview of the activities of the board and the drug utilization review program;

(2) Interventions used and their ability to improve the quality of care; however, this information shall not disclose the identities of individual prescribers, pharmacists, or beneficiaries, but shall specify whether the intervention was a result of underutilization or overutilization of drugs;

(3) The costs of administering the drug utilization review program;

(4) Any cost impact to other areas of the State pharmaceutical benefits program resulting from the drug utilization review program, such as hospitalization rates or changes in long-term care;

(5) A quantitative assessment of how drug utilization review has improved beneficiaries' quality of care;

(6) A review of the total number of prescriptions and medical exception requests reviewed by drug therapeutic class;

(7) An assessment of the impact of the educational program established pursuant to subsection f. of section 2 of P.L.1998, c.41 (C.30:4D-17.17a) and interventions on prescribing or dispensing practices, total program costs, quality of care, and other pertinent patient patterns; and

(8) Recommendations for improvement of the drug utilization review program.

f. The development of a working agreement between the board and other boards or agencies, including, but not limited to: the Board of Pharmacy of the State of New Jersey and the State Board of Medical Examiners, in order to clarify any overlapping areas of responsibility.

g. The establishment of an appeal process for prescribers, pharmacists, and beneficiaries pursuant to P.L.1993, c.16 (C.30:4D-17.16 et seq.) and section 2 of P.L.1998, c.41 (C.30:4D-17.17a).

h. The publication and dissemination of medically correct and balanced educational information to prescribers and pharmacists to identify and reduce the frequency of patterns of

fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among prescribers, pharmacists, and beneficiaries, including:

(1) potential or actual reactions to drugs;

(2) therapeutic appropriateness;

(3) overutilization or underutilization;

(4) appropriate use of generic drugs;

(5) therapeutic duplication;

(6) drug-disease contraindications;

(7) drug-drug interactions;

(8) incorrect drug dosage or duration of drug treatment;

(9) drug allergy interactions; and

(10) clinical abuse or misuse.

i. The development and publication, with the input of the Board of Pharmacy of the State of New Jersey, of the guidelines to be used by pharmacists, including mail order pharmacies, in their counseling of beneficiaries.

j. The adoption and implementation of procedures designed to ensure the confidentiality of any information collected, stored, retrieved, assessed, or analyzed by the board, staff to the board, or contractors to the drug utilization review program, that identifies individual prescribers, pharmacists, or beneficiaries. The board may have access to identifying information for purposes of carrying out intervention activities, but the identifying information may not be released to anyone other than a member of the board, except that the board may release cumulative nonidentifying information for purposes of legitimate research. The improper release of identifying information in violation of this act may subject that person to criminal or civil penalties.

k. The determination of whether nursing or long-term care facilities under 42 CFR 483.60 are exempt from the provisions of this act.

l. The establishment of a medical exception process by regulation.

m. The provision of such staff and other resources as the board requires.

372. Section 4 of P.L.1998, c.41 (C.30:4D-17.18a) is amended to read as follows:

C.30:4D-17.18a Rules, regulations.

4. The Commissioner of Human Services, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), and subject to the approval of the Commissioner of Health as appropriate, shall adopt rules and regulations to effectuate the purposes of P.L.1993, c.16 (C.30:4D-17.16 et seq.) and section 2 of P.L.1998, c.41 (C.30:4D-17.17a); except that, notwithstanding any provision of P.L.1968, c.410 (C.52:14B-1 et seq.) to the contrary, the Commissioner of Human Services, may adopt, immediately upon filing with the Office of Administrative Law, such regulations as the commissioner deems necessary to implement the provisions of P.L.1993, c.16 (C.30:4D-17.16 et seq.) and section 2 of P.L.1998, c.41 (C.30:4D-17.17a), which shall be effective for a period not to exceed six months and may thereafter be amended, adopted or re-adopted by the Commissioner of Human Services, in accordance with the requirements of P.L.1968, c.410 (C.52:14B-1 et seq.).

373. Section 2 of P.L.2006, c.23 (C.30:4D-17.24) is amended to read as follows:

C.30:4D-17.24 Findings, declarations relative to long-term care for Medicaid recipients.

2. The Legislature finds and declares that:

a. The current population of adults 60 years of age and older in New Jersey is about 1.4 million, and this number is expected to double in size over the next 25 years;

b. A primary objective of public policy governing access to long-term care in this State shall be to promote the independence, dignity and lifestyle choice of older adults and persons with physical disabilities or Alzheimer's disease and related disorders;

c. Many states are actively seeking to "rebalance" their long-term care programs and budgets in order to support consumer choice and offer more choices for older adults and persons with disabilities to live in their homes and communities;

d. New Jersey has been striving to redirect long-term care away from an over-reliance on institutional care toward more home and community-based options; however, it is still often easier for older adults and persons with disabilities to qualify for Medicaid long-term care coverage if they are admitted to a nursing home than if they seek to obtain services through one of the Medicaid home and community-based long-term care options available in this State, such as the Global Options Waiver, Adult Day Health Services, Traumatic Brain Injury, AIDS Community Care Alternatives Program, Community Resources for People with Disabilities, or Community Resources for People with Disabilities Private Duty Nursing;

e. The federal "New Freedom Initiative" was launched in 2001 for the purpose of promoting the goal of independent living for persons with disabilities; and Executive Order No. 13217, issued by the President of the United States on June 18, 2001, called upon the federal government to assist states and localities to swiftly implement the 1999 United States Supreme Court decision in Olmstead v. L.C. and directed federal agencies to evaluate their policies, programs, statutes, and regulations to determine whether any should be revised or modified to improve the availability of community-based services for qualified persons with disabilities;

f. Executive Order No. 100, issued by the Governor on March 23, 2004, directed the Commissioner of Health, in consultation with the State Treasurer, to prepare an analysis and recommendations for developing a global long-term care budgeting process designed to provide the Department of Health with the authority and flexibility to move Medicaid recipients into the appropriate level of care based on their individual needs, and to identify specific gaps and requirements necessary to streamline paperwork and expedite the process of obtaining Medicaid eligibility for home care options for those who qualify;

g. Executive Order No. 31, issued by the Governor on April 21, 2005, established a "money follows the person" pilot program and set aside funding in fiscal year 2006 for home and community-based long-term care;

h. Older adults and those with physical disabilities or Alzheimer's disease and related disorders that require a nursing facility level of care should not be forced to choose between going into a nursing home or giving up the medical assistance that pays for their needed services, and thereby be denied the right to choose where they receive those services; their eligibility for home and community-based long-term care services under Medicaid should be based upon the same income and asset standards as those used to determine eligibility for long-term care in an institutional setting; and

i. The enactment of P.L.2006, c.23 (C.30:4D-17.23 et seq.) will ensure that, in the case of Medicaid-funded long-term care services, "the money follows the person" to allow maximum flexibility between nursing homes and home and community-based settings when it does not compromise federal funding or services in the nursing home and, in so doing, significantly expands the choices available to consumers of these services and thereby fulfills

the goal of personal independence so highly valued by the growing number of older adults and persons with disabilities in this State.

374. Section 3 of P.L.2006, c.23 (C.30:4D-17.25) is amended to read as follows:

C.30:4D-17.25 Definitions relative to long-term care for Medicaid recipients.

3. As used in this act:

"Commissioner" means the Commissioner of Human Services.

"Funding parity between nursing home care and home and community-based care" means that the distribution of the amounts expended for these two categories of long-term care under the Medicaid program reflects an appropriate balance between the service delivery costs of those persons whose needs and preferences can most appropriately be met in a nursing home and those persons whose needs and preferences can most appropriately be met in a home or community-based setting.

"Home and community-based care" means Medicaid home and community-based long-term care options available in this State, including, but not limited to, the Global Options Waiver, Adult Day Health Services, Traumatic Brain Injury, AIDS Community Care Alternatives Program, Community Resources for People with Disabilities, and Community Resources for People with Disabilities Private Duty Nursing.

375. Section 4 of P.L.2006, c.23 (C.30:4D-17.26) is amended to read as follows:

C.30:4D-17.26 Process to rebalance allocation of funding for expansion of long-term care services; pilot program, use Statewide.

4. a. (1) Beginning in fiscal year 2008, and in each succeeding fiscal year through fiscal year 2013, the commissioner, in consultation with the State Treasurer and in accordance with the provisions of this section, shall implement a process that rebalances the overall allocation of funding within the Department of Human Services for long-term care services through the expansion of home and community-based services for persons eligible for long-term care as defined by regulation of the commissioner. The expansion of home and community-based services shall be funded, within the existing level of appropriations, by diverting persons in need of long-term care to allow maximum flexibility between nursing home placements and home and community-based services. The State Treasurer, after review and analysis, shall determine the transfer of such funding to home and community-based services provided by the Department of Human Services as is necessary to effectuate the purposes of this act.

(2) Beginning in fiscal year 2008, and in each succeeding fiscal year through fiscal year 2013, funds equal to the amount of the reduction in the projected growth of Medicaid expenditures for nursing home care pursuant to paragraph (1) of this subsection, for State dollars only plus the percentage anticipated for programs and persons that will receive federal matching dollars, shall be reallocated to home and community-based care through a global budget and expended solely for such care, until the commissioner determines that total Medicaid expenditures for long-term care have been sufficiently rebalanced to achieve funding parity between nursing home care and home and community-based care. Any funds so reallocated, which are not expended in the fiscal year in which they are reallocated, shall be reserved for expenditures for home and community-based care in a subsequent fiscal year.

(3) Subject to federal approval, the home and community-based services to which funds are reallocated pursuant to this act shall include services designated by the commissioner and the Medicaid Long-Term Care Funding Advisory Council established pursuant to this act.

(4) Notwithstanding the provisions of this subsection to the contrary, this act shall not be construed to authorize a reduction in funding for Medicaid-approved services based upon the approved State Medicaid nursing home reimbursement methodology, including existing cost screens used to determine daily rates, annual rebasing and inflationary adjustments.

b. The commissioner shall adopt modifications to the Medicaid long-term care intake system that promote increased use of home and community-based services. These modifications shall include, but not be limited to, the following:

(1) commencing March 1, 2007, on a pilot basis in Atlantic and Warren counties, pursuant to Executive Order No. 31 of 2005:

(a) the provision of home and community-based services available under Medicaid, as designated by the commissioner, in consultation with the Medicaid Long-Term Care Funding Advisory Council established pursuant to this act, pending completion of a formal Medicaid financial eligibility determination for the recipient of services, for a period that does not exceed a time limit established by the commissioner; except that the cost of any services provided pursuant to this subparagraph to a person who is subsequently determined to be ineligible for Medicaid may be recovered from that person; and

(b) the use of mechanisms for making fast-track Medicaid eligibility determinations, a revised clinical assessment instrument, and a computerized tracking system for Medicaid long-term care expenditures; and

(2) commencing March 1, 2008, expansion of the services and measures provided for in paragraph (1) of this subsection to all of the remaining counties in the State, subject to the commissioner conducting or otherwise providing for an evaluation of the pilot programs in Atlantic and Warren counties prior to that date and determining from that evaluation that the pilot programs are cost-effective and should be expanded Statewide.

376. Section 6 of P.L.2006, c.23 (C.30:4D-17.28) is amended to read as follows:

C.30:4D-17.28 Duties of commissioner relative to funding parity, coordination, assessment instrument.

6. The commissioner, in consultation with the Medicaid Long-Term Care Funding Advisory Council established pursuant to this act, shall:

a. Implement, by such time as the commissioner certifies to the Governor and the Legislature that funding parity has been achieved pursuant to subsection b. of section 5 of this act, a comprehensive data system to track long-term care expenditures and services and consumer profiles and preferences. The data system shall include, but not be limited to: the number of vacant nursing home beds annually and the number of nursing home residents transferred to home and community-based care pursuant to this act; annual long-term care expenditures for nursing home care and each of the home and community based long-term care options available to Medicaid recipients; and annual percentage changes in both long-term care expenditures for, and the number of Medicaid recipients utilizing, nursing home care and each of the home and community based long-term care options, respectively;

b. Commence the following no later than January 1, 2008:

(1) implement a system of Statewide long-term care service coordination and management designed to minimize administrative costs, improve access to services, and minimize obstacles to the delivery of long-term care services to people in need;

(2) identify home and community based long-term care service models that are determined by the commissioner to be efficient and cost-effective alternatives to nursing

home care, and develop clear and concise performance standards for those services for which standards are not already available in a home and community-based services waiver;

(3) develop and implement a comprehensive consumer assessment instrument that is designed to facilitate an expedited process to authorize the provision of home and community-based care to a person through fast track eligibility prior to completion of a formal financial eligibility determination; and

(4) develop and implement a comprehensive quality assurance system with appropriate and regular assessments that is designed to ensure that all forms of long-term care available to consumers in this State are financially viable, cost-effective, and promote and sustain consumer independence; and

c. Seek to make information available to the general public on a Statewide basis, through print and electronic media, regarding the various forms of long-term care available in this State and the rights accorded to long-term care consumers by statute and regulation, as well as information about public and nonprofit agencies and organizations that provide informational and advocacy services to assist long-term care consumers and their families.

377. Section 7 of P.L.2006, c.23 (C.30:4D-17.29) is amended to read as follows:

C.30:4D-17.29 Medicaid Long-Term Care Funding Advisory Council.

7. a. There is established the Medicaid Long-Term Care Funding Advisory Council within the Department of Human Services. The advisory council shall meet at least quarterly during each fiscal year until such time as the commissioner certifies to the Governor and the Legislature that funding parity has been achieved pursuant to subsection b. of section 5 of this act, and shall be entitled to receive such information from the Departments of Health, Human Services, and the Treasury as the advisory council deems necessary to carry out its responsibilities under this act.

b. The advisory council shall:

(1) monitor and assess, and advise the commissioner on, the implementation and operation of the Medicaid long-term care expenditure reforms and other provisions of this act; and

(2) develop recommendations for a program to recruit and train a stable workforce of home care providers, including recommendations for changes to provider reimbursement under Medicaid home and community-based care programs.

c. The advisory council shall comprise 14 members as follows:

(1) the commissioner and the State Treasurer, or their designees, as ex officio members; and

(2) 12 public members to be appointed by the commissioner as follows: one person appointed upon the recommendation of AARP; one person upon the recommendation of the New Jersey Association of Area Agencies on Aging, one person upon the recommendation of the New Jersey Association of County Offices for the Disabled; one person upon the recommendation of the Health Care Association of New Jersey; one person upon the recommendation of the New Jersey Association of Non-Profit Homes for the Aging; one person upon the recommendation of the New Jersey Hospital Association; one person upon the recommendation of the Rutgers Center for State Health Policy; one person upon the recommendation of the New Jersey Elder Rights Coalition; one person upon the recommendation of the County Welfare Directors Association of New Jersey; one person upon the recommendation of the New Jersey Adult Day Services Association; one person

upon the recommendation of a labor union that represents home and community-based health care workers; and one person who is a representative of the home care industry.

d. The advisory council shall organize as soon as possible after the appointment of its members, and shall annually select from its membership a chairman who shall serve until his successor is elected and qualifies. The members shall also select a secretary who need not be a member of the advisory council.

e. The department shall provide such staff and administrative support to the advisory council as it requires to carry out its responsibilities.

378. Section 8 of P.L.2006, c.23 (C.30:4D-17.30) is amended to read as follows:

C.30:4D-17.30 Waiver of federal requirements.

8. The Commissioner of Human Service shall apply to the federal Centers for Medicare & Medicaid Services for any waiver of federal requirements, or for any State plan amendments or home and community-based services waiver amendments, which may be necessary to obtain federal financial participation for State Medicaid expenditures in order to effectuate the purposes of this act.

379. Section 9 of P.L.2006, c.23 (C.30:4D-17.31) is amended to read as follows:

C.30:4D-17.31 Tracking of expenditures.

9. The commissioner shall track Medicaid long-term care expenditures necessary to carry out the provisions of this act.

380. Section 2 of P.L.2000, c.28 (C.30:4D-19.3) is amended to read as follows:

C.30:4D-19.3 Definitions relative to intergovernmental transfer program under Medicaid.

2. As used in this act:

"Bank" means a State or federally chartered bank, savings bank, or savings and loan association located in this State that is authorized to receive public funds and that is selected by the participating governmental entities to carry out the provisions of this act.

"Intergovernmental transfer" means the transfer of money to the State account by a participating governmental entity as contemplated by an intergovernmental transfer agreement.

"Intergovernmental transfer agreement" means an agreement among the State Treasurer, the Commissioners of Human Services and Health, and a participating governmental entity pertaining to participation in and implementation of the intergovernmental transfer program.

"Intergovernmental transfer program" or "program" means a program to enhance federal financial participation under the Medicaid program by using intergovernmental transfers.

"Medicaid" means the "New Jersey Medical Assistance and Health Services Program" established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

"Medicaid State plan" means the plan submitted by the State to the federal Centers for Medicare & Medicaid Services in the Department of Health and Human Services, including any amendments thereto.

“Participant accounts" means the accounts maintained at the bank by each participating governmental entity for the purpose of effectuating the intergovernmental transfer program.

"Participating governmental entity" means any governmental entity that owns a nursing facility enrolled in the Medicaid program and qualifies for a supplemental payment under the Medicaid State plan, and which signs an intergovernmental transfer agreement.

"State account" means the account maintained at the bank by the State Treasurer for the purpose of the intergovernmental transfer program.

"Supplemental payment" means the Medicaid payment made by the State to a participating governmental entity for a specified fiscal year, as set forth and provided for in an intergovernmental transfer agreement.

381. Section 3 of P.L.2000, c.28 (C.30:4D-19.4) is amended to read as follows:

C.30:4D-19.4 Intergovernmental transfer program established.

3. There is established an intergovernmental transfer program subject to the provisions of this act.

a. Notwithstanding the provisions of any other law to the contrary, a governmental entity eligible to receive a supplemental payment is authorized to participate in the intergovernmental transfer program and to take all actions necessary to effectuate completion of the intergovernmental transfer program, including, but not limited to:

(1) entering into agreements, including an intergovernmental transfer agreement, with any entity, including the State Treasurer, the Commissioner of Human Services, the Commissioner of Health, and other participating governmental entities;

(2) cooperating with a bank in the execution of any additional documentation required by the bank to effect the borrowing by any participating governmental entity through the issuance of short-term notes in the manner prescribed for the issuance of tax anticipation notes pursuant to N.J.S.40A:4-64, except that the short-term notes shall not be subject to the provisions of N.J.S.40A:4-66, or in any other manner permitted by law, and to pledge to the bank a security interest in all of its right, title and interest in and to its participant account for repayment of short-term notes;

(3) transferring participating governmental entity funds to the State account;

(4) executing certifications, letters of instruction or other instruments necessary to effectuate the intergovernmental transfer program; and

(5) receiving and utilizing supplemental payments received in accordance with the Medicaid State plan, in the manner set forth under the terms of an intergovernmental transfer agreement and as may be necessary to achieve the purposes of the intergovernmental transfer agreement.

b. Notwithstanding any other law to the contrary, the State Treasurer, the Commissioner of Human Services and the Commissioner of Health, acting on behalf of the State, are authorized to participate in the intergovernmental transfer program and to take all actions and make payments in connection with the completion of the intergovernmental transfer program, including, but not limited to:

(1) entering into agreements, including the intergovernmental transfer agreement, with any entity, including participating governmental entities, upon such terms and conditions as the State Treasurer deems necessary or desirable to allow for the entity's participation in the intergovernmental transfer program;

(2) cooperating with any bank in the execution of any additional documentation required by the bank to transfer supplemental payments to the participant accounts and otherwise effectuate the intergovernmental transfer program; and

(3) executing, approving, and authorizing certifications, letters of instruction, legal opinions, or other instruments as the State Treasurer deems necessary or desirable to effectuate the intergovernmental transfer program.

382. Section 4 of P.L.2000, c.28 (C.30:4D-19.5) is amended to read as follows:

C.30:4D-19.5 Appropriations for supplemental payments under intergovernmental transfer program; costs.

4. a. There are appropriated to the Department of Human Services such sums as are determined necessary by the Director of the Division of Budget and Accounting in the Department of the Treasury to make supplemental payments in accordance with the Medicaid State plan under the intergovernmental transfer program. The sums so appropriated shall be deposited in the State account and used to make supplemental payments to the participant accounts pursuant to this subsection and as set forth in an intergovernmental transfer agreement.

b. There are appropriated to the Department of Human Services and Department of the Treasury such additional sums as are determined necessary by the Director of the Division of Budget and Accounting in the Department of the Treasury to pay costs incurred by the State in connection with the execution and delivery of any agreements authorized hereunder, including the costs of professional services, attorneys, and any other costs necessary to complete the intergovernmental transfer program.

383. Section 1 of P.L.2003, c.281 (C.30:4D-21.4) is amended to read as follows:

C.30:4D-21.4 PAAD recipients, notification as to error in estimated annual income.

1. a. Notwithstanding the provisions of any other law to the contrary, a recipient of benefits under the "Pharmaceutical Assistance to the Aged and Disabled" program, established pursuant to P.L.1975, c.194 (C.30:4D-20 et seq.), shall notify the Department of Human Services if the recipient unintentionally errs in estimating annual income to determine eligibility for the program due to an unanticipated payment which would render the recipient ineligible for the program. Notification to the department shall be made in the time and manner prescribed by the department.

b. If the department determines that the payment was unanticipated, the recipient shall reimburse the program for only those benefits that were paid by the program after the recipient received the unanticipated payment.

c. If the department determines that the payment was not unanticipated, the recipient shall reimburse the program for all benefits that were paid by the program in the calendar year in which the payment was received.

d. Within 30 days of receipt of a determination by the department that the payment was not unanticipated, a recipient may request a hearing, which shall be conducted pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

e. Nothing in this section shall preclude a recipient from reapplying for benefits in the calendar year following the year in which the recipient notified the department pursuant to subsection a. of this section.

384. Section 1 of P.L.2009, c.272 (C.30:4D-21.5) is amended to read as follows:

C.30:4D-21.5 Automatic enrollment in certain pharmaceutical assistance programs.

1. a. If a person who is a recipient of benefits under the "Pharmaceutical Assistance to the Aged and Disabled," or PAAD, program becomes ineligible for PAAD because the person's income exceeds the program's income eligibility limit and the person still remains eligible for the "Senior Gold Prescription Discount Program," the person shall be enrolled automatically in the "Senior Gold Prescription Discount Program."

b. If a person who is a recipient of benefits under the "Senior Gold Prescription Discount Program" has a decrease in income that renders the person eligible for PAAD, the person shall automatically be enrolled in PAAD.

c. The Department of Human Services shall establish one application form for use in applying for the PAAD program and the "Senior Gold Prescription Discount Program." The form shall provide for the inclusion of all information necessary to determine eligibility for both programs and advise applicants of the automatic enrollment provisions of subsections a. and b. of this section.

385. Section 2 of P.L.2003, c.281 (C.30:4D-38.1) is amended to read as follows:

C.30:4D-38.1 "Hearing Aid Assistance to the Aged and Disabled," notification as to error in estimated annual income.

2. a. Notwithstanding the provisions of any other law to the contrary, a recipient of benefits under the "Hearing Aid Assistance for the Aged and Disabled" program, established pursuant to P.L.1987, c.298 (C.30:4D-36 et seq.), shall notify the Department of Human Services if the recipient unintentionally errs in estimating annual income to determine eligibility for the program due to an unanticipated payment which would render the recipient ineligible for the program. Notification to the department shall be made in the time and manner prescribed by the department.

b. If the department determines that the payment was unanticipated, the recipient shall reimburse the program for only those benefits that were paid by the program after the recipient received the unanticipated payment.

c. If the department determines that the payment was not unanticipated, the recipient shall reimburse the program for all benefits that were paid by the program in the calendar year in which the payment was received.

d. Within 30 days of receipt of a determination by the department that the payment was not unanticipated, a recipient may request a hearing, which shall be conducted pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

e. Nothing in this section shall preclude a recipient from reapplying for benefits in the calendar year following the year in which the recipient notified the department pursuant to subsection a. of this section.

386. Section 2 of P.L.2001, c.96 (C.30:4D-44) is amended to read as follows:

C.30:4D-44 Definitions regarding the "Senior Gold Prescription Discount Act."

2. As used in this act:

"Commissioner" means the Commissioner of Human Services.

"Department" means the Department of Human Services.

"PAAD" means the program of pharmaceutical assistance to the aged and disabled established pursuant to P.L.1975, c.194 (C.30:4D-20 et seq.).

"Prescription drug" means any legend drug which is covered by PAAD.

"Program" means the "Senior Gold Prescription Discount Program" established pursuant to this act.

"Reasonable cost" means the cost of a prescription drug as established for PAAD.

"Resident" means a resident as defined in section 3 of P.L.1975, c.194 (C.30:4D-22) for purposes of eligibility for PAAD.

387. Section 3 of P.L.2001, c.96 (C.30:4D-45) is amended to read as follows:

C.30:4D-45 "Senior Gold Prescription Discount Program."

3. a. There is established the "Senior Gold Prescription Discount Program" in the Department of Human Services.

b. A resident of this State shall be eligible for the program if the person is:

(1) either 65 years of age or older or a recipient of disability insurance benefits under Title II of the federal Social Security Act (42 U.S.C. s.401 et seq.);

(2) receiving an annual income, the amount of which is not more than $10,000 above the applicable PAAD income eligibility limits for single and married persons, which amount is to be determined on the same basis as income is determined for the purpose of eligibility for PAAD; and

(3) not eligible for any other program of State-funded prescription drug benefits.

c. The program shall provide a payment to a pharmacy that is participating in the program for the reasonable cost of one or more prescription drugs purchased by an eligible person who presents an identification card issued by the program in an amount that exceeds the copayment paid by the eligible person. The payments to pharmacies shall commence no later than 120 days after the effective date of this act or after enactment, whichever is later.

At the time of each purchase of a prescription drug, the eligible person shall pay a copayment that shall not be waived, discounted, or rebated in whole or in part, and shall be equal to:

(1) $15 plus 50% of the remaining amount of the reasonable cost for the prescription drug, or the reasonable cost for the prescription drug, whichever is less; or

(2) $15, or the reasonable cost for the prescription drug, whichever is less, in the case of an eligible person who has incurred out-of-pocket expenditures, including copayments and deductibles, for the purchase of prescription drugs, which are not reimbursable by any other plan of assistance or insurance and are credited to that person's account for each 12-month period of eligibility in accordance with procedures established by the commissioner, in the following amounts: $2,000 for a single person and $3,000 for a married couple. These out-of-pocket expense amounts shall include only expenses incurred on or after the date that the person received proof of eligibility for the program from the department.

d. If an interchangeable drug product contained in the latest list approved and published by the Drug Utilization Review Council pursuant to section 7 of P.L.1977, c.240 (C.24:6E-6) is available for the prescribed prescription drug, an eligible person shall either:

(1) purchase an interchangeable drug product, the cost of which is equal to or less than the maximum allowable cost as determined by the commissioner; or

(2) if the prescriber specifically indicates that substitution is not permissible, purchase the prescribed drug product that is higher in cost than the maximum allowable cost as determined by the commissioner and pay the amount of the price above that maximum allowable cost, in addition to the amount of the copayment paid by the eligible person pursuant to subsection c. of this section.

e. An eligible person whose prescription drug costs are covered in part by any other program or plan of assistance or insurance may be required to receive reduced assistance under the Senior Gold Prescription Discount Program. If an eligible person's prescription drug costs are covered in whole or in part by any other program or plan of assistance or insurance, the other program or plan shall be the primary payer and the Senior Gold Prescription Discount Program shall be the payer of last resort.

f. The commissioner may establish limits on the day supply or maximum quantity of prescription drugs which may be purchased by an eligible person under the program in a manner equivalent to those established for prescription drug purchases under PAAD.

g. An eligible person under the program shall, upon the submission of an application and proof of expenditure as the department may prescribe, be reimbursed for 50% of the cost of each prescription drug purchased by that person in an amount that exceeds the required copayment, during the period commencing 30 days after the person's properly completed application was received by the department and ending on the date on which the person received proof of eligibility from the department; except that no reimbursement under this act shall be made for a prescription drug purchased prior to the effective date of this act.

h. The commissioner shall by regulation provide for:

(1) arrangements for providing notice of the availability of the program and the distribution of application forms therefor;

(2) a system of payments to pharmacies that includes the same dispensing fee structure that is used for PAAD and a system for determining eligibility for the program, including evidence of complete or partial coverage of prescription drug costs by any other program or plan of assistance or insurance; and

(3) the issuance of program identification cards to persons who are determined eligible for the program.

388. Section 3 of P.L.2003, c.281 (C.30:4D-45.1) is amended to read as follows:

C.30:4D-45.1 “Senior Gold Prescription Discount Program,” notification as to error in estimated annual income.

3. a. Notwithstanding the provisions of any other law to the contrary, a recipient of benefits under the "Senior Gold Prescription Discount Program," established pursuant to P.L.2001, c.96 (C.30:4D-43 et seq.), shall notify the Department of Human Services if the recipient unintentionally errs in estimating annual income to determine eligibility for the program due to an unanticipated payment which would render the recipient ineligible for the program. Notification to the department shall be made in the time and manner prescribed by the department.

b. If the department determines that the payment was unanticipated, the recipient shall reimburse the program for only those benefits that were paid by the program after the recipient received the unanticipated payment.

c. If the department determines that the payment was not unanticipated, the recipient shall reimburse the program for all benefits that were paid by the program in the calendar year in which the payment was received.

d. Within 30 days of receipt of a determination by the department that the payment was not unanticipated, a recipient may request a hearing, which shall be conducted pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

e. Nothing in this section shall preclude a recipient from reapplying for benefits in the calendar year following the year in which the recipient notified the department pursuant to subsection a. of this section.

389. Section 8 of P.L.2001, c.96 (C.30:4D-50) is amended to read as follows:

C.30:4D-50 Rules, regulations.

8. The Commissioner of Human Services, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this act.

390. Section 9 of P.L.2001, c.96 (C.30:4D-51) is amended to read as follows:

C.30:4D-51 Conditions on expending funds.

9. Notwithstanding the provisions of any law to the contrary, no funds appropriated for the Senior Gold Prescription Discount Program established pursuant to this act shall be expended unless participating pharmaceutical manufacturing companies execute contracts with the Department of Human Services providing for the payment of rebates to the State under terms substantially similar to those of rebate payment contracts under PAAD, provided that the manufacturer's rebates for the Senior Gold Prescription Discount Program shall apply only to the amount paid by the State under the program.

391. Section 10 of P.L.2001, c.96 (C.30:4D-52) is amended to read as follows:

C.30:4D-52 Rebates to DHS for program.

10. Amounts received as rebates under rebate payment contracts executed pursuant to section 9 of this act are appropriated to the Department of Human Services for the support of the Senior Gold Prescription Discount Program.

392. Section 2 of P.L.2007, c.58 (C.30:4D-54) is amended to read as follows:

C.30:4D-54 Findings, declarations relative to the Office of Medicaid Inspector General.

2. The Legislature finds and declares that:

a. The State of New Jersey expends more than $9 billion in taxpayer funds to fund the Medicaid program each year;

b. The State has a continuing responsibility to ensure that funds expended under the Medicaid program are used appropriately and efficiently to promote the public health;

c. Fraud, waste, and abuse by providers and recipients in the Medicaid program reduces the ability of the State to properly fund the program and results in harm to the health of the citizens of this State;

d. Controlling fraud, waste, and abuse in the Medicaid program includes preventing, detecting, and investigating such fraud, waste, and abuse, and referring it for civil or criminal action when appropriate;

e. The current system for controlling Medicaid fraud, waste, and abuse is based largely on formal and informal agreements among the Department of Human Services, the Medicaid Fraud Control Unit of the Department of Law and Public Safety, the Department of Health and other local, State, and federal agencies whose clients are served by the Medicaid

program or who are otherwise responsible for the control of Medicaid fraud, waste, and abuse;

f. Centralizing fraud recovery efforts and establishing an independent Office of the Medicaid Inspector General by statute to prevent, detect, and investigate fraud and abuse and coordinate the anti-fraud efforts of all State agencies funded by Medicaid will enhance the efforts of the State to control Medicaid costs;

g. The current efforts to control Medicaid fraud, waste, and abuse in New Jersey range from investigating providers before they enroll in the Medicaid program to identifying fraud, waste, and abuse on the part of both providers and recipients;

h. Changes in federal and State law, as well as in the health care industry and in available technology, suggest that it is time for a comprehensive review of the Medicaid fraud, waste, and abuse control infrastructure in this State;

i. Toward that end, the Governor has appointed the New Jersey Commission on Government Efficiency and Reform to evaluate the budget, structure, and organization of government in New Jersey, including State agencies, instrumentalities and independent authorities, local and county government and school districts, and advise the Governor on governmental restructuring, effectiveness, best practices, efficiencies, cost-saving measures, and how best to achieve economies of scale in the delivery of services and programs, at the lowest possible cost, consistent with mission and quality; and

j. While the State examines and prepares to implement such fundamental, long-term structural changes, the immediate coordination of State efforts to control Medicaid fraud, waste, and abuse at all levels of government is essential.

393. Section 5 of P.L.2007, c.58 (C.30:4D-57) is amended to read as follows:

C.30:4D-57 Functions, duties, powers, responsibilities of Medicaid Inspector General.

5. a. The Medicaid Inspector General shall have the following general functions, duties, powers, and responsibilities:

(1) To appoint such deputies, directors, assistants, and other officers and employees as may be needed for the office to meet its responsibilities, and to prescribe their duties and fix their compensation in accordance with State law and within the amounts appropriated therefor;

(2) To conduct and supervise all State government activities, except those of the Medicaid Fraud Control Unit in the Department of Law and Public Safety, relating to Medicaid integrity, fraud, and abuse;

(3) To call upon any department, office, division, or agency of State government to provide such information, resources, or other assistance as the Medicaid Inspector General deems necessary to discharge the duties and functions and to fulfill the responsibilities of the Medicaid Inspector General under this act. Each department, office, division, and agency of this State shall cooperate with the Medicaid Inspector General and furnish the office with the assistance necessary to accomplish the purposes of this act;

(4) To coordinate activities to prevent, detect, and investigate Medicaid fraud and abuse among the following: the Departments of Human Services, Health, Education, and Treasury; the Office of the Attorney General; and the special investigative unit maintained by each health insurer providing a Medicaid managed care plan within the State;

(5) To apply for and receive federal grants and monies with all necessary assistance as the Medicaid Inspector General shall require from the department;

(6) To enter into any applicable federal pilot programs and demonstration projects and coordinate with the department in order for the department to apply as requested by the Medicaid Inspector General, for necessary federal waivers;

(7) To recommend and implement policies relating to Medicaid integrity, fraud, and abuse, and monitor the implementation of any recommendations made by the office to other agencies or entities responsible for the administration of Medicaid;

(8) To perform any other functions that are necessary or appropriate in furtherance of the mission of the office; and

(9) To direct all public or private Medicaid service providers or recipients to cooperate with the office and provide such information or assistance as shall be reasonably required by the office.

b. As it relates to ensuring compliance with applicable Medicaid standards and requirements, identifying and reducing fraud and abuse, and improving the efficiency and effectiveness of Medicaid, the functions, duties, powers, and responsibilities of the Medicaid Inspector General shall include, but not be limited to, the following:

(1) To establish, in consultation with the department and the Attorney General, guidelines under which the withholding of payments or exclusion from Medicaid may be imposed on a provider or shall automatically be imposed on a provider;

(2) To review the utilization of Medicaid services to ensure that Medicaid funds, regardless of which agency administers the service, are appropriately spent to improve the health of Medicaid recipients;

(3) To review and audit contracts, cost reports, claims, bills, and all other expenditures of Medicaid funds to determine compliance with applicable laws, regulations, guidelines, and standards, and enhance program integrity;

(4) To consult with the department to optimize the Medicaid management information system in furtherance of the mission of the office. The department shall consult with the Medicaid Inspector General on matters that concern the operation, upgrade and implementation of the Medicaid management information system;

(5) To coordinate the implementation of information technology relating to Medicaid integrity, fraud, and abuse; and

(6) To conduct educational programs for Medicaid providers, vendors, contractors, and recipients designed to limit Medicaid fraud and abuse.

c. As it relates to investigating allegations of Medicaid fraud and abuse and enforcing applicable laws, rules, regulations, and standards, the functions, duties, powers, and responsibilities of the Medicaid Inspector General shall include, but not be limited to, the following:

(1) To conduct investigations concerning any acts of misconduct within Medicaid;

(2) To refer information and evidence to regulatory agencies and professional and occupational licensing boards;

(3) To coordinate the investigations of the office with the Attorney General, the State Inspector General, law enforcement authorities, and any prosecutor of competent jurisdiction, and endeavor to develop these investigations in a manner that expedites and facilitates criminal prosecutions and the recovery of improperly expended Medicaid funds, including:

(a) keeping detailed records for cases processed by the State Inspector General and the Attorney General and county prosecutors. The records shall include: information on the total number of cases processed and, for each case, the agency and division to which the case

is referred for investigation; the date on which the case is referred; and the nature of the suspected fraud, waste, or abuse; and

(b) receiving notice from the Attorney General of each case that the Attorney General declines to prosecute or prosecutes unsuccessfully;

(4) To make information and evidence relating to suspected criminal acts which the Medicaid Inspector General may obtain in carrying out his duties available to the Medicaid Fraud Control Unit pursuant to the requirements of federal law, as well as to other law enforcement officials when appropriate, and consult with the Attorney General and county prosecutors in order to coordinate criminal investigations and prosecutions;

(5) To refer complaints alleging criminal conduct to the Attorney General or other appropriate prosecutorial authority. If the Attorney General or other appropriate prosecutorial authority decides not to investigate or prosecute the matter, the Attorney General or other appropriate prosecutorial authority shall promptly notify the Medicaid Inspector General. The Attorney General or the prosecutorial authority shall inform the Medicaid Inspector General as to whether an investigation is ongoing with regard to any matter so referred. The Medicaid Inspector General shall preserve the confidentiality of the existence of any ongoing criminal investigation.

(a) If the Attorney General or the prosecutorial authority decides not to investigate or act upon the matter referred, the Inspector General is authorized to continue an investigation after the receipt of such a notice.

(b) Upon the completion of an investigation or, in a case in which the investigation leads to prosecution, upon completion of the prosecution, the Attorney General or the prosecutorial authority shall report promptly the findings and results to the Medicaid Inspector General. In the course of informing the Medicaid Inspector General, the Attorney General or prosecutorial authority shall give full consideration to the authority, duties, functions, and responsibilities of the Medicaid Inspector General, the public interest in disclosure, and the need for protecting the confidentiality of complainants and informants.

(c) The Medicaid Inspector General shall maintain a record of all matters referred and the responses received and shall be authorized to disclose information received as appropriate and as may be necessary to resolve the matter referred, to the extent consistent with the public interest in disclosure and the need for protecting the confidentiality of complainants and informants and preserving the confidentiality of ongoing criminal investigations.

(d) Notwithstanding any referral made pursuant to this subsection, the Medicaid Inspector General may pursue any administrative or civil remedy under the law;

(6) In furtherance of an investigation, to compel at a specific time and place, by subpoena, the appearance and sworn testimony of any person whom the Medicaid Inspector General reasonably believes may be able to give information relating to a matter under investigation;

(a) For this purpose, the Medicaid Inspector General is empowered to administer oaths and examine witnesses under oath, and compel any person to produce at a specific time and place, by subpoena, any documents, books, records, papers, objects, or other evidence that the Medicaid Inspector General reasonably believes may relate to a matter under investigation.

(b) If any person to whom a subpoena is issued fails to appear or, having appeared, refuses to give testimony, or fails to produce the books, papers, or other documents required, the Medicaid Inspector General may apply to the Superior Court and the court may order the person to appear and give testimony or produce the books, papers, or other documents, as

applicable. Any person failing to obey that order may be punished by the court as for contempt;

(7) Subject to applicable State and federal law, to have full and unrestricted access to all records, reports, audits, reviews, documents, papers, data, recommendations, or other material available to State and local departments of health and human services, other State and local government agencies, and Medicaid service providers relating to programs and operations with respect to which the office has responsibilities under this act;

(8) To solicit, receive, and investigate complaints related to Medicaid integrity, fraud, and abuse;

(9) To prepare cases, provide expert testimony, and support administrative hearings and other legal proceedings; and

(10) Upon reasonable belief of the commission of a fraudulent or abusive act, to conduct on-site facility inspections.

d. As it relates to recovering improperly expended Medicaid funds, imposing administrative sanctions, damages or penalties, negotiating settlements, and developing an effective third-party liability program to assure that all private or other governmental medical resources have been exhausted before a claim is paid by Medicaid or that reimbursement is sought when there is discovered a liable third party after payment of a claim, the functions, duties, powers, and responsibilities of the Medicaid Inspector General shall include, but not be limited to, the following:

(1) On behalf of the department, to collect all overpayments for reimbursable services that are self-disclosed by providers pursuant to current law;

(2) To pursue civil and administrative enforcement actions against those who engage in fraud, abuse, or illegal acts perpetrated within Medicaid, including providers, contractors, agents, recipients, individuals, or other entities involved directly or indirectly with the provision of Medicaid care, services, and supplies. These civil and administrative enforcement actions shall include the imposition of administrative sanctions, penalties, suspension of fraudulent, abusive, or illegal payments, and actions for civil recovery and seizure of property or other assets connected with such payments;

(3) To initiate civil suits consistent with the provisions of this act, maintain actions for civil recovery on behalf of the State, and enter into civil settlements;

(4) To withhold payments to any provider for Medicaid services if the provider unreasonably fails to produce complete and accurate records related to an investigation that is initiated by the office with reasonable cause;

(5) To ensure that Medicaid is the payor of last resort, and to provide for the coordination of benefits with each health insurer operating in the State and the recoupment of any duplicate reimbursement paid by the State. Every such health insurer shall be required to provide such information and reports as may be deemed necessary by the Medicaid Inspector General for the coordination of benefits and shall maintain files in a manner and format approved by the department; and

(6) To monitor and pursue the recoupment of Medicaid overpayments, damages, penalties, and sanctions.

394. Section 7 of P.L.2007, c.58 (C.30:4D-59) is amended to read as follows:

C.30:4D-59 Transfer of certain functions, powers, employees.

7. a. The Medicaid audit, program integrity, fraud, and abuse prevention and recovery functions, all officers and employees that the Medicaid Inspector General deems qualified

and substantially engaged therein, and any documents and records that the Medicaid Inspector General deems necessary and related to the transfer of such functions and personnel, shall be transferred to the Office of the Medicaid Inspector General from the Medicaid Office of Program Integrity Unit and the Third Party Liability Unit in the Division of Medical Assistance and Health Services, the Division of Aging Services, the Division of Disability Services, the Division of Developmental Disabilities, the Division of Mental Health and Addiction Services, the Division of Child Protection and Permanency, the Division of Child Behavioral Health Services, the Department of Health and the Department of the Treasury. The Medicaid Inspector General shall consult with the head of each department or agency from which such function is to be transferred to determine the officers and employees to be transferred.

b. The Medicaid Inspector General shall have general managerial control over the office and shall establish the organizational structure of the office as the Medicaid Inspector General deems appropriate to carry out the responsibilities and functions of the office. Within the limits of funds appropriated therefor, the Medicaid Inspector General may hire such employees in the unclassified service as are necessary to administer the office. These employees shall serve at the pleasure of the Medicaid Inspector General. Subject to the availability of appropriations, the Medicaid Inspector General may obtain the services of certified public accountants, qualified management consultants, professional auditors, or other professionals necessary to independently perform the functions of the office.

395. Section 10 of P.L.1985, c.307 (C.30:4G-10) is amended to read as follows:

C.30:4G-10 Advisory Council on Personal Attendant Services.

10. a. There is established in the department an Advisory Council on Personal Attendant Services which consists of 19 members as follows: the Director of the Division of Child Protection and Permanency in the Department of Children and Families, the Director of the Division of Aging Services, the Director of the Division of Developmental Disabilities, and the Director of the Division of Medical Assistance and Health Services in the Department of Human Services, the Director of the Division of Veterans' Services in the Department of Military and Veterans' Affairs, and the Director of the Division of Vocational Rehabilitation Services in the Department of Labor and Workforce Development, or their designees, who shall serve ex officio, and 13 members appointed by the commissioner who are residents of this State, one of whom is a member of the New Jersey Association of County Representatives of Disabled Persons, four of whom represent providers of personal attendant services, five of whom represent consumers of personal attendant services and three of whom represent advocacy groups or agencies for the physically disabled.

A vacancy in the membership of the council shall be filled in the same manner as the original appointment.

The members of the council shall serve without compensation, but the department shall reimburse the members for the reasonable expenses incurred in the performance of their duties.

b. The council shall hold an organizational meeting within 30 days after the appointment of its members. The members of the council shall elect from among them a chairperson, who shall be the chief executive officer of the council and the members shall elect a secretary, who need not be a member of the council.

c. The council shall:

(1) Advise the commissioner on matters pertaining to personal attendant services and the development of the personal attendant program, upon the request of the commissioner;

(2) Review the rules and regulations promulgated for the implementation of the personal attendant program and make recommendations to the commissioner, as appropriate;

(3) Evaluate the effectiveness of the personal attendant program in achieving the purposes of this act; and

(4) Assess the Statewide need for personal attendant services and the projected cost for providing these services Statewide.

396. Section 1 of P.L.2006, c.87 (C.30:4J-17) is amended to read as follows:

C.30:4J-17 Annual report on Access to Employer-Based Health Insurance; contents.

1. The Commissioner of Human Services, in consultation with the Commissioners of Health, Labor and Workforce Development, and Banking and Insurance, as appropriate, shall prepare, to the extent data are available, an annual report on Access to Employer-Based Health Insurance, as provided in this act.

a. The report shall include the following information about each employer in the State with an aggregate of 50 or more NJ FamilyCare enrollees or Medicaid recipients:

(1) the employer's name and address, unless the employer has more than one work site, in which case the employer's name and the number of work sites and the counties in which the work sites are located;

(2) the number of NJ FamilyCare enrollees and Medicaid recipients who are employed by the employer;

(3) the number of NJ FamilyCare enrollees and Medicaid recipients who are spouses or dependents of employees of the employer;

(4) whether the employer offers health insurance coverage to its employees; and

(5) the cost to the State of providing NJ FamilyCare and Medicaid coverage for the employer's employees and their dependents.

The commissioner may include comparable information about recipients of other public health care coverage programs, and such other information as the commissioner deems appropriate regarding employer-based coverage for persons covered under public insurance programs.

The commissioner shall also include the information compiled by the Commissioner of Health concerning recipients of charity care pursuant to section 2 of P.L.2006, c.87 (C.26:2H-18.55a). With respect to the information provided by the Commissioner of Health, the commissioner, in consultation with the Commissioners of Labor and Workforce Development and Banking and Insurance, shall ascertain whether the employer of a recipient of charity care offers health insurance coverage to its employees. The commissioner shall include that information about employers in the report.

In addition, the commissioner may make any recommendations the commissioner deems appropriate for legislative action.

b. The report shall not include the name of any NJ FamilyCare enrollee or Medicaid recipient or any family member of an enrollee or recipient.

c. The commissioner shall submit the report by September 1 of each year to the Governor and the chairmen of the Senate and Assembly standing reference committees on human services, health, and appropriations.

397. Section 27 of P.L.2008, c.38 (C.30:4J-19) is amended to read as follows:

C.30:4J-19 Outreach, Enrollment, and Retention Working Group.

27. The Commissioner of Human Services shall establish an Outreach, Enrollment, and Retention Working Group to develop a plan to carry out ongoing and sustainable measures to strengthen outreach to low and moderate income families who may be eligible for Medicaid, NJ FamilyCare, or NJ FamilyCare Advantage, to maximize enrollment in these programs, and to ensure retention of enrollees in these programs.

a. The members of the working group shall include:

(1) The Commissioners of Human Services, Health, Banking and Insurance, Labor and Workforce Development, Education, and Community Affairs, and the Secretary of Agriculture, or their designees, who shall serve ex officio; and

(2) Six public members appointed by the Commissioner of Human Services who shall include: one person who represents racial and ethnic minorities in this State; one person who represents managed care organizations that participate in the Medicaid and NJ FamilyCare programs; one person who represents the vendor under contract with the Division of Medical Assistance and Health Services to provide NJ FamilyCare eligibility, enrollment, and health benefit coordinator services to the division; one person who represents New Jersey Policy Perspective; one person who represents the Advocates for Children of New Jersey; and one person who represents Legal Services of New Jersey.

b. As part of the plan, the working group shall:

(1) determine if there are obstacles to enrollment of minorities in the State in the Medicaid, NJ FamilyCare, and NJ FamilyCare Advantage programs due to ethnic and cultural differences and, if so, develop strategies for the Department of Human Services to overcome these obstacles and increase enrollment among minorities;

(2) recommend outreach strategies to identify and enroll all eligible children in the Medicaid, NJ FamilyCare, and NJ FamilyCare Advantage programs and to retain enrollment of children and their parents in the programs;

(3) establish monthly enrollment goals for the number of children who need to be enrolled in Medicaid, NJ FamilyCare, and NJ FamilyCare Advantage in order to ensure that as many children as possible who are eligible for these programs are enrolled within a reasonable period of time, in accordance with the mandate established pursuant to section 2 of P.L.2008, c.38 (C.26:15-2); and

(4) make such other recommendations to the Commissioner of Human Services as the working group determines necessary and appropriate to achieve the purposes of this section.

c. The working group shall organize as soon as practicable following the appointment of its members and shall select a chairperson and vice-chairperson from among the members. The chairperson shall appoint a secretary who need not be a member of the working group.

(1) The public members shall serve without compensation, but shall be reimbursed for necessary expenses incurred in the performance of their duties and within the limits of funds available to the working group.

(2) The working group shall be entitled to call to its assistance and avail itself of the services of the employees of any State, county, or municipal department, board, bureau, commission, or agency as it may require and as may be available to it for its purposes.

d. Upon completion of the plan, the working group shall report on its activities to the chairperson of the Senate and Assembly standing reference committees on health and human services, and include a copy of the plan and any recommendations for legislative action it deems appropriate.

e. The Commissioner of Human Services shall post the plan on the department's Internet website and include a table showing the monthly enrollment goals established in the plan and

the actual new and continued enrollments for that month. The commissioner shall update the table monthly.

f. The Department of Human Services shall provide staff support to the working group.

C.30:1A-14 Division of Aging Services established.

398. a. There is established the Division of Aging Services in the Department of Human Services.

b. The functions, powers, and duties of the Department of Health and Senior Services, redesignated as the Department of Health pursuant to section 93 of P.L.2012, c.17 (C.26:1A-2.1), to the extent that they relate to the provision of programs or services for senior citizens, including the New Jersey State Commission on Aging established pursuant to section 1 of P.L.1957, c.72 (C.26:1A-107), the Division on Aging and Community Services, and any other division relating to senior benefits, are transferred to the Division of Aging Services, subject to the provisions of P.L.2012, c.17 (C.26:1A-2.1 et al.) and in accordance with the "State Agency Transfer Act," P.L.1971, c.375 (C.52:14D-1 et seq.).

c. All appropriations and other monies available, and to become available, that relate to the provision of programs or services for senior citizens are continued in the Division of Aging Services and shall be available for the objects and purposes for which these monies are appropriated, subject to the provisions of P.L.2012, c.17 (C.26:1A-2.1 et al.) and any other terms, restrictions, limitations, or other requirements imposed by law.

d. The administrator and head of the office shall be a director who shall be known as the Director of the Division of Aging Services. The director shall be a person qualified by training and experience to perform the duties of the office and shall devote his entire time to the performance of those duties. The director shall be appointed by the commissioner.

e. The commissioner shall appoint and remove officers and employees of the division subject to the provisions of Title 11A of the New Jersey Statutes and other applicable statutes as are necessary to enable the division to perform its duties pursuant to this act and shall fix their compensation within the limits of available appropriations and as is provided by law.

f. Whenever, in any law, rule, regulation, order, contract, document, judicial or administrative proceeding or otherwise, reference is made to the Division on Aging in either the Department of State, the Department of Community Affairs, or the Department of Health and Senior Services, the same shall mean and refer to the Division of Aging Services in the Department of Human Services.

399. Section 1 of P.L.1997, c.364 (C.34:5A-10.1) is amended to read as follows:

C.34:5A-10.1 Definitions relative to use, storage of hazardous substances in schools, child care centers.

1. As used in this act:

"Child care center" means a child care center licensed pursuant to the provisions of P.L.1983, c.492 (C.30:5B-1 et seq.);

"Hazardous substance" means any substance, or substance in a mixture, included on the hazardous substance list developed by the Department of Health pursuant to the "Worker and Community Right to Know Act," P.L.1983, c.315 (C.34:5A-1 et seq.).

"Hazardous substance" shall not include:

(1) Any article containing a hazardous substance if the hazardous substance is present in a solid form which does not pose any acute or chronic health hazard to any person exposed to it;

(2) Any hazardous substance constituting less than one percent of a mixture unless the hazardous substance is present in an aggregate amount of 500 pounds or more in a container in a public or private school or child care center building;

(3) Any hazardous substance which is a special health hazardous substance constituting less than the threshold percentage established by the Department of Health pursuant to P.L.1983, c.315 (C.34:5A-1 et seq.), for that special health hazardous substance when present in a mixture;

(4) Any hazardous substance present in the same form and concentration as a product packaged for distribution and use by consumers and which is not a product intended primarily for commercial use;

(5) Any fuel in a motor vehicle;

(6) Tobacco or tobacco products;

(7) Wood or wood products;

(8) Foods, drugs, or cosmetics;

(9) Hazardous substances which are an integral part of a building's structure or furnishings;

(10) Products which are personal property and are intended for personal use; and

(11) Any substance used in the routine maintenance of a public or private school or child care center building or its grounds, any substance used in a classroom science laboratory, any substance used in a school occupational training facility, including laboratories and shops, and any substance used in the normal operation of the classrooms or administrative offices of a public or private school or child care center, including any substance used in the heating or cooling of the school or child care center;

"Hazardous substance fact sheet" means the hazardous substance fact sheets prepared by the Department of Health pursuant to the "Worker and Community Right to Know Act," P.L.1983, c.315 (C.34:5A-1 et seq.);

"Public school or private school" has the same meaning as set forth in N.J.S.18A:1-1.

400. Section 2 of P.L.1997, c.364 (C.34:5A-10.2) is amended to read as follows:

C.34:5A-10.2 Use of hazardous substance prohibited when children are expected to be present; exceptions.

2. a. No person shall use or allow the use of any hazardous substance in or on any building or grounds used as a public school, a private school, or child care center at any time when children are expected to be present in the building. The provisions of this subsection shall not apply when an emergency condition, as deemed by the Board of Education or the chief school administrator in the case of any public school, or the person having responsibility for the operation of any private school or child care center, necessitates the use of a hazardous substance when children are present.

b. Any person who uses or stores, or causes or allows the use or storage of any hazardous substance in or on any building or grounds used as a public school, a private school, or child care center shall ensure that the use or storage of that hazardous substance is in compliance with the regulations adopted by the Department of Health pursuant to section 5 of P.L.1997, c.364 (C.34:5A-10.5).

C.34:5A-10.1 Definitions relative to use, storage of hazardous substances in schools, child care centers.

C.34:5A-10.5 Regulations.

401. Section 5 of P.L.1997, c.364 (C.34:5A-10.5) is amended to read as follows:

5. The Department of Health, in consultation with the Departments of Education, Human Services, Children and Families and Environmental Protection, and within 180 days of the enactment of P.L.1997, c.364 (C.34:5A-10.1 et seq.), shall adopt, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), regulations necessary to implement the provisions of this act which are consistent with federal and State indoor air quality standards and standards governing the exposure of children to hazardous substances as they are adopted by the federal government.

402. Section 14 of P.L.1983, c.315 (C.34:5A-14) is amended to read as follows:

C.34:5A-14 Labeling of containers.

14. a. Every employer shall have until October 30, 1985 to take any action necessary to assure that every container at the employer's facility containing a hazardous substance shall bear a label indicating the chemical name and Chemical Abstracts Service number of the hazardous substance or the trade secret registry number assigned to the hazardous substance. The labels on all containers except pipelines and underground storage tanks shall be designed and affixed in such a manner to ensure that if there is a flood or other natural disaster when the container is transported or stored, the label shall remain in place and visible. Employers may label containers in a research and development laboratory by means of a code or number system, if the code or number system will enable an employee to readily make a cross-reference to a hazardous substance fact sheet which will provide the employee with the chemical name and Chemical Abstracts Service number of the hazardous substance contained in the container, or the trade secret registry number assigned to the hazardous substance. The code or number system shall be designed to allow the employee free and ready access at all times to the chemical name and Chemical Abstracts Service number of the hazardous substance in the container, shall be designed to allow the employee access to this information without the permission or assistance of management, and shall be available to the employee at close proximity to the employee's specific job location or locations. Employers shall be required to label pipelines only at the valve or valves located at the point at which a hazardous substance enters a facility's pipeline system, and at normally operated valves, outlets, vents, drains, and sample connections designed to allow the release of a hazardous substance from the pipeline.

b. Within two years of the effective date of this act, every employer shall take any action necessary to assure that every container at the employer's facility bears a label indicating the chemical name and Chemical Abstracts Service number of the substance in the container, except as provided in subsection d. of this section, or the trade secret registry number assigned to the substance. Employers may label containers in a research and development laboratory by means of a code or number system, if the code or number system will enable an employee to readily make a cross-reference to documentary material retained on file by the employer at the facility which will provide the employee with the chemical name and Chemical Abstracts Service number of the substance contained in the container, except as provided in subsection d. of this section, or the trade secret registry number assigned to the substance. The code or number system shall be designed to allow the employee free and ready access at all times to the chemical name and Chemical Abstracts Service number of the substance in the container, shall be designed to allow the employee access to this information

without the permission or assistance of management, and shall be available to the employee at close proximity to the employee's specific job location or locations. If a container contains a mixture, an employer shall be required to insure that the label identify the chemical names and Chemical Abstracts Service numbers, except as provided in subsection d. of this section, or the trade secret registry numbers, of the five most predominant substances contained in the mixture. The provisions of this subsection shall not apply to any substance constituting less than 1% of a mixture unless the substance is present at the facility in an aggregate amount of 500 pounds or more. Employers shall be required to label pipelines only at the valve or valves located at the point at which a substance enters a facility's pipeline system, and at normally operated valves, outlets, vents, drains, and sample connections designed to allow the release of a substance from the pipeline. One year after the effective date of this act the Department of Health shall establish criteria for containers which, because of the finished and durable characteristics of their contents, shall be exempt from the provisions of this subsection. These standards shall be consistent with the intent of this subsection to provide for the labeling of every container which may contain a substance which is potentially hazardous.

c. The labeling requirements of subsections a. and b. of this section shall not apply to containers labeled pursuant to the "Federal Insecticide, Fungicide, and Rodenticide Act," 61 Stat. 163 (7 U.S.C. s.121 et al.), except that the label for any such container except pipelines and underground storage tanks shall be designed and affixed in such a manner to ensure that if there is a flood or other natural disaster when the container is transported or stored, the label shall remain in place and visible. The Department of Health may, by rule and regulation, certify containers labeled pursuant to any other federal act as labeled in compliance with the provisions of this section.

d. One year after the effective date of this act the Department of Health shall adopt, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), a list of substances the containers of which may be labeled with the common names and Chemical Abstracts Service numbers of their contents. The department shall include on the list adopted pursuant to this subsection only substances which are widely recognized by their common names. An employer shall provide the chemical name of a substance in a container labeled pursuant to this subsection within five working days of the request therefor.

403. Section 21 of P.L.1983, c.315 (C.34:5A-21) is amended to read as follows:

C.34:5A-21 Joint procedures concerning revision of workplace or environmental hazardous substance list.

21. The Department of Health, the Department of Environmental Protection, and the Department of Labor and Workforce Development shall jointly establish a procedure for annually receiving information from the public and any other interested party, concerning any revision of the workplace hazardous substance list and any revision of the environmental hazardous substance list. This procedure shall include a mechanism for revising the workplace hazardous substance list and the environmental hazardous substance list. Any revision of the workplace hazardous substance list or environmental hazardous substance list shall be based on documented scientific evidence. The Department of Health and the Department of Environmental Protection shall publicly announce any revisions of the workplace hazardous substance list or the environmental hazardous substance list, and any such additions or revisions shall be made pursuant to the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

404. Section 26 of P.L.1983, c.315 (C.34:5A-26) is amended to read as follows:

C.34:5A-26 “Worker and Community Right to Know Fund.”

26. a. There is established in the Department of the Treasury a nonlapsing, revolving fund to be known as the "Worker and Community Right To Know Fund." The "Worker and Community Right To Know Fund" shall be credited with all fees collected pursuant to paragraph (1) of subsection b. of this section and interest on moneys in the "Worker and Community Right To Know Fund" shall be credited to the "Worker and Community Right To Know Fund" and all moneys in the "Worker and Community Right To Know Fund" are appropriated for the purposes of the "Worker and Community Right To Know Fund", and no moneys shall be expended for those purposes without the specific appropriation thereof by the Legislature. The State Treasurer shall be the administrator of the "Worker and Community Right To Know Fund", and all disbursements from the "Worker and Community Right To Know Fund" shall be made by the State Treasurer upon the warrant of the Director of the Division of Budget and Accounting.

b. (1) The Department of Labor and Workforce Development shall annually assess each employer a fee of not less than $75.00 nor more than an amount equal to $4.00 per employee to provide for the implementation of the provisions of this act. All fees collected by the department pursuant to this paragraph shall be deposited in the "Worker and Community Right To Know Fund".

(2) The Department of Labor and Workforce Development shall annually assess each employer a fee of $2.00 per employee for the implementation of P.L.1991, c.235 (C.13:1D-35 et seq.). All fees collected by the department pursuant to this paragraph shall be deposited in the "Pollution Prevention Fund" established pursuant to section 16 of P.L.1991, c.235 (C.13:1D-50), and shall be used only for the implementation of P.L.1991, c.235 (C.13:1D-35 et seq.).

c. The moneys in the "Worker and Community Right To Know Fund" shall be disbursed only for the following purposes:

(1) Expenses approved by the Director of the Division of Budget and Accounting and incurred by the Department of Health, the Department of Environmental Protection, the Department of Labor and Workforce Development, the Department of the Treasury, and the county health departments in implementing the provisions of this act; and

(2) Repayment to the General Fund of any moneys appropriated by law in order to implement the provisions of this act.

d. The State Treasurer shall annually disburse the moneys in the "Worker and Community Right To Know Fund" for expenditures approved by the Director of the Division of Budget and Accounting pursuant to paragraph (1) of subsection c. of this section, but in no case in an amount to the several departments that is greater than the following percentages of the "Worker and Community Right To Know Fund" available in any one year: the Department of Health, 40%; the Department of Environmental Protection, 20%; the county health departments, 15%; the Department of Labor and Workforce Development, 15%; and the Department of the Treasury, 10%.

e. Beginning two years after the effective date of this act, the State Treasurer shall make an annual audit of the "Worker and Community Right To Know Fund" to determine the adequacy of moneys on deposit in the "Worker and Community Right To Know Fund" to support the implementation of the provisions of this act. If the State Treasurer, in consultation with the Department of Health, the Department of Environmental Protection,

and the Department of Labor and Workforce Development makes a determination that the revenues in the "Worker and Community Right To Know Fund" are sufficient to warrant a reduction in the fees imposed pursuant to paragraph (1) of subsection b. of this section for the ensuing year, the State Treasurer may reduce the amount of the fees imposed during that year by an amount warranted by the balance in the "Worker and Community Right To Know Fund" at the time of the determination.

405. Section 10 of P.L.1984, c.173 (C.34:5A-41) is amended to read as follows:

C.34:5A-41 Violations; penalties.

10. Any person who knowingly hinders or delays the Commissioners of Labor and Workforce Development or Health or the authorized representative thereof, in the performance of the duty to enforce this act, or knowingly submits false or misleading information on any license or permit application required by this act, or fails to obtain licenses or permits required by the provisions of this act, or refuses to make these licenses or permits accessible to either commissioner, or the authorized representative thereof, or otherwise violates any provision of this act or any regulation adopted under this act, shall, upon conviction, be guilty of a crime of the third degree and, notwithstanding the provisions of N.J.S.2C:43-3, shall be subject to a fine of not more than $25,000 in addition to any other appropriate disposition authorized by subsection b. of N.J.S.2C:43-2.

406. Section 8 of P.L.1983, c.516 (C.34:6A-32) is amended to read as follows:

C.34:6A-32 Promulgation of regulations.

8. The commissioner shall, in consultation with the Commissioner of Health and the Commissioner of Community Affairs and with the advice of the advisory board, promulgate all regulations which the commissioner deems necessary for the proper administration and enforcement of this act. A variance may be granted if the commissioner determines that the applicant is in compliance with the requirements for a permanent variance as set forth in subsection c. of section 15 of this act. The variance shall not be deemed to be a variation approved pursuant to the "State Uniform Construction Code Act," P.L.1975, c.217 (C.52:27D-119 et seq.) or the "Uniform Fire Safety Act," P.L.1983, c.383 (C.52:27D-192 et al.) or any other building or fire safety standard or code.

Space leased by a public employer shall be subject to current health or safety rules and regulations. Any deficiency, including a deficiency resulting either from occupant use or deferred maintenance by the lessor, shall be subject to correction in accordance with the governing rules and regulations at the time that the deficiency is cited by the commissioner or the Commissioner of Health. However, a lease of any duration may not be entered into unless the leased property is in conformance with such rules and regulations as are in effect at the time the lease is executed.

No fire company, first aid, or rescue squad, whether paid, part-paid, or volunteer, shall be required to pay to the Department of Labor and Workforce Development or the Department of Health any registration or inspection fee imposed by rule or regulation with regard to the filling of air cylinders for respiratory equipment used by the fire company, first aid, or rescue squad.

407. Section 1 of P.L.1997, c.92 (C.39:3-27.90) is amended to read as follows:

C.39:3-27.90 Issuance of “Conquer Cancer” license plates; fees; distribution.

1. a. The Chief Administrator of the New Jersey Motor Vehicle Commission may issue for a motor vehicle owned or leased and registered in the State special license plates bearing, in addition to the registration number and other markings or identification otherwise prescribed by law, the slogan "Conquer Cancer." These plates may include an emblem, to be designed by the Commissioner of Health and approved by the chief administrator, indicating support for, or an interest in, finding new methods of treating and preventing cancer.

b. Application for issuance of a "Conquer Cancer" license plate shall be made to the chief administrator on forms and in a manner as may be prescribed by the chief administrator. The chief administrator shall collect for each set of plates issued an application fee of $50, and an annual renewal fee of $10, in addition to the fees otherwise prescribed by law for the registration of motor vehicles.

c. Monies collected from all fees for "Conquer Cancer" license plates shall be deposited in the Cancer Research Fund, established in the Department of Health pursuant to section 5 of P.L.1982, c.40 (C.54:40A-37.1). Any monetary donation made available to the State to support the provisions of P.L.1997, c.92 (C.39:3-27.90 et seq.) shall be deposited in the Cancer Research Fund for use as set forth in this section. Interest or other income earned on monies deposited under this act into the Cancer Research Fund shall be credited to the fund for use as set forth in this section.

Funds shall be utilized by the New Jersey State Commission on Cancer Research: (1) first to reimburse the commission for all costs, including those costs associated with computer programming changes, incurred in producing, issuing, renewing, and publicizing the availability of "Conquer Cancer" license plates; (2) to reimburse the Department of Health for the design and printing of notices, posters and signs to be utilized by the commission; and (3) for approved research projects as defined in section 3 of P.L.1983, c.6 (C.52:9U-3).

d. The chief administrator shall annually certify to the Commissioner of Health the average cost per license plate incurred in the immediately preceding year by the commission in producing, issuing, renewing, and publicizing the availability of "Conquer Cancer" license plates. The commissioner shall annually report the Department of Health's costs and the division's costs to the Office of Management and Budget.

e. The chief administrator shall notify eligible motorists of the opportunity to obtain "Conquer Cancer" license plates by including a notice with all motor vehicle registration renewals, and by posting appropriate posters or signs in all commission facilities and offices, as may be provided by the Department of Health. The notices, posters, and signs shall be designed by the Commissioner of Health after consulting with the New Jersey State Commission on Cancer Research. The designs shall be subject to the approval of the chief administrator. The Department of Health shall supply the commission with the notices, posters, and signs to be circulated or posted by the commission.

f. The Commissioner of Health, the New Jersey State Commission on Cancer Research, and the chief administrator shall develop and enter into an interagency memorandum of agreement setting forth the procedures to be followed by the Department of Health, the commission and the Motor Vehicle Commission in carrying out their respective responsibilities under this act.

g. In the event that the average cost per license plate, as certified by the chief administrator and approved by the Joint Budget Oversight Committee, or its successor, is greater than the $50 application fee established in subsection b. of this section in two consecutive fiscal years, the chief administrator may discontinue the issuance of the "Conquer Cancer" license plate.

408. Section 6 of P.L.1970, c. 248 (C.40:23-6.43) is amended to read as follows:

C.40:23-6.43 Appropriations and payments of State aid.

6. There shall be appropriated and paid annually to each county office on aging, subject to the approval of the Commissioner of Human Services, an amount equal to one-half of the amount of annual expense of the county office on aging; provided, however, that no county shall receive more than $20,000 in State aid hereunder in any calendar year. Payments shall be made by the State Treasurer, upon certificate of the Commissioner of Human Services and warrant of the Director of the Division of Budget and Accounting, on or before December 31 of each calendar year. This payment shall constitute reimbursement to the county for the State aid portion of the annual expense of each county office on aging during the year in which the payment is made.

409. Section 12 of P.L.1989, c.300 (C.45:9-19.12) is amended to read as follows:

C.45:9-19.12 Issuance of permits, registration to practitioners in training.

12. The State Board of Medical Examiners shall, by regulation, provide for the issuance of permits to, or registration of, persons engaging in the practice of medicine or surgery or podiatric medicine while in training, and establish the scope of permissible practice by these persons within the context of an accredited graduate medical education program conducted at a hospital licensed by the Department of Health. A permit holder shall be permitted to engage in practice outside the context of a graduate medical education program for additional remuneration only if that practice is:

a. Approved by the director of the graduate medical education program in which the permit holder is participating; and

b. With respect to any practice at or through a health care facility licensed by the Department of Health, supervised by a plenary licensee who shall either remain on the premises of the health care facility or be available through electronic communications; or

c. With respect to any practice outside of a health care facility licensed by the Department of Health, supervised by a plenary licensee who shall remain on the premises.

410. Section 2 of P.L.1989, c.19 (C.45:9-22.5) is amended to read as follows:

C.45:9-22.5 Referral of patient by practitioner regulated.

2. a. A practitioner shall not refer a patient or direct an employee of the practitioner to refer a patient to a health care service in which the practitioner, or the practitioner's immediate family, or the practitioner in combination with the practitioner's immediate family has a significant beneficial interest; except that, in the case of a practitioner, a practitioner's immediate family, or a practitioner in combination with the practitioner's immediate family who had the significant beneficial interest prior to the effective date of P.L.1991, c.187 (C.26:2H-18.24 et al.), and in the case of a significant beneficial interest in a health care service that provides lithotripsy or radiation therapy pursuant to an oncological protocol that was held prior to the effective date of this section of P.L.2009, c.24, the practitioner may continue to refer a patient or direct an employee to do so if that practitioner discloses the significant beneficial interest to the patient.

b. If a practitioner is permitted to refer a patient to a health care service pursuant to this section, the practitioner shall provide the patient with a written disclosure form, prepared

pursuant to section 3 of P.L.1989, c.19 (C.45:9-22.6), and post a copy of this disclosure form in a conspicuous public place in the practitioner's office.

c. The restrictions on referral of patients established in this section shall not apply to:

(1) medical treatment or a procedure that is provided at the practitioner's medical office and for which a bill is issued directly in the name of the practitioner or the practitioner's medical office;

(2) renal dialysis; and

(3) ambulatory surgery or procedures requiring anesthesia performed at a surgical practice registered with the Department of Health pursuant to subsection g. of section 12 of P.L.1971, c.136 (C.26:2H-12) or at an ambulatory care facility licensed by the Department of Health to perform surgical and related services, if the following conditions are met:

(a) the practitioner who provided the referral personally performs the procedure;

(b) the practitioner's remuneration as an owner of or investor in the practice or facility is directly proportional to the practioner’s ownership interest and not to the volume of patients the practitioner refers to the practice or facility;

(c) all clinically-related decisions at a facility owned in part by non-practitioners are made by practitioners and are in the best interests of the patient; and

(d) disclosure of the referring practitioner's significant beneficial interest in the practice or facility is made to the patient in writing, at or prior to the time that the referral is made, consistent with the provisions of section 3 of P.L.1989, c.19 (C.45:9-22.6).

411. Section 4 of P.L.2009, c.24 (C.45:9-22.5a) is amended to read as follows:

C.45:9-22.5a Certain referrals for ambulatory surgery procedure involving anesthesia.

4. a. A referral for ambulatory surgery or a procedure requiring anesthesia made prior to the effective date of this section of P.L.2009, c.24 by a practitioner to a surgical practice or ambulatory care facility licensed by the Department of Health to perform surgical and related services shall be deemed to comply with the provisions of section 2 of P.L.1989, c.19 (C.45:9-22.5) if the practitioner personally performed the procedure that is the subject of the referral.

b. As used in this section, "surgical practice" means a structure or suite of rooms that has the following characteristics:

(1) has no more than one room dedicated for use as an operating room which is specifically equipped to perform surgery, and is designed and constructed to accommodate invasive diagnostic and surgical procedures;

(2) has one or more post-anesthesia care units or a dedicated recovery area where the patient may be closely monitored and observed until discharged; and

(3) is established by a physician, physician professional association surgical practice, or other professional practice form specified by the State Board of Medical Examiners pursuant to N.J.A.C.13:35-6.16(f) solely for the physician's, association's or other professional entity's private medical practice.

"Surgical practice" includes an unlicensed entity that is certified by the Centers for Medicare and Medicaid Services as an ambulatory surgery center provider.

412. Section 4 of P.L.2003, c.281 (C.48:2-29.16a) is amended to read as follows:

C.48:2-29.16a “Lifeline Credit Program,” notification as to error in estimated annual income.

4. a. Notwithstanding the provisions of any other law to the contrary, a recipient of benefits under the "Lifeline Credit Program," established pursuant to P.L.1979, c.197

(C.48:2-29.15 et seq.), shall notify the Department of Human Services if the recipient unintentionally errs in estimating annual income to determine eligibility for the program due to an unanticipated payment which would render the recipient ineligible for the program. Notification to the department shall be made in the time and manner prescribed by the department office.

b. If the department determines that the payment was unanticipated, the recipient shall reimburse the program for only those benefits that were paid by the program after the recipient received the unanticipated payment.

c. If the department determines that the payment was not unanticipated, the recipient shall reimburse the program for all benefits that were paid by the program in the calendar year in which the payment was received.

d. Within 30 days of receipt of a determination by the department that the payment was not unanticipated, a recipient may request a hearing, which shall be conducted pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

e. Nothing in this section shall preclude a recipient from reapplying for benefits in the calendar year following the year in which the recipient notified the department pursuant to subsection a. of this section.

413. Section 5 of P.L.2003, c.281 (C.48:2-29.32a) is amended to read as follows:

C.48:2-29.32a "Tenants' Lifeline Assistance Program," notification as to error in estimated annual income.

5. a. Notwithstanding the provisions of any other law to the contrary, a recipient of benefits under the "Tenants' Lifeline Assistance Program," established pursuant to P.L.1981, c.210 (C.48:2-29.30 et seq.), shall notify the Department of Human Services if the recipient unintentionally errs in estimating annual income to determine eligibility for the program due to an unanticipated payment which would render the recipient ineligible for the program. Notification to the department shall be made in the time and manner prescribed by the department.

b. If the department determines that the payment was unanticipated, the recipient shall reimburse the program for only those benefits that were paid by the program after the recipient received the unanticipated payment.

c. If the department determines that the payment was not unanticipated, the recipient shall reimburse the program for all benefits that were paid by the program in the calendar year in which the payment was received.

d. Within 30 days of receipt of a determination by the department that the payment was not unanticipated, a recipient may request a hearing, which shall be conducted pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

e. Nothing in this section shall preclude a recipient from reapplying for benefits in the calendar year following the year in which the recipient notified the department pursuant to subsection a. of this section.

414. Section 1 of P.L.1987, c.133 (C.52:27D-29.17) is amended to read as follows:

C.52:27D-29.17 Definitions.

1. a. "Commissioner" means the Commissioner of Human Services.

b. "Department" means the Department of Human Services.

c. "Eligible participant" means a resident of this State who is 60 years of age or older and homebound by reason of illness, incapacitating disability, or is otherwise isolated.

d. "Home delivered nutrition services" means home delivered meals as defined by the "Older Americans Act of 1965," Pub.L. 89-73 (42 U.S.C. s. 3001 et seq.).

e. "Program" means the Home Delivered Meals Expansion Program in the Division of Aging Services, in the Department of Human Services.

415. Section 2 of P.L.1987, c.133 (C.52:27D-29.18) is amended to read as follows:

C.52:27D-29.18 Home Delivered Meals Expansion Program.

2. The commissioner shall establish a Home Delivered Meals Expansion Program in the Division of Aging Services, in the Department of Human Services, to provide home delivered nutrition services to eligible participants on weekends and holidays.

416. Section 6 of P.L.1987, c.133 (C.52:27D-29.22) is amended to read as follows:

C.52:27D-29.22 Allocation of appropriation.

6. a. There is appropriated $1,000,000 from the Casino Revenue Fund to the Department of Human Services to effectuate the purposes of this act.

b. The department shall allocate not less than 95% of the funds appropriated for the purposes of this act to the county offices on aging, and these funds shall be disbursed to the county offices on aging according to the formula used to disburse funds for the home delivered nutrition services provided under Title III of the "Older Americans Act of 1965," Pub.L. 89-73 (42 U.S.C. s. 3001 et seq.).

c. The county shall match the State funds allocated to a county office on aging for this program with an amount equal to 20% of the State funds. The county share may be cash or in kind.

417. Section 2 of P.L.1993, c.4 (C.52:27D-29.33) is amended to read as follows:

C.52:27D-29.33 Definitions.

2. As used in this act:

"County office on aging" means a county office on aging which is also designated as an area agency on aging for funding under the "Older Americans Act of 1965," Pub.L.89-73 (42 U.S.C. s.3001 et seq.).

"Director" means the Director of the Division of Aging Services in the Department of Human Services.

"Senior citizen" means a person 60 years of age or older.

418. Section 3 of P.L.1993, c.4 (C.52:27D-29.34) is amended to read as follows:

C.52:27D-29.34 Senior Health Insurance Counseling Program.

3. a. There is established in the Division of Aging Services in the Department of Human Services a Senior Health Insurance Counseling Program to provide health insurance information and assistance by trained volunteer counselors to senior citizens.

b. The Director of the Division of Aging Services shall establish the program in all counties in the State through the county offices on aging or other appropriate agencies designated by the director.

419. Section 6 of P.L.1993, c.4 (C.52:27D-29.36) is amended to read as follows:

C.52:27D-29.36 Legal representation program to assist Medicare beneficiaries.

6. The Director of the Division of Aging Services in the Department of Human Services shall establish a legal representation program to assist Medicare beneficiaries under Title XVIII of the Social Security Act who are 65 years of age or older, or disabled, in appeals of unfairly denied Medicare coverage. The services provided under this program shall include, but not be limited to, the following: outreach to Medicare beneficiaries, the development and dissemination of educational materials pertaining to the Medicare program and the claims appeal process, the development and dissemination of materials for Medicare beneficiaries to submit their own appeals, and the offer of direct legal representation to appeal unfairly denied coverage under Part A and Part B of the Medicare program. Such legal representation may include, but not be limited to, appeals within the administrative appeals structure and appeals to the United States District Court.

420. Section 40 of P.L.1966, c.293 (C.52:27D-40) is amended to read as follows:

C.52:27D-40 Definitions.

40. Whenever the term "Division of Local Government" occurs or any reference is made thereto in any law, contract or document, the same shall be deemed to mean or refer to the Division of Local Finance in the Department of Community Affairs established hereunder.

Whenever the term "Director of the Division of Local Government" occurs or any reference is made thereto in any law, contract or document, the same shall be deemed to mean or refer to the Director of the Division of Local Finance in the Department of Community Affairs established hereunder.

Whenever the term "Local Government Board" occurs or any reference is made thereto in any law, contract or document, the same shall be deemed to mean or refer to the Local Finance Board of the Division of Local Finance in the Department of Community Affairs established hereunder.

Whenever the term "public housing and development authority" occurs or any reference is made thereto in any law, contract or document, the same shall be deemed to mean or refer to the public housing and development authority in the Department of Community Affairs established hereunder.

Whenever the term "State Housing Council" occurs or any reference is made thereto in any law, contract or document, the same shall be deemed to mean or refer to the State Housing Council in the Department of Community Affairs established hereunder.

Whenever the term "Bureau of Tenement House Supervision" occurs or any reference is made thereto in any law, contract or document, the same shall be deemed to mean or refer to the Bureau of Housing Inspection of the Division of Housing and Urban Renewal in the Department of Community Affairs established hereunder.

Whenever the term "Board of Tenement House Supervision" occurs or any reference is made thereto in any law, contract or document, the same shall be deemed to mean or refer to the Board of Housing Inspection in the Division of Housing and Urban Renewal of the Department of Community Affairs established hereunder.

Whenever the term "office of supervisor of hotel fire safety" occurs or any reference is made thereto in any law, contract or document, the same shall be deemed to mean or refer to the office of supervisor of hotel fire safety in the Bureau of Housing Inspection of the

Division of Housing and Urban Renewal in the Department of Community Affairs established hereunder.

Whenever the term "Division of State and Regional Planning" occurs or any reference is made thereto in any law, contract or document, the same shall be deemed to mean or refer to the Division of State and Regional Planning in the Department of Community Affairs established hereunder.

Whenever the term "Director of the Division of State and Regional Planning" occurs or any reference is made thereto in any law, contract or document, the same shall be deemed to mean or refer to the Director of the Division of State and Regional Planning in the Department of Community Affairs established hereunder.

Whenever the term "Division on Aging" occurs or any reference is made thereto in any law, contract, or document, the same shall be deemed to mean or refer to the Division of Aging Services in the Department of Human Services.

Whenever the term "Director of the Division on Aging" occurs or any reference is made thereto in any law, contract, or document, the same shall be deemed to mean or refer to the Director of the Division of Aging Services in the Department of Human Services.

Whenever the term "New Jersey State Commission on Aging" occurs or any reference is made thereto in any law, contract, or document, the same shall be deemed to mean or refer to the New Jersey State Commission on Aging in the Division of Aging Services in the Department of Human Services.

Whenever the terms "Youth Division" or "Division of Youth" occur or any reference is made thereto in any law, contract or document, the same shall be deemed to mean or refer to the Division of Youth in the Department of Community Affairs established hereunder.

Whenever the terms "Director of the Youth Division" or "Director of the Division of Youth" occur or any reference is made thereto in any law, contract or document, the same shall be deemed to mean or refer to the Director of the Division of Youth in the Department of Community Affairs established hereunder.

Whenever the term "New Jersey State Youth Commission" occurs or any reference is made thereto in any law, contract or document, the same shall be deemed to mean or refer to the New Jersey State Youth Commission of the Division of Youth in the Department of Community Affairs established hereunder.

Whenever the term "New Jersey Office of Economic Opportunity" occurs or any reference is made thereto in any law, contract or document, the same shall be deemed to mean or refer to the New Jersey Office of Economic Opportunity in the Department of Community Affairs established hereunder.

421. Section 2 of P.L.2007, c.1 (C.52:27D-130.5) is amended to read as follows:

C.52:27D-130.5 Issuance of construction permit for child care, educational center for certain locations; certification required; remediation.

2. a. (1) No construction permit shall be issued pursuant to section 12 of P.L.1975, c.217 (C.52:27D-130) for the reconstruction, alteration, conversion, or repair of any building or structure to be used for a child care center licensed pursuant to the provisions of P.L.1983, c.492 (C.30:5B-1 et seq.), or for educational purposes, if that building or structure was previously used for industrial, storage, or high hazard purposes, as a nail salon, dry cleaning facility, or gasoline station, or is on a contaminated site, on a site on which there is suspected contamination, or on an industrial site that is subject to the provisions of the "Industrial Site Recovery Act," P.L.1983, c.330 (C.13:1K-6 et al.), except upon the submission of the

certification issued by the Department of Health pursuant to section 1 of P.L.2007, c.1 (C.52:27D-130.4) to the construction official by the applicant, that the building or structure has been evaluated and assessed for contaminants, and that the building or structure is safe for use as a child care center licensed pursuant to the provisions of P.L.1983, c.492, or for educational purposes.

(2) Notwithstanding the provisions of paragraph (1) of this subsection to the contrary, a construction permit may be issued for the construction or alteration of any building or structure to be used as a child care center licensed pursuant to the provisions of P.L.1983, c.492, or for educational purposes, if the construction permit is necessary to perform work in the building or structure in order to comply with the rules and regulations adopted pursuant to subsection a. of section 1 of P.L.2007, c.1 (C.52:27D-130.4) and obtain the certification issued by the Department of Health pursuant to subsection c. of section 1 of P.L.2007, c.1 (C.52:27D-130.4).

A construction permit issued pursuant to this paragraph shall be limited to the construction or alterations necessary to comply with the rules and regulations adopted pursuant to subsection a. of section 1 of P.L.2007, c.1 (C.52:27D-130.4).

(3) The appropriate enforcing agency shall not grant a certificate of occupancy for any building or structure to be used as a child care center licensed pursuant to the provisions of P.L.1983, c.492, or for educational purposes, that received a construction permit pursuant to paragraph (2) of this subsection, except upon the submission of the certification issued by the Department of Health pursuant to subsection c. of section 1 of P.L.2007, c.1 (C.52:27D-130.4) to the construction official by the applicant, that the building or structure has been evaluated and assessed for contaminants, and that the building or structure is safe for use as a child care center licensed pursuant to the provisions of P.L.1983, c.492, or for educational purposes.

b. (1) No construction permit shall be issued for the construction or alteration of any building or structure to be used as a child care center licensed pursuant to the provisions of P.L.1983, c.492, or for educational purposes, on a site that was previously used for industrial, storage, or high hazard purposes, as a nail salon, dry cleaning facility, or gasoline station, or on a contaminated site, on a site on which there is suspected contamination, or on an industrial site that is subject to the provisions of the "Industrial Site Recovery Act," P.L.1983, c.330 (C.13:1K-6 et al.), except after submission by the applicant to the construction official of documentation sufficient to establish that the Department of Environmental Protection has approved a remedial action workplan for the entire site or that the site has been remediated consistent with the remediation standards and other remediation requirements established pursuant to section 35 of P.L.1993, c.139 (C.58:10B-12) and a no further action letter has been issued by the Department of Environmental Protection for the entire site.

(2) Notwithstanding the provisions of paragraph (1) of this subsection to the contrary, a construction permit may be issued for the construction or alteration of any building or structure to be used as a child care center licensed pursuant to the provisions of P.L.1983, c.492, or for educational purposes, on a site that was previously used for industrial, storage, or high hazard purposes, as a nail salon, dry cleaning facility, or gasoline station, or on a contaminated site, on a site on which there is suspected contamination, or on an industrial site that is subject to the provisions of the "Industrial Site Recovery Act," P.L.1983, c.330 (C.13:1K-6 et al.), if the construction permit is necessary to remediate the site consistent with the remediation standards and other remediation requirements established pursuant to

section 35 of P.L.1993, c.139 (C.58:10B-12) in order to obtain a no further action letter from the Department of Environmental Protection.

A construction permit issued pursuant to this paragraph shall be limited to the construction or alterations necessary to develop a remedial action workplan to be submitted to the Department of Environmental Protection for approval or to remediate the site consistent with the remediation standards and other remediation requirements established pursuant to section 35 of P.L.1993, c.139 (C.58:10B-12) and receive a no further action letter from the Department of Environmental Protection.

(3) The appropriate enforcing agency shall not grant a certificate of occupancy for any building or structure to be used as a child care center licensed pursuant to the provisions of P.L.1983, c.492, or for educational purposes, that received a construction permit pursuant to paragraph (2) of this subsection, except after submission by the applicant to the construction official of documentation sufficient to establish that the site has been remediated consistent with the remediation standards and other remediation requirements established pursuant to section 35 of P.L.1993, c.139 (C.58:10B-12) and a no further action letter has been issued by the Department of Environmental Protection for the entire site.

c. As used in this section: "contaminated site" means any real property on which there is contamination; "contamination," "remediation" or "remediate," and "no further action letter" shall have the same meanings as provided in section 23 of P.L.1993, c.139 (C.58:10B-1); and "educational purposes" means for the purposes of a private school or public school as defined in N.J.S.18A:1-1, or a charter school as defined pursuant to P.L.1995, c.426 (C.18A:36A-1 et seq.).

422. Section 1 of P.L.2011, c.125 (C.52:27D-191.1) is amended to read as follows:

C.52:27D-191.1 Bill of rights for recipients of Congregate Housing Services Program.

l. a. The Department of Human Services shall ensure that a person receiving services under the Congregate Housing Services Program including, but not limited to, meal preparation, housekeeping, shopping, laundry, linens change, companionship, and personal care, receives those services in a manner that promotes the dignity of and shows respect for the person.

b. A Congregate Housing Services Program shall make information related to its services available to the manager of a subsidized housing facility that has contracted with the State to provide a Congregate Housing Services Program. The manager shall be responsible for the distribution and dissemination of the information to its residents and shall include in that information a statement that the services provided by the program shall be provided to:

(1) help meet the needs of a resident;

(2) foster the independence and individuality of a resident;

(3) treat a resident with respect, courtesy, consideration, and dignity; and

(4) assure a resident the right to make choices with respect to services and lifestyle.

c. A Congregate Housing Services Program shall:

(1) advise a resident receiving congregate housing services, in writing, of the availability of information from the Division of Aging Services in the Department of Human Services about issues that may be of concern to a resident; and

(2) make available, upon request, the qualifications of a counselor or other professional who is providing services to residents under the Congregate Housing Services Program.

423. Section 28 of P.L.1986, c.103 (C.52:27D-357) is amended to read as follows:

C.52:27D-357 Continuing Care Advisory Council.

28. a. There is created a Continuing Care Advisory Council which consists of 13 members as follows: the Commissioners of Human Services, Health, and Banking and Insurance, or their designees, who shall serve ex officio and shall be non-voting members; 10 public members appointed by the Governor, with the advice and consent of the Senate, who are residents of the State and two of whom are administrators of continuing care facilities in this State, one of whom is a representative of the business community and knowledgeable in the area of management, one of whom is a certified public accountant, one of whom is an attorney licensed to practice in this State, three of whom are residents of continuing care retirement communities in this State who are recommended by the Organization of Residents Associations of New Jersey, one of whom is a trustee or director of a continuing care retirement community in this State and one of whom is a representative of the New Jersey Association of Non-Profit Homes for the Aging.

b. The term of office for each public member is three years, or until the member's successor has been appointed; except that of the public members first appointed, two shall be appointed for a term of one year, two for a term of two years and three for a term of three years.

A vacancy in the membership of the council shall be filled in the same manner as the original appointment, but for the unexpired term. A member of the council is eligible for reappointment.

The members of the council shall serve without compensation, but the council shall reimburse the members for the reasonable expenses incurred in the performance of their duties.

c. The council shall hold an organizational meeting within 30 days after the appointment of its members. The members of the council shall elect from among them a chairperson, who shall be the chief executive officer of the council, and the members shall elect a secretary, who need not be a member of the council.

d. The council shall meet at least four times a year but may meet more frequently at the discretion of the chairperson or the commissioner.

e. The council may call to its assistance and avail itself of the services and assistance of any officials and employees of the Department of Community Affairs or other State agency and political subdivisions and their departments, boards, bureaus, commissions, and agencies as it requires and as is available to it for this purpose and may expend any funds that are appropriated or otherwise made available to it pursuant to this act.

f. The council shall:

(1) Advise and provide information to the commissioner on matters pertaining to the operation and regulation of continuing care retirement facilities, upon request of the commissioner;

(2) Review and comment upon, as appropriate, any proposed rules and regulations and legislation pertaining to continuing care retirement facilities;

(3) Make recommendations to the commissioner about any needed changes in rules and regulations and State and federal laws pertaining to continuing care retirement facilities; and

(4) Assist in the rehabilitation of a continuing care retirement facility, upon request of the commissioner.

g. The commissioner shall report annually to the Governor and the Legislature, the commissioner's and the council's findings and recommendations concerning continuing care retirement communities and the implementation of this act.

424. Section 2 of P.L.1993, c.249 (C.52:27D-407) is amended to read as follows:

C.52:27D-407 Definitions.

2. As used in this act:

"Abuse" means the willful infliction of physical pain, injury or mental anguish, unreasonable confinement, or the willful deprivation of services which are necessary to maintain a person's physical and mental health.

"Caretaker" means a person who has assumed the responsibility for the care of a vulnerable adult as a result of family relationship or who has assumed responsibility for the care of a vulnerable adult voluntarily, by contract, or by order of a court of competent jurisdiction, whether or not they reside together.

"Commissioner" means the Commissioner of Human Services.

"Community setting" means a private residence or any noninstitutional setting in which a person may reside alone or with others, but shall not include residential health care facilities, rooming houses or boarding homes or any other facility or living arrangement subject to licensure by, operated by, or under contract with, a State department or agency.

"County adult protective services provider" means a county Board of Social Services or other public or nonprofit agency with experience as a New Jersey provider of protective services for adults, designated by the county and approved by the commissioner. The county adult protective services provider receives reports made pursuant to this act, maintains pertinent records and provides, arranges, or recommends protective services.

"County director" means the director of a county adult protective services provider.

"Department" means the Department of Human Services.

"Emergency medical technician" means a person trained in basic life support services as defined in section 1 of P.L.1985, c.351 (C.26:2K-21) and who is certified by the Department of Health to provide that level of care.

"Exploitation" means the act or process of illegally or improperly using a person or his resources for another person's profit or advantage.

"Firefighter" means a paid or volunteer firefighter.

"Health care professional" means a health care professional who is licensed or otherwise authorized, pursuant to Title 45 or Title 52 of the Revised Statutes, to practice a health care profession that is regulated by one of the following boards or by the Director of the Division of Consumer Affairs: the State Board of Medical Examiners, the New Jersey Board of Nursing, the New Jersey State Board of Dentistry, the New Jersey State Board of Optometrists, the New Jersey State Board of Pharmacy, the State Board of Chiropractic Examiners, the Acupuncture Examining Board, the State Board of Physical Therapy, the State Board of Respiratory Care, the Orthotics and Prosthetics Board of Examiners, the State Board of Psychological Examiners, the State Board of Social Work Examiners, the State Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians, the Audiology and Speech-Language Pathology Advisory Committee, the State Board of Marriage and Family Therapy Examiners, the Occupational Therapy Advisory Council, the Certified Psychoanalysts Advisory Committee, and the State Board of Polysomnography. "Health care professional" also means a nurse aide or personal care assistant who is certified by the Department of Health.

"Neglect" means an act or failure to act by a vulnerable adult or his caretaker which results in the inadequate provision of care or services necessary to maintain the physical and

mental health of the vulnerable adult, and which places the vulnerable adult in a situation which can result in serious injury or which is life-threatening.

"Protective services" means voluntary or court-ordered social, legal, financial, medical or psychiatric services necessary to safeguard a vulnerable adult's rights and resources, and to protect a vulnerable adult from abuse, neglect or exploitation. Protective services include, but are not limited to: evaluating the need for services, providing or arranging for appropriate services, obtaining financial benefits to which a person is entitled, and arranging for guardianship and other legal actions.

"Vulnerable adult" means a person 18 years of age or older who resides in a community setting and who, because of a physical or mental illness, disability or deficiency, lacks sufficient understanding or capacity to make, communicate, or carry out decisions concerning his well-being and is the subject of abuse, neglect or exploitation. A person shall not be deemed to be the subject of abuse, neglect or exploitation or in need of protective services for the sole reason that the person is being furnished nonmedical remedial treatment by spiritual means through prayer alone or in accordance with a recognized religious method of healing in lieu of medical treatment, and in accordance with the tenets and practices of the person's established religious tradition.

425. Section 21 of P.L.1993, c.249 (C.52:27D-426) is amended to read as follows:

C.52:27D-426 Transfer of funding, programs, positions.

21. a. All funding, programs, and positions created to provide adult protective services are continued and shall be transferred to the Department of Human Services. The Department of Community Affairs shall provide the Department of Human Services with such information as the Department of Human Services requires to fulfill its federal funding and reporting requirements.

b. The transfers directed by this act shall be made in accordance with the "State Agency Transfer Act," P.L.1971, c.375 (C.52:14D-1 et seq.).

426. Section 15 of P.L.1993, c.288 (C.52:27D-428) is amended to read as follows:

C.52:27D-428 Certification of business firms performing lead evaluation, abatement work.

15. a. A business firm shall neither directly nor indirectly perform lead evaluation or abatement work without first obtaining certification from the department. Certification may be issued to perform lead evaluation or abatement work if the business firm employs or will employ sufficient numbers and types of personnel certified by the Department of Health pursuant to section 3 of P.L.1993, c.288 (C.26:2Q-3) to perform lead abatement work and meets all other requirements that the commissioner may establish pursuant to section 23 of P.L.1993, c.288 (C.52:27D-436). The certification shall be in writing, shall contain an expiration date, and shall be signed by the commissioner.

b. A person or business firm shall not undertake a project involving lead abatement work without first obtaining a construction permit for that project pursuant to section 12 of P.L.1975, c.217 (C.52:27D-130). No permit shall be issued for lead abatement work, except to:

(1) an owner undertaking work on his own premises using his own employees, if those employees are certified by the Department of Health pursuant to section 3 of P.L.1993, c.288 (C.26:2Q-3);

(2) a homeowner proposing to perform lead abatement work himself on a dwelling unit that he owns and occupies as a primary place of residence; or

(3) a business firm certified pursuant to this section to perform such work.

The issuance of a construction permit to an individual homeowner proposing to perform lead abatement work on a dwelling unit that he owns and occupies as a primary place of residence shall be accompanied by written information developed by the department explaining the dangers of improper lead abatement, procedures for conducting safe lead abatement, and the availability of certified lead abatement contractors, or of any available training for homeowners.

c. Nothing in this section shall be construed to restrict or otherwise affect the right of any business firm to engage in painting, woodworking, structural renovation, or other indoor or outdoor contracting services that may result in the disturbance of paint, or to engage in lead safe maintenance work or lead hazard control work, but a business firm shall not hold itself out as certified by the department or otherwise represent that it has specialized competency to perform lead evaluation or abatement work unless it has been certified or otherwise specifically authorized pursuant to this section.

A business firm that seeks to engage in lead safe maintenance work or lead hazard control work shall do so using only persons who, prior to engaging in such work, shall have completed such training courses as may be prescribed by the commissioner and provided by a training provider accredited by the Commissioner of Health.

A business firm that utilizes interim controls to reduce the risk of lead-based paint exposure shall utilize only those methods approved by the appropriate federal agencies, including specialized cleaning, repairs, maintenance, painting, temporary containment, ongoing monitoring of lead-based paint hazards or potential hazards, as may be set forth under 42 U.S.C.s.4851b, or those methods set forth in guidelines established by the commissioner, but shall not be required to be certified pursuant to this section unless performing lead abatement.

427. Section 24 of P.L.2003, c.311 (C.52:27D-437.15) is amended to read as follows:

C.52:27D-437.15 Modification of regulations concerning lead hazards.

24. The Commissioner of Banking and Insurance and the Commissioner of Health shall consult with the Commissioner of Community Affairs and shall modify all regulations concerning lead hazards in accordance with the provisions of P.L.2003, c.311 (C.52:27D-437.1 et al.), to recognize lead hazard control work as an authorized alternative method to lead abatement in control of lead hazards.

428. Section 4 of P.L.1985, c.298 (C.52:27G-23) is amended to read as follows:

C.52:27G-23 Office of the Public Guardian for Elderly Adults.

4. There is created in the Executive Branch of the State Government the Office of the Public Guardian for Elderly Adults. For the purpose of complying with the provisions of Article V, Section IV, paragraph 1 of the New Jersey Constitution, the Office of the Public Guardian for Elderly Adults is allocated to the Department of Human Services, but notwithstanding this allocation, the office shall be independent of any supervision or control by the department or any board or officer thereof.

429. Section 15 of P.L.2005, c.37 (C.52:27G-42) is amended to read as follows:

C.52:27G-42 Registered Professional Guardian Fund.

15. a. There is established in the Department of Human Services a special non-lapsing fund to be known as the Registered Professional Guardian Fund, which shall be a dedicated fund to serve as a depository for monies collected from the estate of an incapacitated adult pursuant to this section. The fund shall be administered by the Office of the Public Guardian for Elderly Adults, and all interest on monies in the fund shall be credited to the fund. The monies in the fund shall be made available to the Office of the Public Guardian for Elderly Adults to be used exclusively for the implementation of this act.

b. Sixty days after receiving plenary letters of guardianship or letters of guardianship of property, a guardian appointed by the Superior Court of New Jersey, with the exception of the appointment of the public guardian pursuant to P.L.1985, c.298 (C.52:27G-20 et seq.), a guardian for a veteran pursuant to N.J.S.3B:13-1 et seq. and guardianship services provided by the Bureau of Guardianship Services in the Division of Developmental Disabilities in the Department of Human Services pursuant to P.L.1965, c.59 (C.30:4-165.1 et seq.), shall pay out of the estate of the incapacitated adult a fee of $150 to the Office of the Public Guardian for Elderly Adults for deposit into the fund, except that no such charge shall be made to an incapacitated adult's estate for an incapacitated adult whose income is less than 150% of the federal poverty level and whose assets are less than $50,000.

c. If the guardian seeks an exemption from the fee based on the ward's income or assets, as set forth in subsection b. of this section, the guardian shall make an application to the Office of the Public Guardian for Elderly Adults on forms adopted by that office.

d. If a guardian who is obligated to pay an assessment imposed pursuant to subsection b. of this section fails to pay the assessment, upon application by the Office of the Public Guardian for Elderly Adults, the court shall afford the guardian notice and an opportunity to be heard on the issue of default. Failure to make the assessed payment when due shall be considered a default. The standard of proof shall be by a preponderance of the evidence, and the burden of establishing good cause for a default shall be on the guardian who has defaulted. If the court finds that the guardian has defaulted without good cause, the court may:

(1) compel the guardian of the estate to account and ascertain the financial condition of the incapacitated adult's estate;

(2) remove the guardian;

(3) enter judgment against the guardian of the estate for the amount of the assessment; or

(4) take such other action as may be permitted by law.

430. Section 16 of P.L.2005, c.37 (C.52:27G-43) is amended to read as follows:

C.52:27G-43 Rules, regulations, Rules of Court.

16. a. The Commissioner of Human Services, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), may adopt rules and regulations necessary for the implementation of this act.

b. The Supreme Court may adopt Rules of Court for the implementation of this act.

431. Section 1 of P.L.1997, c.348 (C.54:4-8.67) is amended to read as follows:

C.54:4-8.67 Definitions relative to homestead property tax reimbursement.

1. As used in this act:

"Base year" means, in the case of a person who is an eligible claimant on or before December 31, 1997, the tax year 1997; and in the case of a person who first becomes an eligible claimant after December 31, 1997, the tax year in which the person first becomes an eligible claimant. In the case of an eligible claimant who subsequently moves from the homestead for which the initial eligibility was established, the base year shall be the first full tax year during which the person resides in the new homestead. Provided however, a base year for an eligible claimant after such a move shall not apply to tax years commencing prior to January 1, 2009.

"Commissioner" means the Commissioner of Community Affairs.

"Director" means the Director of the Division of Taxation.

"Condominium" means the form of real property ownership provided for under the "Condominium Act," P.L.1969, c.257 (C.46:8B-1 et seq.).

"Cooperative" means a housing corporation or association which entitles the holder of a share or membership interest thereof to possess and occupy for dwelling purposes a house, apartment or other unit of housing owned or leased by the corporation or association, or to lease or purchase a unit of housing constructed or to be constructed by the corporation or association.

"Disabled person" means an individual receiving monetary payments pursuant to Title II of the federal Social Security Act (42 U.S.C. s.401 et seq.) on December 31, 1998, or on December 31 in all or any part of the year for which a homestead property tax reimbursement under this act is claimed.

"Dwelling house" means any residential property assessed as real property which consists of not more than four units, of which not more than one may be used for commercial purposes, but shall not include a unit in a condominium, cooperative, horizontal property regime or mutual housing corporation.

"Eligible claimant" means a person who:

is 65 or more years of age, or who is a disabled person;

is an owner of a homestead, or the lessee of a site in a mobile home park on which site the applicant owns a manufactured or mobile home;

has an annual income of less than $17,918 in tax year 1998, less than $18,151 in tax year 1999, or less than $37,174 in tax year 2000, if single, or, if married, whose annual income combined with that of the spouse is less than $21,970 in tax year 1998, less than $22,256 in tax year 1999, or less than $45,582 in tax year 2000, which income eligibility limits for single and married persons shall be subject to adjustments in tax years 2001 through 2006 pursuant to section 9 of P.L.1997, c.348 (C.54:4-8.68);

has an annual income of $60,000 or less in tax year 2007, $70,000 or less in tax year 2008, or $80,000 or less in tax year 2009, if single or married, which income eligibility limits shall be subject to adjustments in subsequent tax years pursuant to section 9 of P.L.1997, c.348 (C.54:4-8.68);

as a renter or homeowner, has made a long-term contribution to the fabric, social structure and finances of one or more communities in this State, as demonstrated through the payment of property taxes directly, or through rent, on any homestead or rental unit used as a principal residence in this State for at least 10 consecutive years at least three of which as owner of the homestead for which a homestead property tax reimbursement is sought prior to the date that an initial application for a homestead property tax reimbursement is filed. A person who has been an eligible claimant for a previous tax year shall qualify as an eligible claimant beginning the second full tax year following a move to another homestead in New Jersey, despite not meeting the three-year minimum residency and ownership requirement required

for initial claimants under this paragraph; provided that the person satisfies the income eligibility limits for the tax year. Provided however, eligibility beginning in a second full tax year after such a move shall not apply to tax years commencing prior to January 1, 2010.

"Homestead" means:

a dwelling house and the land on which that dwelling house is located which constitutes the place of the eligible claimant's domicile and is owned and used by the eligible claimant as the eligible claimant's principal residence;

a site in a mobile home park equipped for the installation of manufactured or mobile homes, where these sites are under common ownership and control for the purpose of leasing each site to the owner of a manufactured or mobile home for the installation thereof and such site is used by the eligible claimant as the eligible claimant's principal residence;

a dwelling house situated on land owned by a person other than the eligible claimant which constitutes the place of the eligible claimant's domicile and is owned and used by the eligible claimant as the eligible claimant's principal residence;

a condominium unit or a unit in a horizontal property regime or a continuing care retirement community which constitutes the place of the eligible claimant's domicile and is owned and used by the eligible claimant as the eligible claimant's principal residence.

In addition to the generally accepted meaning of "owned" or "ownership," a homestead shall be deemed to be owned by a person if that person is a tenant for life or a tenant under a lease for 99 years or more, is entitled to and actually takes possession of the homestead under an executory contract for the sale thereof or under an agreement with a lending institution which holds title as security for a loan, or is a resident of a continuing care retirement community pursuant to a contract for continuing care for the life of that person which requires the resident to bear, separately from any other charges, the proportionate share of property taxes attributable to the unit that the resident occupies;

a unit in a cooperative or mutual housing corporation which constitutes the place of domicile of a residential shareholder or lessee therein, or of a lessee or shareholder who is not a residential shareholder therein, which is used by the eligible claimant as the eligible claimant's principal residence.

"Homestead property tax reimbursement" means payment of the difference between the amount of property tax or site fee constituting property tax due and paid in any year on any homestead, exclusive of improvements not included in the assessment on the real property for the base year, and the amount of property tax or site fee constituting property tax due and paid in the base year, when the amount paid in the base year is the lower amount; but such calculations shall be reduced by any current year property tax reductions or reductions in site fees constituting property taxes resulting from judgments entered by county boards of taxation or the State Tax Court.

"Horizontal property regime" means the form of real property ownership provided for under the "Horizontal Property Act," P.L.1963, c.168 (C.46:8A-1 et seq.).

"Manufactured home" or "mobile home" means a unit of housing which:

(1) Consists of one or more transportable sections which are substantially constructed off site and, if more than one section, are joined together on site;

(2) Is built on a permanent chassis;

(3) Is designed to be used, when connected to utilities, as a dwelling on a permanent or nonpermanent foundation; and

(4) Is manufactured in accordance with the standards promulgated for a manufactured home by the Secretary of the United States Department of Housing and Urban Development pursuant to the "National Manufactured Housing Construction and Safety Standards Act of

1974," Pub.L.93-383 (42 U.S.C. s.5401 et seq.) and the standards promulgated for a manufactured or mobile home by the commissioner pursuant to the "State Uniform Construction Code Act," P.L.1975, c.217 (C.52:27D-119 et seq.).

"Mobile home park" means a parcel of land, or two or more parcels of land, containing no fewer than 10 sites equipped for the installation of manufactured or mobile homes, where these sites are under common ownership and control for the purpose of leasing each site to the owner of a manufactured or mobile home for the installation thereof, and where the owner or owners provide services, which are provided by the municipality in which the park is located for property owners outside the park, which services may include but shall not be limited to:

(1) The construction and maintenance of streets;

(2) Lighting of streets and other common areas;

(3) Garbage removal;

(4) Snow removal; and

(5) Provisions for the drainage of surface water from home sites and common areas.

"Mutual housing corporation" means a corporation not-for-profit, incorporated under the laws of this State on a mutual or cooperative basis within the scope of section 607 of the Langham Act (National Defense Housing), Pub.L.849, (42 U.S.C. s.1521 et seq.), as amended, which acquired a National Defense Housing Project pursuant to that act.

"Income" means income as determined pursuant to P.L.1975, c.194 (C.30:4D-20 et seq.).

"Principal residence" means a homestead actually and continually occupied by an eligible claimant as his or her permanent residence, as distinguished from a vacation home, property owned and rented or offered for rent by the claimant, and other secondary real property holdings.

"Property tax" means the general property tax due and paid as set forth in this section, on a homestead, but does not include special assessments and interest and penalties for delinquent taxes. For the sole purpose of qualifying for a benefit under P.L.1997, c.348 (C.54:4-8.67 et seq.), property taxes paid by June 1 of the year following the year for which the benefit is claimed will be deemed to be timely paid.

"Site fee constituting property tax" means 18 percent of the annual site fee paid or payable to the owner of a mobile home park.

"Tax year" means the calendar year in which a homestead is assessed and the property tax is levied thereon and it means the calendar year in which income is received or accrued.

432. Section 4 of P.L.1999, c.129 (C.56:8-14.5) is amended to read as follows:

C.56:8-14.5 Educational program about consumer protection laws, rights.

4. The Director of the Division of Consumer Affairs in the Department of Law and Public Safety, in consultation with the Director of the Division of Aging Services in the Department of Human Services, the directors of the New Jersey Association of Area Agencies on Aging, and the New Jersey Association of County Offices for Disabled Persons, shall develop and implement an educational program to inform senior citizens and persons with disabilities about consumer protection laws and consumer rights, subject to funds made available pursuant to subsection b. of section 5 of P.L.1999, c.129 (C.56:8-14.6) or any other source. Functions of the program may include:

a. The preparation of educational materials regarding consumer protection laws and consumer rights that are of particular interest to senior citizens and persons with disabilities

and distribution of those materials to the appropriate State and county agencies for dissemination to senior citizens, persons with disabilities and the public; and

b. The underwriting of educational seminars and other forms of educational projects for the benefit of senior citizens and persons with disabilities.

433. Section 5 of P.L.1999, c.336 (C.56:8-96) is amended to read as follows:

C.56:8-96 Certification from veterinarian, recourse.

5. a. Any consumer who purchases from a pet shop an animal that becomes sick or dies after the date of purchase may take the sick or dead animal to a veterinarian within the period of time required pursuant to the notification form provided upon the date of purchase, receive certification from the veterinarian of the health and condition of the animal, and pursue the recourse provided for under the circumstances indicated by the veterinarian certification, as required and provided for pursuant to section 4 of P.L.1999, c.336 (C.56:8-95).

b. Upon receipt of the certification from the veterinarian, the consumer may report the sickness or death of the animal and the pet shop where the animal was purchased to the local health authority with jurisdiction over the municipality in which the pet shop where the animal was purchased is located, and to the Director of the Division of Consumer Affairs in the Department of Law and Public Safety. The consumer shall provide a copy of the veterinarian certificate with any report. The director shall forward to the appropriate local health authority a copy of any report the division receives. The local health authority shall record and retain the records of any report and documentation submitted by a consumer.

c. By the May 1 immediately following the effective date of this act, and annually thereafter, the local health authority with jurisdiction over pet shops shall review any files it has concerning reports filed pursuant to subsection b. of this section and shall recommend to the municipality in which the pet shop is located the revocation of the license of any pet shop with reports filed as follows:

(1) 15% of the total number of animals sold in a year by the pet shop were certified by a veterinarian to be unfit for purchase due to congenital or hereditary cause or condition, or a sickness brought on by a congenital or hereditary cause or condition;

(2) 25% of the total number of animals sold in a year by the pet shop were certified by a veterinarian to be unfit for purchase due to a non-congenital cause or condition;

(3) 10% of the total number of animals sold in a year by the pet shop died and were certified by a veterinarian to have died from a non-congenital cause or condition; or

(4) 5% of the total number of animals sold in a year by the pet shop died and were certified by a veterinarian to have died from a congenital or hereditary cause or condition, or a sickness brought on by a congenital or hereditary cause or condition.

d. By the May 1 immediately following the effective date of this act, and annually thereafter, the local health authority with jurisdiction over pet shops shall review any files it has concerning reports filed pursuant to subsection b. of this section and shall recommend to the municipality in which the pet shop is located a 90-day suspension of the license of any pet shop with reports filed as follows:

(1) 10% of the total number of animals sold in a year by the pet shop were certified by a veterinarian to be unfit for purchase due to congenital or hereditary cause or condition, or a sickness brought on by a congenital or hereditary cause or condition;

(2) 15% of the total number of animals sold in a year by the pet shop were certified by a veterinarian to be unfit for purchase due to a non-congenital cause or condition;

(3) 5% of the total number of animals sold in a year by the pet shop died and were certified by a veterinarian to have died from a non-congenital cause or condition; or

(4) 3% of the total number of animals sold in a year by the pet shop died and were certified by a veterinarian to have died from a congenital or hereditary cause or condition, or a sickness brought on by a congenital or hereditary cause or condition.

e. Pursuant to the authority and requirements provided in section 8 of P.L.1941, c.151 (C.4:19-15.8), the owner of the pet shop shall be afforded a hearing and, upon the recommendation by the local health authority pursuant to subsection c. or d. of this section, the local health authority, in consultation with the Department of Health, shall set a date for the hearing to be held by the local health authority or the State Department of Health and shall notify the pet shop involved. The municipality may suspend or revoke the license, or part thereof, that authorizes the pet shop to sell cats or dogs after the hearing has been held and as provided in section 8 of P.L.1941, c.151 (C.4:19-15.8). At the hearing, the local health authority or the Department of Health, whichever entity is holding the hearing, shall receive testimony from the pet shop and shall determine if the pet shop: (1) failed to maintain proper hygiene and exercise reasonable care in safeguarding the health of animals in its custody, or (2) sold a substantial number of animals that the pet shop knew, or reasonably should have known, to be unfit for purchase.

f. No provision of subsection c. shall be construed to restrict the local health authority or the Department of Health from holding a hearing concerning any pet shop in the State irrespective of the criteria for recommendation of license suspension or revocation named in subsection c. or d., or from recommending to a municipality the suspension or revocation of the license of a pet shop within its jurisdiction for other violations under other sections of law, or rules and regulations adopted pursuant thereto.

g. No action taken by the local health authority or municipality pursuant to this section or section 8 of P.L.1941, c.151 (C.4:19-15.8) shall be construed to limit or replace any action, hearing or review of complaints concerning the pet shop by the Division of Consumer Affairs in the Department of Law and Public Safety to enforce consumer fraud laws or other protections to which the consumer is entitled.

h. The requirements of this section shall be posted in a prominent place in each pet shop in the State along with the name, address, and telephone number of the local health authority that has jurisdiction over the pet shop, and this information shall be provided in writing at the time of purchase to each consumer and to each licensed veterinarian contracted for services by the pet shop upon contracting the veterinarian.

i. The Director of the Division of Consumer Affairs may investigate and pursue enforcement against any pet shop reported by a consumer pursuant to subsection b. of this section.

Repealer.

434. Section 4 of P.L.1999, c.174 (C.26:1A-15.3), section 28 of P.L.1966 c.293 (C.52:27D-28), section 2 of P.L.1975, c.36 (C.52:27D-28.2), section 1 of P.L.1985, c.357 (C.52:27D-28.5), and section 29 of P.L.1966, c.293 (C.52:27D-29) are repealed.

435. This act shall take effect immediately.

Approved June 29, 2012.