N.J. Stat. Title 26, Ch. 2H, Pt. I

Current through New Jersey 220th First Annual Session, L. 2022, c. 130 and J.R. 10

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Part I. Health Care Facilities Planning Act

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Public Health & Welfare Law: Social Security: Medicare: General Overview

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Health Care Facilities Planning Act, *N.J. Stat. Ann. §§ 26:2H-1* to *26:2H-26*, as supplemented by the forms of administrative action permitted under chapter 31, contains reasonably detailed standards to govern the Department

of Health's review of certificate of need applications and thus satisfies due process requirements. *In re Adoption of Regulations Governing the State Health Plan, N.J.A.C., 262 N.J. Super. 469, 621 A.2d 484, 1993 N.J. Super. LEXIS 50 (App.Div. 1993)*, aff'd, *135 N.J. 24, 637 A.2d 1246, 1994 N.J. LEXIS 172 (N.J. 1994)*.

N.J. Stat. Ann. § 26:2H-1 et seq. neither expressly prohibits nor permits regulations requiring nursing homes to provide a reasonable number of beds to indigent persons as a condition of licensure or re-licensure. *New Jersey Asso. of Health Care Facilities v. Finley, 168 N.J. Super. 152, 402 A.2d 246, 1979 N.J. Super. LEXIS 757 (App.Div. 1979)*, aff'd, *83 N.J. 67, 415 A.2d 1147, 1980 N.J. LEXIS 1365 (N.J. 1980)*.

Under *N.J. Stat. Ann. § 26:2H-1* et seq. administrative supervision of hospitals was transferred from the Department of Institutions and Agencies to the State Department of Health in 1971. *Guerrero v. Burlington County Memorial Hospital, 70 N.J. 344, 360 A.2d 334, 1976 N.J. LEXIS 203 (N.J. 1976)*.

Antitrust & Trade Law: Consumer Protection: Deceptive Acts & Practices: General Overview

Hospital was not subject to a claim brought by parents of a patient under the Consumer Fraud Act, *N.J. Stat. Ann. § 56:8-1* et seq.; *N.J. Stat. Ann. § 56:8-2* did not encompass services performed by a hospital; there was no purpose to a requirement that hospital services be within the purview of the Act when those same services fell within the purview of the Department of Health, the Health Care Facilities Planning Act, *N.J. Stat. Ann. § 26:2H-1* et seq., and regulations promulgated by the Department. *Hampton Hosp. v. Bresan, 288 N.J. Super. 372, 672 A.2d 725, 1996 N.J. Super. LEXIS 118 (App.Div.)*, certif. denied, *144 N.J. 588, 677 A.2d 760, 1996 N.J. LEXIS 838 (N.J. 1996)*.

Constitutional Law: Bill of Rights: Fundamental Rights: Procedural Due Process: Scope of Protection

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Where the Department of Health has the authority, pursuant to *N.J. Stat. Ann. § 26:2H-1*, to promulgate regulations requiring health providers to deliver needed services, then it follows that it may employ its licensing function to enforce those regulations. *New Jersey Asso. of Health Care Facilities v. Finley, 168 N.J. Super. 152, 402 A.2d 246, 1979 N.J. Super. LEXIS 757 (App.Div. 1979)*, aff'd, *83 N.J. 67, 415 A.2d 1147, 1980 N.J. LEXIS 1365 (N.J. 1980)*.

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N.J. Administrative Code provision which required nursing homes to make available "a reasonable number of their beds to indigent persons" as a condition of licensure under *N.J. Stat. Ann. §§ 26:2H-5*, *26:2H-8*, and *26:2H-12*, did not exceed the power given to the state under *N.J. Stat. Ann. § 26:2H-1* et seq.; the argument that the state was attempting to regulate the quantity of health care services, rather than the quality of health care services was rejected because the acute shortage of nursing home beds for indigent persons was a public health concern, and the regulations were not arbitrary or unreasonable. *In re Health Care Administration Board, 83 N.J. 67, 415 A.2d 1147, 1980 N.J. LEXIS 1365 (N.J.)*, cert. denied, *449 U.S. 944, 101 S. Ct. 342, 66 L. Ed. 2d 208, 1980 U.S. LEXIS 3668 (U.S. 1980)*.

Healthcare Law: Actions Against Healthcare Workers: ERISA Preemption

N.J. Stat. Ann. § 26:2H-1 which set hospital rates was improperly deemed preempted by Employee Retirement Income Security Act (ERISA) because the statute was one of general applicability designed to regulate health care costs; the ERISA preemption provision was designed to prevent state interference with federal control of ERISA plans and did not require the creation of a fully insulated legal world that excluded the plans from any purely local regulation. United Wire, Metal & Mach. Health & Welfare Fund v. Morristown Memorial Hosp., 995 F.2d 1179, 1993 U.S. App. LEXIS 11112 (3d Cir. N.J.), cert. denied, *510 U.S. 944, 114 S. Ct. 383, 126 L. Ed. 2d 332, 1993 U.S. LEXIS 6694 (U.S. 1993)*.

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In allocating reductions in Medicare payments under Gramm-Rudman to the hospitals there was no evidence that the hospital rate setting commission had considered the effect of the statutory and regulatory scheme under N.J. Stat. Ann. § 26:2H-1 et seq. New Jersey Hospital Asso. v. New Jersey State Dep't of Health, Hospital Rate Setting Com., 227 N.J. Super. 557, 548 A.2d 211, 1988 N.J. Super. LEXIS 355 (App.Div. 1988).

Administrator and the beneficiaries were not entitled to a preliminary injunction to prohibit the Commissioner of the Department of Health from implementing an amendment to the New Jersey Health Care Facilities Planning Act of 1971, N.J. Stat. Ann. § 26:2H-1 et seq., which created a state commission to set a schedule of rates for hospital services based on a patient's diagnosis; the argument that the rate setting system was preempted by the Employee Retirement Income Security Act and the National Labor Relations Act had little chance of success on the merits. *Bonser v. New Jersey, 605 F. Supp. 1227, 1985 U.S. Dist. LEXIS 21162 (D.N.J. 1985)*.

In a proceeding brought by a hospital seeking adjustment of its rate schedule to reflect the costs of pension and dental plans that the hospital had established for its employees, a judgment that vacated the decision of the rate setting commission to uphold a recommendation against the rate adjustment was affirmed because, under the Health Care Facilities Planning Act, N.J. Stat. Ann. §§ 26:2H-1 to 26:2H-52, the rate setting commission's grounds for its action were neither adequately supported by the record nor clearly explained; the court directed the rate setting commission to conduct another hearing to examine the facts, carefully apply the pertinent regulations, and clearly set forth its conclusions. Riverside General Hospital v. New Jersey Hospital Rate Setting Com., 98 N.J. 458, 487 A.2d 714, 1985 N.J. LEXIS 2229 (N.J. 1985).

Healthcare Law: Business Administration & Organization: Licenses: General Overview

Under the Health Care Facilities Planning Act, N.J. Stat. Ann. § 26:2H-1 et seq., hospital rates are subject to regulation, and the legislative policy is to provide for the protection and promotion of the health of the inhabitants of New Jersey, to promote the financial solvency of hospitals and similar health care facilities, and to contain the rising cost of health care services. Slocum v. Hospital Rate Setting Com., Dep't of Health, 240 N.J. Super. 566, 573 A.2d 971, 1990 N.J. Super. LEXIS 137 (App.Div. 1990).

N.J. Stat. Ann. § 26:2H-1 et seq. neither expressly prohibits nor permits regulations requiring nursing homes to provide a reasonable number of beds to indigent persons as a condition of licensure or re-licensure. New Jersey Asso. of Health Care Facilities v. Finley, 168 N.J. Super. 152, 402 A.2d 246, 1979 N.J. Super. LEXIS 757 (App.Div. 1979), aff'd, 83 N.J. 67, 415 A.2d 1147, 1980 N.J. LEXIS 1365 (N.J. 1980).

Where the Department of Health has the authority, pursuant to N.J. Stat. Ann. § 26:2H-1, to promulgate regulations requiring health providers to deliver needed services, then it follows that it may employ its licensing function to enforce those regulations. New Jersey Asso. of Health Care Facilities v. Finley, 168 N.J. Super. 152, 402 A.2d 246, 1979 N.J. Super. LEXIS 757 (App.Div. 1979), aff'd, 83 N.J. 67, 415 A.2d 1147, 1980 N.J. LEXIS 1365 (N.J. 1980).

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Regulation of private hospitals by State, pursuant to the Health Care Facilities Planning Act of 1971, N.J. Stat. Ann. § 26:2H-1 et seq., did not constitute state action; a policy to prohibit use of their facilities for elective abortions was not arbitrary where women could seek procedures within reasonable distances of the hospitals. Doe v. Bridgeton Hospital Asso., 130 N.J. Super. 416, 327 A.2d 448, 1974 N.J. Super. LEXIS 550 (Law Div. 1974), rev'd, 71 N.J. 478, 366 A.2d 641, 1976 N.J. LEXIS 169 (N.J. 1976).

Healthcare Law: Business Administration & Organization: Licenses: Requirements

N.J. Administrative Code provision which required nursing homes to make available "a reasonable number of their beds to indigent persons" as a condition of licensure under N.J. Stat. Ann. §§ 26:2H-5, 26:2H-8, and 26:2H-12, did not exceed the power given to the state under N.J. Stat. Ann. § 26:2H-1 et seq.; the argument that the state was attempting to regulate the quantity of health care services, rather than the quality of health care services was rejected because the acute shortage of nursing home beds for indigent persons was a public health concern, and the regulations were not arbitrary or unreasonable. In re Health Care Administration Board, 83 N.J. 67, 415 A.2d 1147, 1980 N.J. LEXIS 1365 (N.J.), cert. denied, *449 U.S. 944, 101 S. Ct. 342, 66 L. Ed. 2d 208, 1980 U.S. LEXIS 3668 (U.S. 1980)*.

Healthcare Law: Insurance: Reimbursement: General Overview

In allocating reductions in Medicare payments under Gramm-Rudman to the hospitals there was no evidence that the hospital rate setting commission had considered the effect of the statutory and regulatory scheme under N.J. Stat. Ann. § 26:2H-1 et seq. New Jersey Hospital Asso. v. New Jersey State Dep't of Health, Hospital Rate Setting Com., 227 N.J. Super. 557, 548 A.2d 211, 1988 N.J. Super. LEXIS 355 (App.Div. 1988).

Administrator and the beneficiaries were not entitled to a preliminary injunction to prohibit the Commissioner of the Department of Health from implementing an amendment to the New Jersey Health Care Facilities Planning Act of 1971, N.J. Stat. Ann. § 26:2H-1 et seq., which created a state commission to set a schedule of rates for hospital services based on a patient's diagnosis; the argument that the rate setting system was preempted by the Employee Retirement Income Security Act and the National Labor Relations Act had little chance of success on the merits. *Bonser v. New Jersey, 605 F. Supp. 1227, 1985 U.S. Dist. LEXIS 21162 (D.N.J. 1985)*.

Healthcare Law: Managed Healthcare: General Overview

The Health Care Facilities Planning Act, N.J. Stat. Ann. § 26:2H-1 et seq., did not apply to physician groups, who were bound contractually with health management corporations, because the physician groups were still engaged in private practice. Women's Medical Center v. Finley, 192 N.J. Super. 44, 469 A.2d 65, 1983 N.J. Super. LEXIS 976 (App.Div. 1983), certif. denied, *96 N.J. 279, 475 A.2d 578, 1984 N.J. LEXIS 2506 (N.J. 1984)*.

Public Health & Welfare Law: Healthcare: Services for Disabled & Elderly Persons: General Overview

Where the Commissioner of Health issued a certificate of need for the establishment of a nursing home subject to the conversion of a portion of another facility previously established for geriatric care, to a center for the treatment of patients with Acquired Immune Deficiency Syndrome, the Commissioner deviated in material respects from controlling statutes and regulations in issuing a certificate of need; the Commissioner failed to notify the Health Systems Agency of the application, which precluded a review and a determination whether the certificate was

necessary, under N.J. Stat. Ann. § 26:2H-1, to provide for and contribute to required health care in the area. In re Bloomingdale Convalescent Center, 233 N.J. Super. 46, 558 A.2d 19, 1989 N.J. Super. LEXIS 194 (App.Div. 1989).

Pursuant to the Health Care Facilities Planning Act (Act), N.J. Stat. Ann. § 26:2H-1 et seq., the state health department properly denied a hospital's proposed per diem rate for Blue Cross and Medicaid patients for calendar year 1976 based upon the excessiveness of two proposed cost items, the budgets for the hospital's emergency room and newborn nursery center; however, because the emergency room rate was affected by a determination of whether or not the hospital was required by administrative regulations to maintain a physician on duty 24 hours per day, that portion of the state health department's decision was remanded for further fact-finding. In re William B. Kessler Memorial Hospital, 78 N.J. 564, 397 A.2d 656, 1979 N.J. LEXIS 1168 (N.J. 1979).

Public Health & Welfare Law: Healthcare: Services for Disabled & Elderly Persons: Care Facilities: General Overview

Holding, that an agreement between the trustees of a life-care community home and its residents impliedly included the residents' right to an accounting by the trustees on the grounds that the monthly fees were expected to remain stable and reasonable, was consistent with the legislative policy expressed in New Jersey's fairly extensive regulation of the residential health care facilities industry set forth in N.J. Stat. Ann. § 30:11A-1 et seq., N.J. Stat. Ann. § 26:2H-1 et seq., and N.J. Admin. Code tit. 8, § 43-1.1 et seq. Onderdonk v. Presbyterian Homes of New Jersey, 85 N.J. 171, 425 A.2d 1057, 1981 N.J. LEXIS 2589 (N.J. 1981).

Public Health & Welfare Law: Social Security: Medicaid: General Overview

Pursuant to the Health Care Facilities Planning Act (Act), N.J. Stat. Ann. § 26:2H-1 et seq., the state health department properly denied a hospital's proposed per diem rate for Blue Cross and Medicaid patients for calendar year 1976 based upon the excessiveness of two proposed cost items, the budgets for the hospital's emergency room and newborn nursery center; however, because the emergency room rate was affected by a determination of whether or not the hospital was required by administrative regulations to maintain a physician on duty 24 hours per day, that portion of the state health department's decision was remanded for further fact-finding. In re William B. Kessler Memorial Hospital, 78 N.J. 564, 397 A.2d 656, 1979 N.J. LEXIS 1168 (N.J. 1979).

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End of Document

N.J. Stat. § 26:2H-1

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§ 26:2H-1. Declaration of public policy

It is hereby declared to be the public policy of the State that hospital and related health care services and behavioral health care services of the highest quality, of demonstrated need, efficiently provided and accessible at a reasonable cost are of vital concern to the public health. It is further declared that integrating physical and behavioral health care is the most effective way to improve the health of individuals and the population at large. In order to provide for the protection and promotion of the health of the inhabitants of the State, the Department of Health shall have the central responsibility for the development and administration of the State's policy with respect to health planning, hospital and related health care services and health care facility cost containment programs, behavioral health treatment and prevention programs, and all public and private institutions, whether State, county, municipal, incorporated or not incorporated, serving principally as residential health care facilities, nursing or maternity homes, or as facilities for the prevention, diagnosis, care, or treatment of human disease, mental illness, substance use disorder, pain, injury, deformity, or physical condition, shall be subject to the provisions of this act.

History

L. 1971, c. 136, § 1; amended 1978, c. 83, § 1; 1979, c. 496, § 19; *1991, c. 187*, § 27; *1992, c. 160*, § 21; *2017, c. 294*, § 1, effective February 1, 2019.

Annotations

Notes

Effective Dates

Section 4 of L. *2017, c. 294* provides: "This act shall take effect on the first day of the thirteenth month next following the date of enactment, except that the Commissioner of Health may take any anticipatory administrative action in advance as shall be necessary for the implementation of this act." Chapter 294, L. 2017, was approved on Jan. 16, 2018.

Amendment Notes

2017 amendment, by Chapter 294, in the first sentence, inserted "and behavioral health care services", and substituted "accessible" for "properly utilized"; inserted the second sentence; in the last sentence, deleted "State" preceding "Department", inserted "behavioral health treatment and prevention programs", and substituted

"diagnosis, care, or treatment of human disease, mental illness, substance use disorder" for "diagnosis, or treatment of human disease"; and made stylistic changes.

CASE NOTES

Administrative Law: Agency Rulemaking: Formal Rulemaking

Administrative Law: Agency Rulemaking: State Proceedings

Administrative Law: Judicial Review: Standards of Review: Arbitrary & Capricious Review

Administrative Law: Separation of Powers: Legislative Controls: Scope of Delegated Authority

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Healthcare Law: Business Administration & Organization: General Overview

Healthcare Law: Business Administration & Organization: Certificates of Need: Hospitals

Healthcare Law: Business Administration & Organization: Licenses: General Overview

Healthcare Law: Business Administration & Organization: Licenses: Requirements

Healthcare Law: Insurance: Reimbursement: General Overview

Healthcare Law: Managed Healthcare: General Overview

Healthcare Law: Treatment: General Overview

Public Health & Welfare Law: Healthcare: Services for Disabled & Elderly Persons: General Overview

Public Health & Welfare Law: Healthcare: Services for Disabled & Elderly Persons: Care Facilities: General Overview

Public Health & Welfare Law: Social Security: Medicaid: General Overview

Public Health & Welfare Law: Social Security: Medicare: General Overview

Administrative Law: Agency Rulemaking: Formal Rulemaking

Commissioner of the New Jersey Department of Health and Senior Services' adoption of a change in the manner of reporting to the public risk-adjusted mortality data on open heart surgery constituted an informal agency action, not administrative rulemaking, as it impacted only a narrow, select group; it was expressly within the Commissioner's delegated statutory authority; and it did not materially change a long-established administrative practice. Therefore, the decision was not subject to the rulemaking procedures of the New Jersey Health Care Facilities Planning Act, *N.J. Stat. Ann. §§ 26:2H-1* to -26. *Deborah Heart & Lung Center v. Howard, 404 N.J. Super. 491, 962 A.2d 577, 2009 N.J. Super. LEXIS 12 (App.Div.)*, certif. denied, *199 N.J. 129, 970 A.2d 1046, 2009 N.J. LEXIS 554 (N.J. 2009)*.

Administrative Law: Agency Rulemaking: State Proceedings

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Administrative Law: Judicial Review: Standards of Review: Arbitrary & Capricious Review

In an appeal filed by a city, its mayor, and an organization challenging the decision of the Commissioner of the New Jersey Department of Health and Senior Services, which granted an applicant's certificate of need (CN) to shut down an urban hospital in the city, the decision granting the CN to close the hospital was upheld as the decision was not arbitrary or capricious since it was based on the Commissioner properly imposing conditions reflecting community needs, the decision complied with the mandates imposed by case law, and the decision was supported by a financial audit that evidenced the financial distress the hospital had been experiencing. *City of Plainfield v. New Jersey Dept. of Health and Sr. Services, 412 N.J. Super. 466, 991 A.2d 265, 2010 N.J. Super. LEXIS 52 (App.Div.)*, certif. denied, *203 N.J. 93, 999 A.2d 462, 2010 N.J. LEXIS 606 (N.J. 2010)*, certif. denied, *203 N.J. 93, 999 A.2d 462, 2010 N.J. LEXIS 616 (N.J. 2010)*.

Administrative Law: Separation of Powers: Legislative Controls: Scope of Delegated Authority

In an inactive Emergency Medical Technician (EMT)-Paramedic's appeal challenging the validity of the recertification process for EMT-Paramedics, the New Jersey Department of Health and Senior Services was held to have properly upheld the validity of its regulations governing the recertification of EMT-Paramedics, pursuant to the Emergency Medical Services Act, N.J. Stat. Ann. §§ 26:2K-7 to 26:2K-64, because the recertification process is both narrowly designed and tightly controlled by clearly defined standards and is entirely consistent with the legislative scheme. There was no impermissible delegation of authority by the Department, and no deprivation of the inactive EMT-Paramedic's due process rights because there was no protected right to such employment, therefore, there was no corresponding legitimate claim of entitlement to recertification, which by regulation, was made contingent on receiving the endorsement and approval of a Mobile Intensive Care Unit hospital. *Santaniello v. New Jersey Dept. of Health and Sr. Services, 416 N.J. Super. 445, 5 A.3d 804, 2010 N.J. Super. LEXIS 205 (App.Div. 2010)*, certif. denied, *205 N.J. 183, 13 A.3d 1290, 2011 N.J. LEXIS 342 (N.J. 2011)*.

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Hospital was not subject to a claim brought by parents of a patient under the Consumer Fraud Act, N.J. Stat. Ann. § 56:8-1 et seq.; N.J. Stat. Ann. § 56:8-2 did not encompass services performed by a hospital; there was no purpose to a requirement that hospital services be within the purview of the Act when those same services fell within the purview of the Department of Health, the Health Care Facilities Planning Act, N.J. Stat. Ann. § 26:2H-1 et seq., and regulations promulgated by the Department. *Hampton Hosp. v. Bresan, 288 N.J. Super. 372, 672 A.2d 725, 1996 N.J. Super. LEXIS 118 (App.Div.)*, certif. denied, *144 N.J. 588, 677 A.2d 760, 1996 N.J. LEXIS 838 (N.J. 1996)*.

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Where the Department of Health has the authority, pursuant to N.J. Stat. Ann. § 26:2H-1, to promulgate regulations requiring health providers to deliver needed services, then it follows that it may employ its licensing function to enforce those regulations. *New Jersey Asso. of Health Care Facilities v. Finley, 168 N.J. Super. 152, 402 A.2d 246, 1979 N.J. Super. LEXIS 757 (App.Div. 1979)*, aff'd, *83 N.J. 67, 415 A.2d 1147, 1980 N.J. LEXIS 1365 (N.J. 1980)*.

Governments: State & Territorial Governments: Police Power

N.J. Administrative Code provision which required nursing homes to make available "a reasonable number of their beds to indigent persons" as a condition of licensure under N.J. Stat. Ann. §§ 26:2H-5, 26:2H-8, and 26:2H-12, did not exceed the power given to the state under N.J. Stat. Ann. § 26:2H-1 et seq.; the argument that the state was attempting to regulate the quantity of health care services, rather than the quality of health care services was rejected because the acute shortage of nursing home beds for indigent persons was a public health concern, and the regulations were not arbitrary or unreasonable. *In re Health Care Administration Board, 83 N.J. 67, 415 A.2d 1147, 1980 N.J. LEXIS 1365 (N.J.)*, cert. denied, *449 U.S. 944, 101 S. Ct. 342, 66 L. Ed. 2d 208, 1980 U.S. LEXIS 3668 (U.S. 1980)*.

Healthcare Law: Actions Against Healthcare Workers: ERISA Preemption

N.J. Stat. Ann. § 26:2H-1 which set hospital rates was improperly deemed preempted by Employee Retirement Income Security Act (ERISA) because the statute was one of general applicability designed to regulate health care costs; the ERISA preemption provision was designed to prevent state interference with federal control of ERISA plans and did not require the creation of a fully insulated legal world that excluded the plans from any purely local regulation. *United Wire, Metal & Mach. Health & Welfare Fund v. Morristown Memorial Hosp., 995 F.2d 1179, 1993 U.S. App. LEXIS 11112 (3d Cir. N.J.)*, cert. denied, *510 U.S. 944, 114 S. Ct. 383, 126 L. Ed. 2d 332, 1993 U.S. LEXIS 6694 (U.S. 1993)*.

Healthcare Law: Business Administration & Organization: General Overview

N.J. Stat. Ann. § 26:2H-1 which set hospital rates was improperly deemed preempted by Employee Retirement Income Security Act (ERISA) because the statute was one of general applicability designed to regulate health care costs; the ERISA preemption provision was designed to prevent state interference with federal control of ERISA plans and did not require the creation of a fully insulated legal world that excluded the plans from any purely local regulation. *United Wire, Metal & Mach. Health & Welfare Fund v. Morristown Memorial Hosp., 995 F.2d 1179, 1993 U.S. App. LEXIS 11112 (3d Cir. N.J.)*, cert. denied, *510 U.S. 944, 114 S. Ct. 383, 126 L. Ed. 2d 332, 1993 U.S. LEXIS 6694 (U.S. 1993)*.

In allocating reductions in Medicare payments under Gramm-Rudman to the hospitals there was no evidence that the hospital rate setting commission had considered the effect of the statutory and regulatory scheme under N.J. Stat. Ann. § 26:2H-1 et seq. *New Jersey Hospital Asso. v. New Jersey State Dep't of Health, Hospital Rate Setting Com., 227 N.J. Super. 557, 548 A.2d 211, 1988 N.J. Super. LEXIS 355 (App.Div. 1988)*.

Administrator and the beneficiaries were not entitled to a preliminary injunction to prohibit the Commissioner of the Department of Health from implementing an amendment to the New Jersey Health Care Facilities Planning Act of 1971, N.J. Stat. Ann. § 26:2H-1 et seq., which created a state commission to set a schedule of rates for hospital services based on a patient's diagnosis; the argument that the rate setting system was preempted by the Employee Retirement Income Security Act and the National Labor Relations Act had little chance of success on the merits. *Bonser v. New Jersey, 605 F. Supp. 1227, 1985 U.S. Dist. LEXIS 21162 (D.N.J. 1985)*.

In a proceeding brought by a hospital seeking adjustment of its rate schedule to reflect the costs of pension and dental plans that the hospital had established for its employees, a judgment that vacated the decision of the rate setting commission to uphold a recommendation against the rate adjustment was affirmed because, under the Health Care Facilities Planning Act, N.J. Stat. Ann. §§ 26:2H-1 to 26:2H-52, the rate setting commission's grounds for its action were neither adequately supported by the record nor clearly explained; the court directed the rate setting commission to conduct another hearing to examine the facts, carefully apply the pertinent regulations, and clearly set forth its conclusions. *Riverside General Hospital v. New Jersey Hospital Rate Setting Com., 98 N.J. 458, 487 A.2d 714, 1985 N.J. LEXIS 2229 (N.J. 1985)*.

Healthcare Law: Business Administration & Organization: Certificates of Need: Hospitals

In an appeal filed by a city, its mayor, and an organization challenging the decision of the Commissioner of the New Jersey Department of Health and Senior Services, which granted an applicant's certificate of need (CN) to shut down an urban hospital in the city, the decision granting the CN to close the hospital was upheld as the decision was not arbitrary or capricious since it was based on the Commissioner properly imposing conditions reflecting community needs, the decision complied with the mandates imposed by case law, and the decision was supported by a financial audit that evidenced the financial distress the hospital had been experiencing. *City of Plainfield v. New Jersey Dept. of Health and Sr. Services, 412 N.J. Super. 466, 991 A.2d 265, 2010 N.J. Super. LEXIS 52 (App.Div.)*, certif. denied, *203 N.J. 93, 999 A.2d 462, 2010 N.J. LEXIS 606 (N.J. 2010)*, certif. denied, *203 N.J. 93, 999 A.2d 462, 2010 N.J. LEXIS 616 (N.J. 2010)*.

Healthcare Law: Business Administration & Organization: Licenses: General Overview

Under the Health Care Facilities Planning Act, N.J. Stat. Ann. § 26:2H-1 et seq., hospital rates are subject to regulation, and the legislative policy is to provide for the protection and promotion of the health of the inhabitants of New Jersey, to promote the financial solvency of hospitals and similar health care facilities, and to contain the rising cost of health care services. *Slocum v. Hospital Rate Setting Com., Dep't of Health, 240 N.J. Super. 566, 573 A.2d 971, 1990 N.J. Super. LEXIS 137 (App.Div. 1990)*.

N.J. Stat. Ann. § 26:2H-1 et seq. neither expressly prohibits nor permits regulations requiring nursing homes to provide a reasonable number of beds to indigent persons as a condition of licensure or re-licensure. *New Jersey Asso. of Health Care Facilities v. Finley, 168 N.J. Super. 152, 402 A.2d 246, 1979 N.J. Super. LEXIS 757 (App.Div. 1979)*, aff'd, *83 N.J. 67, 415 A.2d 1147, 1980 N.J. LEXIS 1365 (N.J. 1980)*.

Where the Department of Health has the authority, pursuant to N.J. Stat. Ann. § 26:2H-1, to promulgate regulations requiring health providers to deliver needed services, then it follows that it may employ its licensing function to enforce those regulations. New Jersey Asso. of Health Care Facilities v. Finley, 168 N.J. Super. 152, 402 A.2d 246, 1979 N.J. Super. LEXIS 757 (App.Div. 1979), aff'd, 83 N.J. 67, 415 A.2d 1147, 1980 N.J. LEXIS 1365 (N.J. 1980).

Under N.J. Stat. Ann. § 26:2H-1 et seq. administrative supervision of hospitals was transferred from the Department of Institutions and Agencies to the State Department of Health in 1971. Guerrero v. Burlington County Memorial Hospital, 70 N.J. 344, 360 A.2d 334, 1976 N.J. LEXIS 203 (N.J. 1976).

Regulation of private hospitals by State, pursuant to the Health Care Facilities Planning Act of 1971, N.J. Stat. Ann. § 26:2H-1 et seq., did not constitute state action; a policy to prohibit use of their facilities for elective abortions was not arbitrary where women could seek procedures within reasonable distances of the hospitals. Doe v. Bridgeton Hospital Asso., 130 N.J. Super. 416, 327 A.2d 448, 1974 N.J. Super. LEXIS 550 (Law Div. 1974), rev'd, 71 N.J. 478, 366 A.2d 641, 1976 N.J. LEXIS 169 (N.J. 1976).

Healthcare Law: Business Administration & Organization: Licenses: Requirements

N.J. Administrative Code provision which required nursing homes to make available "a reasonable number of their beds to indigent persons" as a condition of licensure under N.J. Stat. Ann. §§ 26:2H-5, 26:2H-8, and 26:2H-12, did not exceed the power given to the state under N.J. Stat. Ann. § 26:2H-1 et seq.; the argument that the state was attempting to regulate the quantity of health care services, rather than the quality of health care services was rejected because the acute shortage of nursing home beds for indigent persons was a public health concern, and the regulations were not arbitrary or unreasonable. In re Health Care Administration Board, 83 N.J. 67, 415 A.2d 1147, 1980 N.J. LEXIS 1365 (N.J.), cert. denied, *449 U.S. 944, 101 S. Ct. 342, 66 L. Ed. 2d 208, 1980 U.S. LEXIS 3668 (U.S. 1980)*.

Healthcare Law: Insurance: Reimbursement: General Overview

In allocating reductions in Medicare payments under Gramm-Rudman to the hospitals there was no evidence that the hospital rate setting commission had considered the effect of the statutory and regulatory scheme under N.J. Stat. Ann. § 26:2H-1 et seq. New Jersey Hospital Asso. v. New Jersey State Dep't of Health, Hospital Rate Setting Com., 227 N.J. Super. 557, 548 A.2d 211, 1988 N.J. Super. LEXIS 355 (App.Div. 1988).

Administrator and the beneficiaries were not entitled to a preliminary injunction to prohibit the Commissioner of the Department of Health from implementing an amendment to the New Jersey Health Care Facilities Planning Act of 1971, N.J. Stat. Ann. § 26:2H-1 et seq., which created a state commission to set a schedule of rates for hospital services based on a patient's diagnosis; the argument that the rate setting system was preempted by the Employee Retirement Income Security Act and the National Labor Relations Act had little chance of success on the merits. *Bonser v. New Jersey, 605 F. Supp. 1227, 1985 U.S. Dist. LEXIS 21162 (D.N.J. 1985)*.

Healthcare Law: Managed Healthcare: General Overview

The Health Care Facilities Planning Act, N.J. Stat. Ann. § 26:2H-1 et seq., did not apply to physician groups, who were bound contractually with health management corporations, because the physician groups were still engaged in private practice. Women's Medical Center v. Finley, 192 N.J. Super. 44, 469 A.2d 65, 1983 N.J. Super. LEXIS 976 (App.Div. 1983), certif. denied, *96 N.J. 279, 475 A.2d 578, 1984 N.J. LEXIS 2506 (N.J. 1984)*.

Healthcare Law: Treatment: General Overview

Commissioner of the New Jersey Department of Health and Senior Services' adoption of a change in the manner of reporting to the public risk-adjusted mortality data on open heart surgery constituted an informal agency action, not administrative rulemaking, as it impacted only a narrow, select group; it was expressly within the Commissioner's delegated statutory authority; and it did not materially change a long-established administrative practice. Therefore, the decision was not subject to the rulemaking procedures of the New Jersey Health Care Facilities Planning Act,

N.J. Stat. Ann. §§ 26:2H-1 to -26. Deborah Heart & Lung Center v. Howard, 404 N.J. Super. 491, 962 A.2d 577, 2009 N.J. Super. LEXIS 12 (App.Div.), certif. denied, *199 N.J. 129, 970 A.2d 1046, 2009 N.J. LEXIS 554 (N.J. 2009)*.

Public Health & Welfare Law: Healthcare: Services for Disabled & Elderly Persons: General Overview

Where the Commissioner of Health issued a certificate of need for the establishment of a nursing home subject to the conversion of a portion of another facility previously established for geriatric care, to a center for the treatment of patients with Acquired Immune Deficiency Syndrome, the Commissioner deviated in material respects from controlling statutes and regulations in issuing a certificate of need; the Commissioner failed to notify the Health Systems Agency of the application, which precluded a review and a determination whether the certificate was necessary, under N.J. Stat. Ann. § 26:2H-1, to provide for and contribute to required health care in the area. In re Bloomingdale Convalescent Center, 233 N.J. Super. 46, 558 A.2d 19, 1989 N.J. Super. LEXIS 194 (App.Div. 1989).

Pursuant to the Health Care Facilities Planning Act (Act), N.J. Stat. Ann. § 26:2H-1 et seq., the state health department properly denied a hospital's proposed per diem rate for Blue Cross and Medicaid patients for calendar year 1976 based upon the excessiveness of two proposed cost items, the budgets for the hospital's emergency room and newborn nursery center; however, because the emergency room rate was affected by a determination of whether or not the hospital was required by administrative regulations to maintain a physician on duty 24 hours per day, that portion of the state health department's decision was remanded for further fact-finding. In re William B. Kessler Memorial Hospital, 78 N.J. 564, 397 A.2d 656, 1979 N.J. LEXIS 1168 (N.J. 1979).

Public Health & Welfare Law: Healthcare: Services for Disabled & Elderly Persons: Care Facilities: General Overview

Holding, that an agreement between the trustees of a life-care community home and its residents impliedly included the residents' right to an accounting by the trustees on the grounds that the monthly fees were expected to remain stable and reasonable, was consistent with the legislative policy expressed in New Jersey's fairly extensive regulation of the residential health care facilities industry set forth in N.J. Stat. Ann. § 30:11A-1 et seq., N.J. Stat. Ann. § 26:2H-1 et seq., and N.J. Admin. Code tit. 8, § 43-1.1 et seq. Onderdonk v. Presbyterian Homes of New Jersey, 85 N.J. 171, 425 A.2d 1057, 1981 N.J. LEXIS 2589 (N.J. 1981).

Public Health & Welfare Law: Social Security: Medicaid: General Overview

Pursuant to the Health Care Facilities Planning Act (Act), N.J. Stat. Ann. § 26:2H-1 et seq., the state health department properly denied a hospital's proposed per diem rate for Blue Cross and Medicaid patients for calendar year 1976 based upon the excessiveness of two proposed cost items, the budgets for the hospital's emergency room and newborn nursery center; however, because the emergency room rate was affected by a determination of whether or not the hospital was required by administrative regulations to maintain a physician on duty 24 hours per day, that portion of the state health department's decision was remanded for further fact-finding. In re William B. Kessler Memorial Hospital, 78 N.J. 564, 397 A.2d 656, 1979 N.J. LEXIS 1168 (N.J. 1979).

Public Health & Welfare Law: Social Security: Medicare: General Overview

Pursuant to the Health Care Facilities Planning Act (Act), N.J. Stat. Ann. § 26:2H-1 et seq., the state health department properly denied a hospital's proposed per diem rate for Blue Cross and Medicaid patients for calendar year 1976 based upon the excessiveness of two proposed cost items, the budgets for the hospital's emergency room and newborn nursery center; however, because the emergency room rate was affected by a determination of whether or not the hospital was required by administrative regulations to maintain a physician on duty 24 hours per day, that portion of the state health department's decision was remanded for further fact-finding. In re William B. Kessler Memorial Hospital, 78 N.J. 564, 397 A.2d 656, 1979 N.J. LEXIS 1168 (N.J. 1979).

Research References & Practice Aids

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Coverage for birth and natal care; group insurance policy, see 17B:27-46.1k.

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N.J.A.C. 13:32-7.1 (2013), CHAPTER STATE BOARD OF EXAMINERS OF MASTER PLUMBERS, Purpose and scope.

N.J.A.C. 13:32-7.2 (2013), CHAPTER STATE BOARD OF EXAMINERS OF MASTER PLUMBERS, Definitions.

N.J.A.C. 13:39-9.2 (2013), CHAPTER STATE BOARD OF PHARMACY, Definitions.

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N.J.A.C. 5:27A-1.3 (2013), CHAPTER STANDARDS FOR LICENSURE OF RESIDENTIAL HEALTH CARE FACILITIES NOT LOCATED WITH, AND OPERATED BY, LICENSED HEALTH CARE FACILITIES, Definitions.

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Hierarchy Notes:

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End of Document

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Current through New Jersey 220th First Annual Session, L. 2022, c. 130 and J.R. 10

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§ 26:2H-2. Definitions

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, that is 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, dementia care home, 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 Traffic Safety Act of 1987," P.L.1987, c.284 (*C.27:5F-18* 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.

q. “Integrated health care” means the systematic coordination of general and behavioral healthcare. This care may address mental illnesses, substance use disorders, health behaviors including their contributions to chronic medical illnesses, life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

History

L. 1971, c. 136, § 2; amended 1975, c. 199; 1977, c. 251; 1977, c. 354; 1978, c. 83, § 2; 1979, c. 388, § 6; 1979, c. 496, § 20; 1980, c. 105, § 5; *1991, c. 187*, § 28; *1992, c. 160*, § 22; *1998, c. 43*, § 2, eff. June 30, 1998; *2004, c. 54*, § 3, eff. July 1, 2004; *2012, c. 17*, § 153, eff. June 29, 2012; *2015, c. 125*, § 1, effective June 1, 2016; *2017, c. 294*, § 2, effective February 1, 2019.

Annotations

Notes

Effective Dates

Section 27 of L. *2015, c. 125* provides: "This act shall take effect on the first day of the seventh month next following the date of enactment, except that section 16 shall take effect immediately, but the Commissioners of Health and Community Affairs may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of this act." Chapter 125, L. 2015, was approved on Nov. 9, 2015.

Section 4 of L. *2017, c. 294* provides: "This act shall take effect on the first day of the thirteenth month next following the date of enactment, except that the Commissioner of Health may take any anticipatory administrative action in advance as shall be necessary for the implementation of this act." Chapter 294, L. 2017, was approved on Jan. 16, 2018.

Amendment Note:

2012 amendment, by Chapter 17, redesignated former l. as i.; substituted "Department of Health" for "State Department of Health and Senior Services" in i. and n.; substituted "Commissioner of Health" for "State Commissioner of Health and Senior Services" in j.; and made stylistic changes.

2015 amendment, by Chapter 125, inserted "dementia care home" in a.; and substituted "'New Jersey Highway Traffic Safety Act of 1987,' P.L.1987, c.284 (*C.27:5F-18* et seq.)" for "'New Jersey Highway Safety Act of 1971,' P.L.1971, c.351 (*C.27:5F-1* et seq.)" in b.

2017 amendment, by Chapter 294, inserted "that is" near the beginning of a.; added q.; and made stylistic changes.

CASE NOTES

Civil Procedure: Pleading & Practice: Pleadings: Complaints: Prelitigation Notices

Healthcare Law: Business Administration & Organization: General Overview

Healthcare Law: Business Administration & Organization: Certificates of Need: General Overview

Healthcare Law: Business Administration & Organization: Licenses: General Overview

Healthcare Law: Insurance: Reimbursement: General Overview

Public Health & Welfare Law: Healthcare: General Overview

Public Health & Welfare Law: Healthcare: Services for Disabled & Elderly Persons: Care Facilities: Nursing Facilities

Real Property Law: Zoning & Land Use: Ordinances

Real Property Law: Zoning & Land Use: Special Permits & Variances

Torts: Malpractice & Professional Liability: Healthcare Providers

Torts: Malpractice & Professional Liability: Professional Services

Civil Procedure: Pleading & Practice: Pleadings: Complaints: Prelitigation Notices

Injured plaintiff who alleges that he received inadequate medical care while housed in a government facility cannot avoid his obligation to serve an Affidavit of Merit under *N.J. Stat. Ann. § 2A:53A-27* by naming only the public entity as a defendant in his complaint and not suing the individual licensed professionals who provided the allegedly inadequate care. *McCormick v. State, 446 N.J. Super. 603, 144 A.3d 1260, 2016 N.J. Super. LEXIS 116 (App.Div. 2016)*.

As a company under contract with the New Jersey Department of Corrections to treat prisoners did not provide evidence that it was a licensed health care facility under *N.J. Stat. Ann. § 2A:53A-26(j)*, it did not show that New Jersey's Affidavit of Merit Statute, *N.J. Stat. Ann. §§ 2A:53A-26* to *2A:53A-29*, applied to it; therefore, the trial court erred in dismissing an inmate's malpractice suit for his failure to provide the company with an affidavit of merit. *Albrecht v. Correctional Medical Services, 422 N.J. Super. 265, 27 A.3d 1260, 2011 N.J. Super. LEXIS 179 (App.Div. 2011)*.

Healthcare Law: Business Administration & Organization: General Overview

Decision of the hospital rate setting commission approving "final reconciliation adjustments" for certain hospitals pursuant to *N.J. Stat. Ann. § 26:2H-2(k)*, former N.J. Stat. Ann. § *26:2H-18.1(b)*, *N.J. Stat. Ann. § 26:2H-2(1)*, and former N.J. Stat. Ann. § *26:2H-4.1(b)*, was not unlawful where the adjustments were automatic pursuant to an approved methodology. *In re 1983 Final Reconciliation Adjustments of Greenville Hospital, 214 N.J. Super. 607, 520 A.2d 809, 1987 N.J. Super. LEXIS 1006 (App.Div. 1987)*.

Healthcare Law: Business Administration & Organization: Certificates of Need: General Overview

Corporation that provided mobile multiphasic health testing and diagnostic services such as blood pressure readings, chest x-rays, and urinalysis and that had a staff physician to review the test results and the participant's medical history was a health care facility as defined under *N. J. Stat. Ann. § 26:2H-2(a)*; thus, the corporation was required to obtain a certificate of need and the health commissioner was not required to hold a hearing to make that determination. *Medcor, Inc. v. Finley, 179 N.J. Super. 142, 430 A.2d 964, 1981 N.J. Super. LEXIS 595 (App.Div. 1981)*.

Healthcare Law: Business Administration & Organization: Licenses: General Overview

Hospital Rate Setting Commission (HRSC) was not required to permit a hospital to calculate the number of full-time equivalent residents it employed based on a 37.5-hour work week instead of the 40-hour week prescribed by regulation; however, the HRSC should have permitted the hospital to recalculate the number of full-time equivalent residents before it registered a disincentive against the hospital pursuant to *N.J. Stat. Ann. § 26:2H-2(d)* and N.J. Admin. Code tit. 8, §§ 31B-3.7 to 31B-3.39. *St. Barnabas Medical Center v. New Jersey Hospital Rate Setting Com., 214 N.J. Super. 599, 520 A.2d 805, 1987 N.J. Super. LEXIS 1018 (App.Div. 1987)*.

Healthcare Law: Insurance: Reimbursement: General Overview

Decision of the hospital rate setting commission approving "final reconciliation adjustments" for certain hospitals pursuant to *N.J. Stat. Ann. § 26:2H-2(k)*, former N.J. Stat. Ann. § *26:2H-18.1(b)*, *N.J. Stat. Ann. § 26:2H-2(1)*, and former N.J. Stat. Ann. § *26:2H-4.1(b)* was not unlawful where the adjustments were automatic pursuant to an

approved methodology. *In re 1983 Final Reconciliation Adjustments of Greenville Hospital, 214 N.J. Super. 607, 520 A.2d 809, 1987 N.J. Super. LEXIS 1006 (App.Div. 1987)*.

Public Health & Welfare Law: Healthcare: General Overview

Respondent Hospital Rate Setting Commission's decision that declined to require respondent New Jersey Department of Health to correct an error affecting the equalization factor used in development of preliminary cost bases pursuant to *N.J. Stat. Ann. § 26:2H-2(k)* for appellant hospitals was reversed; mere practical difficulties could not excuse the necessity to abide by the statutory and regulatory scheme. *Alexian Bros. Hosp. v. State, Dep't of Health, Hosp. Rate Setting Com., 242 N.J. Super. 411, 577 A.2d 164, 1989 N.J. Super. LEXIS 523 (App.Div. 1989)*.

Public Health & Welfare Law: Healthcare: Services for Disabled & Elderly Persons: Care Facilities: Nursing Facilities

In a negligence suit, a trial court erred by denying a rehabilitation facility's motion for summary judgment because it was not a nursing home within the meaning of *N.J. Stat. Ann. § 30:13-2(c)* and, as a consequence, was not subject to the provisions of the Nursing Home Act, *N.J. Stat. Ann. §§ 30:13-1* to *30:13-17*. *Bermudez v. Kessler Institute for Rehabilitation, 439 N.J. Super. 45, 106 A.3d 545, 2015 N.J. Super. LEXIS 6 (App.Div. 2015)*.

Comprehensive rehabilitation hospital is not a nursing home within the meaning of *N.J. Stat. Ann. § 30:13-2(c)* and, as a consequence, is not subject to the provisions of the Nursing Home Act, *N.J. Stat. Ann. §§ 30:13-1* to *30:13-17*. *Bermudez v. Kessler Institute for Rehabilitation, 439 N.J. Super. 45, 106 A.3d 545, 2015 N.J. Super. LEXIS 6 (App.Div. 2015)*.

Real Property Law: Zoning & Land Use: Ordinances

When the need for a health care facility has been demonstrated and a certificate of need issued pursuant to *N.J. Stat. Ann. § 26:2H-2(a)* and *N.J. Stat. Ann. § 26:2H-7*, public policy supports a reasonable interpretation of a municipal zoning ordinance which permits the use. *L & L Clinics, Inc. v. Irvington, 189 N.J. Super. 332, 460 A.2d 152, 1983 N.J. Super. LEXIS 852 (App.Div.)*, certif. denied, *94 N.J. 540, 468 A.2d 191, 1983 N.J. LEXIS 2900 (N.J. 1983)*.

Real Property Law: Zoning & Land Use: Special Permits & Variances

When the need for a health care facility has been demonstrated and a certificate of need issued pursuant to *N.J. Stat. Ann. § 26:2H-2(a)* and *N.J. Stat. Ann. § 26:2H-7*, public policy supports a reasonable interpretation of a municipal zoning ordinance which permits the use. *L & L Clinics, Inc. v. Irvington, 189 N.J. Super. 332, 460 A.2d 152, 1983 N.J. Super. LEXIS 852 (App.Div.)*, certif. denied, *94 N.J. 540, 468 A.2d 191, 1983 N.J. LEXIS 2900 (N.J. 1983)*.

Torts: Malpractice & Professional Liability: Healthcare Providers

Injured plaintiff who alleges that he received inadequate medical care while housed in a government facility cannot avoid his obligation to serve an Affidavit of Merit under *N.J. Stat. Ann. § 2A:53A-27* by naming only the public entity as a defendant in his complaint and not suing the individual licensed professionals who provided the allegedly inadequate care. *McCormick v. State, 446 N.J. Super. 603, 144 A.3d 1260, 2016 N.J. Super. LEXIS 116 (App.Div. 2016)*.

In a negligence suit, a trial court erred by denying a rehabilitation facility's motion for summary judgment because it was not a nursing home within the meaning of *N.J. Stat. Ann. § 30:13-2(c)* and, as a consequence, was not subject to the provisions of the Nursing Home Act, *N.J. Stat. Ann. §§ 30:13-1* to *30:13-17*. *Bermudez v. Kessler Institute for Rehabilitation, 439 N.J. Super. 45, 106 A.3d 545, 2015 N.J. Super. LEXIS 6 (App.Div. 2015)*.

Comprehensive rehabilitation hospital is not a nursing home within the meaning of N.J. Stat. Ann. § 30:13-2(c) and, as a consequence, is not subject to the provisions of the Nursing Home Act, N.J. Stat. Ann. §§ 30:13-1 to 30:13-17. Bermudez v. Kessler Institute for Rehabilitation, 439 N.J. Super. 45, 106 A.3d 545, 2015 N.J. Super. LEXIS 6 (App.Div. 2015).

As a company under contract with the New Jersey Department of Corrections to treat prisoners did not provide evidence that it was a licensed health care facility under N.J. Stat. Ann. § 2A:53A-26(j), it did not show that New Jersey's Affidavit of Merit Statute, N.J. Stat. Ann. §§ 2A:53A-26 to 2A:53A-29, applied to it; therefore, the trial court erred in dismissing an inmate's malpractice suit for his failure to provide the company with an affidavit of merit. Albrecht v. Correctional Medical Services, 422 N.J. Super. 265, 27 A.3d 1260, 2011 N.J. Super. LEXIS 179 (App.Div. 2011).

Torts: Malpractice & Professional Liability: Professional Services

Overview: *Affidavit of Merit (AOM) statute, N.J.S.A. § 2A:53A-27, did not require submission of AOM to support vicarious liability claim against licensed health care facility based only on conduct of non-licensed employee. Patient's vicarious liability claim did not satisfy AOM statute's third element as alleged act was not committed by licensed person.*

- The statute explicitly limits the term licensed person to an accountant; an architect; an attorney admitted to practice law in New Jersey; a dentist; an engineer; a physician in the practice of medicine or surgery; a podiatrist; a chiropractor; a registered professional nurse; a physical therapist; a land surveyor; a registered pharmacist; a veterinarian; an insurance producer; a certified midwife, certified professional midwife, or certified nurse midwife; a licensed site remediation professional; and a health care facility as defined in N.J.S.A. § 26:2H-2, N.J.S.A. § 2A:53A-26. N.J.S.A. § 26:2H-2(a), in turn, defines health care facility as a facility or institution, whether public or private, that is 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.

Haviland v. Lourdes Med. Ctr. of Burlington Cnty., 250 N.J. 368, 272 A.3d 912, 2022 N.J. LEXIS 309 (N.J. 2022).

Research References & Practice Aids

Cross References:

"Licensed person" defined, see 2A:53A-26.

Training courses on handling, response procedures, investigation, prosecution of human trafficking cases [Effective July 1, 2013], see 2C:13-12.

Arson and related offenses, see 2C:17-1.

Certificate of need required for construction, expansion of health care facility, see 26:2H-7.

Religious accommodation regarding admission procedures at licensed health care facilities, see 26:2H-12b.

Definitions relative to adult family care, see 26:2Y-3.

Confidentiality of AIDS, HIV infection records, information, see 26:5C-7.

Definitions, see 45:9-27.11.

Definitions relative to economic stimulus, see 52:27D-489c.

Administrative Code:

N.J.A.C. 8:33-2.2 (2013), CHAPTER CERTIFICATE OF NEED: APPLICATION AND REVIEW PROCESS, Determination of a health care facility or service.

N.J.A.C. 8:41-1.3 (2013), CHAPTER ADVANCED LIFE SUPPORT SERVICES; MOBILE INTENSIVE CARE PROGRAMS, SPECIALTY CARE TRANSPORT SERVICES AND AIR MEDICAL SERVICES, Definitions.

N.J.A.C. 8:57-1.3 (2013), CHAPTER COMMUNICABLE DISEASES, Definitions.

LAW REVIEWS & JOURNALS:

37 Rutgers Computer & Tech. L.J. 281, NOTE & COMMENT: PERSONALIZED GENOMICS: A NEED FOR A FIDUCIARY DUTY REMAINS.

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

End of Document

N.J. Stat. § 26:2H-3

Current through New Jersey 220th First Annual Session, L. 2022, c. 130 and J.R. 10

LexisNexis® New Jersey Annotated Statutes > Title 26. Health and Vital Statistics (Chs. 1 — 17) > Chapter 2H. Health Care Facilities (Pts. I — X) > Part I. Health Care Facilities Planning Act (§§ 26:2H-1 — 26:2H-26)

§ 26:2H-3. Repealed by L.*1991, c. 187*, § 84, eff. July 31, 1991

End of Document

N.J. Stat. § 26:2H-4

Current through New Jersey 220th First Annual Session, L. 2022, c. 130 and J.R. 10

LexisNexis® New Jersey Annotated Statutes > Title 26. Health and Vital Statistics (Chs. 1 — 17) > Chapter 2H. Health Care Facilities (Pts. I — X) > Part I. Health Care Facilities Planning Act (§§ 26:2H-1 — 26:2H-26)

§ 26:2H-4. Health Care Administration Board; membership; appointment; terms; vacancies; meetings; compensation

There shall be in the State Department of Health, a Health Care Administration Board which shall consist of 13 members, 11 of whom shall be appointed by the Governor with the advice and consent of the Senate, and representative of medical and health care facilities and services, labor, industry and the public at large, and two of whom shall be ex officio members. Of the 11 members appointed by the Governor, no less than six shall be consumers of health care services who are not providers of health care services, and at least one shall be representative of long-term health care facilities or services. The State Commissioner of Health and the Commissioner of Insurance or their designated representatives, shall be ex officio voting members of the board and shall serve on the board during their respective terms of office. Of the original members appointed to the board, four shall be appointed for terms of three years, four for terms of two years, and three for terms of one year. Following the expiration of the initial terms, members of the board shall be appointed for terms of four years. Any vacancy occurring in the membership of the board shall be filled in the same manner as the original appointment, but for the unexpired term only. Appointive members of the board shall continue to serve as voting members until their successors are appointed. The board shall meet at least quarterly and at such other times as its rules may prescribe or as in its judgment, may be necessary. The appointive members of the board shall serve without compensation but shall be reimbursed for necessary expenses incurred in the performance of their duties.

Members serving on the board on the effective date of this act shall continue to serve until the expiration of their terms. Successors shall be appointed only from among consumers of health care services who are not providers of such services until there are at last six such members on the board. Successors shall thereafter be appointed from among both consumers and providers of health care services in a manner consistent with the terms of this act.

History

L. 1971, c. 136, § 4; amended 1978, c. 83, § 4; *1993, c. 56*, § 1.

Annotations

Research References & Practice Aids

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

End of Document

N.J. Stat. § 26:2H-4.1

Current through New Jersey 220th First Annual Session, L. 2022, c. 130 and J.R. 10

LexisNexis® New Jersey Annotated Statutes > Title 26. Health and Vital Statistics (Chs. 1 — 17) > Chapter 2H. Health Care Facilities (Pts. I — X) > Part I. Health Care Facilities Planning Act (§§ 26:2H-1 — 26:2H-26)

§ 26:2H-4.1. Repealed by L.*1992, c. 160*, § 41, eff. Jan. 1, 1994

End of Document

N.J. Stat. § 26:2H-5

Current through New Jersey 220th First Annual Session, L. 2022, c. 130 and J.R. 10

LexisNexis® New Jersey Annotated Statutes > Title 26. Health and Vital Statistics (Chs. 1 — 17) > Chapter 2H. Health Care Facilities (Pts. I — X) > Part I. Health Care Facilities Planning Act (§§ 26:2H-1 — 26:2H-26)

§ 26:2H-5. Commissioner's powers

a. The commissioner, to effectuate the provisions and purposes of this act, shall have the power to inquire into health care services and the operation of health care facilities and to conduct periodic inspections of such facilities with respect to the fitness and adequacy of the premises, equipment, personnel, rules and bylaws and the adequacy of financial resources and sources of future revenues.

b. The commissioner, with the approval of the board, shall adopt and amend rules and regulations in accordance with the "Administrative Procedure Act," P.L.1968, c.410 (*C.52:14B-1* et seq.) to effectuate the provisions and purposes of this act, including but not limited to: (1) the establishment of requirements for a uniform Statewide system of reports and audits relating to the quality of health care provided, health care facility utilization and costs; (2) certification by the department of schedules of rates, payments, reimbursement, grants and other charges for health care services as provided in section 18 [*C.26:2H-18*]; and (3) standards and procedures relating to the licensing of health care facilities and the institution of certain additional health care services.

c. The commissioner may enter into contracts with any government agency, institution of higher learning, voluntary nonprofit agency, or appropriate planning agency or council; and such entities are authorized to enter into contracts with the commissioner to effectuate the provisions and purposes of this act.

d. The commissioner may provide consultation and assistance to health care facilities in operational techniques, including but not limited to, planning, principles of management, and standards of health care services, and, in the case of a general hospital, to appoint a monitor if the commissioner determines that a monitor is warranted for a hospital that is in financial distress or at risk of being in financial distress, and to participate in the development and oversight of corrective measures to resolve a hospital's financial or potential financial difficulties, pursuant to section 2 of *P.L.2008, c.58* (*C.26:2H-5.1a*).

e. At the request of the commissioner, health care facilities shall furnish to the Department of Health and Senior Services such reports and information as it may require to effectuate the provisions and purposes of this act, excluding confidential communications from patients.

f. The commissioner may institute or cause to be instituted in a court of competent jurisdiction proceedings to compel compliance with the provisions of this act or the determinations, rules, regulations and orders of the commissioner.

g. Notwithstanding any rules and regulations governing private long-term health care facilities and enforcing the 1967 Life Safety Code, as amended and supplemented, the commissioner shall permit third floor occupancy of such facilities by owners, members of their immediate families, and licensed professionals employed at such facilities.

History

L. 1971, c. 136, § 5; amended 1977, c. 251, § 2; *1998, c. 43*, § 3, eff. June 30, 1998; *2008, c. 58*, § 1, eff. Feb. 4, 2009.

Annotations

Notes

Publisher's Note:

The bracketed material was added by the Publisher to provide a reference.

Effective Dates:

Section 5 of L. *2008, c. 58* provides: “This act shall take effect on the 180th day after the date of enactment, but the Commissioner of Health and Senior Services may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of the act.” Chapter 58, L. 2008, was approved on Aug. 8, 2008.

Amendment Note:

2008 amendment, by Chapter 58, in d., added the language beginning “and, in the case of a general hospital.”

CASE NOTES

Administrative Law: Agency Rulemaking: General Overview

N.J. Administrative Code provision which required nursing homes to make available “a reasonable number of their beds to indigent persons” as a condition of licensure under *N.J. Stat. Ann. § 26:2H-5*, was not unconstitutionally vague because the terms “reasonable number” and “just and reasonable rate on equity” were definite enough to

satisfy the requirements of due process; the regulations specified the precise and adequate criteria that must be determined and the term "just and reasonable" was common parlance in the field of public rulemaking. *In re Health Care Administration Board, 83 N.J. 67, 415 A.2d 1147, 1980 N.J. LEXIS 1365 (N.J.)*, cert. denied, *449 U.S. 944, 101 S. Ct. 342, 66 L. Ed. 2d 208, 1980 U.S. LEXIS 3668 (U.S. 1980)*.

Administrative Law: Judicial Review: Standards of Review: Constitutional Right

Commissioner of the New Jersey Department of Health and Senior Services' adoption of a change in the manner of reporting to the public risk-adjusted mortality data on open heart surgery was not an administrative rule as defined by *N.J. Stat. Ann. §§ 52:14B-2*, but informal agency action that was within the Commissioner's delegated powers. And as this agency action was preceded by adequate notice to the regulated class and an opportunity to be heard, administrative due process was satisfied. *Deborah Heart & Lung Center v. Howard, 404 N.J. Super. 491, 962 A.2d 577, 2009 N.J. Super. LEXIS 12 (App.Div.)*, certif. denied, *199 N.J. 129, 970 A.2d 1046, 2009 N.J. LEXIS 554 (N.J. 2009)*.

Administrative Law: Separation of Powers: Legislative Controls: Scope of Delegated Authority

Commissioner of the New Jersey Department of Health and Senior Services' adoption of a change in the manner of reporting to the public risk-adjusted mortality data on open heart surgery was not an administrative rule as defined by *N.J. Stat. Ann. §§ 52:14B-2*, but informal agency action that was within the Commissioner's delegated powers. And as this agency action was preceded by adequate notice to the regulated class and an opportunity to be heard, administrative due process was satisfied. *Deborah Heart & Lung Center v. Howard, 404 N.J. Super. 491, 962 A.2d 577, 2009 N.J. Super. LEXIS 12 (App.Div.)*, certif. denied, *199 N.J. 129, 970 A.2d 1046, 2009 N.J. LEXIS 554 (N.J. 2009)*.

Constitutional Law: Bill of Rights: Fundamental Rights: Eminent Domain & Takings

N.J. Administrative Code provision which required nursing homes to make available "a reasonable number of their beds to indigent persons" as a condition of licensure under *N.J. Stat. Ann. § 26:2H-5*, did not constitute a taking without just compensation under *N.J. Const. art. I, para. 20* because the regulation served a valid public purpose and the nursing home was given a right to administrative and judicial review of any allotment of beds pursuant to the N.J. Administrative Code and *N.J. Ct. R. 2:2-3(a)(2)*. *In re Health Care Administration Board, 83 N.J. 67, 415 A.2d 1147, 1980 N.J. LEXIS 1365 (N.J.)*, cert. denied, *449 U.S. 944, 101 S. Ct. 342, 66 L. Ed. 2d 208, 1980 U.S. LEXIS 3668 (U.S. 1980)*.

Constitutional Law: Equal Protection: Scope of Protection

N.J. Administrative Code provision which required nursing homes to make available "a reasonable number of their beds to indigent persons" as a condition of licensure under *N.J. Stat. Ann. § 26:2H-5*, did not violate the equal protection rights of private facilities because the private facilities were involved in a quasi-public activity and were therefore subject to extensive regulation in the public interest; the classification was not suspect and did not implicate a fundamental right and the nursing home's obligation to serve the public interest was rationally related to the regulations. *In re Health Care Administration Board, 83 N.J. 67, 415 A.2d 1147, 1980 N.J. LEXIS 1365 (N.J.)*, cert. denied, *449 U.S. 944, 101 S. Ct. 342, 66 L. Ed. 2d 208, 1980 U.S. LEXIS 3668 (U.S. 1980)*.

Criminal Law & Procedure: Postconviction Proceedings: Imprisonment

Pursuant to regulations of the Department of Health under *N.J. Stat. Ann. § 26:2H-5*, a hospital was obligated to accept and treat indigent patients, and therefore a hospital was responsible for an indigent county jail inmate's hospital treatment from and after the expiration of his sentence. *St. Barnabas Medical Center v. County of Essex, 111 N.J. 67, 543 A.2d 34, 1988 N.J. LEXIS 57 (N.J. 1988)*.

Governments: Legislation: Vagueness

N.J. Administrative Code provision which required nursing homes to make available "a reasonable number of their beds to indigent persons" as a condition of licensure under N.J. Stat. Ann. § 26:2H-5, was not unconstitutionally vague because the terms "reasonable number" and "just and reasonable rate on equity" were definite enough to satisfy the requirements of due process; the regulations specified the precise and adequate criteria that must be determined and the term "just and reasonable" was common parlance in the field of public rulemaking. *In re Health Care Administration Board, 83 N.J. 67, 415 A.2d 1147, 1980 N.J. LEXIS 1365 (N.J.)*, cert. denied, *449 U.S. 944, 101 S. Ct. 342, 66 L. Ed. 2d 208, 1980 U.S. LEXIS 3668 (U.S. 1980)*.

Governments: State & Territorial Governments: Police Power

N.J. Administrative Code provision which required nursing homes to make available "a reasonable number of their beds to indigent persons" as a condition of licensure under N.J. Stat. Ann. § 26:2H-5, did not violate the equal protection rights of private facilities because the private facilities were involved in a quasi-public activity and were therefore subject to extensive regulation in the public interest; the classification was not suspect and did not implicate a fundamental right and the nursing home's obligation to serve the public interest was rationally related to the regulations. *In re Health Care Administration Board, 83 N.J. 67, 415 A.2d 1147, 1980 N.J. LEXIS 1365 (N.J.)*, cert. denied, *449 U.S. 944, 101 S. Ct. 342, 66 L. Ed. 2d 208, 1980 U.S. LEXIS 3668 (U.S. 1980)*.

N.J. Administrative Code provision which required nursing homes to make available "a reasonable number of their beds to indigent persons" as a condition of licensure under N.J. Stat. Ann. §§ 26:2H-5, 26:2H-8, and 26:2H-12, did not exceed the power given to the state under N.J. Stat. Ann. § 26:2H-1 et seq.; the argument that the state was attempting to regulate the quantity of health care services, rather than the quality of health care services was rejected because the acute shortage of nursing home beds for indigent persons was a public health concern, and the regulations were not arbitrary or unreasonable. *In re Health Care Administration Board, 83 N.J. 67, 415 A.2d 1147, 1980 N.J. LEXIS 1365 (N.J.)*, cert. denied, *449 U.S. 944, 101 S. Ct. 342, 66 L. Ed. 2d 208, 1980 U.S. LEXIS 3668 (U.S. 1980)*.

N.J. Administrative Code provision which required nursing homes to make available "a reasonable number of their beds to indigent persons" as a condition of licensure under N.J. Stat. Ann. § 26:2H-5, did not constitute a taking without just compensation under N.J. Const. art. I, para. 20 because the regulation served a valid public purpose and the nursing home was given a right to administrative and judicial review of any allotment of beds pursuant to the N.J. Administrative Code and *N.J. Ct. R. 2:2-3(a)(2)*. *In re Health Care Administration Board, 83 N.J. 67, 415 A.2d 1147, 1980 N.J. LEXIS 1365 (N.J.)*, cert. denied, *449 U.S. 944, 101 S. Ct. 342, 66 L. Ed. 2d 208, 1980 U.S. LEXIS 3668 (U.S. 1980)*.

Healthcare Law: Business Administration & Organization: Certificates of Need: General Overview

Department of Health's adopted regulations which imposed moratoria upon the consideration of certificate of need applications for cardiac services pending the completion of studies relating to the need for those services were valid pursuant to the Department's general rule-making authority under N.J. Stat. Ann. § 26:2H-5(b). *Monmouth Medical Ctr. v. State Dep't of Health, 272 N.J. Super. 297, 639 A.2d 1129, 1994 N.J. Super. LEXIS 110 (App.Div.)*, certif. denied, *137 N.J. 310, 645 A.2d 138, 1994 N.J. LEXIS 673 (N.J. 1994)*, certif. denied sub nom. *Somerset Medical Ctr. v. State Dep't of Health, 137 N.J. 310, 645 A.2d 138, 1994 N.J. LEXIS 666 (N.J. 1994)*.

Health Care Commissioner had the power to impose a moratorium on the issuance of certificates of need under N.J. Stat. Ann. § 26:2H-5(b), but nursing home's application for construction of new beds should have been reviewed on the facts existing at the time the application was considered, rather than at the time it was filed. *Cooper River Convalescent Center, Inc. v. Dougherty, 133 N.J. Super. 226, 336 A.2d 35, 1975 N.J. Super. LEXIS 813 (App.Div. 1975)*.

Healthcare Law: Business Administration & Organization: Licenses: Requirements

N.J. Administrative Code provision which required nursing homes to make available "a reasonable number of their beds to indigent persons" as a condition of licensure under N.J. Stat. Ann. § 26:2H-5, was not unconstitutionally vague because the terms "reasonable number" and "just and reasonable rate on equity" were definite enough to satisfy the requirements of due process; the regulations specified the precise and adequate criteria that must be determined and the term "just and reasonable" was common parlance in the field of public rulemaking. *In re Health Care Administration Board, 83 N.J. 67, 415 A.2d 1147, 1980 N.J. LEXIS 1365 (N.J.)*, cert. denied, *449 U.S. 944, 101 S. Ct. 342, 66 L. Ed. 2d 208, 1980 U.S. LEXIS 3668 (U.S. 1980)*.

N.J. Administrative Code provision which required nursing homes to make available "a reasonable number of their beds to indigent persons" as a condition of licensure under N.J. Stat. Ann. § 26:2H-5, did not violate the equal protection rights of private facilities because the private facilities were involved in a quasi-public activity and were therefore subject to extensive regulation in the public interest; the classification was not suspect and did not implicate a fundamental right and the nursing home's obligation to serve the public interest was rationally related to the regulations. *In re Health Care Administration Board, 83 N.J. 67, 415 A.2d 1147, 1980 N.J. LEXIS 1365 (N.J.)*, cert. denied, *449 U.S. 944, 101 S. Ct. 342, 66 L. Ed. 2d 208, 1980 U.S. LEXIS 3668 (U.S. 1980)*.

N.J. Administrative Code provision which required nursing homes to make available "a reasonable number of their beds to indigent persons" as a condition of licensure under N.J. Stat. Ann. § 26:2H-5, did not conflict with the federal Medicaid statute, 42 U.S.C.S. § 1396 et seq.; there was no factual evidence presented to support the claim that the reimbursement rates set in the program violated the federal rates or that compelled participation in the state program violated the voluntary nature of the federal program, constituting an unjust taking, because there was no requirement in the regulations that a facility seek reimbursement from Medicaid. *In re Health Care Administration Board, 83 N.J. 67, 415 A.2d 1147, 1980 N.J. LEXIS 1365 (N.J.)*, cert. denied, *449 U.S. 944, 101 S. Ct. 342, 66 L. Ed. 2d 208, 1980 U.S. LEXIS 3668 (U.S. 1980)*.

N.J. Administrative Code provision which required nursing homes to make available "a reasonable number of their beds to indigent persons" as a condition of licensure under N.J. Stat. Ann. §§ 26:2H-5, 26:2H-8, and 26:2H-12, did not exceed the power given to the state under N.J. Stat. Ann. § 26:2H-1 et seq.; the argument that the state was attempting to regulate the quantity of health care services, rather than the quality of health care services was rejected because the acute shortage of nursing home beds for indigent persons was a public health concern, and the regulations were not arbitrary or unreasonable. *In re Health Care Administration Board, 83 N.J. 67, 415 A.2d 1147, 1980 N.J. LEXIS 1365 (N.J.)*, cert. denied, *449 U.S. 944, 101 S. Ct. 342, 66 L. Ed. 2d 208, 1980 U.S. LEXIS 3668 (U.S. 1980)*.

N.J. Administrative Code provision which required nursing homes to make available "a reasonable number of their beds to indigent persons" as a condition of licensure under N.J. Stat. Ann. § 26:2H-5, did not constitute a taking without just compensation under N.J. Const. art. I, para. 20 because the regulation served a valid public purpose and the nursing home was given a right to administrative and judicial review of any allotment of beds pursuant to the N.J. Administrative Code and *N.J. Ct. R. 2:2-3(a)(2)*. *In re Health Care Administration Board, 83 N.J. 67, 415 A.2d 1147, 1980 N.J. LEXIS 1365 (N.J.)*, cert. denied, *449 U.S. 944, 101 S. Ct. 342, 66 L. Ed. 2d 208, 1980 U.S. LEXIS 3668 (U.S. 1980)*.

Healthcare Law: Treatment: General Overview

Pursuant to regulations of the Department of Health under N.J. Stat. Ann. § 26:2H-5, a hospital was obligated to accept and treat indigent patients, and therefore a hospital was responsible for an indigent county jail inmate's hospital treatment from and after the expiration of his sentence. *St. Barnabas Medical Center v. County of Essex, 111 N.J. 67, 543 A.2d 34, 1988 N.J. LEXIS 57 (N.J. 1988)*.

Public Health & Welfare Law: Social Security: Medicaid: Medicaid Act Interpretation

N.J. Administrative Code provision which required nursing homes to make available "a reasonable number of their beds to indigent persons" as a condition of licensure under N.J. Stat. Ann. § 26:2H-5, did not conflict with the

federal Medicaid statute, *42 U.S.C.S. § 1396* et seq.; there was no factual evidence presented to support the claim that the reimbursement rates set in the program violated the federal rates or that compelled participation in the state program violated the voluntary nature of the federal program, constituting an unjust taking, because there was no requirement in the regulations that a facility seek reimbursement from Medicaid. *In re Health Care Administration Board, 83 N.J. 67, 415 A.2d 1147, 1980 N.J. LEXIS 1365 (N.J.)*, cert. denied, *449 U.S. 944, 101 S. Ct. 342, 66 L. Ed. 2d 208, 1980 U.S. LEXIS 3668 (U.S. 1980)*.

Public Health & Welfare Law: Social Security: Medicaid: State Plans: Mandatory Services

N.J. Administrative Code provision which required nursing homes to make available "a reasonable number of their beds to indigent persons" as a condition of licensure under *N.J. Stat. Ann. § 26:2H-5*, did not conflict with the federal Medicaid statute, *42 U.S.C.S. § 1396* et seq.; there was no factual evidence presented to support the claim that the reimbursement rates set in the program violated the federal rates or that compelled participation in the state program violated the voluntary nature of the federal program, constituting an unjust taking, because there was no requirement in the regulations that a facility seek reimbursement from Medicaid. *In re Health Care Administration Board, 83 N.J. 67, 415 A.2d 1147, 1980 N.J. LEXIS 1365 (N.J.)*, cert. denied, *449 U.S. 944, 101 S. Ct. 342, 66 L. Ed. 2d 208, 1980 U.S. LEXIS 3668 (U.S. 1980)*.

Research References & Practice Aids

Administrative Code:

N.J.A.C. 5:27A (2013), CHAPTER STANDARDS FOR LICENSURE OF RESIDENTIAL HEALTH CARE FACILITIES NOT LOCATED WITH, AND OPERATED BY, LICENSED HEALTH CARE FACILITIES, 5, Chapter 27A — Chapter Notes.

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

End of Document

N.J. Stat. § 26:2H-5a

Current through New Jersey 220th First Annual Session, L. 2022, c. 130 and J.R. 10

LexisNexis® New Jersey Annotated Statutes > Title 26. Health and Vital Statistics (Chs. 1 — 17) > Chapter 2H. Health Care Facilities (Pts. I — X) > Part I. Health Care Facilities Planning Act (§§ 26:2H-1 — 26:2H-26)

§ 26:2H-5a. Coordination of hospital inspections

The Commissioner of Health shall, to the extent possible and reasonable within the Department of Health's responsibilities under P.L. 1971, c. 136 (C.26:2H-1 et seq.), coordinate its annual inspection of a hospital with the triennial inspection conducted by the Joint Commission for the Accreditation of Healthcare Organizations to prevent duplication during the inspection process.

History

L. *1991, c. 187*, § 81.

Annotations

Research References & Practice Aids

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

End of Document

N.J. Stat. § 26:2H-5b

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LexisNexis® New Jersey Annotated Statutes > Title 26. Health and Vital Statistics (Chs. 1 — 17) > Chapter 2H. Health Care Facilities (Pts. I — X) > Part I. Health Care Facilities Planning Act (§§ 26:2H-1 — 26:2H-26)

§ 26:2H-5b. Routine monitoring of pain as fifth vital sign required

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.

History

L. *2000, c. 62*, § 1, eff. July 13, 2000; amended *2012, c. 17*, § 154, eff. June 29, 2012.

Annotations

Notes

Amendment Note:

2012 amendment, by Chapter 17, substituted “Commissioner of Health” for “Commissioner of Health and Senior Services” in the first paragraph of a.; and made a stylistic change.

Research References & Practice Aids

Cross References:

Rules, regulations, see *26:2H-5c*.

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

End of Document

N.J. Stat. § 26:2H-5c

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§ 26:2H-5c. Rules, regulations

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 [C.26:2H-5b, 26:2H-5c], 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.

History

L. 2000, c. 62, § 2, eff. July 13, 2000; amended 2012, c. 17, § 155, eff. June 29, 2012.

Annotations

Notes

Publisher's Note:

The bracketed material was added by the Publisher to provide a reference.

Amendment Note:

2012 amendment, by Chapter 17, substituted "Commissioner of Health" for "Commissioner of Health and Senior Services"; and made a stylistic change.

Research References & Practice Aids

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

End of Document

N.J. Stat. § 26:2H-5d

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§ 26:2H-5d. Provision of information by home health agency to patient

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.

History

L. 2002, c. 81, § 1, eff. Sept. 5, 2002; amended 2012, c. 17, § 156, eff. June 29, 2012.

Annotations

Notes

Amendment Note:

2012 amendment, by Chapter 17, substituted “Commissioner of Health” for “Commissioner of Health and Senior Services” in a.; and made a stylistic change.

Research References & Practice Aids

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

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N.J. Stat. § 26:2H-5d1

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§ 26:2H-5d1. Home health agency to comply with standards for treatment of hemophilia

Each home health agency licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) that provides home care services to an individual with hemophilia shall, when those services include treatment services for bleeding episodes associated with hemophilia, comply with the standards for a provider as provided in subsection a. of section 1 of P.L.2001, c.121 (C.26:2S-10.1). A home health agency that provides home treatment services that include treatment services for bleeding episodes associated with hemophilia that fails to comply with the requirements of this section or the standards provided in subsection a. of section 1 of P.L.2001, c.121 (C.26:2S-10.1) shall be subject to such administrative penalties or disciplinary action as the Commissioner of Health shall prescribe by regulation.

History

L. 2019, c. 322, § 1, effective January 13, 2020.

Annotations

Notes

Editor's Notes

Section 3 of L. 2019, c. 322 provides: “The Commissioner of Health and the State Board of Pharmacy shall, in consultation with the Commissioner of Banking and Insurance, promulgate rules and regulations pursuant to the ‘Administrative Procedure Act,’ P.L.1968, c.410 (C.52:14B-1 et seq.), as may be necessary to implement the provisions of this act.”

Research References & Practice Aids

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

N.J. Stat. § 26:2H-5d1

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N.J. Stat. § 26:2H-5e

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§ 26:2H-5e. Adoption of policies for notifying family members of patient deaths by health care facilities

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.

History

L. *2004, c. 90*, § 1, eff. July 9, 2004; amended *2012, c. 17*, § 157, eff. June 29, 2012.

Annotations

Notes

Amendment Note:

2012 amendment, by Chapter 17, substituted "Commissioner of Health" for "Commissioner of Health and Senior Services"; and made a stylistic change.

Research References & Practice Aids

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

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N.J. Stat. § 26:2H-5f

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§ 26:2H-5f. Findings, declarations relative to staffing in certain health care facilities

The Legislature finds and declares that hospital patients and nursing home residents, in the interest of being fully informed about the quality of health care provided at the facility where they are receiving health care services, are entitled to have access to the information that is required to be posted and otherwise provided to members of the public under this act about direct patient or resident care staffing levels at the facility.

History

L. *2005, c. 21*, § 1, eff. July 23, 2005.

Annotations

Notes

Effective Dates:

Section 4 of L. *2005, c. 21* provides: “This act shall take effect on the 180th day after enactment, except that the Commissioner of Health and Senior Services may take such anticipatory administrative action in advance as shall be necessary for the implementation of the act.” Chapter 21, L. 2005, was approved on January 24, 2005.

Research References & Practice Aids

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

End of Document

N.J. Stat. § 26:2H-5g

Current through New Jersey 220th First Annual Session, L. 2022, c. 130 and J.R. 10

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§ 26:2H-5g. Compilation, posting of certain staffing information by health care facilities

a. A general hospital licensed pursuant to P.L. 1971, c. 136 (*C. 26:2H-1* et seq.) shall compile, and shall post daily in the patient care area of each unit of the hospital and provide upon request to a member of the public, information detailing for each unit and for the end of the prevailing shift, as appropriate:

(1) the number of registered professional nurses providing direct patient care and the ratio of patients to registered professional nurses;

(2) the number of licensed practical nurses providing direct patient care and the ratio of patients to licensed practical nurses;

(3) the number of certified nurse aides providing direct patient care and the ratio of patients to certified nurse aides;

(4) the number of other licensed or registered health care professionals meeting State staffing requirements; and

(5) the methods used by the hospital for determining and adjusting direct patient care staffing levels.

b.

(1) A nursing home licensed pursuant to P.L.1971, c.136 (*C.26:2H-1* et seq.) shall compile, and shall include with the information about health care professionals who are directly responsible for resident care, which it is required under federal law to post in areas where this information can be viewed by residents and members of the public, information that details the ratio of these health care professionals to residents for that particular day on each shift.

(2) The nursing home shall also provide to a member of the public, upon request, the information that is posted in accordance with the provisions of paragraph (1) of this subsection.

c. The information that is posted pursuant to subsections a. and b. of this section shall be displayed in a manner that is visible and accessible to all patients or residents, as applicable, their families and caregivers in the facility, as determined by regulation of the Commissioner of Health and Senior Services and subject to the applicable requirements of federal law.

d. A general hospital and nursing home shall report the information compiled pursuant to subsection a. or b. of this section, respectively, to the commissioner on a monthly basis, on a form and in a manner prescribed by the commissioner. The commissioner shall make this information available to the public on a quarterly basis, accompanied by a written explanation, which the commissioner shall prepare in consultation with the Quality Improvement Advisory Committee established by the commissioner, to assist members of the public in interpreting the information reported pursuant to this section.

e. A general hospital or nursing home that fails to comply with the provisions of this act, or any rules or regulations adopted pursuant thereto, shall be subject to a penalty as determined by the commissioner pursuant to sections 13 and 16 of P.L. 1971, c. 136 (*C. 26:2H-13* and *C.26:2H-16*).

History

L. *2005, c. 21*, § 2, eff. July 23, 2005.

Annotations

Notes

Effective Dates:

Section 4 of L. *2005, c. 21* provides: "This act shall take effect on the 180th day after enactment, except that the Commissioner of Health and Senior Services may take such anticipatory administrative action in advance as shall be necessary for the implementation of the act." Chapter 21, L. 2005, was approved on January 24, 2005.

Research References & Practice Aids

Cross References:

Rules, regulations, see *26:2H-5h*.

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

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N.J. Stat. § 26:2H-5h

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§ 26:2H-5h. Rules, regulations

> 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 [*C.26:2H-5g*] of this act.

History

L. *2005, c. 21*, § 3, eff. July 23, 2005; amended *2012, c. 17*, § 158, eff. June 29, 2012.

Annotations

Notes

Publisher's Note:

The bracketed material was added by the Publisher to provide a reference.

Effective Dates:

Section 4 of L. *2005, c. 21* provides: "This act shall take effect on the 180th day after enactment, except that the Commissioner of Health and Senior Services may take such anticipatory administrative action in advance as shall be necessary for the implementation of the act." Chapter 21, L. 2005, was approved on January 24, 2005.

Amendment Note:

2012 amendment, by Chapter 17, substituted "Commissioner of Health" for "Commissioner of Health and Senior Services" in the first sentence.

Research References & Practice Aids

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

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N.J. Stat. § 26:2H-5i

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§ 26:2H-5i. New Jersey Report Card of Hospital Maternity Care

The Commissioner of Health shall gather and compile information necessary to develop a New Jersey Report Card of Hospital Maternity Care, as provided for in this act. The report card, which shall be updated annually and made available on the website of the Department of Health, shall be designed to inform members of the public about maternity care provided in each general hospital licensed pursuant to P.L.1971, c.136 (*C.26:2H-1* et seq.), so that a member of the public is able to make an informed comparison.

History

L. *2018, c. 82*, § 1, effective August 10, 2018.

Annotations

Research References & Practice Aids

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

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N.J. Stat. § 26:2H-5j

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§ 26:2H-5j. Information included on report card

For each hospital, the report card shall include:

a. the number of vaginal deliveries performed;

b. the number of cesarean deliveries performed; and

c. the rate of complications experienced by a patient receiving maternity care:

(1) for a vaginal delivery, which shall include the rate of maternal hemorrhage, laceration, infection, or other complication as prescribed by the Commissioner of Health; and

(2) for a cesarean delivery, which shall include the rate of maternal hemorrhage, infection, operative complication, or other complication as prescribed by the Commissioner of Health.

History

L. *2018, c. 82*, § 2, effective August 10, 2018.

Annotations

Research References & Practice Aids

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

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N.J. Stat. § 26:2H-5k

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§ 26:2H-5k. Revision, addition of complications

Notwithstanding the provisions of section 2 [C.26:2H-5j] of this act to the contrary, the commissioner shall revise or add complications or other factors to be included in the report card based on maternal quality indicators as may be recommended by the American Congress of Obstetricians and Gynecologists.

History

L. 2018, c. 82, § 3, effective August 10, 2018.

Annotations

Notes

Publisher's Notes

The bracketed material was added by the Publisher to provide a reference.

Research References & Practice Aids

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

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N.J. Stat. § 26:2H-5l

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§ 26:2H-5l. Contract for provision of home health care

Notwithstanding any provision of Title 26 of the Revised Statutes or any regulation promulgated thereunder to the contrary, a county or municipal government that is the licensed operator of a home health agency may contract with a non-governmental entity that is licensed as a home health care agency to provide direct services, administration, and financial services on behalf of the governmental home health care agency, provided that the governmental body that is the licensed operator retains ultimate control over key governance responsibilities. Any such contractual arrangement shall be subject to approval by the Department of Health. Nothing in this section shall be construed to supersede any applicable law or regulation concerning public bidding, licensure of non-governmental home health care agencies, or reimbursement for publicly funded health care programs.

History

L. *2019, c. 173*, § 1, effective February 1, 2020.

Annotations

Notes

Effective Dates

Section 3 of L. *2019, c. 173* provides: “This act shall take effect on the first day of the seventh month next following the date of enactment, except that the Commissioner of Health may take any anticipatory administrative action in advance as shall be necessary for the implementation of this act.” Chapter 173, L. 2019, was approved on July 19, 2019.

Research References & Practice Aids

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

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N.J. Stat. § 26:2H-5m

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§ 26:2H-5m. Rules, regulations

The Commissioner of Health shall, in accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), adopt any rules and regulations as the commissioner deems necessary to carry out the provisions of this act [C.26:2H-5l, C.26:2H-5m].

History

L. 2019, c. 173, § 2, effective February 1, 2020.

Annotations

Notes

Effective Dates

Section 3 of L. 2019, c. 173 provides: "This act shall take effect on the first day of the seventh month next following the date of enactment, except that the Commissioner of Health may take any anticipatory administrative action in advance as shall be necessary for the implementation of this act." Chapter 173, L. 2019, was approved on July 19, 2019.

Research References & Practice Aids

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

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N.J. Stat. § 26:2H-5n

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§ 26:2H-5n. Hospital to provide medical, billing records; fees

a. Except as provided in subsection d. of this section, if a patient of a general, special, or psychiatric hospital licensed pursuant to P.L.1971, c.136 (*C.26:2H-1* et seq.), the patient's legally authorized representative, or an authorized third party requests, in writing, a copy of individual admission records, the hospital shall provide a legible paper or electronic reproduction of the requested records within the dates requested to the patient, the patient's legally authorized representative, or the authorized third party within 30 days of the request, in accordance with the following:

(1)

(a) For a request by a patient or the patient's legally authorized representative for a medical record, whether such record is stored electronically, on microfilm or microfiche, or on paper, the fee for reproducing the record shall not exceed $1 per page or $50 per individual admission record, whichever is less. The fee for reproducing a medical record shall not exceed $50 per individual admission or patient record, exclusive of any additional fees specified in paragraph (3) of this subsection;

(b) If a patient requests a copy of the patient's own medical records in accordance with the federal "Health Insurance Portability and Accountability Act of 1996," *Pub.L.104-191*, the requirements provided under *45 C.F.R. 164.524(b)* with respect to the time required to respond to such requests and the applicable fees shall apply;

(c) A hospital shall not charge any fee to provide an electronic or paper reproduction of a billing record requested by a patient, or a patient's legally authorized representative;

(d) For a request by an authorized third party, the fee for reproducing medical and billing records that are not stored on microfilm or microfiche shall be no more than $1 per page, and the fee for reproducing records stored on microfilm or microfiche shall be $1.50 per image; and

(e) A fee for the reproduction of x-rays or any other material that cannot be routinely copied or duplicated on a commercial photocopy machine, which shall be no more than $15 per printed image or $30 per compact disc (CD) or digital video disc (DVD), plus an administrative fee of $10.

(2) Delivery of an electronic reproduction of a patient's medical or billing record shall be required only if:

(a) the entire request can be reproduced from an electronic health record system;

(b) the record is specifically requested to be delivered in electronic format; and

(c) the record can be delivered electronically.

(3) In addition to per-page fees, a hospital shall apply the following charges for patients, patients' legally authorized representatives, and authorized third parties::

(a) a search fee of no more than $20 per request; provided that no search fee shall be charged to a patient who is requesting the patient's own record. If a search fee may be charged under this subparagraph, the fee shall apply even if no medical records are found as a result of the search;

(b) (Deleted by amendment, *P.L.2022, c.114*)

(c) a fee for certification of a copy of a medical record of no more than $10 per certification; and

(d) costs for delivering records in any medium, plus sales tax, if applicable.

(4) The fees established in this subsection shall be charged for electronic reproductions as well as paper copies of medical records.

(5) The hospital shall establish a policy assuring access to copies of medical records for patients who do not have the ability to pay for the copies.

(6) The hospital shall establish a fee policy providing an incentive for the use of abstracts or summaries of medical records; however, a patient and a patient's legally authorized representative shall have the right to receive a full or certified copy of the medical record.

(7) Subject to the requirements of paragraph (2) of this subsection, medical and billing records shall be delivered in the manner specified by the requestor, which may include, but shall not be limited to, mailing the record to any address or faxing the record to any number specified by the requestor, including the requestor's attorney. Subject to the requirements of federal law, the method of delivery specified by a requestor shall not affect the fees that would ordinarily apply to the request under paragraphs (1) and (3) of this subsection, subject to any policies established pursuant to paragraphs (5) and (6) of this subsection and subject to the provisions of subsections c. and d. of this section.

b. Access to a copy of a patient's medical record shall be limited only to the extent necessary to protect the patient. The patient's attending physician shall provide a verbal explanation for any denial of access to the patient, legally authorized representative, or authorized third party, and shall document the denial and explanation in the medical record. In the event that direct access to a copy by the patient is medically contraindicated, as documented by a physician in the patient's medical record, the hospital or the health care professional shall not limit access to the record to a legally authorized representative of the patient, an authorized third party, or the patient's attending physician.

c. A hospital shall not assess any fees or charges for a copy of individual admission records as provided herein other than those provided for in this section.

d. The fees authorized by this section shall not be imposed on:

(1) A patient who does not have the ability to pay and who presents either: (a) a statement certifying to annual income at or below 250 percent of the federal poverty level; or (b) proof of eligibility for, or enrollment in, a State or federal assistance program including, but not limited to: the federal Supplemental Nutrition Assistance Program established pursuant to the "Food and Nutrition Act of 2008," *Pub.L.110-246* (*7 U.S.C. § 2011* et seq.); the federal Supplemental Security Income program established pursuant to Title XVI of the federal Social Security Act, *Pub.L.92-603* (*42 U.S.C. § 1381* et seq.); the National School Lunch Program established pursuant to the "Richard B. Russell National School Lunch Act," *Pub.L.79-396* (*42 U.S.C. § 1751* et seq.); the federal special supplemental food program for women, infants, and children established pursuant to *Pub.L.95-627* (*42 U.S.C. § 1786*); the State Medicaid program established pursuant to the "New Jersey Medical Assistance and Health Services Act," P.L.1968, c.413 (*C.30:4D-1* et seq.); the NJ FamilyCare Program established pursuant to the "Family Health Care Coverage Act," *P.L.2005, c.156* (*C.30:4J-8* et al.); the Work First New Jersey program established pursuant to the "Work First New Jersey Act," *P.L.1997, c.38* (*C.44:10-55* et seq.); the New Jersey Supplementary Food Stamp Program established pursuant to the "New Jersey Supplementary Food Stamp Program Act," *P.L.1998, c.32* (*C.44:10-79* et seq.); any successor program; or any other State or federal assistance program now or hereafter established by law;

(2) A not-for-profit corporation indicating in writing that it is representing a patient;

(3) A health care practitioner;

(4) An attorney representing a patient on a pro bono basis, provided that the attorney submits with the request a certification that the attorney is representing the patient on a pro bono basis. An attorney representing a patient on a contingency fee basis shall be assessed the ordinary fees to obtain a copy of individual admission records; or

(5) A patient or an attorney representing a patient who has a pending application for, or is currently receiving, federal Social Security disability benefits provided under Title II or Title XVI of the federal Social Security Act, *Pub.L.92-603* (*42 U.S.C. § 1351* et al.).

e. As used in this section:

"Authorized third party" means a third party, who is not a legally authorized representative of the patient, with a valid authorization, subpoena, legal process, or court order granting access to a patient's medical or billing records.

"Legally authorized representative" means: the patient's spouse, domestic partner, or civil union partner; the patient's immediate next of kin; the patient's legal guardian; the patient's attorney; the patient's automobile insurer; or the patient's worker's compensation carrier, if the carrier is authorized to access to the patient's treatment or billing records by contract or law, provided that access by a worker's compensation carrier shall be limited only to that portion of the treatment or billing record that is relevant to the specific work-related incident at issue in the worker's compensation claim.

History

L. *2019, c. 217*, § 1, effective March 1, 2020; amended by *2021, c. 359*, § 1, effective January 10, 2022; *2021, c. 427*, § 1, effective May 1, 2022; *2022, c. 114*, § 1, effective September 22, 2022.

Annotations

Notes

OLS Corrections:

Pursuant to *R.S.1:3-1*, the Office of Legislative Services, through its Legislative Counsel and with the concurrence of the Attorney General, corrected L. *2021, c. 427*, § 1 to incorporate the provisions of the amendment of this section by L. *2021, c. 359*, § 1.

Editor's Notes

Section 3 of L. *2019, c. 217* provides: "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.), shall adopt rules and regulations as necessary to effectuate the purposes of this act."

Effective Dates

Section 4 of L. *2019, c. 217* provides: "This act shall take effect on the first day of the seventh month next following the date of enactment, except that the Commissioner of Health and the State Board of Medical Examiners may take such anticipatory administrative action in advance thereof as may be necessary for the implementation of this act." Chapter 217, L. 2019, was approved on Aug. 9, 2019.

Section 2 of L. *2021, c. 427* provides: “This act shall take effect on the first day of the fourth month next following the date of enactment.” Chapter 427, L. 2021, was approved on Jan. 18, 2022.

Amendment Notes

2021 amendment, by Chapter 359, added a.(7) and d.(4); and made a related change.

2021 amendment, by Chapter 427, in a., inserted “or of a State-licensed health care professional,” deleted “or billing” following “medical” and “or both” following “records”; rewrote a.(1)(a); deleted a.(1)(b); redesignated former a(1)(c) as a.(1)(b); added a.(1)(c); inserted “or a health care professional” and “provided that the total fees charged per individual admission record or patient record do not exceed $50” in a.(3); deleted “and billing” following “medical” in a.(5); redesignated former d.(3) as d.(4); added “A health care practitioner” in d.(3); deleted “and billing” following “medical” in d.(4); added the definition of “Health care professional” in e.; and inserted “or the health care professional” throughout the section.

Research References & Practice Aids

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

End of Document

N.J. Stat. § 26:2H-5o

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§ 26:2H-5o. Definitions relative to palliative, hospice care

As used in this act:

"Appropriate" means consistent with applicable legal, health, and professional standards, the patient's clinical and other circumstances, and the patient's reasonably known wishes and beliefs.

"Hospice care" means a coordinated program of home, outpatient, and inpatient care and services that is operated by a public agency or private organization, or subdivision of either of these entities, and that provides care and services to hospice patients and to hospice patients' families, through a medically directed interdisciplinary team, under interdisciplinary plans of care in order to meet the physical, psychological, social, spiritual, and other special needs that are experienced during the final stages of illness, dying, and bereavement. A hospice care program includes: nursing care by or under the supervision of a registered professional nurse; physical, occupational, or speech or language therapy; medical social services by a certified or licensed social worker under the direction of a physician; services of a certified home health aide; medical supplies, including drugs and biologicals, and the use of medical appliances related to terminal diagnosis; physician's services; short-term inpatient care, including both palliative and respite care and procedures; spiritual and other counseling for hospice patients and hospice patients' families; services of volunteers under the direction of the provider of the hospice care program; and bereavement services for hospice patients' families.

"Medical care" means services provided, requested, or supervised by a physician, physician assistant, or advanced practice nurse.

"Palliative care" means patient-centered and family-centered medical care that optimizes quality of life by anticipating, preventing, and treating suffering caused by serious illness. Palliative care throughout the continuum of illness involves addressing physical, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice. Palliative care includes, but is not limited to: comprehensive pain and symptom management and discussion of treatment options appropriate to the patient, including hospice care, when appropriate.

"Serious illness" means any medical illness or physical injury or condition that substantially impacts quality of life for more than a short period of time. Serious illness includes, but is not limited to: cancer; heart, renal, or liver failure; lung disease; and Alzheimer's disease and related dementias.

History

L. 2019, c. 227, § 1, effective December 1, 2019.

Annotations

Notes

Effective Dates

Section 5 of L. *2019, c. 227* provides: “This act shall take effect on the first day of the fourth month next following enactment.” Chapter 227, L. 2019, was approved on Aug. 9, 2019.

Research References & Practice Aids

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

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N.J. Stat. § 26:2H-5p

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§ 26:2H-5p. "Palliative Care and Hospice Care Consumer and Professional Information and Education Program"

a. There is established the "Palliative Care and Hospice Care Consumer and Professional Information and Education Program" in the Department of Health.

b. The purpose of the program is to maximize the effectiveness of palliative care and hospice care initiatives in the State by ensuring that comprehensive and accurate information and education about palliative care and hospice care are available to the public, to health care providers, and to health care facilities.

c. The Palliative Care and Hospice Care Advisory Council, established pursuant to section 4 of *P.L.2019, c.227* (*C.26:2H-5r*) shall, in collaboration with the Cancer Institute of New Jersey, develop and implement the program established under this section, including developing and implementing any initiatives regarding palliative care and hospice care services and education that the council determines would further the purposes of this section.

History

L. *2019, c. 227*, § 2, effective December 1, 2019.

Annotations

Notes

Effective Dates

Section 5 of L. *2019, c. 227* provides: "This act shall take effect on the first day of the fourth month next following enactment." Chapter 227, L. 2019, was approved on Aug. 9, 2019.

Research References & Practice Aids

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

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N.J. Stat. § 26:2H-5q

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§ 26:2H-5q. Provision of information to certain patients, residents and family members

a. Every hospital, nursing home, rehabilitation facility, and other facility which is identified by the Commissioner of Health to be appropriate and which is licensed in this State shall provide information about appropriate palliative care and hospice care services to patients and residents with a serious illness or, in the event the patient or resident lacks capacity to make health care decisions, to a family member or other person legally authorized to make health care decisions for the patient or resident.

b. If a hospital, nursing home, or facility fails to comply with the requirements of subsection a. of this section, the Commissioner of Health may require the hospital, nursing home, or facility to provide a plan of action to bring the hospital, nursing home, orfacility into compliance.

c. In implementing the provisions of this section, the department shall:

(1) consult with the Palliative Care and Hospice Care Advisory Council established pursuant to section 4 of *P.L.2019, c.227* (*C.26:2H-5r*); and

(2) take into account factors that may impact the ability of a hospital, nursing home, or facility to comply with the requirements of subsection a. of this section. These factors may include, but are not limited to: the size of the hospital, nursing home, or facility; access and proximity to palliative care and hospice care services, including the availability of palliative care and hospice care board-certified practitioners and related workforce staff; and geographic factors.

History

L. *2019, c. 227*, § 3, effective December 1, 2019.

Annotations

Notes

Effective Dates

Section 5 of L. *2019, c. 227* provides: “This act shall take effect on the first day of the fourth month next following enactment.” Chapter 227, L. 2019, was approved on Aug. 9, 2019.

Research References & Practice Aids

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

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N.J. Stat. § 26:2H-5r

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§ 26:2H-5r. Palliative Care and Hospice Care Advisory Council

a. There is established in the Department of Health the Palliative Care and Hospice Care Advisory Council.

b. It shall be the duty of the council, in collaboration with the Cancer Institute of New Jersey, to implement the provisions of P.L.2019, c.227 (C.26:2H-5o et seq.), including establishing the Palliative Care and Hospice Care Consumer and Professional Information and Education Program pursuant to section 2 of P.L.2019, c.227 (C.26:2H-5p), developing and facilitating the provision of information about palliative care and hospice care for the purposes of section 3 of P.L.2019, c.227 (C.26:2H-5q), and developing resources and programs to facilitate access to palliative care and hospice care services for patients and residents.

c.

(1) The council shall be comprised of eleven members, to be appointed as follows: one member of the Senate appointed by the Senate President; one member of the General Assembly appointed by the Speaker of the General Assembly; three public members appointed by the Senate President; three public members appointed by the Speaker of the General Assembly; and three public members appointed by the Governor.

(2) In selecting the public members, the Senate President, the Speaker of the General Assembly, and the Governor shall seek to include persons who have experience, training, or academic background in issues related to the provision of palliative care or hospice care, with an emphasis on addressing physical, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice. Seven of the nine public members shall be comprised as follows: one physician, one advanced practice nurse or physician assistant, one nurse, one social worker, one chaplain, one pediatric oncologist, and one hospice administrator. The public members shall be board certified or have a hospice and palliative care certification, as appropriate to their discipline. Selections of public members may be made in consultation with: the State Board of Medical Examiners, the New Jersey Board of Nursing, the Physician Assistant Advisory Committee, the Board of Pharmacy, the New Jersey Hospital Association, the Health Care Association of New Jersey, the Medical Society of New Jersey, the New Jersey Association of Osteopathic Physicians and Surgeons, the New Jersey State Nurses Association, the Home Care and Hospice Association of New Jersey, LeadingAge New Jersey, the New Jersey State Society of Physician Assistants, and the New Jersey Hospice and Palliative Care Organization.

d. All appointments shall be made within 30 days after the effective date of P.L.2019, c.227 (C.26:2H-5o et seq.).

e. The public members shall serve for a term of five years; but, of the members first appointed, three shall serve for a term of three years, three for a term of four years, and three for a term of five years. Members are eligible for reappointment upon the expiration of their terms. Vacancies in the membership shall be filled in the same manner as the original appointments.

f. The council shall organize as soon as is practicable upon the appointment of a majority of its members, and shall select a chairperson from among the members.

g. The members of the council shall serve without compensation but may be reimbursed, within the limits of funds made available to the council, for necessary travel expenses incurred in the performance of their duties.

h. 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 for its purposes.

i. The Department of Health shall provide staff support to the council.

History

L. *2019, c. 227*, § 4, effective December 1, 2019.

Annotations

Notes

Effective Dates

Section 5 of L. *2019, c. 227* provides: “This act shall take effect on the first day of the fourth month next following enactment.” Chapter 227, L. 2019, was approved on Aug. 9, 2019.

Research References & Practice Aids

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

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N.J. Stat. § 26:2H-5s

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§ 26:2H-5s. Provision of palliative care services for patients treated in the emergency department

The emergency department of a general hospital licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall develop and implement a plan to integrate the provision of palliative care services for patients treated in the emergency department for whom palliative care is appropriate. The plan shall include:

(1) the adoption of a standardized screening tool, as recommended by the Department of Health, for use by health care professionals in the emergency department to facilitate the identification of patients who present to the emergency department for acute symptom management, pain relief, or otherwise, who would benefit from palliative care services;

(2) the provision of patient-centered information, as developed by the Department of Health, concerning the benefits of palliative care, the conditions, diagnoses, and disease stage for which palliative care is generally appropriate, and referrals to providers of outpatient palliative care services, when appropriate; and

(3) consideration of the unique needs of patients with intellectual or developmental disabilities or behavioral health issues who present to the emergency department and for whom palliative care may be indicated.

History

L. 2019, c. 421, § 1, effective August 1, 2020.

Annotations

Notes

Effective Dates

Section 2 of L. 2019, c. 421 provides: “This act shall take effect on the first day of the seventh month next following enactment, except that the Commissioner of Health may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of this act.” Chapter 421, L. 2019, was approved on Jan. 21, 2020.

Research References & Practice Aids

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

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N.J. Stat. § 26:2H-5.1

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§ 26:2H-5.1. Collection of information on costs and revenues; report to legislature

The Commissioner of the Department of Health shall, on a continuous basis, collect information concerning all costs and revenues of residential health care facilities licensed pursuant to P.L.1971, c. 136 (*C. 26:2H-1* et seq.) so as to provide a means for the Legislature to determine whether it is advisable for the commissioner to set variable rates for payment to such facilities and whether payments for Supplemental Security Income under P.L.1973, c. 256 (*C. 44:7-85* et seq.) for eligible residents of such facilities should be supplemented in accordance with any such rates.

One year following the effective date of this act, the commissioner shall submit a report to the Legislature's Joint Appropriations Committee and Standing Reference Committees on Institutions, Health and Welfare containing the information required herein to be collected.

To collect information concerning the costs and resources of residential health care facilities, the commissioner is authorized to conduct such field visits and audits as may be necessary, and the owners of such facilities shall submit such reports, audits and accountings of cost as the commissioner may require by regulation; provided, however, that such reports, audits and accountings shall be the minimum necessary to implement the provisions of this section.

History

L. 1979, c. 496, 18.

Annotations

Research References & Practice Aids

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

End of Document

N.J. Stat. § 26:2H-5.1a

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§ 26:2H-5.1a. Regulations for oversight of hospitals

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) average daily census;

(3) days in accounts receivable;

(4) average payment period;

(5) operating margin;

(6) operating margin adjusted to account for fees, allocations, and other business interactions with interested persons as those terms are defined in IRS Form 990, with the term "interested person" to include owners for the purposes of a for-profit hospital; 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 provide notice of the hospital's financial state to the mayor, city administrator, and members of the Legislature who represent the municipality in which the hospital is located. The commissioner may appoint, in consultation with the hospital, a monitor to prevent further financial deterioration, in which case the commissioner, within 30 days of making the appointment, shall provide notice of the appointment of the monitor to the mayor, city administrator, and members of the Legislature who represent the municipality in which the hospital is located.

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.

History

L. *2008, c. 58*, § 2, eff. Feb. 4, 2009; amended *2012, c. 17*, § 159, eff. June 29, 2012; *2019, c. 349*, § 1, effective January 13, 2020; *2019, c. 512*, § 1, effective January 21, 2020.

Annotations

Notes

Editor's Notes

Section 4 of L. *2008, c. 58* provides: “The Commissioner of Health and Senior Services, 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.”

Health Care Stabilization Fund, see *26:2H-18.74* et seq.

Effective Date Notes

Section 5 of L. *2008, c. 58* provides: “This act shall take effect on the 180th day after the date of enactment, but the Commissioner of Health and Senior Services may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of the act.” Chapter 58, L. 2008, was approved on Aug. 8, 2008.

Amendment Notes

2012 amendment, by Chapter 17, substituted “Commissioner of Health” for “Commissioner of Health and Senior Services” in the first sentence of a.; substituted “Department of Health” for “Department of Health and Senior Services” in the introductory language of b.; and made a stylistic change.

2019 amendment, by Chapter 349, substituted “average daily census” for “cushion ratio” in b.(2); substituted “operating” for “total” in b.(5); inserted b.(6); redesignated former b.(6) as b.(7); in c., inserted “and any additional financial indicators as the commissioner specifies by regulation” in the first sentence and deleted the former second and third sentences.

2019 amendment rewrote the first paragraph of c.

Research References & Practice Aids

Cross References:

Commissioner’s powers, see *26:2H-5*.

Conditions for licensure of general hospital, see *26:2H-5.1b*.

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

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N.J. Stat. § 26:2H-5.1b

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§ 26:2H-5.1b. Conditions for licensure of general hospital

As a condition of licensure under P.L.1971, c.136 (*C.26:2H-1* et al.), a general hospital shall:

a.

(1) provide to the Department of Health: monthly and quarterly unaudited financial information, quarterly unaudited financial statements, annual audited financial statements, and such other financial information as the department may request; and

(2) annually, upon renewal of its license, post on its Internet website the most recent public inspection copy that is available of Internal Revenue Service Form 990 and all schedules and supporting documentation required to be submitted to the Internal Revenue Service in conjunction with Form 990; except that, if the hospital does not file a Form 990 with the Internal Revenue Service, the hospital shall post on its Internet website all governance, financial, and operating information that would otherwise be reported on Form 990 for the prior tax year, including the information that would be required to be submitted in the schedules and supporting documentation in conjunction with Form 990, to the extent that such information exists with respect to a for-profit hospital; and

(3) no less than 90 days prior to signing an agreement for the sale or the lease of the land or property on which the hospital is located, provide notice to the Department of Health of the hospital's intent to sign an agreement to sell or lease land or property on which the hospital is located. Notification to the department shall include a copy of the agreement, the names of all parties included, and the intended use of proceeds from the sale or lease of land or property;

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*); and

c. if the hospital is owned or managed by a for-profit entity, including an entity that has a majority ownership interest in the hospital, provide to the department the following information, to the extent that such information is not otherwise reported pursuant to subsection a. of this section:

(1) a report of each business transaction in the fiscal year with an interested person which exceeds $10,000. The report of business transactions with interested persons shall be the same as defined in Internal Revenue Service Form 990, except that the term "interested persons" shall also include owners of any for-profit hospital;

(2) a chart that identifies all related organizations, including any corporation, company, limited liability company, partnership, individual trust, or other governing body, entity, or person as defined

in Internal Revenue Service Form 990 , including the full name, location, and tax-exempt status of the entity or person;

(3) whether the owners or managers of the hospital maintain one or more offices, employees, or agents outside the United States that do business with the hospital, and any revenues and expenses of more than $10,000 transacted outside the United States;

(4) a list of investors and joint ventures between the hospital owners and its investors, including the name of the joint venture entity, whether for-profit or nonprofit, a description of its primary activity, and the percent of profit or stock ownership held by each of the officers, directors, physicians, and key employees of the hospital in the joint venture;

(5) the name and address of any management company paid to provide services to the hospital, a description of the primary activity of the company, and the percent of profit or stock ownership held by each of the officers, directors, physicians, and key employees of the hospital in the management company;

(6) the amounts paid to any affiliates for management or consulting services;

(7) a description of any trust that holds an interest in the hospital, including the names of the trustees, beneficial owners, and grantor or settlor of the trust, along with a copy of the full trust agreement;

(8) a list of any properties for which the hospital has claimed a tax abatement; and

(9) if the hospital had surplus revenues for the prior fiscal year, the total amount of any such surplus revenue used for each of the following: debt retirement; plant or facility expansion; or a reserve for operating contingencies.

d. The information submitted to the department pursuant to this section during the period of time encompassing the hospital's current or most recent tax year shall be posted on the hospital's Internet website, with the exception of any information provided to the department under subsection c. deemed proprietary by the Commissioner of Health. The department shall provide a link on the department's Internet website to the information posted on the hospital's Internet website, as required pursuant to this subsection.

History

L. *2008, c. 58*, § 3, eff. Feb. 4, 2009; amended *2012, c. 17*, § 160, eff. June 29, 2012; *2019, c. 513*, § 1, effective July 19, 2020.

Annotations

Notes

OLS Corrections:

Pursuant to *R.S.1:3-1*, the Office of Legislative Services, through its Legislative Counsel and with the concurrence of the Attorney General, corrected a technical error in L. *2008, c. 58*, § 3.

Editor's Notes

Section 2 of L. *2019, c. 513* provides: "The Commissioner of Health shall, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (*C.52:14B-1* et seq.), adopt rules and regulations to implement the provisions of this act."

Effective Dates:

Section 5 of L. *2008, c. 58* provides: "This act shall take effect on the 180th day after the date of enactment, but the Commissioner of Health and Senior Services may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of the act." Chapter 58, L. 2008, was approved on Aug. 8, 2008.

Section 3 of L. *2019, c. 513* provides: "This act shall take effect on the 180th day after the date of enactment, except that the Commissioner of Health may take any anticipatory administrative action in advance thereof as shall be necessary for the implementation of this act." Chapter 513, L. 2019, was approved on Jan. 21, 2020.

Amendment Note:

2012 amendment, by Chapter 17, substituted "Department of Health" for "Department of Health and Senior Services" in a.; and substituted "Commissioner of Health" for "Commissioner of Health and Senior Services" in b.

2019 amendment, by Chapter 513, rewrote the section.

Research References & Practice Aids

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

End of Document

N.J. Stat. § 26:2H-5.1c

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§ 26:2H-5.1c. Ambulatory care facility to use common billing form

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.

History

L. *2009, c. 263*, § 1, eff. July 1, 2011; amended *2012, c. 17*, § 161, eff. June 29, 2012.

Annotations

Notes

Effective Dates:

Section 5 of L. *2009, c. 263* provides: "This act shall take effect on the first day of the 18th month next following the date of enactment." Chapter 263, L. 2009, was approved on Jan. 17, 2010.

Amendment Note:

2012 amendment, by Chapter 17, substituted "Commissioner of Health" for "Commissioner of Health and Senior Services" in the first sentence.

Research References & Practice Aids

Cross References:

Quarterly report from ambulatory care facility; required information, see *26:2H-5.1e*.

Rules, regulations, see *26:2H-5.1f*.

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

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N.J. Stat. § 26:2H-5.1d

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§ 26:2H-5.1d. Identification numbers of physicians publicly available

The commissioner shall make publicly available the identification number for the physician or physicians, as applicable, that appear on hospital billing forms and billing forms of ambulatory care facilities licensed to provide surgical services, to the extent that doing so is consistent with the "Health Insurance Portability and Accountability Act of 1996," *Pub.L.104-191*.

History

L. *2009, c. 263*, § 2, eff. July 1, 2011.

Annotations

Notes

Effective Dates:

Section 5 of L. *2009, c. 263* provides: "This act shall take effect on the first day of the 18th month next following the date of enactment." Chapter 263, L. 2009, was approved on Jan. 17, 2010.

Research References & Practice Aids

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

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N.J. Stat. § 26:2H-5.1e

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§ 26:2H-5.1e. Quarterly report from ambulatory care facility; required information

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 [C.26:2H-5.1c et seq.], 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.

History

L. 2009, c. 263, § 3, eff. July 1, 2011; amended 2012, c. 17, § 162, eff. June 29, 2012.

Annotations

Notes

Publisher's Note:

The bracketed material was added by the Publisher to provide a reference.

Editor's Notes

"Health Care Facility-Associated Infection Reporting and Prevention Act," see *26:2H-12.39* et seq.

Effective Dates:

Section 5 of L. *2009, c. 263* provides: "This act shall take effect on the first day of the 18th month next following the date of enactment." Chapter 263, L. 2009, was approved on Jan. 17, 2010.

Amendment Note:

2012 amendment, by Chapter 17, substituted "Department of Health" for "Department of Health and Senior Services" in a.

Research References & Practice Aids

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

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§ 26:2H-5.1f. Rules, regulations

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 [C.26:2H-5.1c et seq.].

History

L. 2009, c. 263, § 4, eff. July 1, 2011; amended 2012, c. 17, § 163, eff. June 29, 2012.

Annotations

Notes

Publisher's Note:

The bracketed material was added by the Publisher to provide a reference.

Effective Dates:

Section 5 of L. 2009, c. 263 provides: "This act shall take effect on the first day of the 18th month next following the date of enactment." Chapter 263, L. 2009, was approved on Jan. 17, 2010.

Amendment Note:

2012 amendment, by Chapter 17, substituted "Commissioner of Health" for "Commissioner of Health and Senior Services."

Research References & Practice Aids

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

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§ 26:2H-5.1g. Regulations

a. Pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), the Commissioner of Health shall adopt regulations necessary to develop an integrated licensing system in which facilities licensed under the authority of P.L.1971, c.136 (C.26:2H-1 et seq.); P.L.1957, c.146 (C.30:9A-1 et seq.); P.L.1975, c.305 (C.26:2B-7 et seq.); sections 5 and 6 of P.L.1989, c.51 (C.26:2BB-5 and C.26:2BB-6); P.L.1969, c.152 (C.26:2G-1 et seq.); or Reorganization Plan No. 001-2017 may provide primary care, mental health care, or substance use disorder treatment services, or a combination of such services, under a single license.

b. The regulations shall:

(1) identify services authorized to be provided as primary care, mental health care, or substance use disorder treatment pursuant to an integrated health care facility license;

(2) require a single integrated health care facility license for a facility, which license shall specify the scope of primary care, mental health care, and substance use disorder treatment services that the facility is authorized to provide under the integrated health care facility license;

(3) permit a facility to hold a designation as an ambulatory care facility, community mental health program, substance use disorder treatment facility, or other type of facility recognized under State or federal law under the integrated health care facility license without requiring a separate license;

(4) identify staffing requirements consistent with staff members' scope of professional practice and credentials;

(5) establish standards for information sharing among providers and among core and non-core team members;

(6) establish requirements for collection of data on identified outcome measures;

(7) permit sharing of clinical space, administrative staff, medical records storage, and other facility resources among different categories of services, unless a separation is necessary to protect the health and safety of patients or the public or to comply with federal or State health privacy laws and regulations; and

(8) establish application requirements, compliance inspections, investigations, and enforcement actions, including but not limited to fees and penalties.

c. In developing the regulations, the commissioner shall:

(1) consult with the Division of Medical Assistance and Health Services in the Department of Human Services to develop policies that minimize barriers to participation and reimbursement in the Medicaid and NJ FamilyCare programs faced by licensed facilities for all qualifying services; and

(2) promote policies that:

(a) support an effective and efficient administration of a full range of integrated, comprehensive health care;

(b) support providers' identification of risk factors for mental illness and substance use disorders, which may include physical health diagnoses;

(c) support an increased awareness of prevention and treatment;

(d) reduce the stigma associated with receiving behavioral health treatment;

(e) will lead to improved access to mental health care and substance use disorder treatment services for all persons;

(f) will lead to improved general health and wellness, including physical health, mental health, and substance use disorders, and prevent chronic disease; and

(g) will leverage partnerships with local health authorities, employers, faith-based organizations, and others involved in promoting community health.

History

L. *2017, c. 294*, § 3, effective February 1, 2019.

Annotations

Notes

Effective Dates

Section 4 of L. *2017, c. 294* provides: "This act shall take effect on the first day of the thirteenth month next following the date of enactment, except that the Commissioner of Health may take any anticipatory administrative action in advance as shall be necessary for the implementation of this act." Chapter 294, L. 2017, was approved on Jan. 16, 2018.

Research References & Practice Aids

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

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N.J. Stat. § 26:2H-5.2

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§§ 26:2H-5.2 to 26:2H-5.6. Repealed by L. *1991, c. 187*, § 84, eff. July 31, 1991

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N.J. Stat. § 26:2H-5.7

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§ 26:2H-5.7. State Health Planning Board established

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.

History

L. *1991, c. 187*, § 33; amended *1998, c. 43*, § 4, eff. June 30, 1998; *2006, c. 47*, § 108, eff. July 1, 2006; *2012, c. 17*, § 164, eff. June 29, 2012.

Annotations

Notes

Effective Dates:

Section 205 of L. *2006, c. 47* provides: “This act shall take effect July 1, 2006 and, if enacted after that date, shall be retroactive to July 1, 2006.” Chapter 47, L. 2006 was approved on July 11, 2006.

Amendment Note:

2006 amendment, by Chapter 47, in the second sentence of the first paragraph, inserted “Children and Families.”

2012 amendment, by Chapter 17, in the first paragraph, substituted “Department of Health” for “Department of Health and Senior Services” in the first sentence and substituted “Health” for “Health and Senior Services” in the second sentence; and made stylistic changes.

Research References & Practice Aids

Cross References:

Definitions, see *26:2H-2*.

Administrative Code:

N.J.A.C. 8:33-1.3 (2013), CHAPTER CERTIFICATE OF NEED: APPLICATION AND REVIEW PROCESS, Definitions.

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

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N.J. Stat. § 26:2H-5.8

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§ 26:2H-5.8. Review of application for certificate of need

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.

History

L. *1991, c. 187*, § 34; amended *1992, c. 31*, § 1; *1998, c. 43*, § 5, eff. June 30, 1998; *2012, c. 17*, § 165, eff. June 29, 2012.

Annotations

Notes

Amendment Note:

2012 amendment, by Chapter 17, substituted “Commissioner of Health” for “Commissioner of Health and Senior Services” in b. and the second sentence of the first paragraph of c.; and substituted “Department of Health” for “Department of Health and Senior Services” in the first sentence of the first paragraph of c.

CASE NOTES

Administrative Law: Separation of Powers: Constitutional Controls: General Overview

N.J. Stat. Ann. § 26:2H-5.8(a), which restricts the authority of the department of health to adopt regulations relating to the issuance of certificates of need by providing that the state health plan, and the goals, objectives and recommendations contained therein, shall be advisory only, was duly enacted in conformity with the constitution's required procedures when, subsequent to the Governor's veto, it was passed into law by a two-thirds vote of both houses of the legislature; thus the enactment of the statute fully complied with the constitutional scheme of checks and balances in exercising policy-making power. *In re Adoption of Regulations Governing the State Health Plan, N.J.A.C., 262 N.J. Super. 469, 621 A.2d 484, 1993 N.J. Super. LEXIS 50 (App.Div. 1993)*, aff'd, *135 N.J. 24, 637 A.2d 1246, 1994 N.J. LEXIS 172 (N.J. 1994)*.

Research References & Practice Aids

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

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N.J. Stat. § 26:2H-5.9

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§ 26:2H-5.9. Repealed by L. *1998, c. 43*, § 19, eff. June 30, 1998

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N.J. Stat. § 26:2H-5.10

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§ 26:2H-5.10. Findings, declarations relative to use of needles, sharp devices in health care facilities

The Legislature finds and declares that:

a. The use of conventional needles results in increased risk of HIV infection and hepatitis B and C to health care workers;

b. Each year, from 150 to 200 health care workers die and many suffer chronic and debilitating diseases due to needle stick injuries;

c. Equipment exists to prevent most injuries that result from needle stick injuries but overall concern with cutting health care costs has impeded the widespread use of advanced, safer technology; and

d. Newer, safer needle technology should be adopted in health care facilities.

History

L. *1999, c. 311*, § 1, eff. Jan. 4, 2000.

Annotations

Research References & Practice Aids

Administrative Code:

N.J.A.C. 8:43E-7.1 (2013), CHAPTER GENERAL LICENSURE PROCEDURES AND STANDARDS APPLICABLE TO ALL LICENSED FACILITIES, Use of needles and sharp instruments containing integrated safety features.

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

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N.J. Stat. § 26:2H-5.11

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§ 26:2H-5.11. Definitions relative to use of needles, sharp devices in health care facilities

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.

History

L. *1999, c. 311*, § 2, eff. Jan. 4, 2000; amended *2012, c. 17*, § 166, eff. June 29, 2012.

Annotations

Notes

Amendment Note:

2012 amendment, by Chapter 17, substituted "Commissioner of Health" for "Commissioner of Health and Senior Services" in the definition of "Commissioner"; and substituted "Department of Health" for "Department of Health and Senior Services" in the definition of "Department."

Research References & Practice Aids

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

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N.J. Stat. § 26:2H-5.12

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§ 26:2H-5.12. Integrated safety features required on needles, etc.; dentists, exempt, certain circumstances

a. No later than 12 months after the date of enactment of this act, the commissioner shall require that a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) use only needles and other sharp devices with integrated safety features, which needles and other sharp devices have been cleared or approved for marketing by the federal Food and Drug Administration and are commercially available for distribution.

b. By a date established by the commissioner by regulation, but no later than 36 months after the date of enactment of this act, the requirements of subsection a. of this section shall also apply to pre-filled syringes, as that term is defined by the commissioner by regulation pursuant to this act.

c. No later than six months after the date of enactment of this act, the commissioner shall develop evaluation criteria for use by an evaluation committee established pursuant to subsection a. of section 4 of this act in selecting needles and other sharp devices for use by a health care facility.

d. In the event that there is no cleared or approved for marketing product with integrated safety features for a specific patient use, the licensed health care facility shall continue to use the appropriate needle or other sharp device that is available, including any needle or other sharp device with non-integrated, add-on safety features, until such time as a product with integrated safety features is cleared or approved for marketing and is commercially available for that specific patient use.

e. No later than six months after the date of enactment of this act, the commissioner shall develop and make available to health care facilities a standardized form that shall be used by health care professionals and the health care facility's evaluation committee for applying for a waiver and in reviewing a request for a waiver, respectively, and for reporting the use of a needle or other sharp device without integrated safety features in an emergency situation by a health care professional, pursuant to the provisions of subsection d. of section 4 of this act.

f. Notwithstanding the provisions of this section to the contrary, a dentist who determines that use of a needle or other sharp device with integrated safety features potentially may have a negative impact on patient safety or the success of a specific medical procedure may use a needle or other sharp device without integrated safety features, without obtaining a waiver from the evaluation committee and without providing notification to the evaluation committee pursuant to section 4 of P.L.1999, c.311 (C.26:2H-5.13).

History

L. 1999, c. 311, § 3, eff. Jan. 4, 2000; amended 2005, c. 278, § 1, eff. Jan. 6, 2006.

Annotations

Research References & Practice Aids

Administrative Code:

N.J.A.C. 8:44-3.10 (2013), CHAPTER CHAPTER IV OF THE STATE SANITARY CODE, Disposable equipment.

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

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N.J. Stat. § 26:2H-5.13

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§ 26:2H-5.13. Responsibilities of health care facility

A health care facility shall:

a. Establish an evaluation committee in which at least half of the members are direct-care health care workers who shall select needles and other sharp devices from each class of needle or other sharp device for which the commissioner has developed evaluation criteria pursuant to subsection c. of section 3 of this act [26:2H-15.12];

b. Provide for education and training, as appropriate, in the use of designated needles and other sharp devices;

c. Develop a mechanism to continually review and evaluate newly introduced needles and other sharp devices available in the marketplace for use in a health care facility;

d. Establish a waiver procedure for health care professionals wherein a health care professional practicing at the health care facility may request the evaluation committee to grant the professional a waiver from the requirements of subsection a. or b. of section 3 of this act [26:2H-15.12] for a specific product that will be used for a specific medical procedure that shall be performed on a specific class of patients. The evaluation committee shall grant a waiver if it determines that use of a needle or other sharp device with integrated safety features potentially may have a negative impact on patient safety or the success of a specific medical procedure.

A health care professional may use a needle or other sharp device without integrated safety features in an emergency situation, without obtaining a waiver from the evaluation committee, if the professional determines that use of a needle or other sharp device with integrated safety features potentially may have a negative impact on patient safety or the success of a specific medical procedure, and the professional notifies the evaluation committee, in writing, within five days of the date the needle or other sharp device was used of the reasons why that needle or other sharp device was necessary.

The use of a needle or other sharp device that does not meet the requirements of subsection a. or b. of section 3 of this act [26:2H-5.12] shall be permitted under this act if it is used in accordance with the requirements of this subsection;

e. Record needle stick injuries in a Sharps Injury Log or an OSHA 200 Log, and shall include in the log a description of the injury, including the type and brand name of the needle or other sharp device involved in the injury; and

f. Report to the department quarterly, in a form and manner prescribed by the department: (1) all entries of an injury in a Sharps Injury Log or an OSHA 200 Log; and (2) all waivers granted to health care professionals and the reasons therefor, and all emergency uses by health care professionals of needles and other sharp devices without integrated safety features and the reasons therefor, pursuant to subsection d. of this section.

History

L. *1999, c. 311*, § 4, eff. Jan. 4, 2000.

Annotations

Research References & Practice Aids

Cross References:

Integrated safety features required on needles, etc.; dentists, exempt, certain circumstances, see *26:2H-5.12*.

Administrative Code:

N.J.A.C. 8:43E-7.2 (2013), CHAPTER GENERAL LICENSURE PROCEDURES AND STANDARDS APPLICABLE TO ALL LICENSED FACILITIES, Definitions.

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

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N.J. Stat. § 26:2H-5.14

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§ 26:2H-5.14. Review of health care facilities reports, recommendations

The department shall review the reports submitted by health care facilities pursuant to section 4 of this act [26:2H-15.13] on a quarterly basis and shall make recommendations to the respective health care facility for reducing the incidence of needle stick injury, when appropriate.

History

L. *1999, c. 311*, § 5, eff. Jan. 4, 2000.

Annotations

Research References & Practice Aids

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

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N.J. Stat. § 26:2H-5.15

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§ 26:2H-5.15. Annual report to Legislature

The commissioner shall report annually to the Senate and General Assembly Health Committees on the implementation of this act. The report shall include the number of needle stick injuries, the type and brand names of the needles or other sharp devices involved in the injuries, the number of waivers that were granted and the number of emergency uses of needles or other sharp devices without integrated safety features. The report shall include such recommendations for legislative action as the commissioner deems appropriate to ensure that the purposes of this act are realized.

History

L. *1999, c. 311*, § 6, eff. Jan. 4, 2000.

Annotations

Research References & Practice Aids

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

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N.J. Stat. § 26:2H-5.16

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§ 26:2H-5.16. Rules, regulations

The commissioner, pursuant to the "Administrative Procedure Act," P.L. 1968, c. 413 (C. 52:14B-1 et seq.), shall adopt rules and regulations to effectuate the purposes of this act.

History

L. 1999, c. 311, § 7, eff. Jan. 4, 2000.

Annotations

Research References & Practice Aids

Hierarchy Notes:

N.J. Stat. Title 26, Ch. 2H, Pt. I

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