CHAPTER 33A

CERTIFICATE OF NEED: HOSPITAL POLICY MANUAL

Authority

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

Source and Effective Date

R.1992 d.512, effective November 25, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).

Executive Order No. 66(1978) Expiration Date

Chapter 33A, Certificate of Need: Hospital Policy Manual, expires on November 25, 1997.

Chapter Historical Note

Chapter 33A, originally Surgical Facilities, became effective April 15, 1985, pursuant to authority of N.J.S.A. 26:2H–1 et seq., specifically 26:2H–5, as R.1985 d.188. See: 17 N.J.R. 154(a), 17 N.J.R. 915(a). Pursuant to Executive Order No. 66(1978), Chapter 33A was readopted as R.1990 d.168 effective February 20, 1990. See: 21 N.J.R. 3888(a), 22 N.J.R. 983(b). Chapter 33A, Surgical Facilities, expired on February 20, 1992, pursuant to Executive Order No. 66(1978).

Chapter 43I, Certificate of Need: Hospital Policy Manual was recodified to N.J.A.C. 8:33A, by R.1992 d.512, effective December 21, 1992.

See section annotations for specific rulemaking activity.

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SUBCHAPTER 1. GENERAL PROVISIONS

8:33A–1.1 Purpose

(a) The 1971 Health Care Facilities Planning Act (N.J.S.A. 26:2H–1 et seq. as amended) and the Health Care Cost Reduction Act, P.L. 1991, c.187, established as public policy of the State of New Jersey "that hospital and related health care services of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost are of vital concern to the public health." (N.J.S.A. 26:2H–1)

(b) To implement this policy, the State Department of Health has "the central, comprehensive responsibility for the development and administration of the State's policy with respect to health planning, hospital and related health care services, and all public and private institutions, whether State, county, municipal, incorporated and not incorporated, serving principally as boarding, nursing or maternity homes or other homes for the sheltered care of adult persons or as facilities for the prevention, diagnosis or treatment of human disease, pain, injury, deformity, or physical condition(s)."

(c) No health care facility shall be constructed or expanded, and no new health care services shall be instituted except upon application for and receipt of a Certificate of Need.

(d) The Department of Health has a major responsibility for the promotion of quality health services rendered in an efficient and economical manner and available to all residents of the State. To ensure significant progress toward the achievement of this policy goal, planning and Certificate of Need activities will be directed toward the provision of facilities and services which:

1. Improve the health of residents of a hospital service area;

2. Increase the accessibility (including overcoming economic, geographic, architectural and transportation barriers), acceptability, continuity and quality of health services provided the residents;

3. Restrain unnecessary increases in the cost of providing the health services;

4. Prevent unnecessary duplication of health resources and encourage the development of cost effective alternative delivery modes; and

5. Reduce financial barriers to care.

(e) The general policies, standards and guidelines set forth in the chapter are intended to provide substantive criteria for the regulation, planning, review and implementation of health care facilities and services within the State of New Jersey.

(f) The general policies presented in this chapter apply to all acute care facility and service planning within the State. In addition to these general policies, specific planning and review standards and guidelines are presented in this chapter for broad categories of health care facilities and services, as well as for specialized types of health care which shall be made available on a regionalized basis.

(g) This chapter is to be distinguished from the "Certificate of Need Application and Review Process" promulgated by the New Jersey State Department of Health (N.J.A.C. 8:33) which identifies the procedures, rules, and regulations which carry out the Certificate of Need program pursuant to N.J.S.A. 26:2H–1 et seq.

(h) This chapter presents substantive criteria for the planning of health care facilities and services as provided by acute care hospitals within the State. These policies, standards and guidelines shall be applied in the review of proposed actions requiring Certificate of Need authorization.

Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
References to Health Care Cost Reduction Act added.

8:33A–1.2 General policies

(a) The general policies identified in this chapter shall apply to all facilities licensed and regulated under N.J.S.A. 26:2H–1 et seq. and amendments thereto.

(b) No certificate of need shall be issued unless the action proposed in the application for such certificate is necessary to provide required health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of adequate and effective health care services. (N.J.S.A. 26:2H–8)

(c) Each Certificate of Need shall comply with all appropriate health planning and rate setting rules adopted by the Department of Health with the approval of the Health Care Administrative Board.

(d) In reviewing Certificate of Need applications, the Department will consider the following policy goals for capital projects:

1. The reduction of duplicative services and excess bed capacity and the development of cost effective alternatives to inpatient care.

2. Accessibility to all inpatient and outpatient services by medically underserved residents of the State.

3. The efficient operation of licensed hospitals in the State.

4. The achievement of operational cost savings or cost avoidances as a result of proposed new capital expenditures.

5. Maintenance of a level of capital debt as appropriate to a cost efficient health care delivery system.

6. The orderly development of health care services.

(e) Any applicant for a Certificate of Need must agree in writing at the time of filing its Certificate of Need application that it will comply with the following:

1. In order to assure access to patient care services, under no circumstances may any patient be denied admission to the applicant institution or, once admitted, transferred to another institution due to inability to pay for services. This condition shall remain in effect for the life of the approved project.

2. The applicant will not practice discrimination on the basis of medical diagnosis if it has the ability to treat that medical diagnosis.

3. The applicant will assure that indigents and Medicaid patients have access to all services offered by the facility.

(f) Each applicant must demonstrate an historical commitment to caring for the medically indigent (that is, provision of uncompensated charity care, excluding bad debt accounts) and that it has taken steps to develop services for this population; for example, primary care programs followed-up with appropriate specialty referral. The applicant shall submit evidence from its medical staff that staff physicians with admitting privileges will insure access to care by all indigent and Medicaid patients who present.

(g) The Department of Health encourages planning by hospitals which promotes:

1. Actions consistent with State Department of Health policies and rules;

2. Prevention of disease through early intervention and the provision of primary care services, and encourages the continued development of alternative service modalities to substitute for inpatient hospital care and alternative facilities to substitute for hospital inpatient construction as appropriate.

3. Regionalization of medical resources to achieve cost efficiencies and to enhance the quality of care as appropriate.

4. Accessibility and the availability of services to those persons unable to pay for services (in whole or in part).

5. Reductions in environmental and occupational accidents, illness and disease.

(h) Institutions which engage in cooperative regional planning and which demonstrate that they are sharing their resources on a regional basis shall be given special consideration in the awarding of certificate of need.

(i) In making determinations on applications for Certificates of Need, there shall be taken into consideration the availability of facilities or services which may serve as alternatives or substitutes, the need for special equipment and services in the area, the possible economies and improvement in services to be anticipated from the operation of joint central services, the adequacy of financial resources and sources of present and future revenues, the availability of sufficient manpower in the several professional disciplines, and such other factors as may be established by regulation. (See N.J.S.A. 26:2H–8.)

(j) The Department of Health shall give preference to applicants which do any of the following:

1. Document existing working relationships with other area hospitals and health care facilities providing primary care services, including, but not limited to, referral arrangements for regionalized services;

2. Make services available to persons who are unable to pay; or

3. Propose mergers, consolidations, or other joint arrangements, or closure of underutilized and unneeded services and document quantifiable cost savings in future years resulting from such actions.

(k) The applicant shall identify alternative approaches to the project which were considered and demonstrate in specific terms how the option selected, relative to all other alternatives, most effectively benefits the health care system through achieving capital and operational savings, increasing access, and/or improving quality of care.

(*l*) If a hospital has closed, ceased or not maintained operation of any of its beds, facilities, or services for any consecutive two year period, these beds, facilities or services may be removed from the inventory of the facility and a certificate of need shall be required to reopen such beds, facilities, or services.

(m) All hospitals shall report to the Department annually any transfer of funds from the general hospital to affiliated or subsidiary corporations.

Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
References to Health Care Cost Reduction Act added.
Amended by R.1993 d.669, effective December 20, 1993.
See: 24 N.J.R. 4476(a), 25 N.J.R. 6019(a).

8:33A–1.3 Definitions

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

"Acquisition" means the obtainment of a health care facility or service through purchase, lease, donation or other means which requires a Certificate of Need.

"Adjusted admission" as defined at N.J.A.C. 8:31B–3.24 (as amended), the Uniform Bill–Patient Summary (Inpatient) Regulation, means inpatient admissions multiplied by total gross divided by inpatient gross revenue.

"Admissions" means all inpatients admitted to the hospital, including Same Day Medical Admissions and excluding Same Day Surgery, Outpatient Surgery, and internal transfers within the hospital.

"Commissioner" means the Commissioner of the Department of Health.

"Construction" means the erection, building, alteration, reconstruction, improvement, renovation, extension or modification of a health care facility, including fixed equipment, the inspection and supervision thereof; and the studies, surveys, designs, plans, working drawings, specifications, procedures, and other actions necessary thereto.

"Debt service" means those funds allocated to the repayment of principal, depreciation, and interest as a result of the financing of a capital expenditure.

"Department" means the New Jersey Department of Health.

"Equity" means a voluntary non-operating liquid asset contribution which will reduce the total size of the debt. Equity may include cash, donations, and net projected cash from fundraising.

"Fixed equipment" means equipment which is attached to the physical plant of a facility.

"Guidelines" means those general factors to be considered in applying a given standard, or to guide decision-making in areas for which specific standards are not available or would not be appropriate.

"Hospital Service Area" means those municipalities in an area that can be determined through the most recent patient origin/market share data collected by the Department to meet one or more of the following criteria:

1. The hospital derives five percent or more of total admissions from the municipality; or

2. Greater than 20 percent of residents of the municipality who are hospitalized utilize the subject hospital; or

3. It is the municipality in which the hospital is located.

"Inpatient" means either a patient appropriately admitted to a licensed acute care hospital bed for an overnight stay and/or a patient appropriately admitted to a licensed acute care bed following a same day medical procedure.

"Labor-delivery-recovery-postpartum (LDRP) bed" means a licensed obstetrical bed, the primary function of which is to accommodate an obstetrical patient during the entire course of labor, delivery, recovery, and postpartum.

"Local Advisory Board" means an independent, private non-profit corporation which is not a health care facility, a subsidiary thereof, or an affiliated corporation of a health care facility, that is designated by the Commissioner of the Department of Health to serve as the regional health planning agency for a designated region in the State.

"Major movable equipment" means equipment, including installation and renovation, which is the subject of a health planning rule or which is proposed by the Commissioner to be the subject of a health planning rule. For purposes of this chapter, major moveable equipment includes all equipment which has received pre-marketing approval from the U.S. Food and Drug Administration, unless the Health Care Administration Board explicitly excludes a specific piece of equipment or a specific technology from the classification of major moveable equipment. Examples of major moveable equipment are identified at Exhibit 3 of the appendix to N.J.A.C. 8:33.

"Medically underserved groups" means segments of the population which currently fail to use health care services in numbers approximately proportionate to their presence in the population, as adjusted to account for their need for such services. This means all population groups including racial, ethnic, and sexual minorities, migrant workers, the handicapped, Medicaid recipients, individuals and families with incomes below 80 percent of the median income for either the state or the Standard Metropolitan Statistical Area in which they reside, and other identifiable segments of the population which currently fail to use health care services in numbers approximately proportionate to their presence in the population as adjusted to account for their need for such services.

"Modernization/renovation" means the alteration, expansion, major repair (to the extent permitted by rules), remodeling, replacement, and renovation of existing buildings (including initial equipment thereof), and the replacement of obsolete equipment or existing buildings.

"Outpatient surgery" means a minor surgical procedure appropriately performed in private practice settings, or in hospital outpatient departments, on patients who do not require a licensed free standing ambulatory surgery facility or same-day surgery (SDS) status in a hospital. Anesthesia is generally of a local type. In a hospital setting, outpatient surgery is counted as an outpatient visit.

"Postpartum bed" means a licensed obstetrical bed, the function of which is to accommodate a postpartum or antepartum patient.

"Proposed capital expenditure" means the sum total of expenditures anticipated by the facility at the conclusion of a project, which includes expenditures by a facility acting as its own contractor, which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance.

"Replacement funding" means the amount of reimbursement as determined under Chapter 83 Rate Setting Regulations (N.J.A.C. 8:31 B–3 and 4 which provides for replacement of capital facilities and fixed equipment.

"Same day medical admissions" means those patients who were provided elective treatment (diagnostic and nonsurgical procedures as defined ICD–9–CM Codes) and were discharged in a routine status before midnight of the day of admission.

"Same day surgery" means a surgical procedure performed on patients who:

1. Have these procedures performed in a licensed health care facility, but do not stay overnight.

2. Require a licensed health care facility as a setting for these procedures and generally require some form of anesthesia (typically general or regional in nature) and a facility-based post surgery recovery period of at least one hour.

"Standards" means the specific requirements that applicants must satisfy in developing applications for Certificate of Need approval. To the extent practicable, standards shall address measurable characteristics that such applications must meet.

"Total project cost" means all costs associated with the proposed project, including all capital costs, carrying and financing costs, net interest on borrowings during construction, and debt service reserve fund. Total project cost excludes any contingency amounts.

Amended by R.1990 d.463, effective September 17, 1990.
See: 22 N.J.R. 1891(a), 22 N.J.R. 3014(a).
Definitions added for LDRP and postpartum beds.
Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
Definitions for "equity," "major moveable equipment," "medically underserved groups," "total project cost" amended; definition for "local health planning agency" deleted; definition for "Local Advisory Board" added.

8:33A–1.4 Scope

This chapter shall apply to all hospitals licensed and regulated under N.J.S.A. 26:2H–1 et seq. and amendments thereto.

8:33A–1.5 Standards regarding minimum size; acute general hospitals

(a) The minimum size for an acute general hospital shall be 200 beds. This standard shall not apply to:

1. Facilities licensed for fewer than 200 beds at the time of adoption of this chapter;

2. Facilities of less than 200 beds proposing to expand to at least 200 beds, where the need for expansion is consistent with health planning rules;

3. Facilities with less than 200 beds which are operated by or have submitted a Certificate of Need to merge with a full-service general acute hospital with over a 200–bed capacity and which provide or will provide only those services which are necessary to meet the community's need without duplication of service.

4. Facilities with less than 200 beds that are granted exceptions according to the criteria identified at N.J.A.C. 8:33A–1.13(a)2 and 1.13(b)1.–3.

Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
Text at (a)2 revised to delete "justified" and require need to be consistent with health planning rules.

8:33A–1.6 Minimum size of obstetrics units

(a) The minimum size of an obstetric service shall be 20 beds. Exceptions will be considered where:

1. The distance to an alternate obstetric unit exceeds 15 miles; or

2. At the proposed lower capacity, occupancy will exceed minimum occupancy standards identified at N.J.A.C. 8:33A–1.11, and the applicant demonstrates that an appropriate level of care will be provided in a cost-effective manner.

(b) In no case shall the minimum size of an obstetric unit fall below 10 beds.

8:33A–1.7 Standards regarding minimum size; pediatric services

(a) The minimum size of a pediatric unit shall be 20 beds. Exceptions will be considered where it is documented that:

1. The distance to an alternate pediatric unit exceeds 15 miles; or,

2. At the proposed lower capacity, occupancy will exceed minimum occupancy standards identified at N.J.A.C. 8:43I–1.11, and the applicant demonstrates an appropriate level of care will be provided in a cost-effective manner.

8:33A–1.8 Limitations on approvals

Certificate of Need approval for construction, renovation, or purchase of a facility is limited to the project as contained in the Certificate of Need application. No implicit approval for additional beds, services, or equipment can be inferred from the approval unless specifically defined in the application.

8:33A–1.9 Standards regarding shelled space

Shelled space (any area of a facility built without the intent for immediate use) has generally not been proven to be cost effective. Projects proposing shelled space shall not be approved unless the applicant can demonstrate significant cost savings using present value analysis to both the institution and the health care system as well as the future need for the space. The Department will not recognize the capital costs of shell space within the cost base of the hospital while it remains shell space.

8:33A–1.10 Project need

(a) Any application for establishment of or expansion of licensed beds must demonstrate need for these beds in the proposed service area based upon needs assessment methodologies represented in the most recent acute care bed need estimates developed and promulgated by the Department. All applicants, prior to submission, should consult with their respective LABs regarding their plans to assure that the projects address community needs, project needs, project goals, cost issues and revenue stability criteria (to the extent that this information is available) and will be competitive in accordance with the review process for the hospital capital cap at N.J.A.C. 8:33A–1.29.

(b) Where the applicant is proposing beds to support specialized services for which there are no methodologies referenced in the documents cited at (a) above, the need for beds shall be documented by an analysis of empirical evidence which demonstrates that beds for a new service are cost effective, beneficial to patients, will measureably improve accessibility and quality of care, and could not be provided in a less costly setting. In addition, an applicant shall provide evidence establishing the need for beds by documenting:

1. Referrals from major referral sources, as reflected in letters of support; and

2. Projected admissions, patient days, and average length of stay (the bases for these projections must be specifically identified in the application); and

3. Utilization based upon methodologies established by federal, regional, or other health planning or financing authorities; and

4. Occupancy level projections which shall be demonstrated to have achieved a minimum of 80 percent (for the beds proposed in the application) within two complete calendar years from initial licensure.

Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
Subsection (c) added, permitting CN applications to the December 1992 call only to be made without LAB bed need study.
Amended by R.1993 d.570, effective November 15, 1993.
See: 25 N.J.R. 3710(a), 25 N.J.R. 5161(a).

8:33A–1.11 Standards regarding occupancy rates

(a) For purposes of review of certificate of need applications, the minimum and optimal occupancy rates based upon licensed beds for an acute general hospital, by service category, shall be:

	Minimum	Optimal
Medical/Surgical	75%	90%
Obstetrics		
Units of less than 20 beds		
LDRP	50%	70%
Postpartum	60%	80%
Units of 20 and above		
LDRP	50%	75%
Postpartum	60%	85%
Pediatrics		
Units of less than 40 beds	60%	85%
Units of 40 and above	65%	90%
ICU/CCU	60%	85%
Psychiatric	70%	90%

(b) The level of excess beds within a hospital shall be that number of licensed beds, which, when deleted from a service, will allow a hospital to achieve minimum occupancy levels as identified in (a) above, for a period two years beyond the projected completion date of the project, defined as the "target year". Utilization levels for the target year shall be based on a projection method defined at N.J.A.C. 8:33A–1.15(b), applied forward to the target year.

(c) For purpose of review of Certificate of Need applications for modernization/renovation, new construction or changes in licensed bed capacity, where occupancy falls below minimums within services identified above for the two most recent consecutive calendar years, the hospital must file a plan with the Department of Health that identifies an appropriate bed reduction or services closure. This plan must have hospital board approval and be filed within six months of the end of the second calendar year that occupancy falls below minimum. In addition, the plan and its implementation schedule must be acceptable to the Department.

Amended by R.1990 d.463, effective September 17, 1990.
See: 22 N.J.R. 1891(a), 22 N.J.R. 3014(a).
LDRP and postpartum occupancy rates specified in (a).

8:33A–1.12 Standards regarding addition or replacement of beds

(a) Certificate of Need applications may be approved for the replacement or addition of licensed bed capacity where the applicant reflects consideration of approved health planning rules and all of the following:

1. In the previous 18 months, the applicant hospital must exceed both minimum occupancy rates for all existing services as well as optimal occupancy rates for the service(s) being proposed for expansion and demonstrate that it will achieve an occupancy rate for the service(s) being expanded of no less than 10 percentage points higher than the minimum occupancy rates established for that service identified at N.J.A.C. 8:33A–1.11(a) for the year which is two years beyond project completion.

2. For projects proposing the replacement of existing acute care beds, the applicant hospital must exceed minimal occupancy rates identified at N.J.A.C. 8:33A–1.11(a) in all existing services, and demonstrate that it will achieve an occupancy rate in service(s) being replaced of no less than 10 percentage points higher than the minimum occupancy rates identified at N.J.A.C. 8:33A–1.11(a) for each of the two years beyond project completion.

3. The hospital must demonstrate an appropriate average length of stay in the service for which beds are being renovated or expanded.

4. For bed additions, where there are acute care hospitals within the applicant's service area which, during the 18 months preceding the filing of the Certificate of Need application failed to meet the minimum occupancy levels identified at N.J.A.C. 8:33A–1.11 within the service type(s) for which expansion is being requested, the applicant must provide written evidence that the Board of Directors has undertaken good faith efforts to develop mergers, joint ventures, or other shared service arrangements with the underutilized facility(ies). The applicant must document these efforts, identify the status of these negotiations at the time the application is filed, describe the impact of agreements made between the boards of hospitals on the proposed project, and, where agreements have not been reached, describe in detail the obstacles preventing the formalization of agreements. Moreover, where an applicant has failed to enter into good faith efforts to achieve agreements of the type referred to in this chapter, a detailed explanation authorized by the board of the applicant institution must accompany the application.

(b) Exceptions to (a)1 and (a)2 above may be considered where:

1. The applicant is proposing to reduce licensed beds through conversion or decertification, thereby demonstrating that occupancy levels will be in compliance with minimum standards at the completion of the project; or

2. The applicant can demonstrate that there will be a net bed reduction in its County resulting from cooperative planning with neighboring hospitals; or

3. The applicant can demonstrate additional bed need by documenting rapid changes in demographics or case mix, as well as having evidenced appropriate increases in utilization over the previous 18 months.

4. The applicant demonstrates to the satisfaction of the Department of Health that a reduction in beds in order to meet minimum occupancy standards will not measurably reduce capital or operating costs.

Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
References to consideration of health planning rules added.

8:33A–1.13 Community need standards

(a) A hospital may be approved for necessary capital renovation projects except where it fails to demonstrate that it meets the following standards:

1. Utilization Standards:

i. Minimum occupancy rates in each licensed bed category as specified at N.J.A.C. 8:33A–1.11(a) at the conclusion of the project; and

ii. Trends in volume (admissions, ALOS, and/or patient days) which indicate occupancy will continue to be above minimum occupancy of remaining licensed beds in each licensed bed category for a period of at least each of the two years beyond completion of the project.

2. Efficient size: A hospital must maintain at least 200 beds at the conclusion of the project while maintaining an overall occupancy rate of at least 75 percent. Where it fails to meet this standard, capital projects may only be approved where the hospital is efficiently operated, geographically isolated, merged into a multi-hospital system in its area, or there is a demonstrated need for continued operation. These criteria are further defined in (b) below.

3. Hospital efficiency: The applicant must demonstrate that it is operated in an economically efficient manner through generally accepted industry efficiency standards. Exceptions may be considered if the applicant meets criteria defined in (b) below.

4. Excess bed areas: Where the total number of excess beds as determined under N.J.A.C. 8:33A–1.11(b) in a county exceeds 75 percent of the licensed bed capacity of an applicant hospital at the time of application no approval may be granted unless the applicant qualifies under one or more of the exception conditions outlined in (b) below. As an example, in County A, the Department determined that there is an excess of 300 beds. Hospital A with 200 beds does not meet the standard, as 75 percent of 200 is 150, and the excess of 300 is greater than 150. Hospital B, with 440 beds, meets the standard as 75 percent of 440 is 330, which exceeds the county bed excess. The intent is to examine need for the institution as a whole in areas of substantial bed excess prior to investment of major new capital obligation.

(b) Exceptions to (a)2 through 4 above will be granted to applicants meeting any of the following:

1. The hospital is geographically isolated, defined as follows:

i. There is a lack of another acute care hospital within a 15 mile radius of an applicant hospital; and

ii. Where at least 40 percent of the residents of the service area utilize the hospital; or

2. The hospital is efficient, that is, its occupancy rates are above 80 percent overall for the last four quarters reported to the Department; or

3. Where a multi-hospital system application is being proposed in one of two forms:

i. Joint Community Application: An application submitted jointly by all hospitals (or a combination of hospitals constituting a majority of needed beds) within a 15 mile radius of a hospital seeking replacement and/or addition of beds or in a service area as approved by the Department, that accomplishes the following objectives:

(1) Consolidation and regionalization of services in the area, accomplishing the significant reduction of duplicative inpatient, outpatient, therapeutic and diagnostic services and of ancillary and administrative functions between institutions; and,

(2) Creation of specific operational cost savings which will be incorporated into the rates upon completion of the project; and

(3) Establishment of a joint planning committee for the area which includes all hospitals identified in the application, as well as community participants.

ii. Hospital Merger Applications: An application for transfer of ownership between two or more institutions within a 15 mile radius or in a service area as approved by the Department in which all assets are merged under a single corporate entity operated by a single board of trustees, which accomplishes the following objectives:

(1) Reduction of an appropriate level of excess beds within the merged institutions and conversion, closure, or consolidation of unnecessary physical plant areas in a manner achieving cost savings to the system;

(2) Consolidation of duplicative inpatient, outpatient, therapeutic and diagnostic services and ancillary and administrative functions where appropriate

to the overall health care needs of the health service area.

(3) Compliance with accessibility standards identified at N.J.A.C. 8:33–2.1.

4. The project scope is limited to correction of conditions constituting an imminent hazard to the health and safety of patients and staff, as determined by the Department.

(c) Planning Alternatives: Hospitals not meeting the criteria for community need identified in (a) above may apply for a one time rate adjustment under Chapter 83 Hospital Reimbursement regulations (N.J.A.C. 8:31B) for each of the following types of studies:

i. Conversion of Acute–Care Beds Study: A hospital will analyze all available options in converting all or a portion of its acute care beds to non-acute care use. The study must determine the capital and operating costs associated with each option, and assess reimbursement implications.

ii. Closure Study: A closure study will address the impact on medically underserved populations, the ambulatory-care needs of the community, an employee retraining or job relocation plan, and a financial analysis of both short-term and long-term debt. To be eligible for a closure study, the hospital must not be in default or in bankruptcy.

Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
Minimum occupancy rates specified for capital projects; exceptions provided.

8:33A–1.14 Project component need

(a) In addition to demonstrating continued community need, as defined in N.J.A.C. 8:33A–1.13, all hospitals must demonstrate the need for each component part of the proposed project. A component means any element of the overall project that is associated with the modernization or renovation, expansion, or new construction of an identifiable physical plant area, such as a nursing unit, ancillary department, administrative area, or any structural element of the facility.

(b) Approval of components proposing to address modernization/renovation or construction of physical plant areas for needed services and departments may be made where capital expenditures are necessary for:

1. Correcting functional or structural obsolescence;

2. Correcting life-safety code A and B violations; or

3. Achieving demonstrable and proportionate improvements in patient care as determined by the Department.

(c) Where a component is the subject of an approved planning rule, that component must satisfy all applicable criteria of the specific rule(s).

(d) The applicant must demonstrate the need for the expansion of total square footage to the hospital's physical plant within any component(s) of the proposed project.

(e) The applicant must demonstrate that the proposed costs for the modernization/renovation or new constructions are reasonable in relation to accepted industry standards for its area.

(f) Any component(s) of a certificate of need project not demonstrated to be needed as determined by the Department, based on a review of the applicant's physical plant survey, Statewide prioritization criteria, and all other criteria in this chapter, may be denied.

Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
References to compliance with planning rules added.

8:33A–1.15 Volume projections

(a) All applications must contain historical volume data and projections of inpatient and outpatient volume for purposes of Certificate of Need review. These must be submitted in a form prescribed by the Department.

1. All data must be consistent with the hospital statistics as reported to the Center For Health Statistics for the New Jersey General Hospital Inpatient Utilization Reports on official SHARE reporting forms, unless the application can demonstrate to the Department with verifiable evidence that there are inaccuracies in the statistical information which was reported.

(b) Historical hospital volume data must incorporate the last complete three calendar years preceding the date of filing the Certificate of Need application, as well as year-to-date data for the current year, and at a minimum include the following data components:

1. Inpatient admissions by licensed bed category and total hospital;

2. Adjusted admissions by total hospital;

3. Patient days by licensed bed category and total hospital;

4. Outpatient visits by department or service;

5. Emergency room visits;

6. Inpatient surgical cases;

7. Outpatient surgical cases;

8. Same day surgery cases;

9. Same day medical admissions;

10. Births.

(c) Each application shall provide an estimate of projected volume in all categories as listed in (b) above for each year inclusive from the time of application to that year which is two complete calendar years beyond estimated project completion. This estimate must be based on historical data delineated in (b) above, using at a minimum, a straight-line projection and one or more of the following methodologies:

1. Linear regression modeling;

2. Constant volume;

3. Official county-based-volume projections and market share statistics published by or acceptable to the Department, if available;

4. A methodology chosen by the applicant but in each instance the assumptions utilized in making the projections must be clearly substantiated in the application.

(d) The volume projections must be deemed acceptable to the Department based on conformance to the results of one or more of the methodologies listed in (c) above. While these projections will be evaluated as an element in the review of the application for Certificate of Need purposes, the Department reserves the right to identify specific methodologies (separate and distinct from those referenced in (c) above) for purposes of establishing reimbursement standards that may be applied to the Certificate of Need application as approved.

Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
Inpatient surgical cases, outpatient surgical cases and same day surgery cases specified at (b)6, 7, and 8.

8:33A–1.16 Standards regarding equity contributions and financing

(a) Financing of hospital construction modernization/renovation, or equipment projects requires a minimum equity contribution from the hospital of at least 15 percent of total project costs, including all capital costs, all financing and carrying charges, net interest on borrowings during construction, and debt service reserve fund. The Commissioner may reduce the equity requirement for applicants who can demonstrate financial hardship and that the proposed project will primarily serve a medically underserved population, and the applicant hospital has historically demonstrated that it has provided significant levels of charity care for which it has not been reimbursed. This equity requirement may be reduced by one half of one percent for each full percentage point the hospital uncompensated care percentage exceeds the Statewide average uncompensated care percentage for acute care hospitals.

(b) All projects involving long-term financing of capital construction costs shall demonstrate use of the least-cost financing reasonably available.

(c) Financing arrangements for construction, expansion, renovation, or purchase of facilities shall not entail debt obligations of greater duration than the expected useful life of the assets financed.

(d) All applicants shall demonstrate the financial feasibility of their projects. An appropriate financial feasibility study shall be submitted for projects in excess of $15 million at the time of application. The financial feasibility study shall be prepared by an accounting firm approved by the New Jersey Health Care Facility Financing Authority for such studies, and shall express an opinion based on an examination of projections as defined in the American Institute of Certified Public Accountants' Guide to Prospective Financial Information. A project will be determined financially feasible where the applicant can demonstrate a net positive income beginning in the calendar or fiscal year which is two years beyond project completion. Financial projections shall be provided for the first two full years after project completion. These projections shall indicate the method of funding any losses incurred during this time period.

(e) All projects will be evaluated based on relative cost considerations in comparison to Statewide norms including capital expense per adjusted admission, and total operating expense per adjusted admission.

Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
Equity contributions and financing requirements revised to conform to N.J.A.C. 8:33.
Amended by R.1993 d.570, effective November 15, 1993.
See: 25 NJ.R. 3710(a), 25 N.J.R. 5161(a).
Amended by R.1993 d.669, effective December 20, 1993.
See: 24 N.J.R. 4476(a), 25 N.J.R. 6019(a).

8:33A–1.17 Standards regarding the transfer of services from an acute care hospital

(a) The transfer of a service from one corporation to another, regardless of their relationship, requires a Certificate of Need application through procedures identified at N.J.A.C. 8:33–1.1 et seq.

(b) The facility or corporation transferring out the service must comply with the following criteria and conditions:

1. Implementation of the proposed transfer of service will not violate any bond, covenant or any loan and security agreement between itself and the New Jersey Health Care Facility Financing Authority or any other financing agency.

2. The applicant must assure within the application that:

i. No portion of the operating or capital costs incurred by or related to the proposed service will be incorporated into rates approved for the acute care hospital transferring out the service.

ii. Any losses generated by this proposed service will not be used as a justification for increases in the rates of the acute care hospital transferring out the service.

3. The hospital must guarantee that services which are corporately and/or physically transferred from hospitals to other areas are accessible and available to all persons, independent of their ability to pay, with special attention given to medically underserved groups in the existing hospital service area. The hospital must document that public transportation is available to the aforementioned groups, and if it is not, the hospital must make arrangements to guarantee that transportation will be made available to those individuals.

(c) The facility or corporation receiving the new service must comply with the following criteria and conditions:

1. Any service transferred in whole must provide indigent care at the same level as provided for that same service in the two calendar years preceding the submission of the application or at a level commensurate with other hospitals in the area over the preceding two calendar years, or at a level specified as a condition of the certificate of need at the time of issuance, whichever is greater.

2. Any service transferred in part must, together with the applicant hospital, provide in the aggregate the same level of indigent care as provided for that same service in the two years preceding the application or at a level commensurate with other hospitals in the area over the preceding two years, or at a level specified as a condition of the certificate of need at the time of issuance, whichever is greater.

3. A quality assurance and review program for the health services must be provided and it must be documented that such a program will be implemented at the proposed service.

4. The hospital must guarantee that services which are corporately and/or physically transferred from hospitals to other areas are accessible and available to all persons, independent of their ability to pay, with special attention given to medically underserved groups in the existing hospital service area. The hospital must document that public transportation is available to the aforementioned groups, and if it is not, the hospital must make arrangements to guarantee that transportation will be made available to those individuals.

Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
Level of indigent care to be considered a factor in review for transfer of services.

8:33A–1.18 Standards regarding acquisition or replacement of major moveable equipment

(a) Where a Certificate of Need is required for the acquisition or replacement of major moveable equipment, it will not be awarded unless the applicant has demonstrated compliance with all applicable Departmental rules for the proposed service.

(b) Where a Certificate of Need is required for the acquisition or replacement of major movable equipment it will not be awarded unless the applicant has:

1. Documented use of least-cost financing;

2. Where method of acquisition is through an operating lease arrangement, it must be demonstrated that the proposed lease arrangement is more cost-effective than purchase, giving consideration to maintenance costs, warranties, and other related costs, as well as to the imputed value of a 15 percent equity contribution.

(c) Equity contributions to the financing of the project must meet minimum requirements identified at N.J.A.C. 8:33A–1.16(a). In projects proposing both acquisition of major moveable equipment and modernization/renovation, equity contributions must be pro-rated between equipment costs and costs of the remainder of the project.

Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
Certain cost data requirements eliminated at (b)2 and 3.

8:33A–1.19 Single-bedded rooms

No Certificate of Need proposing the construction, modernization, renovation, or change in licensed bed capacity of acute care beds shall be approved where the total number of single-bedded rooms at the completion of the project exceeds 15 percent of the total complement of licensed medical/surgical, pediatric, and obstetric/gynecological beds. In calculating the percentage of single-bedded rooms, isolation rooms as determined necessary by Departmental licensure standards, will not be included. An exception may be permitted where the hospital can demonstrate clinical necessity or that no additional operational or capital costs will be incurred as a result.

8:33A–1.20 Outpatient clinics

Applicants for any bed-related Certificate of Need must demonstrate the availability of follow-up care for all discharged patients and all residents of the service area either through direct provision of such services by the hospital or its physicians, or through formal written linkages with other health care providers in the area.

Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
Competitive pricing requirement eliminated at (b).

8:33A–1.21 Standards regarding energy conservation projects

(a) Where a Certificate of Need is required for a proposed energy conservation project, the following items must be addressed in the application and will be considered indicators of the cost effectiveness of the project:

1. Description of measures to be undertaken and why these measures were chosen over possible alternatives;

2. Cost of design, acquisition, and installation;

3. Useful life of the measure to be undertaken;

4. Effect of this measure on operating and maintenance costs;

5. Salvage value at the end of useful life of the measure to be undertaken;

6. Annual energy consumption by appropriate category for the three previous years;

7. Estimated energy consumption and energy savings at least three years into the future or until the pay-back year, whichever is longer.

8:33A–1.22 Standards regarding location of hospitals

(a) Any Certificate of Need application proposing the relocation, major new construction at an existing hospital by a new corporate entity, or new construction of an acute care hospital must meet all criteria in this chapter and must specifically address the following:

1. No Certificate of Need shall be awarded to a hospital proposing to relocate, unless it demonstrates compliance with the following criteria:

i. There must be a bed need in the area of proposed location for all services to be relocated, or a reduction of an appropriate level of excess beds within the relocated facility which will be implemented upon relocation;

ii. The applicant must demonstrate that there are sufficient resources in the former area to ensure access to care to the former patient population;

iii. The proposed site must be accessible to patients of the newly-defined service area both economically and in terms of driving time and public transportation, where available;

iv. All alternatives have been considered and the proposed project is responsive to identified health needs and represents the most cost-effective course of action to meet those needs;

v. The applicant must at a minimum demonstrate long term reductions in total health system costs.

2. Applicants proposing construction of a new hospital shall demonstrate compliance with all of the following:

i. Bed need in the area has been documented for each proposed service;

ii. The hospital at its proposed location must be physically and economically accessible to patients of the defined services area;

iii. All hospitals located within a 25–mile radius of the proposed location shall have occupancy levels which exceed optimal levels as defined in N.J.A.C. 8:33A–1.11 for each of the previous two calendar years;

iv. The applicant must demonstrate that the proposed project represents the most cost-effective approach to meeting identified health care needs of the area.

Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
Exception to bed need requirement added, when relocation reduces beds.

8:33A–1.23 Standards regarding costs of parking garages, medical arts buildings, child day care centers or other non-direct patient care services/construction

(a) No Certificate of Need is required for a parking garage or a medical arts building, child day care center or other non-direct patient care services/construction.

(b) The costs of purchase, construction, renovation, expansion and operation of the proposed parking garage shall be fully underwritten by charges to users, as the costs will not be financed, directly or indirectly, in whole or in part, by charges to patients. An exception may be made for components of cost which are reasonable and necessary and conform to the reimbursement definitions and procedures for employee benefits related to patient care set forth in N.J.A.C. 8:31B.

(c) The costs of the purchase, construction, renovation, expansion and operation of a proposed medical arts building or other non-direct patient care services shall be wholly underwritten by charges to users. An exception can be made when documentation is provided and the Department determines that it is cost effective to locate hospital services in the building.

(d) The costs of purchase, construction, renovation, expansion and operation of a proposed child day care center shall be fully underwritten by charges to users, with no costs financed, directly or indirectly, in whole or in part, by charges to patients. An exception may be made for components of cost which are reasonable and necessary and conform to the reimbursement definitions and procedures for employee benefits related to patient care set forth in N.J.A.C. 8:31B.

Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
Child day care and other non-direct costs allowed; (d) added.

8:33A–1.24 Standards regarding accessibility

The applicant must demonstrate compliance with all accessibility criteria as identified in N.J.A.C. 8:33.

8:33A–1.25 Standards regarding transfers of ownership of hospitals

(a) Where a Certificate of Need is required for a transfer of ownership of a licensed New Jersey hospital through merger, acquisition, or other joint arrangement, the following must be demonstrated in the application:

1. Cost efficiencies will be affected and will result in significant net operational savings to the participating hospitals and to the health care system as a whole; and

2. A reduction of all excess bed capacity, as determined under standard N.J.A.C. 8:33A–1.11, will result for all participating hospitals through decertification or conversion of acute care beds; and

3. Duplication of services will be eliminated where appropriate; and

4. Compliance with all other appropriate criteria contained in this chapter.

Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
Stylistic changes.

8:33A–1.26 Standards regarding relocation or closure of services

A Certificate of Need may be awarded for the relocation or closure of a service except where the applicant fails to demonstrate compliance with Specific Criteria for Review contained in N.J.A.C. 8:33, and other applicable requirements of these rules.

Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
Stylistic changes.

8:33A–1.27 Decertification of unused beds

(a) Pursuant to the Health Care Cost Reduction Act (N.J.S.A. 26:2H–12d), the Commissioner may amend a facility's license to reduce that facility's licensed bed capacity to reflect actual utilization at the facility. This authority may be exercised if the Commissioner determines that 10 or more licensed beds in the health care facility have not been used for at least the last two succeeding years. For purposes of this rule, the Commissioner may review hospital utilization from January 1, 1990.

(b) In determining if licensed beds have been unused, the Commissioner may employ the minimum occupancy rates identified at N.J.A.C. 8:33A–1.11(a), and reduce licensed beds to a number which would permit conformance with these minimum occupancy rates.

New Rule, R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).

8:33A–1.28 Hospital physical plant survey

(a) Certificate of Need applications shall not be accepted by the Department from any hospital which is subject to these rules, unless such hospital has filed a complete physical plant survey or update with the Department at least 60 days prior to filing the application.

(b) Each hospital that is approved (either through the Certificate of Need process or through construction plans review) for any modernization, renovation, construction or expansion project shall provide an update of the hospital physical plant survey to the Division of Health Facilities Evaluation and Licensing. This update shall be provided in a format prescribed by the Division of Health Facilities Evaluation and Licensing and shall be submitted within 60 days of project completion.

New Rule, R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).

8:33A–1.29 Hospital capital cap and review process

(a) Certificate of Need applications for hospital capital construction projects that would be financed by the New Jersey Health Care Facilities Financing Authority shall be subject to the Statewide cap of $225,000,000 per year. Review of these projects shall follow N.J.A.C. 8:33–4.9(e) of the "Certificate of Need Application and Review Process."

(b) Having met all other applicable criteria in this chapter and N.J.A.C. 8:33, for the 1993 and 1994 hospital acute care calls only, projects shall be prioritized according to the criteria below. Those projects meeting the greater number of criteria shall receive priority consideration for approval. Approval of certificates of need as limited by the Statewide cap of $225,000,000 will be determined based on the prioritization criteria.

1. Community need: A hospital will be deemed to have exhibited priority community need when it has the following characteristics:

i. Occupancy in excess of optimal occupancy rates (as specified in N.J.A.C. 8:33A–1.11(a)) in all services proposed for expansion, and adjusted occupancy rates in excess of minimum rates by at least 10 percent in all other bed categories during the last 18 months preceding the application. Adjusted occupancy, for each bed category not being expanded, shall be calculated as follows:

(1) Adjusted bed-day capacity = Licensed beds in a category minus changes in beds in the category multiplied by the total days in the 18 month period (547 days);

(2) Adjusted occupancy = Actual patient days in the categories in the prior 18 month period (547 days) divided by the adjusted bed-day capacity for that category; and

ii. The county's and hospital's rates of inpatient admission and length of stay have been demonstrated to be appropriate and not likely to decline as a result of changing medical practice or reimbursement policy. Appropriateness of a hospital's average length of stay (ALOS) shall be determined by comparison, in each licensed bed category, to the Statewide average ALOS for that category. A hospital ALOS, in any bed category, in excess of the Statewide ALOS for that category by more than 20 percent shall be considered inappropriate. A hospital whose ALOS, in any bed category, has been deemed inappropriate in the above manner shall provide justification to the Department. The Department will evaluate such justifications and make a determination of appropriateness of the ALOS, based upon the data provided by the hospital, as well as data maintained by the Department. If the Department determines that a hospital's ALOS is appropriate, even though it exceeds the Statewide ALOS plus 20 percent, an exception to this criterion may be made.

2. Project need:

i. The project is substantially directed to correcting Life Safety Code deficiencies, or other conditions that pose imminent peril to the health and safety of patients and staff; or

ii. The overall average age of the physical plant exceeds 10 years based on the Department's calculations using generally accepted accounting principles; and

3. Project goals:

i. The certificate of need application has been submitted in order to address a public health priority or a specific recommendation set forth in Department health planning guidelines, and is determined by the Department to be essential to achieving that goal. Specifically, these may include hospital closure or merger applications that demonstrate significant cost savings to the health care system, projects which significantly and demonstrably improve access for populations which have been shown historically to lack access to hospital services, or projects implementing ambulatory care initiatives that improve health care delivery patterns and reduce system expenditures; and

ii. The facility historically has served a greater than average proportion of medically underserved populations in comparison to the percent of the population in its community; meets Federal and State obligations for providing uncompensated care, community services, access by minorities (race, ethnic, others) and special needs populations (for example, AIDS); offers a range of means by which persons will have access and availability to its services (for example, outpatient services, admission by house staff, admission by personal physician); is accessible by public or private transportation; as applicable, assures effective communication between the staff of the proposed project and non-English speaking people and those with speech, hearing, or visual handicaps; and to the extent possible, eliminates architectural barriers to care for handicapped individuals and/or describes other unique circumstances.

(c) The strength of the demonstration and the number of prioritization factors demonstrated will be considered in the ranking of projects. The projects will also be evaluated based on relative cost considerations including total operating expense per adjusted admission and capital expense per adjusted admission in comparison to Statewide medians.

New Rule, R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
Amended by R.1993 d.570, effective November 15, 1993.
See: 25 N.J.R. 3710(a), 25 N.J.R. 5161(a).

CHAPTER 33B

(RESERVED)

Chapter Historical Note

Chapter 33B, Extracorporeal Shock Wave Lithotripsey, became effective October 7, 1985 as R.1985 d.497. Pursuant to Executive Order No. 66(1978), Chapter 33B was readopted as R.1990 d.418, effective July 27, 1990. See: 22 N.J.R. 1495(a), 22 N.J.R. 2506(b). Chapter 33B expired on July 27, 1995 pursuant to Executive Order No. 66(1978).