Report

of the

Certificate of Need Study Commission

Presented to the Governor and Legislature of the State of New Jersey

Christine Grant, Chairperson
Commissioner of Health and Senior Services

FEBRUARY, 2000

Table of Contents

Attachments

Executive Summary

Background

Public Law 1998, chapter 43 made changes, including removing many of the health care services and facilities previously subject to the state's certificate of need (CN) process. It also called for a CN Study Commission to determine the impact that elimination of CN requirements would have on all health care services or facilities remaining subject to the CN process. The Commission was required to assess the impact that deregulation of these services or facilities would have on urban hospitals; access to care by residents of the state; quality of care; services that are delivered on a statewide or regional basis; and the state general fund, including funding for programs such as Medicaid. The law provided for a fifteen member Commission, including the Commissioner of Health and Senior Services, the Commissioner of Human Services, the Chair of the Senate Health Committee, the Chair of the General Assembly Health Committee, and eleven public members appointed by the Governor and the leadership of the Legislature.

The services and facilities to be examined by the Commission include: nursing homes; home health agencies; assisted living residences and assisted living programs; comprehensive personal care homes; psychiatric beds; comprehensive rehabilitation services; trauma services; transfer of ownership of existing general acute care hospitals; new general acute care hospitals; special hospitals; children's hospitals; organ banks; organ and bone marrow transplantation, including stem cell; burn centers; specialized perinatal and pediatric services, including maternal and child health consortia, pediatric intensive care and neonatal intermediate and intensive care.

The Commission began meeting in November 1998 and concluded its work in December 1999. Although there is consensus in some areas, there is not universal agreement among Commission members on whether the state should retain a CN process, and which services and facilities should be subject to a CN process.

Recommendations and Rationale for Retaining Certificate of Need

The majority of Commission members support retaining CN requirements for most of the currently services subject to CN review. Specifically, a majority supports retaining direct CN review, which entails a public process before the State Health Planning Board, for the following services:

psychiatric	pediatric intensive care units
trauma	burn care
transplantation	maternal & child health consortia
comprehensive rehabilitation	children's hospitals
cardiac surgery	new acute care hospitals
cardiac catheterization	nursing homes
neonatal intermediate & intensive bassinets	home health services

For maternal and child health consortia, a study of their effectiveness is additionally recommended.

A majority of the Commission also supports expedited CN review, which entails review only by the Department, for:

transfer of ownership of an acute care hospital
assisted living residences and programs and comprehensive personal care homes

For transfer of ownership of an acute care hospital, the recommendation also calls for development of standards pertaining to the track record of the new owner, access to services, and other key issues. For assisted living and comprehensive personal care homes it is recommended that the Department study the impact of assisted living options on the long term care system as a whole and nursing facilities in particular, as well as develop mechanisms to assess quality in assisted living.

Finally, a majority of the Commission supports elimination of CN requirements for:

organ banks
closure of an entire acute care hospital or a service within such a hospital

In the case of organ banks, the existence of national standards governing this process makes a New Jersey-specific CN process unnecessary. In the case of closure of an acute care hospital or one of its services, while the majority supports removal from the CN process, they also recommend development of strict standards for notification, as well as a process to review access issues. The process must require consultation by the hospital with all interested parties in the community, and assurance of an orderly transition providing continuity of care.

Those Commission members who support retaining a CN process also note the need to revise the current CN process, including updating the criteria and need methodologies used in CN review. Additionally, all Commission members agree on the need for the state to strengthen its licensure requirements, to assure provision of quality health services at licensed facilities.

Those Commission members who recommend that CN be maintained agreed that CN is required to:

- help maintain the volumes necessary to ensure services are delivered to each patient consistent with the highest possible quality standards;

- help maintain quality by enhancing staff skills, particularly as the state and nation move into an era of nursing and other staff shortages;

- maintain the financial viability of urban/inner city hospitals where many of the services under study are concentrated;

- maintain access to a variety of preventive and primary care services by enhancing the financial viability of urban/inner city hospitals through continuation of certificate of need for tertiary services that both attract professional staff and are generally well covered by third party payers

- maintain appropriate access to care for all residents through recommended CN process changes that will permit managed growth of services and facilities as population needs change;

- maintain, where appropriate, the system of regionalized services that are part of a formal, well-defined referral network where patients are placed according to acuity;

- maintain an appropriate rate of growth in the parts of the state budget that pay for health care services.

Those recommending the continuation of certificate of need do not believe that licensing standards, by themselves, are appropriate or sufficient to realize these benefits. Licensing standards by themselves cannot adequately assure quality or development of the health care delivery system in a manner that takes into account the Commission's charge, because:

- it is extremely difficult and time-consuming to withdraw a license due to quality concerns for an existing service when the provider pursues a full appeal process to avoid closing the service;

- existing, well-developed and utilized programs would be irreparably harmed both financially and in terms of quality by numerous new low volume programs;

- in contrast to the orderly start-up inherent in certificate of need, licensure standards cannot address the negative impact on quality for consumers and other providers that occurs when a new provider is granted a period of time to attempt to meet the standards;

- licensure standards alone cannot address access issues or the concerns of inner-city facilities;

- licensure standards cannot address potentially large negative impacts on the state budget.

<u>Recommendations and Rationale for Deregulation of Certificate of Need</u>

Those members opposed to the continuation of CN agreed with those who recommend retaining it that New Jersey should not rely entirely on the marketplace to

assure quality and access to health care services. However, they believe that enhanced licensing standards are the most appropriate vehicle for doing this, not certificate of need. They disagree with their fellow Commission members that the noted objections to using licensure standards cannot be overcome with careful crafting of new standards.

Importantly, they believe that the current trend towards more reliance on the health care marketplace, coupled with the growth of managed care, declines in third-party reimbursement for both acute and long term care services, and the 1993 deregulation of state acute care rate controls all argue for the elimination of the CN process. This would enable hospital and other health care facility managers to quickly move to seize any market opportunities they believe are available and sensible for their institutions. They also believe that this increased competition will ultimately improve access and lower costs, and that quality will be assured by strict and consistent enforcement of licensure standards. While they also agree that some method to assure the financial viability of urban/inner city hospitals must be developed (e.g., mergers with suburban facilities; increased state subsidies), they argue the state should not intervene to "rescue" facilities that make poor business decisions in the newly competitive healthcare marketplace.

In summary, those arguing for the elimination of CN view it as an inflexible barrier to managers attempting to address and react to market pressures; those arguing for the retention of CN see it as a public process that protects consumers and communities from poorly conceived parochial decisions made by individual health care providers. This group also believes that the recommended CN process revisions will provide facilities a larger degree of flexibility than they currently have available.

Chapter 1

History of the Certificate of Need Study Commission

In June 1998 Senate Bill No. 1181 was introduced to address Certificate of Need Reform and to ensure quality and access to health care services. The bill was signed on June 30, 1998 and required removal of various services from CN (e.g., MRIs, hospital-based subacute care, and inpatient operating rooms) within 45 days. A second phase of reform required deregulation from CN of certain other services (i.e., hyperbaric chamber, lithotripsy, PET scanners, residential drug and alcohol services, ambulatory surgical facilities, basic obstetrics and pediatrics and birth centers, and megavoltage radiation oncology). Further, it also provided for a CN Study Commission to determine the impact that elimination of CN requirements would have on each of all remaining health care services or facilities. These services include those that either have a potentially large impact on the state budget, or are specialized. The Commission was charged to complete this study and report to the Legislature and Governor by March 1, 2000. In the interim, all services under review remain subject to CN requirements.

A third phase of the CN reform was the actual formation of a 15-member certificate of need study commission. As stated above, the Commission's task was to conduct a comprehensive study in order to examine the impact that elimination of certificate of need requirements would have on the following health care services and facilities which remain under the CN process: nursing homes; home health agencies; assisted living residences and assisted living programs; comprehensive personal care homes; psychiatric beds; comprehensive rehabilitation services; trauma services; transfer of ownership of an existing general acute care hospital; new general acute care hospitals; special hospitals; children's hospitals; organ and bone marrow transplantation, including stem cell; burn centers; specialized perinatal and pediatric services, including maternal and child health consortia, pediatric intensive care and neonatal intermediate and intensive care.

As part of its legislative mandate, the Commission was to assess the impact that deregulation of the services of facilities would have on urban hospitals; access to care by residents in the state; quality of care; services that are delivered statewide or on a regional basis; and the state general fund, including programs such as Medicaid.

In accordance with the statute, Commission members include: the Commissioner of Health and Senior Services, who is also the Chairperson; Commissioner of Human Services, both of whom serve ex officio; the Chairman of the Senate Health Committee; the Chairman of the General Assembly Health Committee; and 11 public members. The public members were appointed as follows: two persons of the same political party were appointed by the President of the Senate, one of whom is a state-licensed health care professional and one of whom is a representative of a state-licensed health care facility; two persons were appointed by the Speaker of the General Assembly, who are not of the same political party, one of whom is a state-licensed health care professional and one representative of a state-licensed health care facility; and two state-licensed health care professionals, three representatives of a state-licensed health care facility, one health economist and one consumer of health care services who is knowledgeable about health care financing issues who is a resident of New Jersey were appointed by the Governor.

The Commission adopted a work plan, (see attachment 4). Tasks for the members included reviewing their charge, work plan and organization, an overview of CN reform and services still subject to regulation, reviewing background on certificate of need including current need criteria and methodologies, developing a framework for receiving and reviewing public testimony and surveying CN activity in other states. They also decided to hold public hearings and divide into two subcommittees – one to review acute care services and the other to review long term care services.

As part of the work plan, the Commission members heard expert opinions related to CN from Raymond D. Sweeney, Executive Vice President, Healthcare Association of New York State (HANYS); James W. Jordan, Jr., Deputy Secretary for Health Planning and Assessment, Pennsylvania Department of Health; Thomas R. Piper, Director of Certificate of Need Program and State Health Planning and Development Agency, Missouri Department of Health; Clark Havighurst, Wm. Neal Reynolds Professor of Law, Duke University School of Law; and Pamela Dickson, Senior Program Officer, Robert Wood Johnson Foundation.

Mr. Sweeney basically supported deregulation of CN because of the difficulty in balancing market forces and a strong CN program which might limit entry into the market. However, he believes CN is needed for controls on some services, such as tertiary care services, to assure quality. Mr. Piper's position was in support of regulation of health services through CN to assure both quality and access. Mr. Jordan, who made a presentation on sunsetting of CN in Pennsylvania, developing a statewide health plan and creating quality licensure requirements in lieu of CN, expressed a moderate position on CN. He expressed the strong need for data collection requirements to track changes in the healthcare marketplace and urged protection of volume quality standards from being either reduced or stripped from regulations; Mr. Havighurst was very critical of CN and supports a totally free market approach to the development of health care facilities and services. He believes CN is poorly conceived and has been responsible for serious policy mistakes that actually increased costs in the health care system; Ms. Dickson provided an historic overview and analytical analysis of CN. Her analysis indicated that CN does not reduce acute care costs, but has some positive effect on limiting diffusion of technology and services and on maintaining access to underserved populations and quality of care. She also discussed some factors that have contributed to success in regulating supply of services, and explained why CN has limitations as a policy tool.

John Steen, Consultant in Health Planning and Health Policy provided his article, "Regionalization for Quality: Certificate of Need and Licensure Standards" to the Commission members, which supported the role of certificate of need in regionalizing various tertiery services to ensure quality through volume requirements.

In addition, copies of a study related to Safety Net Hospitals; an article from the University of California, San Francisco; and a report from the National Conference on State Legislatures (NCSL) were also provided for review by Commission members.

Darrell J. Gaskin, author of the study regarding Safety Net hospitals indicated that, although the mission of these hospitals is to provide care for the poor and uninsured, his study is an attempt to address the public health and specialty care services that these hospitals provide to the entire community. The study demonstrated that these hospitals are the primary providers of burn care, pediatric and neonatal intensive care, trauma care, psychiatric inpatient and outpatient care, and alcoholism inpatient treatment in their communities.

Mr. Gaskin indicates that subsidies to promote the overall financial health of safety net hospitals are determined through often complex allocation mechanisms not directly related to the provision of services, and that the demarcation of support for public health and specialty services versus care for the poor and uninsured is unclear. He suggests that in order to assure community access to vital public health and specialized services grants should be used to target, financial support for those services essential for community care.

The article from the University of California, San Francisco entitled "Can Patients' Odds of Survival be Improved through the Use of High Volume Hospitals?" concludes that there is substantive scientific evidence that, for some procedures or diagnoses, higher hospital volume is associated with lower patient mortality. However, it suggests that policymakers must consider the uncertainty about whether this finding reflects "practice makes perfect" or "selective referral."

The National Conference of State Legislatures (NCSL)'s report provided a history of the Federal Certificate of Need Program, the repeal of Certificate of Need Laws by some states and the ramifications for states following repeal of their CN Programs. The study included nine states, that underwent CN Program repeal at some point between 1983 through 1995. Of those nine states, four experienced a flurry of nursing home construction after CN was repealed; one experienced an increase in hospital construction, prompting a decrease in occupancy rates; two states noted a rush to construct psychiatric beds; and five states indicated no inordinate amount of overbedding or major hospital expansion occurred following CN repeal. They suggested that a changing health care industry has prevented overdevelopment of such acute care inpatient services.

The March of Dimes, NJ Chapter provided a recommendation for the continuation of the certificate of need process for facilities which provide specialized maternal, perinatal and pediatric services.

The Commission work plan continued with public hearings, which were held on April 23, 1999 and May 14, 1999 for long term care services; and April 30, 1999 and May 14, 1999 for acute care services. In June 1999, Commission members were provided copies of all testimony from the hearings, as well as a summary of the testimony, which can also be found in attachment 5 of this report.

The Commission subcommittees met again in July, August and October to discuss their recommendations. On October 5, 1999 the CN Study Full Commission met with the

Commissioner to discuss their recommendations. However, no votes were taken at this meeting.

The final meeting of the full Commission was held on December 2, 1999. Members voted to retain certificate of need or not for each specific service identified in the legislation. A majority of members voted to retain certificate of need for most services. Attachment 6 indicates how each member voted on each service.

Chapter 2

Commission Process and Deliberations

The Commission, at its first meeting, elected Gregory Marks, as vice-chairman. At this time the Commission also agreed to a workplan (see appendix 4).

The second and third meetings of the Commission were devoted to testimony from experts on certificate of need from both within New Jersey and from other states, as well as reviewing the available literature on certificate of need.

The Commission also decided to subdivide into two subcommittees for purposes of the public hearings and for making service specific recommendations to the full Commission. Each member was asked to volunteer for either the long term care services (nursing homes, assisted living and home health) or acute care services (all others) subcommittee (see appendix for Subcommittee members). Since Commission members would be asked to make recommendations on all services, all members were encouraged to come to each public hearing no matter the topic of the hearing.

After the public hearings, the two subcommittees met to review this testimony in conjunction with all the other material previously presented to them. The long term care subcommittee met twice and recommended retention of the current certificate of need process for the services under their review. In addition, they also recommended that licensing standards be enhanced and that an evaluation of the total array of services within the state's long term care system be undertaken. This evaluation is necessary to more accurately project need as the population ages, as well as assess the impact of assisted living on other modalities of long term care delivery.

The acute care subcommittee met three times. This was a larger and more diverse group than that reviewing long term care. At its first meeting, the general discussion tended to favor retaining certificate of need. At its second meeting, the subcommittee very carefully discussed the issue of quality standards through enhanced licensing requirements versus certificate of need (entry into the market) requirements, with members divided on the advantages/disadvantages of each approach.

At the third meeting, each service noted in the legislation was specifically discussed. Subcommittee members were in favor of retaining certificate of need as is for most services. They recommended removing certificate of need requirements for organ banks and for the closure of an entire general acute hospital or the closure of a service within such a hospital. It was decided that there are sufficient Federal safeguards for quality regarding organ banks.

Hospital closures generally must occur quickly to avoid further deterioration of an already critical financial position. Thus, the certificate of need process and its public hearing provisions were perceived as exacerbating an already unstable financial situation.

However, the subcommittee did recommend that the Department develop strict notification requirements regarding closure, as well as a process for the Department to review any access issues outside of a formal certificate of need process. The Subcommittee did not examine alternatives such as: 1) retaining CN, but further streamlining the process, reducing the current 2-3 month time frame or modifying standards; 2) legislative proposals under current review that either mandate a particular public hearing process or require a public offering of a closing hospital for sale.

However, it must be noted that if a hospital's documented charity care volume declines based on a service closure in a given calendar year, this may potentially result in a lower charity care subsidy amount for the hospital in the subsequent fiscal year.

The subcommittee also recommended that the transfer of ownership of an acute care hospital be moved from direct to expedited review. Similar to closures, members felt a transfer also usually occurred during difficult financial times and that speed was of the essence. However, they also believed it was necessary for the process to be more extensive than notification, in order to review the proposed new owner's licensing track record and commitment to maintaining existing services, with the associated access implications of the latter. It was recommended that the Department develop specific regulatory standards for the review of transfers.

For Maternal and Child Health Consortia, the subcommittee recommended that these remain in certificate of need for the present. However, they also recommended that a study be undertaken to assess the effectiveness and continued need for such consortia. The Division of Family Health Services, which works closely with the consortia, will need to be involved in the design and implementation of such a study.

Several process changes, including revisions to the service-specific regulations and a revision to the current "call schedule," were also recommended, as noted in the Executive Summary.

Chapter 3

Summary of Public Hearings

The Commission held two public hearings each for both long term care and acute care services. A court reporter attended each hearing to record the testimony.

The first public hearing for long term care services was held on April 23, 1999. Although there was a large audience, no one chose to speak for the record. The second and last public hearing for long term care services was on May 14, 1999. At this hearing, seven speakers spoke in favor of retaining certificate of need for long term care services, with two of these suggesting that assisted living be moved from expedited to direct review. Another commentor suggested moving home health from direct to expedited review. An additional speaker was in favor of removing certificate of need requirements for all long term care services but only when enhanced licensing standards were developed. A final commentor urged that home health be removed from the certificate of need process.

The first public hearing for acute care service was held on April 30, 1999. Eight speakers commented in favor of retaining certificate of need, particularly emphasizing quality, access and inner-city hospital issues. A number of these individuals commented specifically on the value of retaining certificate of need for comprehensive rehabilitation and mobile intensive care unit services. On this date, no one spoke against retaining certificate of need.

The second acute care public hearing was held on May 14, 1999, when 20 persons commented. Two speakers were generally in favor of deleting certificate of need except where it could enhance quality and access for tertiary services, particularly in inner-city hospitals. One other speaker urged that certificate of need be retained as is or completely eliminated – no piecemeal deregulation. The remaining speakers favored retaining certificate of need in general or for specific services.

All members of the commission were provided with a transcript of each hearing, as well as copies of additional testimony where the testifier provided a copy of the testimony. Copies of the testimony are available to the public upon request to the Department of Health and Senior Services.

Chapter 4

Service Specific Recommendations

Commission members carefully reviewed all the materials related to each specific service under consideration. As noted in the Executive Summary, the retention of certificate of need is a majority recommendation of the Commission but it is not unanimous.

Recommendations to Retain Certificate of Need Requirements

The majority of the Certificate of Need Study Commission recommends that the following remain subject to certificate of need review for the reasons noted:

Acute Care Services

Psychiatric Services: strongly recommended for retention by the Department of Human Services because of its impact on the state budget, and because there is a well-developed and functioning system that is appropriately meeting the mental health needs of the state; concern that quality will deteriorate with numerous new providers, especially in view of looming nursing and other specialized staff shortages.

Trauma Services: strongly recommended for retention during the public hearing process; currently a regionalized service with a well-developed and functioning delivery and referral system; a highly specialized service where quality is dependent on volume; recommended for retention as a regionalized service by the American College of Surgeons; very costly to initiate, particularly with shortages of nursing and other highly specialized staff; negative impact on urban/inner-city facilities, where this service is concentrated.

Transplantation Services: a highly specialized service where quality is dependent on volume; costly to initiate, particularly with shortages of nursing and other highly specialized staff; access to organs is limited and would be negatively impacted by new providers.

Comprehensive Rehabilitation: strongly recommended for retention during the public hearing process; a specialized service, thus quality is dependent on volume; could be costly to initiate, particularly with shortages of nursing and other highly specialized staff.

Cardiac Catheterization and Pilot Cardiac Catheterization: A highly specialized service

where quality is dependent on volume; pilot low risk catheterization process has shown that a number of programs failed to meet volume and normal study requirements, potentially negatively affecting quality.

Cardiac Surgery: a highly specialized service where quality is very closely dependent on volume; recommended for retention as a regionalized service by the American College of Cardiology; costly to initiate, particularly with shortages of nursing and other highly specialized staff; negative impact on urban/inner-city facilities where this service is concentrated.

Neonatal Intermediate and Intensive Bassinets: recommended for retention as regionalization is consistent with recommendations of the American College of Obstetricians and Gynecologists and the March of Dimes; costly to initiate, particularly with shortages of nursing and other specialized staff; currently a regionalized service with a well-developed referral system based on acuity of patients; negative impact on urban/inner-city hospitals where these services are concentrated.

Mobile Intensive Care Units (MICU): strongly recommended for retention during the public hearing process; part of a well-developed regional system with Trauma Centers that is currently providing an appropriate array of emergency services; a highly specialized service where quality is dependent on volume; could be costly to initiate, particularly with the difficulty in retaining the services of paramedics.

Pediatric Intensive Care Services: a highly specialized service where quality is dependent on volume, especially since the trend is for fewer and fewer hospital admissions of pediatric patients; quality and cost issues are also associated with shortage of nursing and other highly specialized staff.

Burn Program Services: a highly specialized service where quality is dependent on volume; costly to initiate, particularly with shortages of nursing and other specialized staff.

Specialized Perinatal and Pediatric Services, including Maternal and Child Health Consortia: neonatal bassinets and pediatric intensive care have been noted above. Retain Consortia under certificate of need until a study, conducted by the Division of Family Health Services, of their effectiveness and need for continued funding is completed. Until then, the consortia serve a public and provider education function and coordinate the delivery of a number of preventive and primary care programs, as well as assist hospital inpatient units in developing regional perinatal care plans, including a transport and referral system. This entire system is recommended to remain with certificate of need pending the study outcome.

Children's Hospital: a highly specialized form of care delivery for very ill children and, thus, quality is dependent on volume; costly to initiate, particularly with shortages of nursing and other highly specialized staff; negative impact on urban/inner city

hospitals where this service currently exists. Strongly recommend that Children's Hospital designation occur through a public certificate of need process.

New General Acute Care Hospitals: costly to initiate, particularly with shortages of nursing and other specialized personnel; negative impact on existing hospitals, especially those in urban/inner city areas; may facilitate the development of "boutique" (i.e., one service, eg., heart or cancer) hospitals that would not have the charity care and other community requirements and obligations that existing general hospitals have; negative impact on the underserved as new and/or "boutique" hospitals may choose (explicitly or implicitly) the kinds of patients they serve.

Transfer of Ownership of an Existing Acute Care Hospital: recommend that this be moved from direct review (with a formal public process, including a public hearing) to expedited review, with review by Department of Health and Senior Services staff only. This will streamline the process, particularly in a time when more rapid action may be necessary to avoid a worsening of the financial condition of a hospital. However, it is recommended that the Department develop and implement specific standards for use in expedited review that address the applicant's licensing track record, maintenance of access to existing services, and other critical issues, including a method for public comment.

Long Term Care Services

Nursing Homes (including general, pediatric, ventilator and behavioral beds): Potential to undercut the state's priorities to promote community based services; potentially a large impact on the state budget; substantial majority of those speaking at the public hearings favored retention; costs are highly related to staffing and increased numbers of providers, especially in view of nursing and other staff shortages will exacerbate costs; highly staff sensitive, thus these shortages will negatively affect both quality of care and quality of life of residents.

Assisted Living Residences and Programs and Comprehensive Personal Care Homes: Potentially a large impact on the state budget should these services become a Medicaid entitlement; substantial majority of those speaking at the public hearing favored retention; costs and quality are highly related to staffing; particularly in view of nursing and other staff shortages, costs may increase and both quality of life and quality of care deteriorate. However, it is recognized that there is a lack of data regarding these assisted living options and their impact on the long term care system as a whole and on nursing facilities in particular. It is recommended that the Department of Health and Senior Services study this impact, as well as develop mechanisms to assess quality in assisted living. It is further recommended these remain in expedited review, with particular emphasis placed on an applicant's licensing track record.

Home Health:

Potentially a large impact on the state budget; additional agencies will produce additional administrative costs, further impacting the budget; quality and costs are related to staffing and both will be negatively impacted by nursing and other staff shortages; continuity of care will be negatively affected by large numbers of providers going in and out of the field; reimbursement is being decreased by many third-party payers, including Medicare and managed care, at the same time that appropriate staff is more difficult to find and retain, unlimited additional providers will exacerbate this situation.

Recommendations for Removal from Certificate of Need Requirements

Organ Banks: Commission members recommend formal removal since there has never been a certificate of need process or application for this type of facility; additionally, there are sufficient federal requirements and standards to ensure appropriate quality and access.

Closure of an Acute General Hospital or a Service Within Such a Hospital: removal from certificate of need and its public review and public hearing processes will enable a financially distressed institution to rapidly take action to forestall or reduce a continued deterioration of its financial condition; potential for significant negative financial and quality of care concerns if an orderly transition process to centralize and/or reduce beds/services is prolonged. It will also change the necessary process for dealing with community concerns. However, it is also recommended that the Department of Health and Senior Services develop and enforce strict notification requirements, as well as a process to review access issues. The Subcommittee did not examine alternatives such as: 1) retaining CN, but further streamlining the process, reducing the current 2-3 month time frame, or modifying standards: 2) legislative proposals under current review that either mandate a particular public hearing process or require a public offering of a closing hospital for sale.

Process Recommendations

1. All need methodologies and criteria need revision and updating on an expedited basis and the Department of Health and Senior Services must move expeditiously to accomplish this.

2. On-going updating of methodologies and criteria must occur on a regularly scheduled basis.

3. The current "call" system results in irregular calls for applications and it cannot be predicted when such calls will occur. Therefore, this system needs to be replaced with one that permits applications to be submitted:

   A. On a regularly scheduled timetable (eg., every year or every 2 years); or

   B. After a required, scheduled review of methodologies and criteria indicate a need; or

   C. Some combination of these depending on the service.

4. The Department of Health and Senior Services must continue to strengthen its licensing requirements and, where appropriate, include volume, performance and outcome standards.

Chapter 5

Conclusions

Based on the testimony of experts both from New Jersey and other states, a research of the literature concerning certificate of need , the remarks of those speaking at the public hearings, a review of the current health care delivery system in the state and our own careful study of the current certificate of need process and its current need methodologies and criteria, the Commission concludes, though not unanimously, that certificate of need continues to serve the public interest for those services under our review.

We reach this conclusion because:

A. Quality and volume are closely interrelated for many of the services we studied. Certificate of need, as opposed to licensing standards, is a tool to prevent quality problems in these areas by promoting expansion of services only when a population-based need can be shown, thus assuring sufficient volume to maintain staff skills and program financial viability.

B. While enhanced licensing standards addressing volume, performance and outcome standards are important in and of themselves, they cannot substitute for certificate of need because:

- it is extremely difficult and time-consuming to close an existing, underutilized service provider that pursues a legal appeal process to avoid closure.
- existing, well-developed and utilized programs would be irreparably harmed by numerous, new low-volume providers.
- they cannot address the negative quality impact on consumers and other providers while a new provider is granted a period of time to meet standards.
- they cannot address issues of access or the concerns of urban/inner-city facilities.
- they cannot address the potentially large negative impact on the state budget.

Rationale for Retention of Certificate of Need

The majority of Commission members agree that certificate of need should remain because it strongly helps maintain:

- the volumes necessary to ensure that services are delivered to each patient at the highest possible quality standards.
- quality by enhancing staff skills, particularly as the state and the nation moves into a time of nursing and other staff shortages.
- the financial viability of urban/inner-city hospitals where many of the services under review are concentrated.

- access for the underserved to a variety of preventive and primary care services by enhancing the financial viability of urban/inner-city hospitals for tertiary services that both attract professional staff and are generally well covered by third party payers.
- appropriate access to care for all residents through recommended certificate of need process changes that will permit managed growth of services and facilities as population needs change.
- the system of regionalized services that are part of a formal, well-defined referral network where patients are placed according to acuity. This is particularly true for psychiatric, trauma and MICU, pediatric intensive care and Children's Hospital services.
- an appropriate rate of growth in those parts of the state budget that pay for health care services.

Therefore, the Commission recommends that the following services remain in direct certificate of need review with a public process before the State Health Planning Board:

- Psychiatric
- Trauma
- Transplantation
- Comprehensive rehabilitation
- Cardiac surgery
- Cardiac catheterization
- Neonatal intermediate and intensive bassinets
- Mobile intensive care units
- Pediatric intensive care units
- Burn care
- Maternal and Child Health Consortia, with a study to determine effectiveness
- Children's Hospitals
- New Acute Care Hospitals
- Nursing Homes
- Home Health

It is recommended that the following remain in certificate of need but in expedited review (review only by the Department of Health and Senior Services, no public review process):

- transfer of ownership of an acute care hospital with standards regarding track record, access and other critical issues to be developed.
- Assisted living residences and programs and comprehensive personal care homes.

It is recommended that the following no longer be subject to certificate of need review:

- organ banks, because of the existence of federal standards to assure quality

and access.

- closure of entire acute care hospital or a service within such a hospital, with strict notification requirements to be developed and enforced and a process developed to review access issues. This process must require that the hospital document both that it has consulted with all interested parties in the community regarding closure and that it has arranged for an orderly and timely transition to assure continuity of care.

The Commission further concludes that several process changes are required for certificate of need to function effectively. These include:

- expedited review and revision of all need methodologies and criteria
- ongoing reevaluation and updating of methodologies and criteria must occur on a regularly scheduled basis.
- the current "call" system must be replaced with one that permits applications to be submitted:
    - on a regularly scheduled timetable; or
    - after a require, scheduled review of methodologies and criteria indicate a need; or
    - some combination of these depending on the service.
- a strengthening of licensing requirements and, where appropriate, include volume, performance and outcome standards.

Thus, it is our conclusion that certificate of need (for the services under our review) continue to serve the public interest, with particular regard to those issues included in our charge, in a manner that cannot be done by any other process. Additionally, the direct review certificate of need process permits the public to participate in the development of the health care system in the area in which they reside.

ATTACHMENT 1

CN STUDY COMMISSION MEMBERS

1. The Honorable Christine Grant, Chairperson
   Commissioner of Health and Senior Services

2. The Honorable Michele K. Guhl
   Commissioner, Department of Human Services

3. The Honorable Jack Sinagra
   Senator
   Chair, Senate Health Committee

4. The Honorable Charlotte Vandervalk
   Assemblywoman
   Chair, General Assembly Health Committee

5. Ronald J. Del Mauro
   President and CEO
   St. Barnabas Medical Center

6. Charles A. Dennis, M.D.
   Chairman, Department of Cardiology
   Deborah Heart and Lung Center

7. Most Reverend Nicholas A. DiMarzio, Ph.D.
   Bishop
   Camden Diocese

8. Harvey Holzberg
   President and CEO
   Robert Wood Johnson University Hospital

9. Gregory Marks, LNHA
   Administrator
   Rennaissance Nursing Center

10. John E. Matuska
    President and CEO
    St. Peter's Medical Center

11. Ruth Odgren, RN
    Chief Operating Officer
    Visiting Nurse Service System

12. Patricia Ostaszewski, CEO
Health South
Health South Rehabilitation Hospital

13. Alfred Rosenblatt
Vice President Medical Affairs
AtlantiCare Health System

14. Daniel Straus, President
Straus Capital Group, Inc.

15. Catherine Yaxley
Vice President, Planning
Holy Name Hospital

ATTACHMENT 2

November 1, 1999

Ms. Anne F. Weiss
Senior Assistant Commissioner
Department of Health & Senior Services
P.O. Box 360
Trenton, NJ 08625-0360

Re: Certificate of Need Study Commission – Draft Summary

Dear Anne:

I have reviewed the preliminary staff write up of the conclusions of the Certificate of Need Study Commission and have the following observations:

1. The granting of a Certificate of Need should require that some level of educational, preventative and primary care services be provided by the applicant.
2. Certificate of Need performance should be reviewed on a regularly scheduled basis.
3. I don't believe that we came to a definitive conclusion on the maternal/child health consortiums. In my opinion, they should be deregulated.
4. The submission of Certificates of Need should be on a regularly scheduled timetable and not be subjected to methodology updates that may not be done on a timely basis.
5. Certain services, already scheduled for deregulation, should be regulated, such as ambulatory surgery.
6. While it was not discussed, regulated services should be under a rate-setting mechanism. These services require a high level of infrastructure and rates should be set at the appropriate levels to pay for that infrastructure and not be subject to the whims of the market.
7. Impact on an existing provider should not be the basis for accepting or not granting a Certificate of Need. I would like to see the regulations modified to stipulate that only if an existing provider's volume is expected to fall below the minimum level required to maintain competency should impact criteria apply.
8. The definition of services to be regulated are extremely critical. For example, what services fall under a general pediatric license vs. the license for a pediatric intensive care unit?
9. Transfer of services should be deregulated.

I also believe that additional meetings after November 16th would be desirable to ensure that our findings are well thought out.

Sincerely,

John Matuska
President & CEO

Holy Name Hospital
718 Teaneck Road
Teaneck New Jersey 07666
Tel 201 833-3000
www.holyname.org

Holy Name Hospital

November 8, 1999

Anne F. Weiss
Senior Assistant Commissioner
New Jersey Department of Health and Senior Services
PO Box 360
Trenton, NJ, 08625-0360

Re : Draft CON Commission Report

Dear Ms. Weiss :

I reviewed the draft CON Commission report, and while it seems to reflect the discussions, I was struck by the fact that the lack of consensus has resulted in a report that is only a notch up from a hung jury. This is unfortunate, but not surprising. Nevertheless, since consensus seems beyond reach, I think the agenda for future meetings needs to pinpoint specific changes to be made to each service (e.g., the elimination of restricted county line service areas), so that the report includes a number of useful recommendations.

With respect to my own thoughts, and as I have discussed with you before, I am not in favor of retaining CON. While appropriate at its inception, the implementation of New Jersey's CON process has deteriorated to the point where the concept of "need" is unrecognizable. Similarly, an oft-discussed core tenet, quality, is not ensured through CON: it is promised by the potential provider and rarely monitored thereafter. Access, also cited as crucial, is not ensured through CON: one need only review the geographic distribution of many "choice" services to see this plainly. Finally, cost reduction is not ensured through CON: a course in basic economics shows that (in the absence of regulated rates) competition, not restriction, reduces cost. That the Commission's report favors continued regulation with a constant echo of "volume equals quality" rings hollowly. As I have mentioned at our meetings, one need only review the history of renal dialysis and, more recently, radiation oncology, to recognize that the "volume equals quality" argument lasts only as long as needed to maintain a restricted service.

Certificate of Need seems counter to the legislative intent of the Health Care Reform Act of 1992, which sought to increase the integration of market forces within health care. That Act's dismantling of the all-payor system was only part of the equation; dismantling the CON system is the missing portion. I am disappointed that this necessary final step continues to remain out of reach.

Given the current financial turmoil in which New Jersey's health care system finds itself, the consequences of health care's potential demise are more far reaching than most Commission members may realize. It is myopic to view hospital downfalls and closures as events unto themselves; rather, they are *indicators* of future financial stability. Health care is the third largest industry in the state. It is a labor-intensive industry, and thus a major source of employment, and contributes significantly to the financial stability of New Jersey's residents. Its operations also massively purchase and thus heavily support other industries, e.g., medical suppliers and pharmaceuticals, which in turn have huge employment rosters.

Clearly, this is a far-reaching financial web. The stability of this web of employment translates into so many New Jersey residents' ability to allocate their personal dollars toward the purchase of services provided by yet other industries, and to provide tax revenue to the state. Indeed, given the magnitude of both direct (health care providers) and indirect (suppliers to health care) labor pools, a significant drop in health care viability can easily send countless thousands to the welfare and Medicaid rolls, quickly upsetting our current financial equilibrium. Perhaps we have "had it good" for so long that we are blinded to the fragility of that equilibrium.

I am not advocating the protection of hospitals through artificial means; to the contrary, I am asking that the artificial barriers be lifted so that hospitals can do their best to flourish. And, yes, some hospitals will close, regardless of continuation or dismantling of CON. However, my approach to Certificate of Need would be the dismantling of it, *coupled with stringent licensing standards and the use of independent auditors to ensure adherence to those licensing requirements.* Licensing can be creative; it need not be restricted to equipment, facility and personnel standards. It can embody access plans, including transportation requirements to ensure inner city, indigent and elderly persons' paths of access. It can and should include quality standards and improvement programs. To counter the difficulties of closing down a non-compliant service, a tip from the JCAHO can be incorporated: DOH-certified versus non-certified services. Display these certifications on the Web for ready review by doctors and consumers. A variation to the use of independent auditors could be the creation of a new subdivision within the Department of Health, employing auditors to perform (and to charge for) such quality reviews. This would allow the Department close control, instant feedback, and a new state revenue stream. Again, licensing can be creative and can embody whatever is needed to ensure excellent care for New Jerseyans.

In summary, I am asking Commission members to look beyond the traditional arguments for retaining CON, and to consider the true statewide financial challenge that is unfolding the longer CON restrictions remain in place. Included among the Commission's duties was consideration of the financial impact of deregulation. Such discussions were focused on individual services, not on the overall statewide impact of regulation versus deregulation. The "big picture" was lost, and I feel that we are quickly fueling an economic disaster.

Very truly yours,

Catherine

Catherine Yaxley, CPA, MBA, RN
Vice President, Planning

STATEMENT

RONALD J. DEL MAURO

CN Reform Commission

October 5, 1999

The Certificate of Need process was developed to ensure that quality, cost-effective health care services remain accessible for all New Jersey residents.

The Saint Barnabas Health Care System supports this underlying philosophy while, at the same time, favoring total deregulation of Certificate of Need. We hold this view with one caveat, namely, that major inner city hospitals must be protected in order to preserve access for inner city populations. Deregulation, while protecting inner city hospitals, is achievable.

Hospitals in New Jersey are at a critical juncture and we must be prepared to respond aggressively. Several factors affect our ability to deliver quality care and provide access to the low income segments of our population.

The United States Census Bureau reported yesterday that an astounding 16.3% of the nation's population is uninsured. This means that 1.3 million New Jerseyans have no insurance, a 45% increase since the early 1990's. At the same time New Jersey's Charity Care system is failing. While New Jersey's hospitals continue to provide care for all

patients, this remains a burden disproportionately shouldered by New Jersey's major urban hospitals.

This uninsurance / charity crisis is compounded by the 1997 Balanced Budget Act which automatically reduces Medicare payments. As well, the exponential growth of managed care throughout the state and the increased number of denied and delayed payments result in fewer dollars to care for more patients.

Critical times call for a critical response and sweeping Certificate of Need reform is called for. Competition and deregulation must be achieved, giving our industry the flexibility to respond to this changed environment while, at the same time, meeting the needs of a core set of inner city hospitals.

Charity care must be restructured, and targeted to the hospitals most needing it. Only in this way can we ensure that access is preserved for low income patients.

Suburban hospitals must be encouraged to support inner city providers. The Saint Barnabas Health Care System has developed this type of relationship through its inner city cardiac satellite demonstration project. Newark Beth Israel Medical Center has established a cardiac satellite program at Saint Barnabas Medical Center, in suburban Livingston. As an extension of the Cardiac program at Newark Beth, all net revenue generated at the Saint Barnabas campus in Livingston will be used to the benefit of the Beth. Net revenues will promote the financial stability of Newark Beth further enhancing

its ability to fulfill its inner city missions. This model must be expanded and the CN program – or a new program with a different name – employed to that end.

There is a compelling need that major services provided at a core set of inner city hospitals remain intact to meet the health care needs of the State's inner city population. Located in some of the State's poorest urban settings, major institutions such as Cooper/Our Lady of Lourdes; Jersey City Medical Center; Newark Beth Israel and Saint Joseph's Hospital and Medical Center serve unique roles in the supporting state's goal to assure access to health care. Their ability to remain financially sound can be strengthened if we agree to protect selected, key services such as Cardiac Surgery, Transplant Services and High Risk Perinatal from unfettered competition. We do not propose applying this "protection" to all inner city hospitals – only a short list of major facilities – but this protection should be preserved as long as needed.

An enhanced ability for the DHSS to conduct its licensure function must be assured. Licensure regulations set minimum standards, which, if enforced, can serve as a guideline for quality services. To improve licensing as a core function, the State should allocate the needed resources to the New Jersey Department of health and Senior services to strength its licensure program.

In my view we should end piece meal deregulation. Let us move aggressively to free hospitals to compete. At the same time let us identify a short list of key inner city

hospitals that need support and protection and let us provide this support through the tools of increased charity care and protected "franchises."

SAINT BARNABAS
HEALTH CARE SYSTEM

NALD J. DEL MAURO
ident and Chief Executive Officer

OFFICE OF THE PRESIDENT
(973) 322-4001
Fax: (973) 322-4004

November 22, 1999

RECEIVED
NOV 24 1999
OFFICE OF
SENIOR ASSISTANT
COMMISSIONER

Anne F. Weiss
Senior Assistant Commissioner
State of New Jersey
Department of Health and Senior Services
PO Box 360
Trenton, NJ 08625-0360

Dear ~~Ms. Weiss:~~ Anne

I have reviewed the draft report of the Certificate of Need Study Commission and I have two comments.

First, the report makes clear that there was significant disagreement within the Commission regarding the desirability of further deregulation. As the Executive Summary is structured, both sides of this debate are set forth and as a result, I believe that the format report to the Legislature should include the actual votes of each member of the Commission identified by name and organizational affiliation.

Second, as you are aware, I believe that a new initiative is required to encourage suburban hospitals to take financial responsibility for urban hospitals along the model of the Cardiac Demonstration Project between Saint Barnabas Medical Center and Newark Beth Israel Medical Center. The minority position should include the development of some financial incentives to encourage stronger hospitals or systems to merge, affiliate, convert or close institutions that cannot survive as acute care hospitals.

This recommendation may even coincide with the recommendations of the Advisory Commission on Hospitals and, since it was discussed at our Commission meeting, I feel it should be publicly noted.

Sincerely,

C: John Calabria

Office of the Bishop
Diocese of Camden
631 Market Street
Camden, New Jersey 08102

Phone: (856) 756-7900, Ext. 5213
Fax: (856) 963-5777
E-Mail: DiMarzio@CamdenDiocese.org

November 5, 1999

Ms. Anne F. Weiss
Senior Assistant Commissioner
Health Planning and Regulations
Department of Health and Senior Services
PO Box 360
Trenton, New Jersey 08625-0360

Dear Ms. Weiss:

I have had the opportunity to review the October 27, 1999 draft summary of the conclusions of the Certificate of Need Study Commission. Unfortunately, I will not be able to attend the November 16 meeting, as I will be at the annual meeting of the United States Bishops in Washington, D.C.

As a whole, the report seems an accurate reflection of what has transpired throughout our deliberations and I support continued regulation of those services which are outlined.

When we began our discussions there seemed to be widely divergent views of the utility of the Certificate of Need process and whether it remained an unneeded vestige of a former regulated system. I think a strong consensus has emerged that, with refinement, the Certificate of Need (CON) can be a valuable component of our state regulatory system.

Having said this, I must find one item I have previously discussed as very disappointingly handled in the report. We have been drilled by your staff that volume equals good outcomes. By extension, quality outcomes standards protect the general health of our society. In reading the bottom of the first page of Chapter 6, you have noted as a defense of CON that "While enhanced licensing standards addressing volume, performance and outcome standards are important in and of themselves, they cannot substitute for Certificate of Need because:

> "It is extremely difficult and time consuming to close an underutilized service provider that pursues a legal process to avoid closure."

This cannot be the standard of quality enforcement we can tolerate. Some seem to believe in standards and not in enforcement. One cannot have it both ways. Standards without enforcement make the standards moot. The preceding statement seems to say we need to restrict entry because we cannot get anyone out of the service once they are in business.

With this one major exception, I believe the report gives a solid frame work for a final report.

Sincerely,

+ Nicholas DiMarzio

Most Reverend Nicholas DiMarzio, Ph.D., D.D.
Bishop of Camden

ATTACHMENT 3

LIST OF HANDOUTS

1. **SERVICE NEED METHODOLOGY AND/OR CRITERIA**

   a. Psychiatric Services

   b. Trauma Services

   c. Transplantation Services

   d. Comprehensive Rehabilitation Services

   e. Cardiac Catheterization Services

   f. Pilot Cardiac Catheterization Services

   g. Cardiac Surgery Services

   h. Neonatal Intermediate Bassinet Services

   i. Neonatal Intensive Bassinet Services

   j. Specialized Perinatal and Pediatric Services, Including Consortia

   k. Children's Hospitals

   l. Mobile Intensive Care Unit (MICU) Services

   m. Pediatric Intensive Care Unit (PICU) Services

   n. Burn Program Services

   o. Organ Bank

   p. New General Acute Care Hospitals

   q. Transfer of Ownership of Existing Acute Care Hospitals

   r. Closure of Acute Care Hospitals.

2. **LIST OF INNER CITY & NON-INNER CITY HOSPITALS**

PSYCHIATRIC SERVICES

TOTAL HOSPITAL SUPPLY

49 Total Hospital Programs
- 1,215 Adult Open Beds
- 276 Adult Closed Beds
- 84 Adult Specialized Beds
- 86 Child/Adolescent Acute Beds
- 30 Child/Adolescent Intermediate

INNER CITY SUPPLY

22 of 49 Inner City Hospital Programs
- 448 of 1,215 Adult-Open Beds
- 125 of 276 Adult-Closed Beds
- 24 of 84 Adult Specialized Beds
- 67 of 86 Child/Adolescent Acute Beds
- 19 of 30 Child/Adolescent Intermediate Beds

NEED METHODOLOGY (Yes or No)

Adult Open - NO
Staffing Levels & Staff qualification requirements.
Adult Closed - YES
County-Based; uses population projections X average length of stay (ALOS) & "Z" score
Adult Specialized - YES
County-Based: uses projected admissions per 100,000 population X project population, Target Year X Average Length of Stay (ALOS)
Child Adolescent - YES
Community-Based. Uses population projections + "T" score.

NEED METHODOLOGIES

PSYCHIATRIC BEDS

1. ADULT OPEN

No need methodology;
Applicant must comply with requirements for staff qualifications and staffing patterns to ensure quality of care.

2. ADULT CLOSED

The need methodology includes county population as defined by New Jersey Department of Labor projections(economic/demographic model) for one year beyond the date the need calculation occurs,

The need methodology is derived using a formula and the "z Score" developed by the Division of Mental Health and Hospitals.

Note: The Division of Mental Health no longer calculates the "z Score".

In addition, the applicants must provide the following documentation:

(a) Projected average length of stay not > 30 days and projected average length of stay not > 120% of State average length of stay for existing like beds.

(b) Projected numbers of admissions to the proposed adult closed acute psychiatric beds shall be justified through letters of support from the local psychiatric screening centers, local impatient units and from the State hospitals indicating the number of involuntary commitments which are currently admitted.

3. CHILD/ADOLESCENT ACUTE PSYCH

The child need formula identified in N.J.A.C. 8:33R-4.2(a) & (b) of the Planning and Certificate of Need Reviews of Psychiatric Health Care Facilities and Services derived using annual patient days, service area, child population and a children's mental health risk factor or "T Score" developed by the Division of Mental Health and Hospitals.

Note: The Division of Mental Health and Hospitals no longer calculates the "T Score".

TRAUMA SERVICES

TOTAL HOSPITAL SUPPLY

10 Total Hospital Programs
Level I - 3
Level II - 7

INNER CITY SUPPLY

8 of 10 Total Hospitals Program
Level I - 3 of 3
Level II - 5 of 7

NEED METHODOLOGY (Yes or No)

HSA-Based.
Level I or II Center per million population.

TRAUMA CENTERS

I. LEVEL I & LEVEL II

Shall comply with required staff qualifications and staffing patterns as identified N.J.A.C. 8:33P.

II. The need shall be calculated as follows:

The total number of trauma centers, including both level I and Level II centers needed in each of the four HSA regions, shall be equal to the total population for the region divided by one million (1,000,000) rounded to the nearest whole number.

Note: There are no longer HSA regions in the state.

The current 10 trauma centers exhaust the need based criteria contained in N.J.A.C. 8:33P.

CERTIFICATE-OF-NEED APPROVED TRAUMA CENTERS IN NEW JERSEY

TRAUMA CENTER LOCATION	COUNTY	TRAUMA LEVEL
LAB I		
Morristown Memorial Hospital	Morris	LEVEL II
St. Joseph's Hospital and Medical Center	Passaic	LEVEL II
LAB II		
Hackensack Medical Center	Bergen	LEVEL II
Jersey City Medical Center	Hudson	LEVEL II
LAB III		
University Hospital/UMDNJ	Essex	LEVEL I
LAB IV		
Robert Wood Johnson Medical Center/UMDNJ	Middlesex	LEVEL I
Helene Fuld Medical Center	Mercer	LEVEL II
LAB V		
Cooper Hospital/University Medical Center	Camden	LEVEL I
LAB VI		
Jersey Shore Medical Center	Monmouth	LEVEL II
Atlantic City Medical Center	Atlantic	LEVEL II

TRANSPLANTATION SERVICES

No specific need methodology. However, approved services must meet the following general criteria as specified in 8:33Q-1.2:

(a) Educational Programs

(b) Institutional membership in the National Organ Procurement and Transplantation Network within one year of CN approval.

(c) Departmental review of the program within two years of initiation.

The applicant must also meet staff qualifications, staffing patterns, and volume requirements.

The applicant for a kidney, heart, liver or pancreas transplant service shall have an institutional plan with the capability and commitment to perform the following minimum transplant procedures annually by the end of the second full year of operation:

1. Kidney: a minimum of 25 procedures;
2. Heart: a minimum of 12 procedures;
3. Liver: a minimum of 15 procedures; and
4. Pancreas: a minimum of 15 procedures.

Note: There is currently no criteria for lung transplants.

TRANSPLANTATION SERVICES

TOTAL HOSPITAL SUPPLY

4 Total Existing Hospital Programs*
- 1 Heart & Kidney (Newark Beth Israel Medical Center)
- 2 Kidney & Pancreas (Our Lady of Lourdes Med. Center, St. Barnabas Med. Center)
- 1 Liver (University Hospital)

INNER CITY SUPPLY

3 of 4 Existing Inner City Hospital Programs**
- 1 of 1 Heart & Kidney
- 1 of 2 Kidney & Pancreas
- 1 of 1 Liver

NEED METHODOLOGY (Yes or **No**)

Minimum annual volume requirement for Heart, Kidney, Liver and Pancreas Transplantation:

Heart:	12 procedures/yr.
Kidney:	25 procedures/yr.
Liver:	15 procedures/yr.
Pancreas:	15 procedures/yr.

Criteria include participation in education programs and institutional membership in the national Organ Procurement and Transplantation Network (currently - United Network for Organ Sharing or UNOS).

* As a result of the completion of the state's initial direct certificate of need (CN) review process involving solid organ transplantation services, a fifth hospital program, Robert Wood Johnson University Hospital was granted CN approval for both Kidney and Heart Transplantation services. A sixth hospital program, Hackensack Medical Center, was approved for Kidney transplantation services and Our Lady of Lourdes Medical Center was approved to provide Liver Transplantation services. (CNs granted January 27, 1998).

** 5 of 6 Existing and/or Approved Inner City Hospital Programs

2	of 2	Heart and Kidney	(Newark Beth Israel, Robert Wood Johnson)
0	of 1	Kidney and Pancreas	(St. Barnabas Medical Center)
1	of 1	Kidney	(Hackensack Medical Center)
1	of 1	Kidney, Pancreas and Liver	(Our Lady of Lourdes)
1	of 1	Liver	(University Hospital)

COMPREHENSIVE REHABILITATION SERVICES

TOTAL COMPREHENSIVE REHABILITATION SERVICES SUPPLY

12 Total Free Standing Programs
783 Licensed Freestanding Adult Comprehensive Rehabilitation Beds
120 Licensed Pediatric Comprehensive Rehabilitation Beds

* There are 272 CN approved Freestanding Adult Comprehensive Beds not yet operational.

9 Total Programs Located Within Hospitals
217 Adult Comprehensive Rehabilitation Beds
0 Pediatric Comprehensive Rehabilitation Beds

* There are 10 CN approved Comprehensive Rehab. Beds within one hospital that are not yet operational.

INNER CITY SUPPLY

2 of 12 Free Standing Programs
178 of 738 Adult Comprehensive Rehabilitation Beds
0 of 120 Pediatric Comprehensive Rehabilitation Beds

3 of 9 Programs Located Within Hospitals
110 of 217 Comprehensive Rehabilitation Beds
0 Pediatric Comprehensive Beds

NEED METHODOLOGY (Yes or No)

Region-Based Methodology (Survey of existing comprehensive rehabilitation providers)

Adult: 10 step formula by LAB region: includes population projections, rates of use by adult age cohorts, ALOS & 85 % occupancy adjustment.

Pediatric: Includes rates of use. Population projections & 85% occupancy adjustment.

NEW JERSEY
COMPREHENSIVE REHAB HOSPITALS BY LAB REGION
STATEWIDE INVENTORY OF EXISTING AND CON-APPROVED BEDS

LAB I

Welkind Rehabilitation Hospital 72 Adult Beds
Pleasant Hill Road
Chester, NJ 07830

Newton Memorial Hospital 8 Adult Beds
175 High Street
Newton, N.J. 07860

Morristown Memorial Hospital - Mount Kemble Division 38 Adult Beds
95 Mt. Kemble Ave.
Morristown, NJ 07960

LAB II

Liberty/Meadowlands Hospital Medical Center 30 Adult Beds
55 Meadowlands Parkway
Secaucus, NJ 07096

Kessler Institute for Rehabilitation, Inc.-North 72 Adult Beds
JFK Hospital-Saddle Brook
300 Market Street
Saddle Brook, NJ 07662

St. Francis Hospital/Franciscan Health Systems of NJ 30 Adult Beds
25 McWilliams Place
Jersey City, NJ 07302

LAB III

Kessler Institute for Rehabilitation- West 80 Adult Beds
1199 Pleasant Valley Way
West Orange, NJ 07052

Kessler Institute for Rehabilitation - East 98 Adult Beds
240 Central Avenue
East Orange, NJ 07018

Children's Specialized Hospital 60 Pediatric Beds
150 New Providence Road
Mountainside, NJ 07091

LAB IV

St. Lawrence Rehabilitation Center 86 Adult Beds
3281 Lawrenceville Road
Lawrenceville, NJ 08648

JFK Johnson Rehabilitation Institute 94 Adult Beds + 13 Adult Beds+
65 James St., PO Box 3059
Edison, N.J. 08818

Medical Center at Princeton — 17 Adult Beds
253 Witherspoon Street
Princeton, NJ 08542

LAB V

Our Lady of Lourdes Medical Center — 50 Adult Beds
1600 Haddon Ave.
Camden, NJ 08103-3117

Mediplex-Cumberland Rehabilitation Partnership — 30 Adult Beds**
(Newcomb Hospital)
65 South Street
Vineland, NJ 08360

**CON-Approved, But Not Implemented

West Jersey/Mediplex Rehabilitation Limited Partnership — 40 Adult Beds, 30 Pediatric Beds
92 Brick Road
Marlton, NJ 08053

Lourdes Regional Rehab Center at Meadow View — 30 Adult Beds*
1328 South Black Horse Pike
Williamstown, N.J. 08094

LAB VI

Bacharach Rehabilitation Hospital — 89 Adult Beds
61 West Jim Leeds Road
P.O. Box 723
Pomona, NJ 08240-0723

HealthSouth Rehabilitation Hospital of NJ — 92 Adult Beds
14 Hospital Drive
Toms River, N.J. 08753

HealthSouth Rehabilitation Hospital of NJ — 60 Adult Beds*
Tinton Falls, N.J.

Riverview Medical Center — 24 Adult Beds + 6 Adult Beds*
1 Riverview Plaza
Red Bank, N.J. 07701

Shore Rehabilitation Institute — 30 Adult Beds + 10 Adult Beds*
Medical Center of Ocean County
2121 Edgewater Place
Point Pleasant, N.J. 08742-2290

Burdette Tomlin Memorial Hospital — 20 Adult Beds*
2 Stone Harbor Boulevard
Cape May Court House, N.J. 08210

Children's Specialized Hospital — 30 Pediatric Beds
94 Stevens Road
Toms River, N.J. 08753

* CON-Approved beds granted approval September 3, 1998 and not as yet implemented.

\+ CON-Approved beds granted approval September 28, 1998 and not as yet implemented.

CARDIAC CATHETERIZATION SERVICES

TOTAL HOSPITAL SUPPLY

26 Total Hospital Programs
51 Adult Labs
1 Pediatric Lab

INNER CITY SUPPLY

14 of 25 Inner City Hospital Programs
29 of 51 Adult Labs
1 of 1 Pediatric Lab

NEED METHODOLOGY (Yes or No)

Staff & Staff qualification & minimum volume requirements
Adult cases-500/Lab;
50/year/physician.
Pediatric-150 cases/Lab by end of 3 years.
50/yr/physician.

CARDIAC CATHETERIZATION

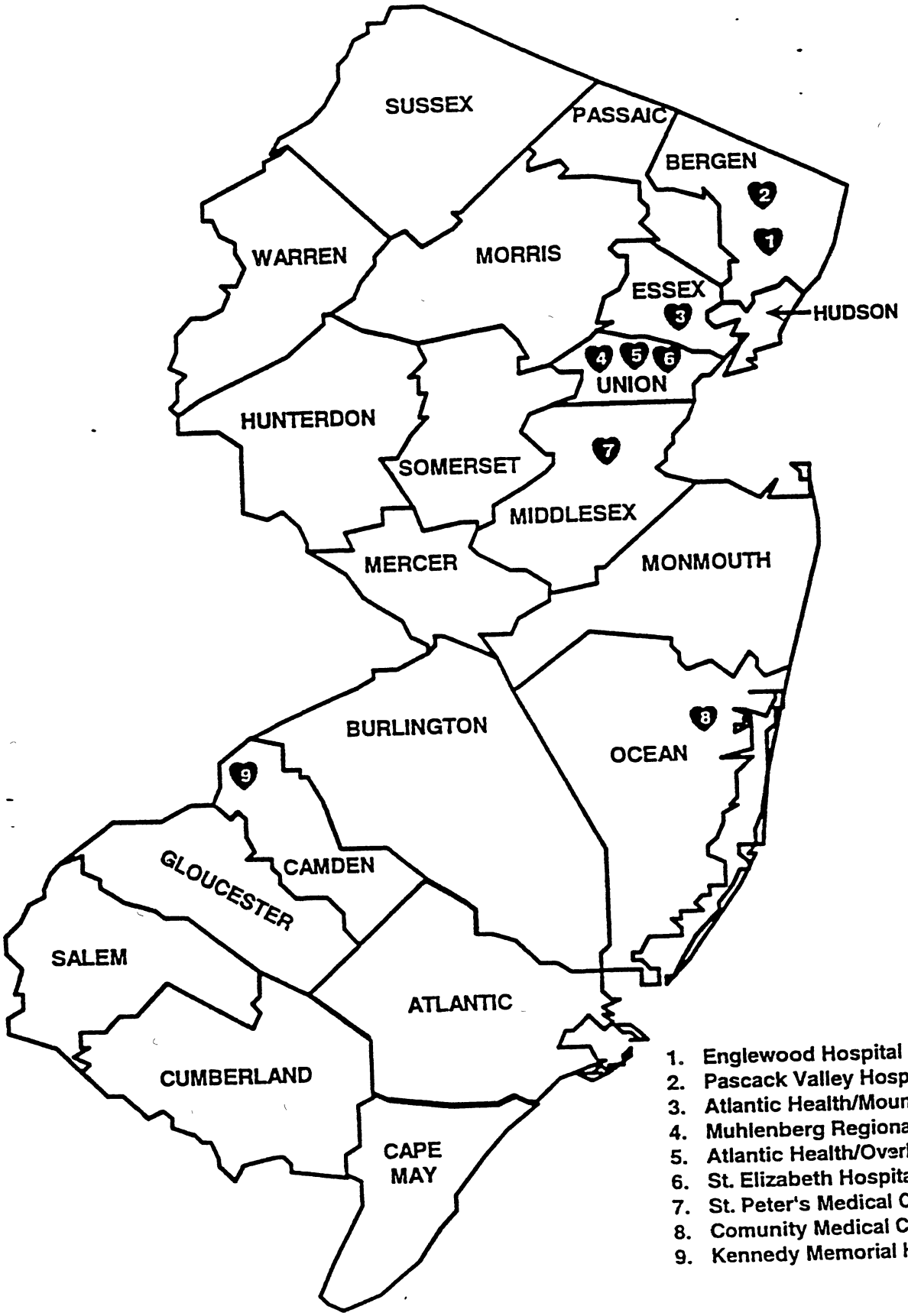
(Full Service, low and high risk patients)

There is no current need methodology. However, the applicant must comply with required staff qualifications and staffing patterns.

Approved laboratories must meet the minimum volume requirement of 500 adult cardiac catheterization patients per cardiac laboratory is required in order to main the skills of the of the catheterization team and the efficiency and effectiveness of the invasive cardiac diagnostic service.

In addition the physician performance requirements must be meet: Each physician must perform 50 cases a year with a minimum of 100 cases over a two year time period.

LOCATION OF FULL SERVICE CARDIAC CATHETERIZATION SERVICES IN HOSPITALS WITHOUT CARDIAC SURGERY



1. Englewood Hospital & Medical Center
2. Pascack Valley Hospital
3. Atlantic Health/Mountainside Hosp.
4. Muhlenberg Regional Medical Ctr.
5. Atlantic Health/Overlook Hospital
6. St. Elizabeth Hospital
7. St. Peter's Medical Center
8. Comunity Medical Center
9. Kennedy Memorial Hospitals/Cherry Hill

PILOT CATHETERIZATION SERVICES

TOTAL HOSPITAL SUPPLY

31 Total Hospital Pilot Programs

INNER CITY SUPPLY

11 of 31 Inner City Hospital Pilot Programs

NEED METHODOLOGY (Yes or No)

High risk patients excluded.

Staff & Staff qualifications.
Minimum volume requirements 150/yr/physician for Pilot LAB Director.
50/yr/other catheterizing physicians.

PILOT CARDIAC CATHETERIZATION

There is currently no need methodology.

The applicant shall meet staff and staff qualifications same as for conventional diagnostic cardiac catheterization facility.

Patients with the conditions listed below are considered high risk and shall be excluded from catheterization at pilot facilities and shall be transferred in accordance with N.J.A.C. 8:33E-1.8.

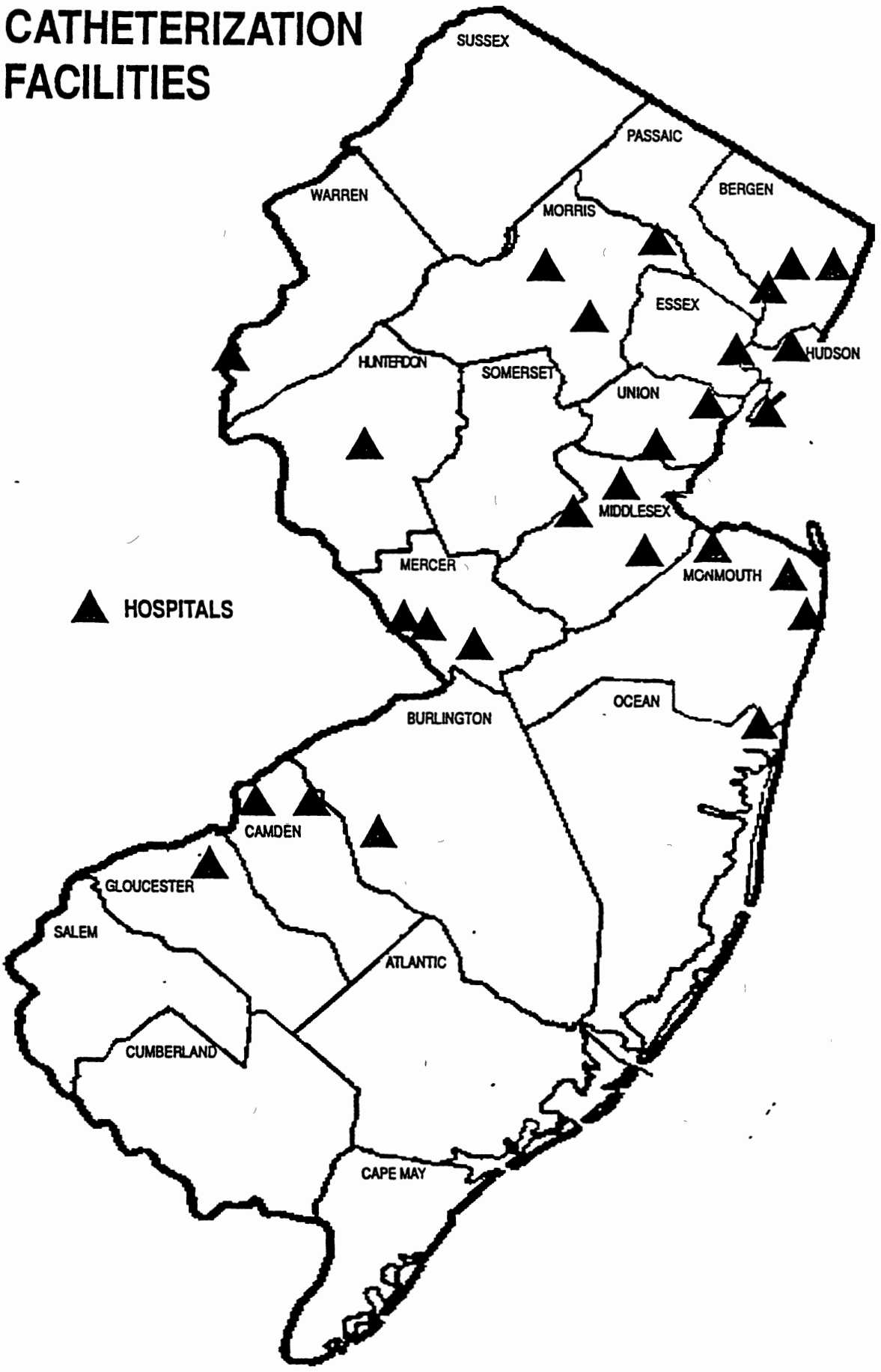
1. Left main coronary syndrome;
2. Unstable myocardial infarction;
3. Acute myocardial infarction within three days;
4. Unstable angina with persistent angina;
5. Congestive heart failure, defined as NYHA Class III or IV;
6. Cardiogenic shock or severe hemodynamic instability;
7. Aortic stenosis, as measured by Doppler mean gradient over 40mm of Hg;
8. Ejection fraction below 30 percent, or
9. Concomitant severe medical or vascular problems.

Volume Criteria:

Physician Director - left-heart catheterization on 150 patients per year, at least 100 of which must be performed at the pilot lab of which the physician is director.

Other physicians - 50 left-heart catheterizations per year. (may be accomplished at more than one lab)

LOW RISK CARDIAC CATHETERIZATION FACILITIES



CARDIAC SURGERY SERVICES

TOTAL HOSPITAL SUPPLY

14 Total Hospital Programs
27 Adult Operating Rooms
2 Pediatric Operating Rooms

INNER CITY SUPPLY

10 of 14 Inner City Hospital Programs
19 of 27 Adult Operating Rooms
1 of 2 Pediatric Operating Rooms

NEED METHODOLOGY (Yes or No)

Staff & Staff qualification & minimum volume requirements
Adult cases-350/ cases/year by end of 3rd year.
100 cases/surgeon/year by end of 3rd year.
Pediatric cases-150/yr by end of 3rd yr.
100 cases/surgeon/year over 2 yr. time period.

CARDIAC SURGERY

There is currently no specific need methodology for cardiac surgery services. However all existing regional adult cardiac surgical centers shall meet the criteria identified in N.J.A.C. 8:33E-2.3 regarding the following:

1. Provision of written documentation of the ability to achieve an annual volume of 350 open heart surgical cases by the end of the third year of operation and annually thereafter.

2. All existing regional adult cardiac surgical centers shall continue to perform at least 350 open heart surgical procedures per year to insure the competency of the surgical services team and to provide for efficient and economical operation.

3. Each cardiac surgical center shall establish a minimum caseload per physician and team in order to ensure a consistent level of proficiency within the surgical program. Within three years, a minimum of 100 cases per year shall be performed by each cardiac surgeon as the primary surgeon on each case. This minimum annual volume is to be achieved at the conclusion of a phase-in period, requiring 50 cases during the first year, 75 cases during the second year, and 100 cases by the third year and annually thereafter. This volume shall be achieved at each licensed site in New Jersey at which the physician practices.

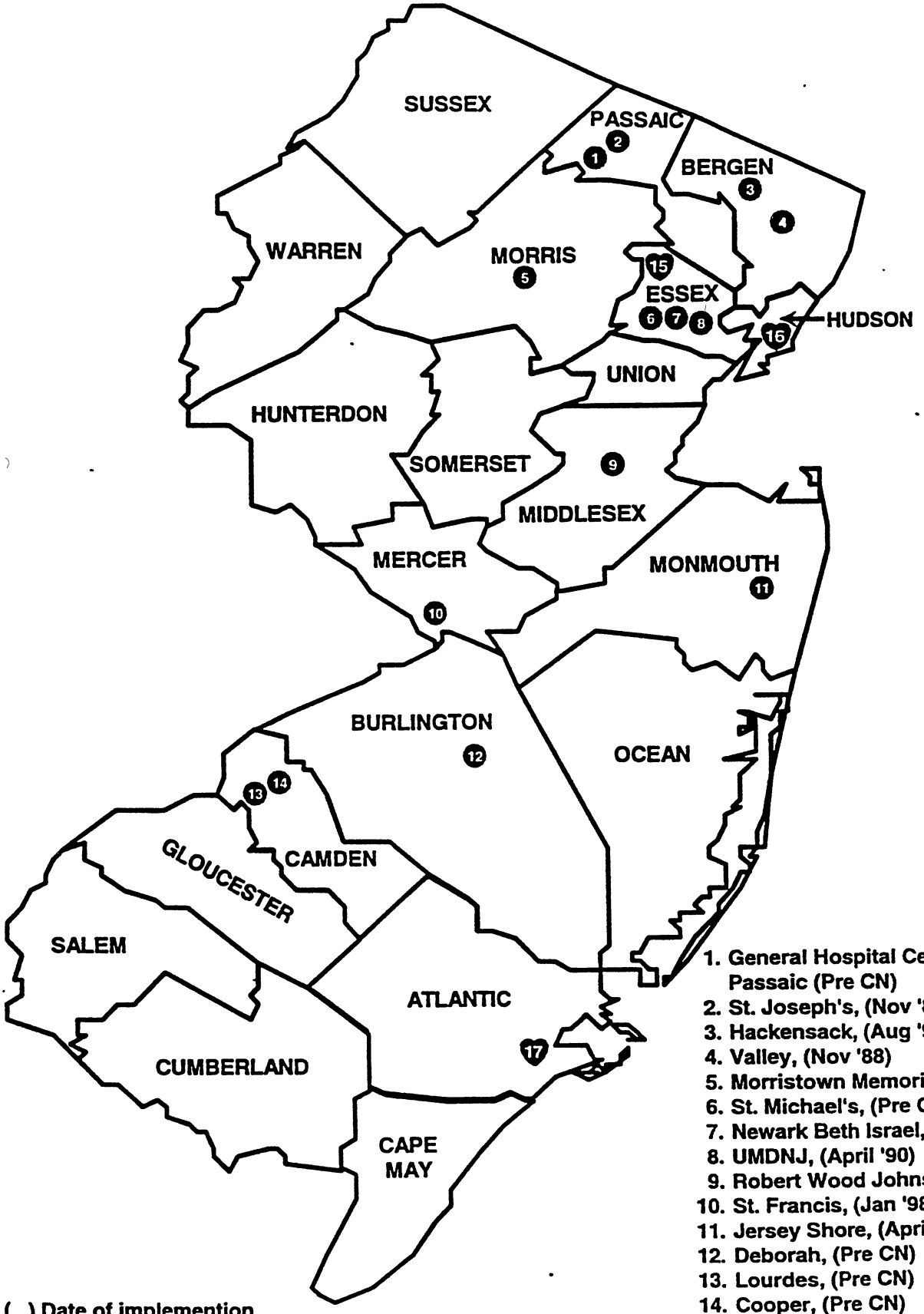
Pediatric Cardiac Diagnostic and Surgical Services:

1. New providers shall perform at least 150 pediatric open and closed heart surgery procedures per year, at least 75 of which must be open heart procedures, for each OR utilized for pediatric open heart surgery by the end of the third year of operation and each year thereafter.

2. Existing providers shall perform at least 150 pediatric open and closed heart surgery procedures per year per OR within one year of the effective date of this subchapter and shall maintain the standard on an annual basis thereafter.

3. Minimum of 150 per year of pediatric cardiac catheterization procedures per invasive pediatric cardiac laboratory per year. New pediatric surgical centers shall achieve this minimum level of utilization in their invasive pediatric cardiac diagnostic laboratory within three years from the initation of the service.

LOCATION OF CARDIAC SURGERY SERVICES
(Also provide full service catheterization services)



( ) Date of implemention

♥ Recent CN approval

1. General Hospital Center at Passaic (Pre CN)
2. St. Joseph's, (Nov '82)
3. Hackensack, (Aug '95)
4. Valley, (Nov '88)
5. Morristown Memorial, (Nov '88)
6. St. Michael's, (Pre CN)
7. Newark Beth Israel, (Pre CN)
8. UMDNJ, (April '90)
9. Robert Wood Johnson, (Aug '80)
10. St. Francis, (Jan '98)
11. Jersey Shore, (April '90)
12. Deborah, (Pre CN)
13. Lourdes, (Pre CN)
14. Cooper, (Pre CN)
15. Newark Beth Israel at St. Barnabas Medical Center (Nov '98)
16. Jersey City Medical Center (Jan '99)
17. Atlantic City Medical Center (Jan '99)

NEONATAL INTERMEDIATE BASSINETS SERVICES

TOTAL HOSPITAL SUPPLY

51 Total Hospital Programs
389 Bassinets

INNER CITY SUPPLY

22 of 51 Inner City Hospital Programs
224 of 389 Bassinets

NEED METHODOLOGY (Yes or **No**)

Staffing Levels & Staff qualification licensing requirements.

4 bed minimum unit size.

NEONATAL INTERMEDIATE BASSINETS

No existing need methodology. However, the applicant must meet the following requirements as identified in N.J.A.C. 33C-2.7(b)5 and N.J.A.C. 8:43G-19.19.

1. Minimum size of four bassinets

2. Applicant must meet required staff qualifications and Staffing patterns.

NEONATAL INTENSIVE BASSINETS

1. The need methodology is identified in N.J.A.C. 33C-2.7(b)4.i; it includes a 16 step formula. The latter includes live births at varying weight levels with varying acuities and length of stay calculations.

2. Applicant must meet required staff qualifications and staffing requirements.

3. Minimum size of six bassinets.

NEONATAL INTENSIVE BASSINETS SERVICES

TOTAL HOSPITAL SUPPLY

18 Total Hospital Programs
264 Bassinets

INNER CITY SUPPLY

9 of 18 Inner City Hospital Program
120 of 264 Bassinets

NEED METHODOLOGY (Yes or No)

16 Step formula includes live births (at varying weight & acuity levels) X Average Length of Stay (ALOS).
6 bed minimum unit size.

SPECIALIZED PERINATAL AND PEDIATRIC SERVICES, INCLUDING CONSORTIA

CON APPROVED NEW JERSEY MATERNITY HOSPITALS BY CONSORTIUM

CENTRAL NJ MATERNAL AND CHILD HEALTH CONSORTIUM

Mercer Medical Center -- REGIONAL PERINATAL CENTER
St. Peter's Medical Center -- REGIONAL PERINATAL CENTER
Helene Fuld Medical Center -- CPC - INTENSIVE
Hunterdon Medical Center -- CPC - INTERMEDIATE
Medical Center at Princeton -- CPC - INTERMEDIATE
Muhlenberg Regional Medical Center -- CPC - INTERMEDIATE
Robert Wood Johnson University Hospital -- CPC - INTERMEDIATE
Robert Wood Johnson Univ Hosp at Hamilton -- CPC - BASIC
Somerset Medical Center -- CPC - INTERMEDIATE
St. Francis Medical Center -- CPC - BASIC

GATEWAY MATERNAL AND CHILD HEALTH CONSORTIUM, INC

Hackensack Medical Center -- REGIONAL PERINATAL CENTER
Newark Beth Israel Medical Center -- REGIONAL PERINATAL CENTER
University Hospital - UMDNJ -- REGIONAL PERINATAL CENTER
Clara Maass Medical Center -- CPC - INTERMEDIATE
Elizabeth General Medical Center -- CPC - INTERMEDIATE
John F. Kennedy Medical Center -- CPC - INTERMEDIATE
Raritan Bay Medical Center -- CPC - INTERMEDIATE
St. Elizabeth Hospital -- CPC - INTERMEDIATE
St. Michael's Medical Center -- CPC - INTERMEDIATE
Rahway Hospital -- CPC - BASIC
E. Orange General Hospital -- CPC - BASIC (Pending construction)
St. James Hospital -- CPC - BASIC
The Birthing Center at Raritan Bay Medical Center -- CPC - BIRTH CENTER

HUDSON PERINATAL CONSORTIUM, INC.

Jersey City Medical Center -- REGIONAL PERINATAL CENTER
Meadowlands Hospital Medical Center -- CPC - INTERMEDIATE
Palisades General Hospital -- CPC - INTERMEDIATE
St. Mary's Hospital (Hoboken) -- CPC - INTERMEDIATE
Bayonne Hospital -- CPC - BASIC
Christ Hospital -- CPC - BASIC
West Hudson Hospital -- CPC - Birth Center (Pending construction)

NORTHERN NJ MATERNAL/CHILD HEALTH CONSORTIUM

St. Barnabas Medical Center -- REGIONAL PERINATAL CENTER
St. Joseph's Hospital and Medical Center -- REGIONAL PERINATAL CENTER
Valley Hospital -- CPC - INTENSIVE
Englewood Hospital -- CPC - INTENSIVE
Barnert Memorial Hospital -- CPC - INTERMEDIATE
Columbus Hospital -- CPC - INTERMEDIATE
Holy Name Hospital -- CPC - INTERMEDIATE
Pascack Valley Hospital -- CPC - INTERMEDIATE
Hospital Center at Orange -- CPC - BASIC
St. Mary's Hospital (Passaic) -- CPC - BASIC
Wayne General Hospital -- CPC - BASIC
The Childbirth Center -- CPC - BIRTH CENTER
Northwest Covenant Medical Center, St. Clare's Riverside Medical Center Campus -- CPC - INTERMEDIATE

NORTHWEST NJ MATERNAL AND CHILD HEALTH NETWORK

Morristown Memorial Hospital -- REGIONAL PERINATAL CENTER
Overlook Hospital -- CPC - INTENSIVE
Chilton Memorial Hospital -- CPC - INTERMEDIATE
Newton Memorial Hospital -- CPC - INTERMEDIATE
St. Clare's Riverside Medical Center -- CPC - INTERMEDIATE
Hackettstown Community Hospital -- CPC - BASIC
Warren Hospital -- CPC - BASIC
The General Hospital Center at Passaic -- CPC - INTERMEDIATE
Mountainside Hospital -- CPC - INTERMEDIATE

REGIONAL PERINATAL CONSORTIUM OF MONMOUTH AND OCEAN COUNTIES

Jersey Shore Medical Center -- REGIONAL PERINATAL CENTER
Monmouth Medical Center -- REGIONAL PERINATAL CENTER
CentraState Medical Center -- CPC - INTERMEDIATE
Community Medical Center - CPC - INTERMEDIATE
Kimball Medical Center -- CPC - INTERMEDIATE
Medical Center of Ocean County -- CPC - INTERMEDIATE
Brick Hospital Division
Riverview Medical Center -- CPC - INTERMEDIATE
Southern Ocean County Hospital -- CPC - Basic (To be operational 9/98)
Community/Kimball Health Care System Birthing Center -- CPC - Birth Center (Pending construction)
New Beginnings Birthing Center (Monmouth Med Cntr) -- CPC - Birth Center (Pending construction)

SOUTHERN NEW JERSEY PERINATAL COOPERATIVE

Cooper Hospital/University Medical Center -- REGIONAL PERINATAL CENTER
Our Lady of Lourdes Medical Center -- REGIONAL PERINATAL CENTER
Atlantic City Medical Center -- CPC - INTENSIVE
City Division
Kennedy Memorial Hospital -- CPC - INTENSIVE
University Medical Center-Stratford Division
West Jersey Health System - Voorhees -- CPC - INTENSIVE
Atlantic City Medical Center -- CPC - INTERMEDIATE
Mainland Division
Burdette Tomlin Memorial Hospital -- CPC - INTERMEDIATE
Kennedy Memorial Hospital -- CPC - INTERMEDIATE
University Medical Center-Washington Township Division
Memorial Hospital of Burlington County -- CPC - INTERMEDIATE
Newcomb Medical Center -- CPC - INTERMEDIATE
Shore Memorial Hospital -- CPC - INTERMEDIATE
Underwood Memorial Hospital -- CPC - INTERMEDIATE
Zurbrugg Memorial Hospital -- CPC - INTERMEDIATE
Rancocas Valley Division
Memorial Hospital of Salem County -- CPC - BASIC
South Jersey Hospital Association -- CPC - BASIC
- Bridgeton Division
Atlantic City Med Cntr-Mainland Birth Center---(Pending construction-approved with conditions)

4/1/99

CPC - Community Perinatal Center

CHILDREN'S HOSPITALS

TOTAL HOSPITAL SUPPLY

Cooper Medical Center, Camden
Newark Beth Israel Medical Center, Newark
St. Joseph's Hospital & Medical Center, Paterson
St. Peter's Medical Center/RWJ University Hospital, New Brunswick.

NEED METHODOLOGY

Currently no need methodology or specific licensing requirements.

MOBILE INTENSIVE CARE UNIT (MICU) SERVICES

TOTAL MICU SUPPLY

31 Total MICU Programs

INNER CITY MICU SUPPLY

11 of 31 Inner City MICU Programs

NEED METHODOLOGY (Yes or No)

Population Ratio/MICU Program.

1 MICU vehicle/100,000 population.

MICU (MOBILE INTENSIVE CARE UNIT)

There is no specific need methodology. However, the applicants must meet the following criteria.

1. The applicant must meet the ratio of no less than one MICU vehicle per 100,000 residents in the primary service areas.

2. The service area to be provided shall not adversely impact on existing area providers.

3. The applicant must meet required staff qualifications and staffing patterns.

Note: The rules where the above criteria are identified N.J.A.C. 8:33N expired on May 15, 1994. MICU services have been approved for the entire state.

PEDIATRIC INTENSIVE CARE UNIT (PICU) SERVICES

TOTAL HOSPITAL PICU SUPPLY

6 Total Hospital Programs
50 PICU Beds

INNER CITY SUPPLY

6 of 6 Inner City Hospital Programs
50 of 50 PICU Beds

NEED METHODOLOGY (Yes or **No**)

Staffing Levels & Staff qualification licensing requirements.

PEDIATRIC INTENSIVE CARE

There is no specific need methodology. However, the applicant must meet required staff qualifications and staffing patterns, identified in the licensing standards at N.J.A.C. 8:43G-22.15&16.

BURN PROGRAM SERVICES

TOTAL HOSPITAL SUPPLY

1 Hospital Program - St. Barnabas Medical Center
- 18 Burn Unit M/S Beds
- 12 Burn Units ICU Beds

INNER CITY SUPPLY

None

NEED METHODOLOGY (Yes or No)

Average daily census (ADC) + 1.65 times square root of ADC.

BURN CARE UNIT

There is currently no CN methodology for Burn Care Units. However, the formula which the Department has used in the past:

Bed Need = ADC + 1.65 times The square root of ADC
ADC is the Average Daily Census and is equal to

$$\frac{\text{Admissions X Length of Stay}}{\text{365 days per year}}$$

Proposed standards for level of burn care in New Jersey were included in a past "Report of the New Jersey Health Commissioner's Task Force on Burn Care". The levels were defined in terms of the quantity and type of facilities, equipment, personnel and services required. The four levels identified were as follows:

1. Emergency medical services for burns
2. Burn programs
3. Burn units
4. Burn centers

There are currently no licensing standards specific to burn care.

ORGAN BANK SERVICES

TOTAL HOSPITAL SUPPLY

None

INNER CITY SUPPLY

None

NEED METHODOLOGY (Yes or **No**)

ORGAN BANK

The Department currently does not license Organ Bank services.

NEW GENERAL ACUTE CARE HOSPITALS

NEED METHODOLOGY - NO

Need would be based on utilization criteria from Hospital Policy Manual and based on occupancy rates of surrounding facilities and projected occupancy of proposed new facility.

TRANSFER OF OWNERSHIP OF EXISTING GENERAL ACUTE CARE HOSPITALS

NEED METHODOLOGY - NO

Track Record of Buyer
New Owners Commitment To Maintain Current Array Of Services

CLOSURE OF ACUTE CARE HOSPITALS

NEED METHODOLOGY - NO

Criteria to be evaluated include access to other inpatient services, access to other emergency services, occupancy history of facility, financial history of facility and access to alternative providers to all services to be closed.

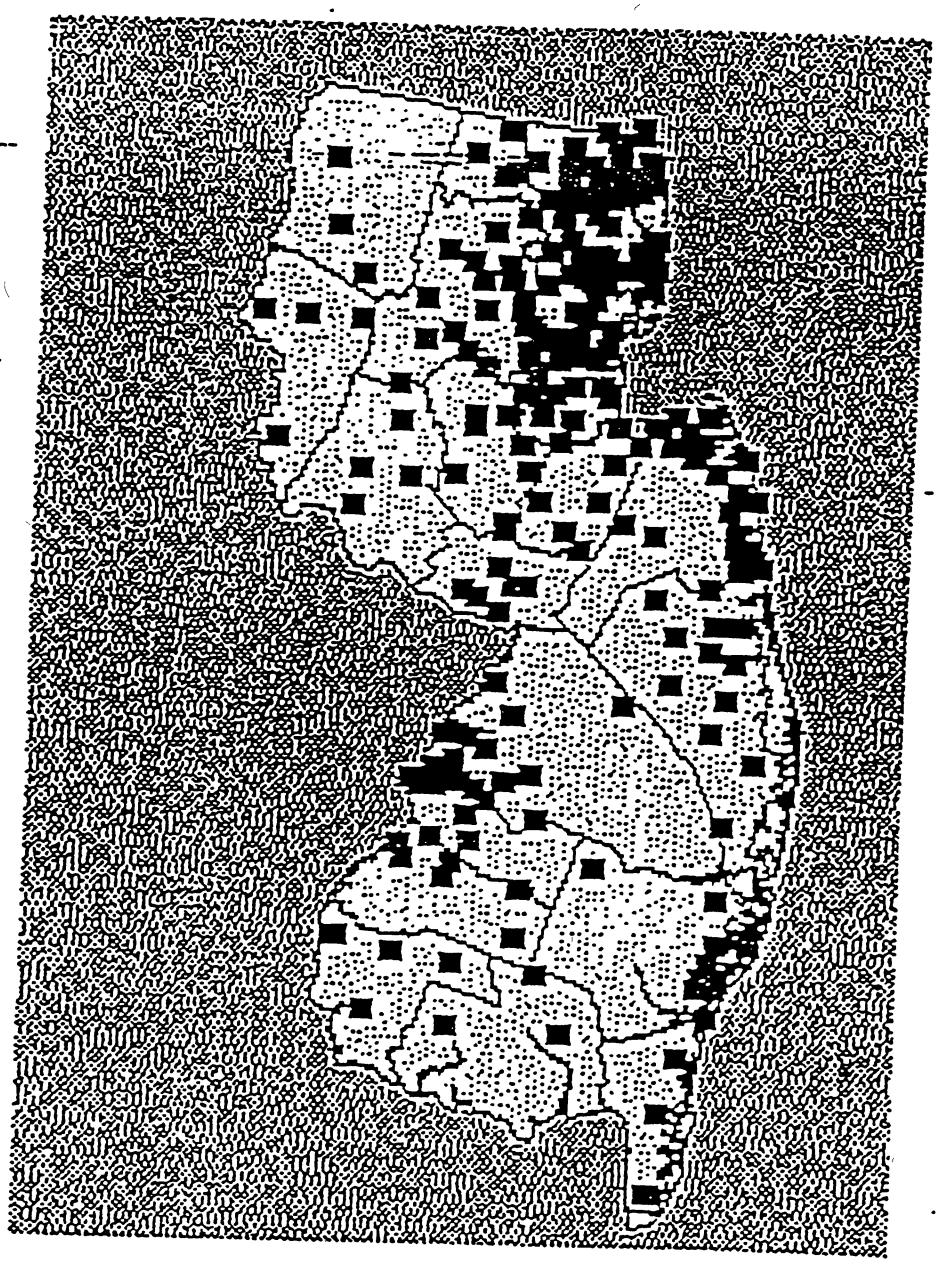
Inner City Hospitals
Study Commission Services

Atlantic City M.C. City Div.
Barnett
Bayonne Hospital
Capital Health, System at Fuld
Capital Health System at Mercer
Christ Hospital
Columbus
Cooper Hospital
East Orange Gen. Hosp.
Elizabeth General M.C. East
Elizabeth General M.C. West
Greenville
Hackensack U.M.C.
Irvington Gen. Hosp.
Jersey City M.C.
JFK Medical Center (Edison)
Meadowlands Hospital Medical Center
Muhlenberg Regional M.C.
Newark Beth Israel M.C.
Our Lady of Lourdes M.C.
Passaic Beth Israel
Raritan Bay M.C. Perth Amboy Div.
Robert Wood Johnson Univ. Hospital
St. James Hospital
St. Elizabeth Hospital
St. Francis Community Hospital
St. Francis Medical Center
St. Joseph's Hospital & M.C.
St. Mary Hospital (Hoboken)
St. Mary's Hospital (Passaic)
St. Michael's Medical Center
St. Peters M.C.
The General Hospital at Passaic
The Hospital Center at Orange
UMDNJ
West Hudson Hospital
West Jersey Hospital (Camden Division)

Non-Inner City Hospitals
Study Commission Services

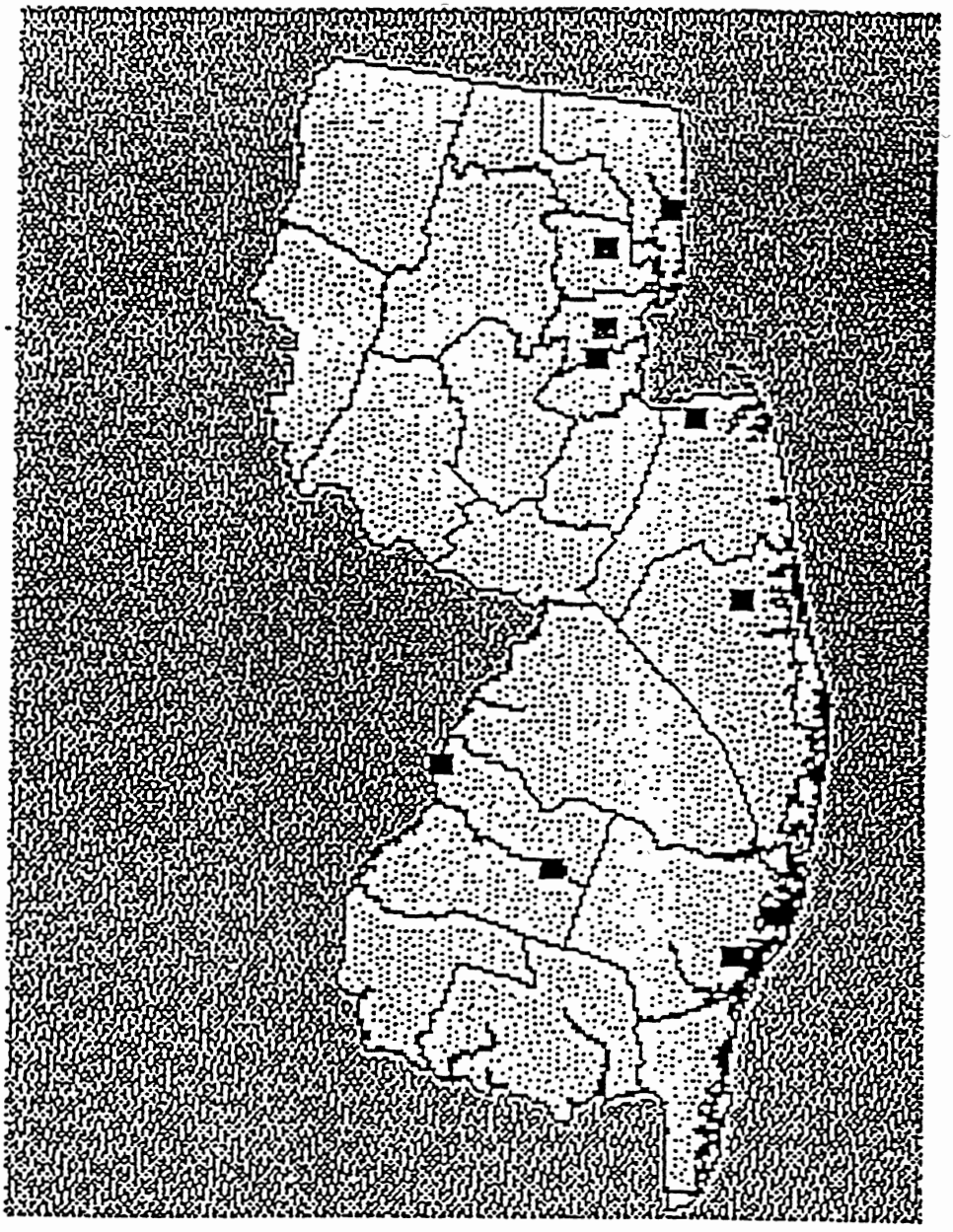
Allegheny U. Hospitals-Rancocas
Atlantic City M.C.-Mainland Div.
Bayshore Community Hospital
Bergen Regional M.C.
Burdette Tomlin
CentraState M.C.
Chilton Memorial Hospital
Clara Maass M.C.
Community M.C.
Deborah Heart & Lung Center
Englewood Hospital & M.C.
Hackettstown Community Hospital
Holy Name Hospital
Hunterdon Medical Center
Jersey Shore Medical Center
Kennedy Memorial Hospitals U.M.C.-Cherry Hill Div.
Kennedy Memorial Hospitals U.M.C-Stratford Division
Kennedy Memorial Hospitals U.M.C-Washington Twp.
Kessler Memorial Hospital
Kimball Medical Center
Medical Center of Ocean County (Brick Division)
Medical Center of Ocean County (Point Pleasant Division)
Memorial Hospital of Burlington County
Memorial M.C. at South Amboy
Monmouth Medical Center
Montclair Community Hospital
Morristown Mem. Hosp.
Mountainside Hospital
Newcomb M.C.
Newton Mem. Hosp.
Overlook
Palisades General Hosp.
Pascack Valley Hosp.
Rahway Hosp.
Raritan Bay M.C.-Old Bridge Div.
Riverview M.C.
RWJUH at Hamilton
St. Barnabas
Shore Mem. Hosp.
Somerset M.C.
South Jersey Hospital-Bridgeton
South Jersey Hospital-Elmer
South Jersey Hospital-Millville
Souther Ocean County Hosp.
St. Clares-Dover
St. Clares-Riverside
St. Clares-Denville
The M.C. at Princeton
Warren Hospital
Wayne General-Hosp.
West Jersey Hospital-Berlin
West Jersey Hospital-Marlton
West Jersey Hospital-Voorhees

Long-Term Care Facilities: March 1999



Need Methodology: County-based. Includes projected population at three age cohorts over age 65 and one under age 65 and calculation of a long-term care placement rate for each of the four age cohorts.

Long-Term Care Facilities With Licensed Ventilator Beds: March 1999

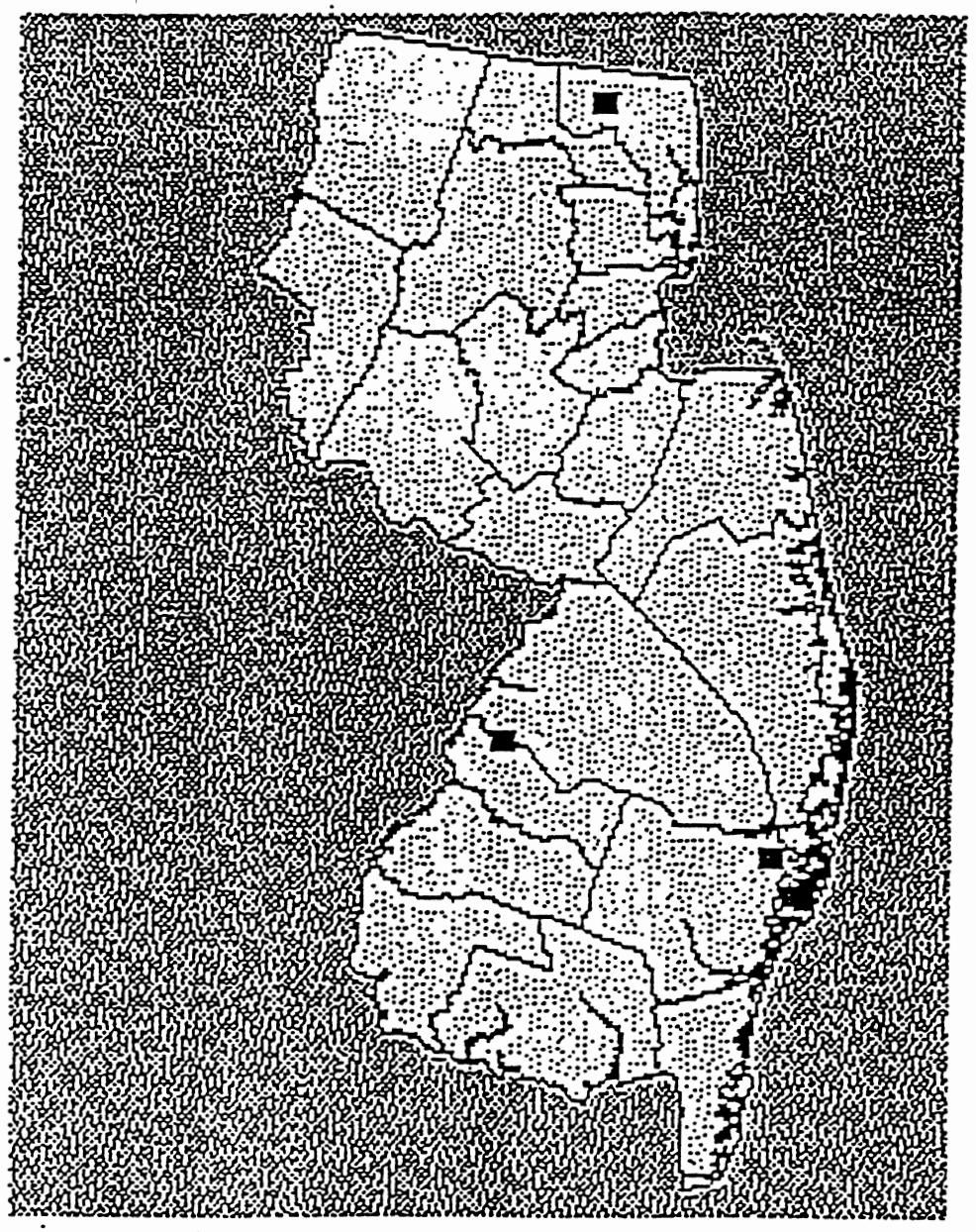


Need Methodology: LAB region-based. Conduct survey of hospitals to identify those patients ready for discharge to long-term care; calculate projected rate of growth in 20-yr-old and over population; increase number identified in survey by product of original number and growth rate; adjust for 85% occupancy.

Long-Term Care Pediatric Facilities: March 1999

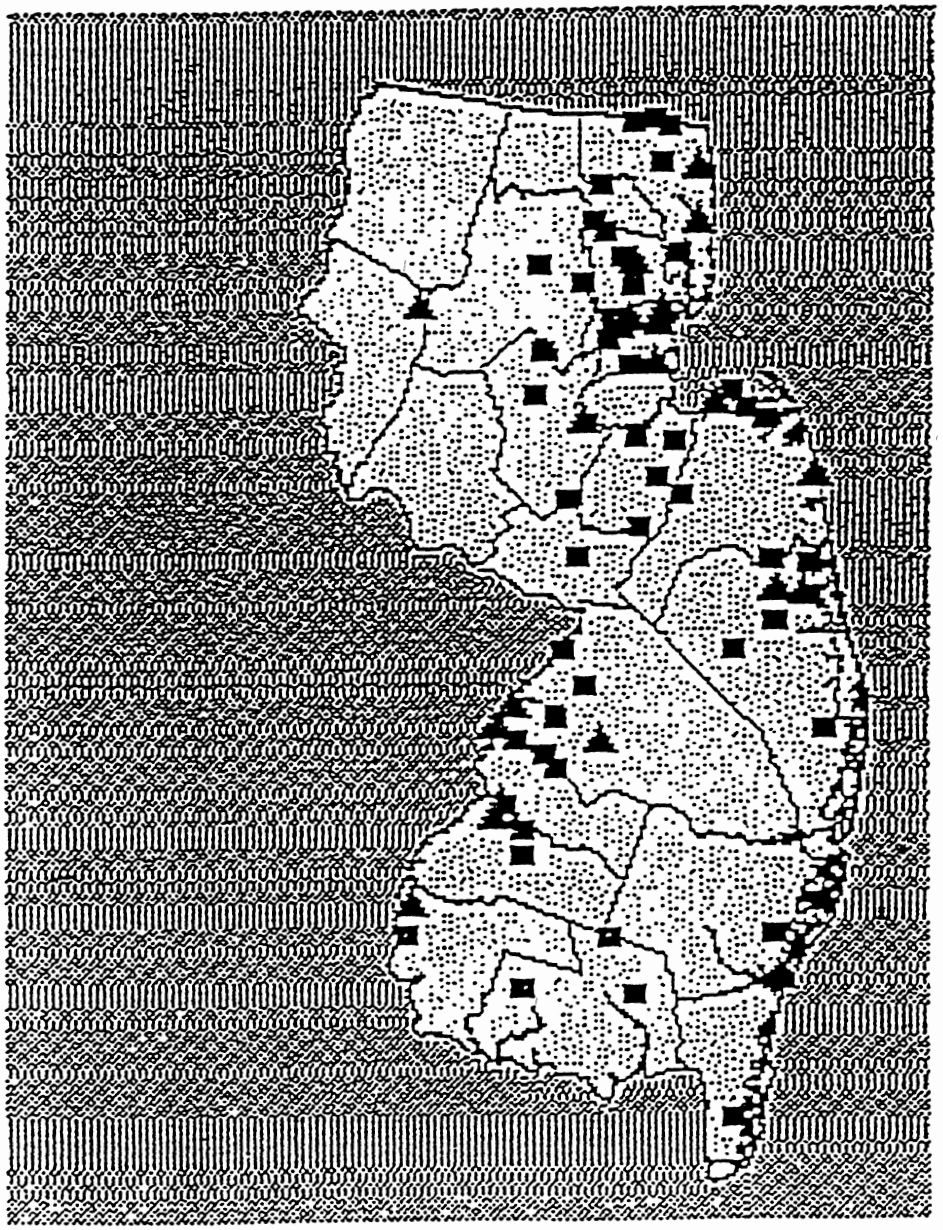
Need Methodology: LAB region-based. Conduct survey of acute care hospitals to identify children ready for discharge and those placed in LTC outside of NJ; group by county and LAB region; calculate projected rate of growth in under 20-yr-old population in LAB; increase number identified in survey by product of original number and growth rate; adjust for 85% occupancy.

Long-Term Care Facilities With Licensed Behavioral Management Beds: March 1999



Need Methodology: No specific methodology. NJAC 8:33H-1.7(e) calls for one "Model Program" in each LAB region; maximum size per facility is 32 beds; must maintain affiliation with schools of nursing, social work, and medicine; program must include formal research and program evaluation, admission and discharge criteria, and plan for [illegible].

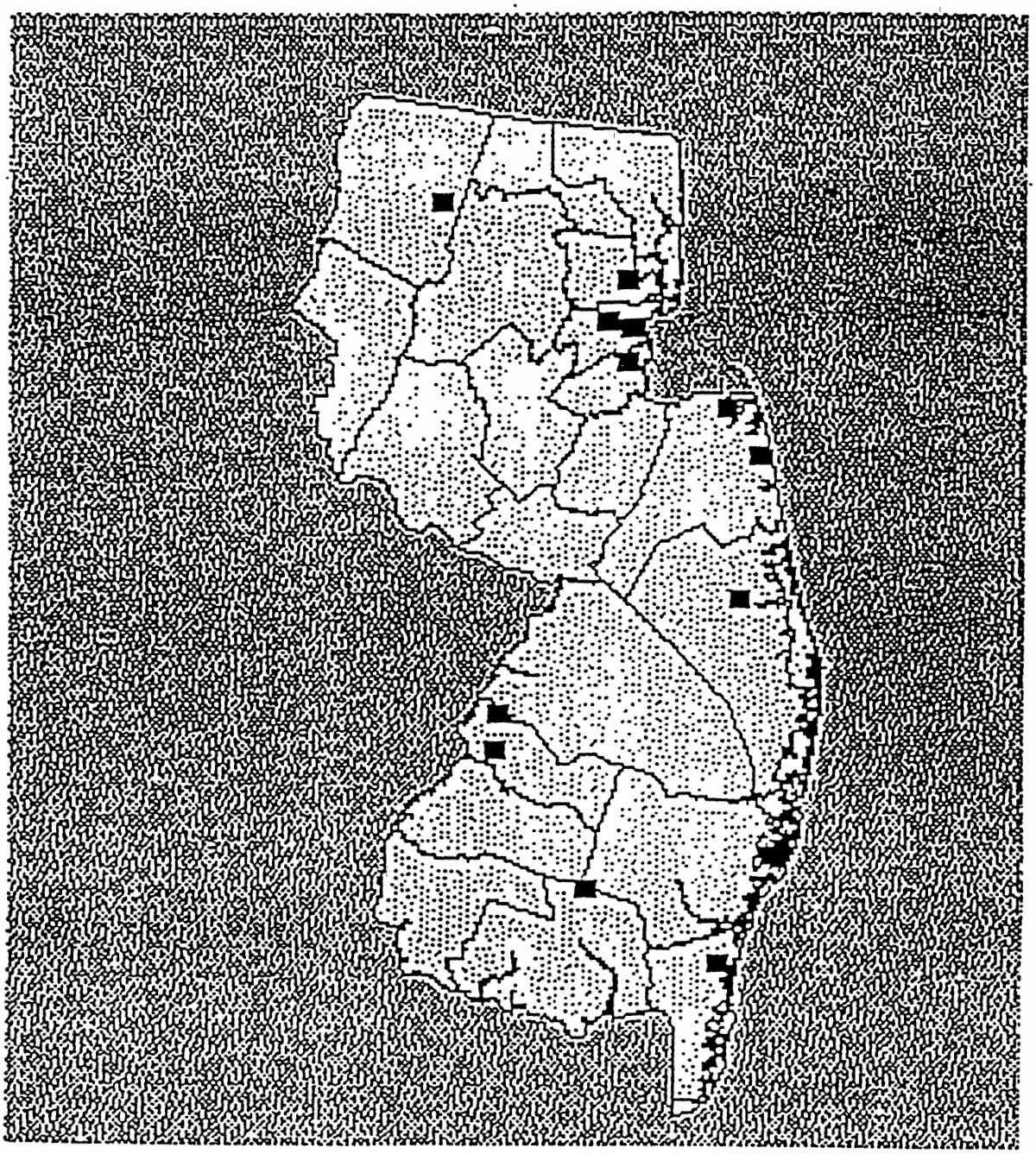
Assisted Living Residences and Comprehensive Personal Care Homes: March 1999



■ ALR ▲ CPCH

Need Methodology: None. CN process examines applicant track record and financial feasibility.

Assisted Living Programs: March 1999



Need Methodology: None. CN process examines applicant track record and financial feasibility.

HOME HEALTH AGENCIES:

MARCH 1999

58 Licensed Home Health Agencies

12 of 58 have Licensed Branch offices for a total of 22 Branch offices.

HOME HEALTH

Certificate of Need Requirement:

A certificate of need is required for the establishment or expansion of home health agencies in accordance with the provisions of N.J.A.C. 8:33L and N.J.S.A. 26:2H-1 et seq.

Need Methodology:

In accordance with N.J.A.C. 8:33L-2.4(a)3, a certificate of need may only be granted to expand an existing home health agency or institute a new agency where one or more of the following documented access problems exist:

1) The absence of an existing home health agency providing care in the proposed service area which offers skilled nursing services on a seven-day-a-week, 24 hour-a-day basis (N.J.A.C. 8:33L-2.4(a)3i);

2) The absence of an existing home health agency providing care in the proposed service area which, in addition to those forms of care required for agency licensure, offers speech pathology, occupational therapy, and social work services (N.J.A.C. 8:33L-2.4(a)3ii);

3) The absence of an existing home health agency providing care in the proposed service area which offers complex treatment modalities (i.e., mechanical ventilator care, intravenous and central line infusion therapies) (N.J.A.C. 8:33L-2.4(a)3iii);

4) The absence of an existing home health agency providing care in the proposed service area which offers a Medicare-certified hospice program providing care for the terminally ill (N.J.A.C. 8:33L-2.4(a)3iv).

or

In accordance with N.J.A.C. 8:33L-2.4(d), every county or subarea of a county shall be served by a minimum of three home health agencies. If an area is served by fewer than three agencies, and it exhibits none of the access problems identified at N.J.A.C. 8:33L-2.4(a)3, additional agencies for a total of three may be approved provided that they comply with all other applicable requirements set fourth at N.J.A.C. 8:33L et seq.

Note: As a result of the last call for home health agencies, there are now at least 3 home health agencies in every one of the State's 21 counties.

ATTACHMENT 4

CN STUDY COMMISSION WORKPLAN

November, 1998	**First Meeting of Full Commission:** ◦ Review Charge ◦ Review Workplan and Organization ◦ Overview of CN Reform and Services Subject to Regulation
January, 1999	**Second Meeting of Full Commission:** ◦ Background on Certificate of Need ◦ Develop Framework for Review (Expert Opinions)
February, 1999	**Third Meeting of Full Commission:** ◦ Develop Framework for Review: (cont'd) ◦ Survey Activity in Other States
March, 1999	**Subcommittees Meet:** ◦ Background on Services
April 23, 1999 - Long-term Care Facilities and Services Public Hearing April 30, 1999 - Acute Care Facilities and Services Public Hearing May 14, 1999 - Long-Term Care (am) Facilities and Services Public Hearing May 14, 1999 - Acute Care Facilities and (pm) Services Public Hearing	**Subcommittees Continue to Meet:** ◦ Hear from stakeholders about whether CN should be continued and, if so, how to determine need and monitor quality
June, 1999	Staff summarizes input from stakeholders
July 13, 1999 - a.m. - LTC and August 17, 1999 - p.m. -Acute Care	**Subcommittees Meet:** ◦ Develop recommendations with regard to whether CN should be continued and, if so, how to determine need and monitor quality
October, 1999	**Fourth Meeting of Full Commission:** ◦ Discussion of draft subcommittee recommendations
November, 1999	**Fifth Meeting of Full Commission:** ◦ Discussion of draft subcommittee recommendations
November, 1999 (If necessary)	Staff develops draft recommendations
December, 1999 (If necessary)	**Sixth Meeting of Full Commission:** ◦ Vote on final recommendations

ATTACHMENT 5

CN Study Commission
Staff Summary of Public Hearings
General Synopsis of Comments

April 23, 1999

Long-Term Care: No members of the public appeared to testify.

April 30, 1999

Acute Care: 8 speakers testified in general support of the retention of the CN requirement. Testimony related to the importance of CN to urban, inner-city hospitals, for access to the poor, and for overall quality, particularly in tertiary services. A number commented specifically on the value of CN for comprehensive rehabilitation services and MICU services.

May 14, 1999

Long-Term Care: 10 members of the public testified. One speaker urged that CN for home health be eliminated; another that home health be placed in expedited review. A third commentor recommended continuation of the movement to deregulation, but with enhanced licensing standards for quality and a safety-net for inner-city hospitals serving the poor; and, to the extent that CN for tertiary care can help meet these access and quality goals, it may be appropriate. The remaining seven speakers favored retention of CN with two suggestions that assisted living be moved from expedited to full review.

Acute Care: 20 individuals commented; two speakers were generally in favor of deregulation, except where CN for tertiary services could enhance quality and access. One speaker urged that CN either be retained as it exists, or should be deregulated completely, not piecemeal. The remaining speakers favored maintaining CN in general or for specific services.

Comments in Specific Services (both hearing)

Long-Term Care

Assisted Living: Two speakers (Sendell, Abrams) argued for retention of CN and suggested it be moved from expedited to full review. Another (Cunningham) suggested a moratorumum on new CN approvals. Two other speakers (Goodrich, Gerding) acknowledged that any change in state policy should concentrate on ensuring access to lower income elderly.

Home Health: Three speakers (Spoltore, Gerding and Beck) argued in favor of retaining full CN review, although both suggested a number of changes that should be made in the review criteria. Two speakers (Alan-Bestafka, Goodrich) argued that this service should either be deregulated entirely or at least made expedited review. One speaker (Baiada) suggested it be entirely deregulated. All speakers cited opposing arguments regarding access, quality and cost should CN be retained or removed.

Nursing Facilities: One speaker (Ahlfeld) argued in favor of retaining CN for pediatric long term care. Abrams and Cunningham argued in favor of retaining full CN review for all nursing facilities. One speaker (Gerding) discussed the "uneven" state requirements for nursing facilities and assisted living and suggested all long term care options be evaluated. He also suggested that hospitals be exempt from any CN requirements to convert unused acute care beds to "lower levels of care".

It is also noted that one speaker (McDonald) at the acute care hearing noted in his testimony that the CN requirement for long term care facilities and home health should be eliminated.

Acute Care

General: Several speakers (Brady, Terrill, Bienkowski, Donlen, Gebhard, and Wright) argued for retention of CN for all or most of the services under consideration; another speaker (Carter) noted that the New Jersey Hospital Association has voted in favor of deregulation, though with some debate; two other speakers (Goodrich, McDonald) argued for deregulation of many services, though Goodrich supported a mechanism for supporting inner-city hospitals with "selected" tertiary services and McDonald did note a number of services for retention in CN.

Of those one spoke specifically to a particular service, most were in favor of retaining CN for those services for quality, access, cost and public interest reasons, although most suggested substantive revisions to need criteria and methodologies. Gerding argued for deregulation of cardiac catherization, PTCA, any hospital bed category changes, and the conversion of acute care beds to a "lower level of care"; McDonald argued for the deregulation of comprehensive rehabilitation, psychiatric beds, home health and long term care facilities.

Those speaking in favor of CN retention for specific services included:

Children's Hospitals: Levine, Ahlfeld
Cardiac Surgery: Levine, Gerding, Steen, Pilgrim, McDonald

Other Cardiac Interventional Procedures: Levine, Steen
Transplants: Levine, Gerding, Steen, McDonald, Shapiro
Perinatal: Levine, Gerding, Pilgrim, Donlen
Neonatal and Pediatrics ICU: Levine, Steen
Burn Care: Levine, Gerding, McDonald
Trauma Centers: Levine, Gerding, Pilgrim, McDonald, Valeziano, Murphy
Linear Accelerator: Levine (note: this service is scheduled for deregulation by 3/1/99 by legislation)
Comprehensive Rehab: Levine, Ferguson, Feuer, Hatiras, Zanko, Moore, Pilgrim, Brehm, Krotenberg
MICU: Levine, Pruden, Goldstone, Gerding, Pilgrim, McDonald, Hogan
Hospital Transfer of Ownership: Levine, Gerding
New Hospitals: Gerding, McDonald

Other: Boscamp argued that Children's Hospitals, whether designated by legislation or regulations, should be subject to standards with "real meaning", and suggested the standards developed by the National Association of Children's Hospitals and Related Institutions (NACHRI).

Barnes supported either the retention of all existing CN requirements or the immediate (not piecemeal) elimination of all CN requirements for hospitals.

ATTACHMENT 6

COMMISSION MEMBERS

Y=MAINTAIN CN
N=DO NOT MAINTAIN CN

ACUTE CARE SERVICES	DEL MAURO	DIMARZIO	DENNIS	GRANT	GUHL	HOLZBERG	MARKS	MATUSKA	ODGREN	OSTASZEWSKI	ROSENBLATT	SINAGRA	STRAUSS	VANDERVAULK	YAXLEY
1. PSYCHIATRIC SERVICES	N *	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	ABST.	Y	Y	N
2. TRAUMA SERVICES	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	ABST.	Y	Y	N
3. TRANSPLANTATION SERVICES	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	ABST.	Y	Y	N
4. COMPREHENSIVE REHABILITATION SERVICES	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	ABST.	Y	Y	N
5. CARDIAC CATHETERIZATION SERVICES	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	ABST.	Y	Y	N
6. PILOT CARDIAC CATHETERIZATION SERVICES	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	ABST.	Y	Y	N
7. CARDIAC SURGERY SERVICES	N	Y	Y	Y	Y	Y	Y	N	Y	N	Y	ABST.	Y	Y	N
8. NEONATAL INTERMEDIATE	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	ABST.	Y	Y	N
9. NEONATAL INTERMEDIATE	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	ABST.	Y	Y	N
10. MOBILE INTENSIVE CARE UNIT (MICU) SERVICES	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	ABST.	Y	Y	N

* Mr. Del Mauro noted on each vote that while he favored deletion of CN, he had one caveat on this position: that major inner city hospitals must be protected in order to assure access for inner city populations.

COMMISSION MEMBERS

Y=MAINTAIN CN
N=DO NOT MAINTAIN CN

ACUTE CARE SERVICES	DEL MAURO	DIMARZIO	DENNIS	GRANT	GUHL	HOLZBERG	MARKS	MATUSKA	ODGREN	OSTASZEWSKI	ROSENBLATT	SINAGRA	STRAUSS	VANDERVAULK	YAXLEY
11 PEDIATRIC INTENSIVE CARE UNIT (PICU) SERVICES	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	ABST.	Y	Y	N
12 BURN PROGRAM SERVICES	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	ABST.	Y	Y	N
13 ORGAN BANK	N	N	N	N	N	N	N	N	N	N	N	ABST.	N	N	N
14 SPECIALIZED PERINATAL AND PEDIATRIC SERVICES	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	ABST.	Y	ABST.	N
15 CHILDREN'S HOSPITALS	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	ABST.	Y	ABST.	N
16 NEW GENERAL ACUTE CARE HOSPITALS	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	ABST.	Y	Y	N
17 CLOSURE OF ACUTE CARE HSOPTIALS	N	N	N	No with qualifica-tions	N	N	N	N	N	N	N	ABST.	N	If not CN, need more than notice	N
18 TRANSFER OF OWNERSHIP OF EXISTING GENERAL ACUTE CARE HOSPITALS-MORE FROM DIRECT TO EXPEDITED REVIEW, DHSS TO DEVELOP & IMPLEMENT REVIEW CRITERIA	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	ABST.	Y	Same as above: need more than ER or notice	Y

COMMISSION MEMBERS

Y=MAINTAIN CN
N=DO NOT MAINTAIN CN

LONG-TERM CARE SERVICES	DEL MAURO	DIMARZIO	DENNIS	GRANT	GUHL	HOLZBERG	MARKS	MATUSKA	ODGREN	OSTASZEWSKI	ROSENBLATT	SINAGRA	STRAUSS	VANDERVAULK	YAXLEY
NURSING HOMES	N	Y	Y	Y	Y	Y	Y	N	Y	N	Y	ABST.	Y	Y	N
ASSISTED LIVING RESIDENCES AND COMPREHENSIVE PERSONAL CARE HOMES	N	Y	Y	Y	Y	Y	Y	N	Y	N	Y	ABST.	Y	NEED MORE THAN CURRENT ER PROCESS	N
ASSISTED LIVING PROGRAMS	N	Y	Y	N	Y	Y	Y	N	Y	N	N	ABST.	Y	NEED MORE THAN CURRENT ER PROCESS	N
HOME HEALTH	N	Y	Y	Y	Y	Y	Y	N	Y	N	Y	ABST.	Y	Y	N