CHAPTER 33A

CERTIFICATE OF NEED: HOSPITAL POLICY MANUAL

Authority

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

Source and Effective Date

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

Executive Order No. 66(1978) Expiration Date

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

Chapter Historical Note

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

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

See section annotations for specific rulemaking activity.

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SUBCHAPTER 1. GENERAL PROVISIONS

8:33A–1.1 Purpose and scope

(a) The purpose of these rules is to set forth requirements governing certificate of need applications for all inpatient and outpatient hospital-based capital "projects" (as that term is defined below), which are not specifically addressed elsewhere in the Department's health planning rules.

1. These rules specifically do not apply to hospital capital projects in which the total project or purchase cost does not exceed five percent of the applicant hospital's operating revenues for the year in which the project or purchase is undertaken, which projects are exempt from the certificate of need requirement pursuant to N.J.S.A. 26:2H–7b.

(b) Inasmuch as the hospital capital projects subject to these rules can include components which may themselves implicate other certificate of need standards and criteria not fully set forth herein, applicants are advised that the policies, standards, and criteria set forth in this chapter are in addition to and not in limitation of any other applicable certificate of need authorities, specifically including, but not limited to, those in N.J.S.A. 26:2H–1 et seq. and N.J.A.C. 8:33, the various service specific health planning rules, any applicable licensing authorities, or any specific conditions imposed upon facilities in their certificate of need approvals. Failure to comply with these requirements will result in the application not being accepted for processing, pursuant to N.J.A.C. 8:33–4.5.

Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
References to Health Care Cost Reduction Act added.
Amended by R.1996 d.102, effective February 20, 1996.
See: 27 N.J.R. 4190(a), 28 N.J.R. 1242(a).

8:33A–1.2 Definitions

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

"Acquisition" means the obtaining of a health care facility or service which requires a certificate of need, through purchase, lease, donation or other means.

"Adjusted admission" means inpatient admissions multiplied by total gross revenue divided by inpatient gross revenue.

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

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"Ambulatory surgical case" and "same day surgical case" are synonymous terms for a surgical procedure performed on a patient in a surgical facility generally requiring anesthesia, with a facility-based post surgery period of at least one hour, and generally without the requirement of an overnight stay.

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

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

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

"Department" means the New Jersey Department of Health.

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

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

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

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

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

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

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

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

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

"Local Advisory Board" means an independent, private non-profit corporation established pursuant to N.J.S.A. 26:2H–5.9, which is not a health care facility, a subsidiary thereof or an affiliated corporation of a health care facility, that is designated by the Commissioner of Health to serve as the regional health planning agency for a designated region in the State.

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

"Medically underserved " means those segments of the population whose utilization of health care services is less than those numbers approximately proportionate to their presence in the population as adjusted to account for their need for such services. Medically underserved includes, but is not limited to, racial and ethnic minority populations, migrant workers, the handicapped, Medicaid recipients, and the medically indigent, defined as those individuals lacking third party insurance coverage whose income is less than or equal to 200 percent of the United States Department of Health and Human Services Income Poverty Guidelines, 42 U.S.C. 9902(2).

"Modernization/renovation" means the alteration, expansion, major repair, remodeling, replacement, and renovation of existing buildings, and the replacement of obsolete equipment of existing buildings.

"Operating room" means a room specifically dedicated to the performance of surgical cases which meets the State Uniform Construction Code, at N.J.A.C. 5:23–3 and the Department's licensing requirements. For purposes of this definition, rooms specifically dedicated to endoscopic and cytoscopic procedures are not considered operating rooms.

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

"Postanesthesia care unit" means a room, or area, used for postanesthesia recovery of patients which meets the State Uniform Construction Code, at N.J.A.C. 5:23–3 and the Department's licensing requirements.

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

"Project" is used interchangeably with "capital project" and means the compilation, during a single calendar year, of architectural, engineering and/or construction services for renovation provided by individuals or firms which are not employees of the hospital and for which financing is required to fund the project. If the hospital incurs capital expenditures without use of the external services as described above, then each planned renovation of any discrete area or unit of the hospital shall be considered a separate project.

"Project component" means any element of a project as proposed in a certificate of need application submitted in accordance with the provisions of this chapter that is associated with the modernization or renovation, expansion, or new construction of an identifiable physical plant area, such as a nursing unit, ancillary department, administrative area, or any structural element of the facility.

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

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

"Same day surgical case" and "ambulatory surgical case" are synonymous terms for a surgical procedure performed on a patient in a surgical facility generally requiring anesthesia, with a facility-based post surgery period of at least one hour and without the requirement of an overnight hospital stay.

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

"Surgical facility" means a structure or suite of rooms which has the following characteristics:

1. At least two rooms dedicated for use as operating rooms which are specifically equipped to perform surgery. These rooms are designed and constructed to accommodate invasive diagnostic and surgical procedures; and,

2. One or more postanesthesia care units or a dedicated recovery area where the patient may be closely monitored and observed until discharged.

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

Amended by R.1990 d.463, effective September 17, 1990.
See: 22 N.J.R. 1891(a), 22 N.J.R. 3014(a).
Definitions added for LDRP and postpartum beds.
Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
Definitions for "equity," "major moveable equipment," "medically underserved groups," "total project cost" amended; definition for "local health planning agency" deleted; definition for "Local Advisory Board" added.
Recodified from 8:33A–1.3 and amended by R.1996 d.102, effective February 20, 1996.
See: 27 N.J.R. 4190(a), 28 N.J.R. 1242(a).

8:33A–1.3 General policies

(a) As set forth in N.J.A.C. 8:33A–1.1(b), all applications for certificate of need under this chapter shall be subject to the general policies for certificate of need review set forth at N.J.S.A. 26:2H–8 and N.J.A.C. 8:33.

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

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

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

3. The applicant will assure that the medically underserved as defined at N.J.A.C. 8:33A–1.3 have access to all services offered by the facility.

(c) The Department of Health shall, all other factors being equal, give preference to applicants which do any of the following:

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

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

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

(d) The applicant shall identify alternative approaches to the project which were considered and demonstrate in specific terms how the option selected, relative to all other

alternatives, most effectively benefits the health care system through achieving capital and operational savings, increasing access, and/or improving quality of care.

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

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

Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
References to Health Care Cost Reduction Act added.
Amended by R.1993 d.669, effective December 20, 1993.
See: 24 N.J.R. 4476(a), 25 N.J.R. 6019(a).
Recodified from 8:33A–1.2 and amended by R.1996 d.102, effective February 20, 1996.
See: 27 N.J.R. 4190(a), 28 N.J.R. 1242(a).

8:33A–1.4 Standards regarding minimum size; acute general hospitals

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

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

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

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

4. Facilities with less than 200 beds that are granted exceptions according to the criteria identified at N.J.A.C. 8:33A–1.11(a)2 and 1.11(b)1–2.

Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
Text at (a)2 revised to delete "justified" and require need to be consistent with health planning rules.
Recodified from 8:33A–1.5 and amended by R.1996 d.102, effective February 20, 1996.
See: 27 N.J.R. 4190(a), 28 N.J.R. 1242(a).
Former section, "Scope", repealed.

8:33A–1.5 Minimum size of obstetric units

(a) The minimum size of an obstetric service shall be 10 beds.

(b) All hospitals seeking to initiate or expand obstetric services shall demonstrate the ability to comply with current hospital licensure standards at N.J.A.C. 8:43G–19.

(c) In addition to the standards and criteria set forth in this section, applications for the initiation or expansion of obstetric services shall be submitted and reviewed in accordance with N.J.A.C. 8:33 and Regionalized Perinatal Services at N.J.A.C. 8:33C. Pending conforming amendments to N.J.A.C. 8:33C, Regionalized Perinatal Services, and notwithstanding any provisions of N.J.A.C. 8:33C to the contrary, applications for community perinatal center-birthing center and community perinatal center-basic shall be subject to expedited review pursuant to N.J.A.C. 8:33–5.

Recodified from 8:33A–1.6 and amended by R.1996 d.102, effective February 20, 1996.
See: 27 N.J.R. 4190(a), 28 N.J.R. 1242(a).

8:33A–1.6 Standards regarding minimum size; pediatric units

(a) The minimum size of a pediatric unit shall be six beds.

(b) All hospitals seeking to initiate or expand pediatric services shall demonstrate the ability to comply with current hospital licensure standards at N.J.A.C. 8:43G–22.

(c) Applications for the initiation or expansion of pediatric services shall be submitted and reviewed in accordance with N.J.A.C. 8:33. Applications for the initiation or expansion of basic pediatric services shall be subject to expedited review pursuant to N.J.A.C. 8:33–5.

Recodified from 8:33A–1.7 and amended by R.1996 d.102, effective February 20, 1996.
See: 27 N.J.R. 4190(a), 28 N.J.R. 1242(a).

8:33A–1.7 Limitations on approvals

Certificate of Need approval for construction, renovation, or purchase of a facility is limited to the project as specifically defined in the certificate of need application. Applicants should not infer approval of any additional beds, services, or equipment as a component of the project unless those components are specifically identified in the application and expressly approved by the Commissioner.

Recodified from 8:33A–1.8 and amended by R.1996 d.102, effective February 20, 1996.
See: 27 N.J.R. 4190(a), 28 N.J.R. 1242(a).

8:33A–1.8 Standards regarding shelled space

Projects proposing shelled space shall not be approved unless the applicant can demonstrate significant cost savings using present value analysis as well as the proposed future use for the space.

Recodified from 8:33A–1.9 and amended by R.1996 d.102, effective February 20, 1996.
See: 27 N.J.R. 4190(a), 28 N.J.R. 1242(a).

8:33A–1.9 Standards regarding occupancy rates

(a) Facilities applying for certificate of need approval to provide and/or providers of the following services must demonstrate the ability to attain and/or must maintain the following minimum occupancy rates:

	Minimum
Medical/Surgical	75%
Obstetrics	
LDRP	50%
Postpartum	60%
Pediatrics	
Units of less than 30 beds	50%
Units of 30 and above	60%
ICU/CCU	60%
Psychiatric	70%

(b) The level of excess beds within a hospital shall be that number of licensed beds, which, when deleted from a service, will allow a hospital to achieve minimum occupancy levels as identified in (a) above, for a period two years beyond the projected completion date of the project, as defined at N.J.A.C. 8:33A–1.2 and within the context of capital projects subject to these rules, defined as the "target year". Utilization levels for the target year shall be based on a projection method defined at N.J.A.C. 8:33A–1.13(b), applied forward to the target year.

Amended by R.1990 d.463, effective September 17, 1990.
See: 22 N.J.R. 1891(a), 22 N.J.R. 3014(a).
LDRP and postpartum occupancy rates specified in (a).
Recodified from 8:33A–1.11 and amended by R.1996 d.102, effective February 20, 1996.
See: 27 N.J.R. 4190(a), 28 N.J.R. 1242(a).

8:33A–1.10 Bed need requirements and criteria for the addition, expansion, replacement or conversion of beds

(a) Except as specifically set forth at N.J.A.C. 8:33–3.4 and 6.1(f) and (g), all facilities subject to these rules seeking to add, expand, replace or convert existing beds must obtain certificate of need approval to do so in accordance with the certificate of need review procedures applicable to the particular category of bed need as set forth in N.J.A.C. 8:33. All certificate of need applicants subject to this section should, prior to submitting their applications to the Department, consult with their respective LABs regarding their plans to assure that the projects address community needs. All applicants shall demonstrate compliance with all applicable standards and criteria of N.J.A.C. 8:33, pertinent licensing and health planning regulations and any outstanding certificate of need or licensure conditions.

(b) In addition to all of the requirements set forth in (a) above, applicants for addition, expansion, replacement or conversion of beds shall also be required to document compliance with the following requirements to the extent they apply to the specific category of bed requests:

1. Applicants for bed expansions must exceed, on average, in the previous 18 months the minimum occupancy rates set forth at N.J.A.C. 8:33A–1.9(a) for the service(s) being proposed for expansion and shall demonstrate that they will achieve and maintain an occupancy rate for the service(s) being expanded of no less than the minimum occupancy rates established for that service identified at N.J.A.C. 8:33A–1.9(a) for the year which is two full facility fiscal years after the year of project completion.

2. Applicants for the replacement of existing acute care beds, shall demonstrate that they will achieve an occupancy rate in the service(s) being replaced of no less than the minimum occupancy rates identified at N.J.A.C. 8:33A–1.9(a) for each of the two years beyond project completion.

3. Applicants for bed additions, where there are other acute care hospitals within the applicant's service area which, during the 18 months preceding the filing of the Certificate of Need application failed to meet the minimum occupancy levels identified at N.J.A.C. 8:33A–1.9 within the service type(s) for which expansion is being requested, must provide evidence that the Board of Directors has undertaken good faith efforts to develop mergers, joint ventures, or other shared service arrangements with the underutilized facility(ies).

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

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

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

(d) Applicants seeking to initiate a new service or services, whether by bed additions, expansions, replacement or conversions, shall document the need for the requested beds by an analysis of empirical evidence which demonstrates that beds for the proposed new service are cost effective, beneficial to patients, will measurably improve accessibility and quality of care, and could not be provided in a less costly setting. This analysis shall include, but shall not necessarily be limited to, consideration of the following factors:

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

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

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

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

References to consideration of health planning rules added.
Recodified from 8:33A–1.12 and amended by R.1996 d.102, effective February 20, 1996.
See: 27 N.J.R. 4190(a), 28 N.J.R. 1242(a).
Former section, "Project need", repealed.

8:33A–1.11 Certificate of need requirements for necessary capital modernization/renovation projects

(a) Except as specifically set forth at N.J.A.C. 8:33–3.4 and 6.1, all facilities subject to these rules, seeking to undertake capital modernization/renovation projects as that term is defined above, shall obtain certificate of need approval prior to doing so, in accordance with the applicable certificate of need procedures set forth in N.J.A.C. 8:33. In addition to demonstrating compliance with all applicable standards and criteria of N.J.A.C. 8:33, applicable licensing and planning rules, and outstanding certificate of need or licensure conditions, applicants for certificates of need for capital modernization/renovation shall also meet the following standards and criteria:

1. Utilization standards are as follows:

i. Minimum occupancy rates in each licensed bed category as specified at N.J.A.C. 8:33A–1.9(a) at the conclusion of the project; and

ii. Trends in volume as specified in N.J.A.C. 8:33A–1.10 (admissions, ALOS, and patient days) which indicate occupancy will continue to be above minimum occupancy of remaining licensed beds in each licensed bed category for a period of at least each of the two years beyond completion of the project.

2. Efficient size: A hospital must maintain the minimum size criteria set forth in N.J.A.C. 8:33A–1.4, at the conclusion of the project while maintaining an overall occupancy rate of at least 75 percent. Where it fails to meet this standard, modernization/renovation projects may only be approved where the hospital is geographically isolated, where the application is part of a "joint community application" or where it is part of a hospital merger application as these terms are more specifically defined below.

i. "Geographic isolation" means a lack of another acute care hospital within a 15 mile radius of an applicant hospital, and where at least 40 percent of the residents of the service area utilize the hospital;

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

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

(2) Creation of specific operational cost savings;

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

(4) The continuation of essential community-based psychiatric services (for example, STCF, CCIS, designated screening centers).

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

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

(2) Consolidation of duplicative inpatient, outpatient, therapeutic and diagnostic services and ancillary and administrative functions where appropriate to the overall health care needs of the health service area;

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

(4) The continuation of essential community-based psychiatric services (for example, STCF, CCIS, designated screening centers).

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

4. Track Records will be evaluated in accordance with the following:

i. At the time of application for a certificate of need, the applicant hospital or hospital system shall be in substantial compliance with rules and standards contained in the Hospital Licensing Standards, N.J.A.C. 8:43G. In accordance with the provisions of N.J.A.C. 8:33–4.10(e)3, certificate of need applications shall not be approved for hospitals which are not in substantial compliance.

ii. An exception to (a)4i above shall be granted to applicants who are seeking to remedy areas of noncompliance through implementation of the certificate of need.

Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
Minimum occupancy rates specified for capital projects; exceptions provided.
Recodified from 8:33A–1.13 and amended by R.1996 d.102, effective February 20, 1996.

See: 27 N.J.R. 4190(a), 28 N.J.R. 1242(a).

8:33A–1.12 Certificate of need requirements for capital project components

(a) As referenced at N.J.A.C. 8:33A–1.1(b), capital projects subject to these rules may include distinct components which implicate other certificate of need standards and criteria not specifically set forth herein. A component means any element of the overall project that is associated with the modernization or renovation, expansion, or new construction of an identifiable physical plant area, such as a nursing unit, ancillary department, administrative area, or any structural element of the facility. Each applicant for a capital project subject to these rules shall assess its proposal and determine the extent to which it incorporates such distinct component facilities, equipment or services. For all component parts of the proposed capital project which are not specifically exempted from the requirement of obtaining a certificate of need, the applicant for a capital project subject to this chapter shall also demonstrate compliance with all standards and criteria of N.J.A.C. 8:33, all provisions of the licensing and planning rules, and all outstanding certificate of need or licensure conditions applicable to each distinct component part, specifically including, but not limited to, the following:

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

   i. Correcting functional or structural obsolescence; or

   ii. Correcting life-safety code A and B violations.

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

3. Any component(s) of a certificate of need project not demonstrated to be needed as determined by the Department, based on a review of the applicant's physical plant survey evaluated in accordance with N.J.A.C. 8:43, and all other criteria in this chapter, may be denied.

Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
References to compliance with planning rules added.
Recodified from 8:33A–1.14 and amended by R.1996 d.102, effective February 20, 1996.
See: 27 N.J.R. 4190(a), 28 N.J.R. 1242(a).

8:33A–1.13 Volume projections

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

1. All data shall be consistent with the hospital statistics as reported to the Center for Health Statistics for the New Jersey General Hospital Inpatient Utilization Reports on official SHARE B–2 reporting forms, unless the applicant can demonstrate to the Department with verifiable evidence that there are inaccuracies in the statistical information which was reported.

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

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

2. Adjusted admissions by total hospital;

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

4. Outpatient visits by department or service;

5. Emergency room visits;

6. Inpatient surgical cases;

7. Outpatient surgical cases;

8. Same day surgery cases;

9. Same day medical admissions;

10. Births.

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

1. Linear regression modeling;

2. Constant volume;

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

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

(d) The volume projections must be deemed acceptable to the Department based on conformance to the results of one or more of the methodologies listed in (c) above.

Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
Inpatient surgical cases, outpatient surgical cases and same day surgery cases specified at (b)6, 7, and 8.
Recodified from 8:33A–1.15 and amended by R.1996 d.102, effective February 20, 1996.
See: 27 N.J.R. 4190(a), 28 N.J.R. 1242(a).

8:33A–1.14 Equity contributions and financing

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

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

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

(d) All applicants for capital projects shall demonstrate the financial feasibility of their projects. An appropriate financial feasibility study shall be submitted for projects in excess of $15 million at the time of application. The financial feasibility study shall be prepared by a Certified Public Accountant who has prepared studies for at least three similar health care facilities and shall express an opinion based on an examination of projects as defined in the American Institute of Certified Public Accountant's Guide to Prospective Financial Information. A project will be determined financially feasible where the applicant can demonstrate a net positive income beginning in the calendar or fiscal year which is two years beyond project completion. Financial projections shall be provided for the first two full years after project completion. These projections shall indicate the method of funding any losses incurred during this time period.

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

Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
Equity contributions and financing requirements revised to conform to N.J.A.C. 8:33.
Amended by R.1993 d.570, effective November 15, 1993.
See: 25 N.J.R. 3710(a), 25 N.J.R. 5161(a).
Amended by R.1993 d.669, effective December 20, 1993.
See: 24 N.J.R. 4476(a), 25 N.J.R. 6019(a).
Recodified from 8:33A–1.16 and amended by R.1996 d.102, effective February 20, 1996.
See: 27 N.J.R. 4190(a), 28 N.J.R. 1242(a).

8:33A–1.15 Transfer of services from an acute care hospital

(a) The transfer of a service from one corporation to another, regardless of their relationship, requires a Certificate of Need application in accordance with procedures identified at N.J.A.C. 8:33. In addition to demonstrating compliance with all applicable standards and criteria of N.J.A.C. 8:33, applicable licensing and planning rules, and outstanding certificate of need or licensure conditions, applicants for certificates of need for the transfer of a service from one entity, person or corporation to another must also demonstrate compliance with the following standards and criteria.

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

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

3. The entity, person, or corporation receiving the new service must comply with the following criteria and conditions:

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

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

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

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

Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
Level of indigent care to be considered a factor in review for transfer of services.
Recodified from 8:33A–1.17 and amended by R.1996 d.102, effective February 20, 1996.
See: 27 N.J.R. 4190(a), 28 N.J.R. 1242(a).

8:33A–1.16 Acquisition or replacement of major moveable equipment

(a) Except as specifically set forth at N.J.A.C. 8:33–3.7 and 6.1, the acquisition or replacement of major moveable equipment requires a certificate of need, in accordance with the procedures set forth at N.J.A.C. 8:33. In addition to demonstrating compliance with all applicable standards and criteria of N.J.A.C. 8:33, applicable licensing and planning rules, and outstanding certificate of need or licensure conditions, applicants for the acquisition or replacement of major moveable equipment must also document use of least-cost financing.

(b) Equity contributions to the financing of the project must meet minimum requirements identified at N.J.A.C. 8:33A–1.14(a). In projects proposing both acquisition of major moveable equipment and modernization/renovation, equity contributions must be pro-rated between equipment costs and costs of the remainder of the project.

Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
Certain cost data requirements eliminated at (b)2 and 3.
Recodified from 8:33A–1.18 and amended by R.1996 d.102, effective February 20, 1996.
See: 27 N.J.R. 4190(a), 28 N.J.R. 1242(a).

8:33A–1.17 Outpatient services

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

Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
Competitive pricing requirement eliminated at (b).
Recodified from 8:33A–1.20 and amended by R.1996 d.102, effective February 20, 1996.
See: 27 N.J.R. 4190(a), 28 N.J.R. 1242(a).

8:33A–1.18 Location of hospitals

(a) Proposals for the relocation of or major new construction at an existing hospital by a new corporate entity or for the new construction of an acute care hospital requires certificate of need approval in accordance with the procedures set forth at N.J.A.C. 8:33. In addition to demonstrating compliance with all applicable standards and criteria of N.J.A.C. 8:33–1, applicable licensing and planning rules, and outstanding certificate of need or licensure conditions, applicants for such projects shall also demonstrate compliance with the following standards and criteria:

1. There must be a bed need which complies with standards set forth in N.J.A.C. 8:33A–1.10 in the area of proposed location for all services to be relocated, or a reduction of an appropriate level of excess beds within the relocated facility which will be implemented upon relocation;

2. The applicant must demonstrate that there are sufficient resources (for example, transportation) in the former area to ensure access to care to the former patient population;

3. The proposed site must be accessible to medically underserved populations in the newly-defined service area in terms of driving time and/or public transportation;

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

5. The applicant must at a minimum demonstrate long term reductions in costs.

(b) In addition to the requirements referenced in paragraph (a) above, applicants proposing construction of a new hospital shall demonstrate compliance with all of the following:

1. Bed need as specified in N.J.A.C. 8:33A–1.10 in the area has been documented for each proposed service;

2. The hospital at its proposed location must be physically accessible to patients of the defined service area and must provide care to the medically underserved populations in the proposed location; and

3. All hospitals located within a 25–mile radius of the proposed location shall have occupancy levels which exceed minimum levels as defined in N.J.A.C. 8:33A–1.9 for an average for each year of each of the previous two calendar years.

Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
Exception to bed need requirement added, when relocation reduces beds.
Recodified from 8:33A–1.22 and amended by R.1996 d.102, effective February 20, 1996.
See: 27 N.J.R. 4190(a), 28 N.J.R. 1242(a).

8:33A–1.19 Standards regarding accessibility

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

Recodified from 8:33A–1.24 by R.1996 d.102, effective February 20, 1996.
See: 27 N.J.R. 4190(a), 28 N.J.R. 1242(a).
Former section, "Single-bedded rooms", repealed.

8:33A–1.20 Transfers of ownership of hospitals

(a) Certificates of need for transfer of ownership interests in acute care hospitals shall be required in accordance with the provisions of N.J.A.C. 8:33–3.3. In reviewing certificate of need applications for transfer of ownership of acute care hospitals, the Department shall consider whether or not the anticipated benefits which are reasonably expected to occur will outweigh any potential disadvantages attributable to any reduction in competition that may result from the implementation of the proposed transfer of ownership. A preponderance of the following benefits should occur as a result of any proposed transfer of ownership between acute care hospitals: improved quality of care; the preservation or expansion of access, particularly by medically indigent or medically underserved populations; the diffusion of community-based services and the regionalization of tertiary services; the promotion of affordable health care through gains in cost efficiency, improvements in utilization, and reduced duplication of resources and technological advances.

(b) Pursuant to (a) above, applicants for certificates of need to transfer ownership shall, in addition to demonstrating compliance with all N.J.S.A. 26:2H–1 et seq., N.J.A.C. 8:33, all applicable health planning and licensing rules, and outstanding certificate of need conditions, also demonstrate in their application the following standards and criteria:

1. The extent to which the proposed change will improve the response to documented health care needs in the area(s) served by the hospital(s) proposing the change. Documentation shall include a summary of health care needs in the affected market areas as determined by the appropriate Local Advisory Board(s) (LABs), as well as a description of any proposed changes in services designed to meet those needs;

2. The impact that the proposed change will have on consumer access to health care, in particular the effect on access to medically indigent and medically underserved populations. The applicant shall include:

i. A description of the medically indigent and medically underserved populations in the service area, that is, the numbers and percentages of these populations served by each participating institution; and

ii. Analysis and quantification, to the extent possible, of any anticipated impact, whether positive or negative, that the proposal will have on access by consumers, including medically indigent and medically underserved populations, in the affected market areas;

3. The extent to which the proposed change will affect the availability, array, and location of health care services at the participating hospitals and within the health care system as a whole, with particular concern for the impact it will have within the markets historically served by the participating hospitals. The applicant shall include:

i. A description of the existing array of services at each of the participating hospitals and any proposed changes to that array of services;

ii. A description of the geographic location of the hospitals in relation to one another and descriptions of any services located away from the main hospital campus;

iii. A description of existing physician referral patterns for all participating hospitals; and

iv. A discussion of any changes in costs of services to consumers that are anticipated as a result of this proposal;

4. The extent to which cost efficiencies will be effected and will result in significant net operational savings. The applicant shall include:

i. A description of any services or administrative functions which will be eliminated or modified as a result of the proposed change; and

ii. A quantification, to the extent possible, of the savings to the participating hospitals and the health care system as a whole that are anticipated as a result of the proposed change;

5. A reduction of all excess bed capacity, as determined under the standards at N.J.A.C. 8:33A–1.9, which will result for all participating hospitals through decertification or conversion of acute care beds;

6. The extent to which duplication of services will be eliminated where appropriate;

7. The extent to which the proposed change will have an adverse economic or financial impact on the delivery of health care services in the region or Statewide;

8. The extent to which the proposed change is likely to result in any reduction in competition and the extent to which any reduction in competition is necessary to achieve the benefits that can be expected from the proposed change. The applicant shall include:

i. A description of the geographic areas presently being served by each participating hospital, including the market share percentages served by each hospital in each area;

ii. A description of the impact on each hospital's market share anticipated as a result of the proposed change;

iii. A description of the impact on each hospital's physician referral patterns; and

iv. A description of the market formed as a result of the proposed change, that is, the redefined service area(s) and the percentage market share(s) of the newly formed hospital system within that redefined service area; and

9. The extent of any change in financial status for the parties involved in the transfer of ownership. The applicant shall include:

i. Audited financial statements for the two most recent years, and projected financial statements for the current year and following four years. Financial statements shall include a delineation of any cost savings which are expected to occur as a result of the transfer of ownership; and

ii. A description of project costs and an independently verified purchase price when appropriate. Compliance with the requirements of N.J.A.C. 8:33A–1.16 equity contributions and financing shall be demonstrated.

Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
Stylistic changes.
Recodified from 8:33A–1.25 and amended by R.1996 d.102, effective February 20, 1996.
See: 27 N.J.R. 4190(a), 28 N.J.R. 1242(a).

8:33A–1.21 Closure of services

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

Amended by R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
Stylistic changes.
Recodified from 8:33A–1.26 and amended by R.1996 d.102, effective February 20, 1996.
See: 27 N.J.R. 4190(a), 28 N.J.R. 1242(a).
Former section, "Standards regarding energy conservation projects", repealed.

8:33A–1.22 Decertification of unused beds

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

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

New Rule, R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
Recodified from 8:33A–1.27 by R.1996 d.102, effective February 20, 1996.
See: 27 N.J.R. 4190(a), 28 N.J.R. 1242(a).

8:33A–1.23 Hospital physical plant survey

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

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

New Rule, R.1992 d.512, effective December 21, 1992.
See: 24 N.J.R. 3280(a), 24 N.J.R. 4528(a).
Recodified from 8:33A–1.28 by R.1996 d.102, effective February 20, 1996.
See: 27 N.J.R. 4190(a), 28 N.J.R. 1242(a).
Former section, "Standards regarding costs of parking garages, medical arts buildings, child day care centers or other non-direct patient care services/construction", repealed.

8:33A–1.24 Surgical facilities

(a) In addition to demonstrating compliance with all applicable standards and criteria of N.J.A.C. 8:33, applicable licensing and planning rules and outstanding certificate of need conditions, applicants proposing addition, deletion or alteration of hospital-based operating rooms, surgical facilities and services shall follow the certificate of need requirements identified at N.J.A.C. 8:33–4.1(a). These rules shall not apply to the provision of cardiac surgical services or any other special surgical service which is the subject of a separate Department of Health planning regulation. Applications for additions, deletions, or alteration of operating rooms and surgical facilities shall be accepted in accordance with policies and procedures of the full certificate of need review process set forth in N.J.A.C. 8:33.

(b) Information provided by all applicants for inpatient operating rooms shall include the following:

1. The expected number of recovery beds and/or recliners;

2. The total expected number of surgical cases, by each type of surgery;

3. The expected payor percentages; and

4. A detailed description of the proposed service area, accompanied by a legible map which includes a distance scale and physical relationship to other existing surgical services within the proposed service area and immediately

bordering the area. The rationale justifying the delineation of the service area chosen by the applicant shall be included, with supporting quantifiable evidence. The Department shall determine the reasonableness of the defined service area, using existing market share and patient origin date.

(c) For the purposes of certificate of need review, the capacity of each type of licensed inpatient/mixed operating room (OR) shall be calculated as follows:

1. Dedicated inpatient OR = 1,000 surgical cases annually;

2. Mixed (inpatient/same day surgery) OR = 1,090 surgical cases annually; and

3. Dedicated SDS OR = 1,500 surgical cases annually.

(d) Where all other criteria of this section are met, no application for a new inpatient/mixed surgical service, or increase in the number of operating rooms in an existing surgical service, shall be approved unless all of the following conditions are met:

1. The applicant has documented that its existing surgical caseload exceeds the capacity of its licensed operating rooms for the past 12 months prior to the submission of this certificate of need application;

2. The applicant has agreed, as part of the application, to limit the proposed addition of operating room capacity to that number of operating rooms necessary to reduce its surgical case utilization level to 80 percent of its operating room capacity at the time the application is submitted; and

3. The applicant has documented that sufficient access to alternative surgical providers that share the service area is not readily available.

(e) Applicants seeking to replace their existing inpatient/mixed operating rooms shall document that existing annual surgical caseload, during the year immediately prior to the submission of the application, exceeds 75 percent of the hospital's surgical capacity, using the capacity levels specified at (c)1 through 3 above.

(f) An ambulatory surgery facility shall comply with the State Uniform Construction Code, at N.J.A.C. 5:23–3 and the Department's licensing requirements.

(g) A postanesthesia care unit shall comply with the State Uniform Construction Code, at N.J.A.C. 5:23–3 and the Department's licensing requirements.

(h) Hospitals may submit applications for dedicated SDS operating rooms, either freestanding or within the hospital, as an expedited CN review and in accordance with criteria identified at N.J.A.C. 8:33–5.1 and 5.3(a)4. These facilities shall also comply with Standards for Licensure of Ambulatory Care Facilities at N.J.A.C. 8:43A.

New Rule, R.1996 d.102, effective February 20, 1996.
See: 27 N.J.R. 4190(a), 28 N.J.R. 1242(a).

8:33A–1.25 (Reserved)
Recodified as 8:33A–1.20 by R.1996 d.102, effective February 20, 1996.
See: 27 N.J.R. 4190(a), 28 N.J.R. 1242(a).

8:33A–1.26 (Reserved)
Recodified as 8:33A–1.21 by R.1996 d.102, effective February 20, 1996.
See: 27 N.J.R. 4190(a), 28 N.J.R. 1242(a).

8:33A–1.27 (Reserved)
Recodified as 8:33A–1.22 by R.1996 d.102, effective February 20, 1996.
See: 27 N.J.R. 4190(a), 28 N.J.R. 1242(a).

8:33A–1.28 (Reserved)
Recodified as 8:33A–1.23 by R.1996 d.102, effective February 20, 1996.
See: 27 N.J.R. 4190(a), 28 N.J.R. 1242(a).

8:33A–1.29 (Reserved)
Repealed by R.1996 d.102, effective February 20, 1996.
See: 27 N.J.R. 4190(a), 28 N.J.R. 1242(a).
Section was "Hospital capital cap and review process".