CHAPTER 33H

CERTIFICATE OF NEED: POLICY MANUAL FOR LONG TERM CARE SERVICES

Authority

N.J.S.A. 26:2H–5 and 26:2H–8.

Source and Effective Date

R.2001 d.104, effective March 1, 2001.
See: 32 N.J.R. 4071(a), 33 N.J.R. 1101(a).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1c, Chapter 33H, Certificate of Need: Policy Manual for Long Term Care Services, expires on September 12, 2004. See: 36 N.J.R. 1641(a).

Chapter Historical Note

Chapter 33H, Certificate of Need: Reviews of Long–Term Care Facilities and Services, was adopted as R.1980 d.404, effective September 18, 1980. See: 12 N.J.R. 393(a), 12 N.J.R. 579(b).

Pursuant to Executive Order No. 66(1978), Chapter 33H was readopted as R.1985 d.413, effective July 19, 1985. See: 17 N.J.R. 1216(a), 17 N.J.R. 2034(a).

Pursuant to Executive Order No. 66(1978), Chapter 33H, Certificate of Need: Reviews of Long–Term Care Facilities and Services, was readopted as R.1990 d.303, effective May 16, 1990. See: 22 N.J.R. 897(a), 22 N.J.R. 1938(a).

Chapter 33H, Certificate of Need: Reviews of Long–Term Care Facilities and Services, was repealed and a new Chapter 33H, Certificate of Need Policy Manual for Long Term Care Services, was adopted by R.1992 d.344, effective September 8, 1992. See: 24 N.J.R. 2014(a), 24 N.J.R. 3144(a).

Pursuant to Executive Order No. 66(1978), Chapter 33H, Certificate of Need Policy Manual for Long Term Care Services, expired on September 8, 1997.

Chapter 33H, Certificate of Need: Policy Manual for Long Term Care Services, was adopted as new rules by R.1998 d.134, effective March 16, 1998. See: 29 N.J.R. 3794(a), 30 N.J.R. 1085(a).

Pursuant to Executive Order No. 66(1978), Chapter 33H, Certificate of Need: Policy Manual for Long Term Care Services, was readopted as R.2001 d.104, effective March 1, 2001. See: Source and Effective Date.

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SUBCHAPTER 1. GENERAL PROVISIONS

8:33H–1.1 Purpose; scope

(a) The purpose of this chapter is to set forth Certificate of Need and related planning requirements for long-term care services.

(b) The Department has a major responsibility for the promotion of high quality, efficiently and economically rendered health services which are available to all citizens of the State. To ensure significant progress toward the achievement of this goal, the Department should direct planning and Certificate of Need activities toward the following:

1. Health promotion and minimization of debilitation;

2. Enhancement of the quality of life of long-term care consumers/patients and their families and/or significant others;

3. Expansion of long-term care options to maximize consumer choice;

4. Increased geographic, economic, and architectural accessibility of long-term care services;

5. Expansion of long-term care services to the extent that they are needed, while minimizing excess, underutilized capacity;

6. Increased affordability of long-term care services, the cost of which must be borne by consumers and the government;

7. Access to long-term care services without regard to race, ethnicity, or medical diagnoses, including HIV infection or a history of psychiatric illness;

8. Coordination of long-term care services; and

9. Community participation in decision-making about the development of expanded long-term care services.

(c) The rules contained in this chapter address the Certificate of Need requirements for the following categories and types of facilities, as they are defined in N.J.A.C. 8:33H–1.2:

1. Nursing homes;
2. Comprehensive personal care homes;
3. Pediatric long-term care;
4. Specialized long-term care;
5. Assisted living residences;
6. Assisted living programs;
7. Statewide restricted admissions facilities;
8. Residential health care facilities;
9. Alternate family care programs; and
10. Hospital-based subacute long term care units.

(d) Home health care is recognized as an important component of the long-term care system; however, the Certificate of Need requirements for home health care agencies are not contained in this chapter. Applicants interested in offering home health services in New Jersey should refer to N.J.A.C. 8:33L.

(e) Some patients in nursing homes may, on occasion, require rehabilitative care. The rehabilitative services offered to patients in most nursing homes are distinguished from comprehensive rehabilitation, which may only be offered by a licensed rehabilitation hospital. Applicants interested in offering comprehensive rehabilitation should refer to N.J.A.C. 8:33M.

(f) The provisions contained in this chapter shall apply uniformly to Certificate of Need applications for private and public facilities, whether State, county, municipal, incorporated, not incorporated, proprietary, or nonprofit, unless it is otherwise stated.

(g) Where a Certificate of Need is granted for long-term care beds, the applicant shall agree to occupy those beds with patients who require general nursing home care or, if so designated in the letter of approval, specialized long-term care. Applicants approved for long-term care beds shall not admit patients who require a different licensing category of care, such as comprehensive rehabilitation, unless the Commissioner has determined that admission is warranted to respond to an emergency situation and has granted approval in writing.

1. Applicants shall not advertise their facilities' services in such a way that consumers might reasonably construe that the level of care provided is something other than general nursing home care or, if so designated in the letter of approval, specialized long-term care.

Amended by R.1993 d.671, effective December 20, 1993.
See: 25 N.J.R. 3719(a), 25 N.J.R. 6031(a).

Case Notes

Religiously sponsored nursing homes not exempt from certificate of need requirements: religious need another factor in certificate determination. Attorney General Formal Opinion 1974–No. 2.

8:33H–1.2 Definitions

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

"Adult day health care program" means a facility which is licensed by the Department of Health to provide preventive, diagnostic, therapeutic, and rehabilitative services under medical supervision to meet the needs of functionally impaired adult patients. Adult day health care facilities provide services to patients for a period of time which does not exceed 12 hours during any calendar day.

"Aging in place" means a process whereby individuals remain in their living environment despite the physical and/or mental decline and growing needs for supportive services that may occur in the course of aging. For aging in place to occur, services are added, increased, or adjusted to compensate for the person's physical and/or mental decline.

"AIDS Community Care Alternatives Program" or "AC-CAP" means a Medicaid Federal waiver program which offers all Medicaid services plus special home and community-based services, including case management, to persons who are financially eligible and diagnosed as having AIDS. At a minimum, the person must meet the nursing facility level of care criteria and be maintained in the community at a cost that is no greater than the cost to Medicaid for institutional care.

"Alternate family care" means a contractual arrangement whereby no more than three persons receive room, board, personal care, and other health care services from and in the home of an unrelated individual who has been approved by a sponsor agency and trained to provide the necessary caregiving.

"Alternate family care program" means a program operated by a community-based agency, institution, facility, or private entity which is responsible for recruiting, screening, training, and supervising alternate family caregivers, as well as matching clients with alternate family caregivers and monitoring client status within this arrangement.

"Applicant" means an individual, a partnership, a corporation (including associations, joint-stock companies, and insurance companies), or a political subdivision (including a county or municipal corporation) that submits a Certificate of Need application.

"Assisted living" means a coordinated array of supportive personal and health services, available 24 hours per day, to residents who have been assessed to need these services, including residents who require formal long-term care. Assisted living promotes resident self-direction and participation in decisions that emphasize independence, individuality, privacy, dignity, and homelike surroundings.

"Assisted living program" means the provision of or arrangement for meals and assisted living services, when needed, to the tenants (also known as residents) of publicly subsidized housing which because of any Federal, State, or local housing laws, regulations or requirements cannot become licensed as an assisted living residence. An assisted living program may also provide staff resources and other services to a licensed assisted living residence and a licensed comprehensive personal care home.

"Assisted living program provider" means an organization licensed by the New Jersey Department of Health and Senior Services, in accordance with N.J.A.C. 8:36, to provide all services required of an assisted living program.

"Assisted living residence" means a facility which is licensed by the Department, in accordance with N.J.A.C. 8:36, to provide apartment-style housing and congregate dining and to assure that assisted living services are available when needed, to four or more adult persons unrelated to the proprietor. Apartment units offer, at a minimum, one unfurnished room, a private bathroom, a kitchenette, and a lockable door on the unit entrance.

"Commissioner" means the New Jersey State Commissioner of Health and Senior Services.

"Community Care Program for the Elderly and Disabled" or "CCPED" means a Medicaid-funded, Federally waivered program offering all Medicaid services plus special home and community-based services, including case management to persons who meet specific medical and financial nursing facility eligibility criteria. At a minimum, the person must meet the nursing facility level of care criteria and be maintained in the community at a cost that is no greater than the cost to Medicaid for institutional care.

"Comprehensive personal care home" means a facility which is licensed by the Department, in accordance with N.J.A.C. 8:36, to provide room and board and to assure that assisted living services are available when needed, to four or more adults unrelated to the proprietor. Residential units in comprehensive personal care homes house no more than two residents and have a lockable door on the unit entrance.

"Continuing care retirement community" means the provision of lodging and nursing, medical, or other related services at the same or another location to an individual pursuant to an agreement effective for the life of the individual or for a period greater than one year, including mutually terminable contracts, and in consideration of the payment of an entrance fee with or without other periodic charges. A fee which is less than the sum of the regular periodic charges for one year of residency is not considered an entrance fee. For Certificate of Need exemption purposes, a new or proposed community which will have fewer than four independent living units per nursing facility bed, or an existing community which proposes to construct additional nursing facility beds which will be utilized by persons who have not paid the entrance fee, is not a continuing care retirement community. The required four to one ratio shall be maintained at all times. Beds licensed as assisted living residence, comprehensive personal care home or residential health care may be counted in the numerator of this ratio, at the discretion of the applicant.

"Deficiency" means a finding or findings by the Department that a facility is not in compliance with applicable State licensure requirements and/or Federal requirements for a health care facility. A deficiency remains valid unless overruled by the Commissioner of Health and Senior Services or a judicial appeal process.

"Department" means the New Jersey State Department of Health and Senior Services.

"Direct admission Medicaid patient" or "resident" means an individual who is admitted to a long-term care bed as a Medicaid eligible patient, or a private paying patient who will spend down to Medicaid eligibility within 180 days of placement in the long-term care bed.

"Financially feasible" means revenues exceed expenses during or before the third year subsequent to implementation of a certificate of need-approved project.

"General long-term care bed" means a long-term care bed for which there is no restriction imposed by certificate of need approval requirements or stipulations that would limit the type of nursing home patient who may occupy the bed or the type of nursing home care which may be provided to the occupant of the bed.

"Hospice" means a program of palliative and supportive services provided to terminally ill persons and their families in the form of physical, psychological, social, and spiritual care.

"Hospital-based subacute long term care unit" means a unit located within an acute care general hospital which utilizes licensed long-term care beds to provide subacute care for patients.

"Local Advisory Board" or "LAB" means a regional health planning agency designated by the Department to make assessments and recommendations regarding the health needs within a specified geographical area. Local Advisory Board areas are as follows:

1. LAB region I: Morris, Sussex, Passaic, Hunterdon, Mercer, Middlesex, Somerset and Warren Counties;

2. LAB region II: Bergen, Essex, Union and Hudson Counties; and

3. LAB region III: Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Monmouth, Ocean and Salem Counties.

"Long-term care" means a wide range of personal care, psycho-social, nursing, and other supportive services for people with functional limitations due to chronic—and frequently degenerative—physical or cognitive disorders. Long-term care services range from in-home assistance provided by family members or a home care agency to nursing home care.

"Long-Term Care Committee" or "Committee" means a county-based group of volunteers which is designated by the Local Advisory Board for the purpose of identifying and addressing the county's service coordination issues, access problems, and public education needs pertaining to long-term care. In counties where there is a need for additional long-term care placements, the Committee has responsibility for formulating a placement mix proposal.

"Long-term care placement" means a unit of service provided to an individual requiring long-term care. The unit may be a bed, for example, a nursing home bed, or a slot, for example, an adult day health care slot.

"Medicaid-eligible patient" means, for the purpose of this chapter, a person who has received a determination of medical and financial eligibility for Medicaid coverage, or a person who qualifies medically and financially for Medicaid but who does not apply for Medicaid coverage, or a person whose care is paid for through General Assistance funds.

"Nursing home" or "nursing facility" means a facility that is licensed by the Department to provide health care under medical supervision and continuous nursing care for 24 or more consecutive hours to two or more patients who do not require the degree of care and treatment which a hospital provides and who, because of their physical or mental condition, require continuous nursing care and services above the level of room and board.

"Nursing home-level care" means care provided to individuals who have chronic medical condition(s) resulting in moderate to severe impairments in physical, behavioral, cognitive, and/or psychosocial functioning. The need for nursing home-level care and services is determined by a registered nurse and identified in a plan of care, in accordance with N.J.A.C. 8:36–7.1 "Nursing home-level care" includes, but is not limited to, partial or total assistance with activities of daily living (for example, bathing, dressing, eating, toileting, mobility), assistance with self-administering or administration of medications, and provision of treatments and periodic reassessments as directed by the plan of care. It may also include the provision of physiotherapy, occupational therapy, therapeutic counseling, and other rehabilitative services as indicated by the individual's medical condition.

"Pediatric long-term care" means a facility, distinct nursing unit, or program which is dedicated for occupancy by patients under age 20.

"Placement mix proposal" means a proposal formulated by a county Long-Term Care Committee specifying the number and types of long-term care placements which should be developed in order to meet the future needs of county residents.

"Project" means the construction, renovation, and/or related activities which are required in order to implement a certificate of need.

"Residential health care facility" means a facility which provides food, shelter, supervised health care and related services to four or more persons 18 years of age or older who are unrelated to the owner or administrator.

"Respite care" means a service that provides a brief period of relief from caregiving responsibilities for the family members and friends of individuals who require long-term care. It may be offered either on an outpatient basis, for example, in the form of adult day health care, or an inpatient basis, for example, in the form of residential health care.

"Specialized care" or "specialized long-term care" means a program of care provided in licensed long-term care beds for patients who require technically complex treatment with life supporting equipment, or who have serious problems accessing appropriate nursing home care due to their special treatment requirements as dictated by their medical diagnoses and level of functional limitation.

"Statewide restricted admissions facility" means a non-profit nursing home owned and operated by a religious or fraternal organization that serves only members of that organization and their immediate families.

"Subacute care" in an acute care general hospital means a comprehensive in-patient program for patients who have had an acute illness, injury or exacerbation of a disease process, have a determined course of treatment prescribed, and do not require intensive diagnostic or intensive invasive procedures, but the patient's condition requires physician direction, intensive nursing care, frequent recurrent patient assessment and review of the clinical course and treatment plan for a period of time, significant use of ancillary medical services and an interdisciplinary approach using professional teams of physicians, nurses and other relevant professional disciplines to deliver complex clinical interventions.

8:33H–1.3 Role of counties, Local Advisory Boards, and the State in long-term care planning

(a) Local Advisory Boards shall appoint a Long-Term Care Committee in each county within their region.

1. Each Long-Term Care Committee shall have at least 15 members, with equal representation from the following three sectors and no more than one person representing any agency or organization. The three sectors shall be:

i. Consumers, including users and potential users of long-term care services and their family members. To be recognized as a consumer, the person shall have no employment or ownership ties (either direct or familial) to an agency, facility, or program that provides long-term care or related health services in the county;

ii. Providers, including health and social service professionals, and the employees and owners of agencies, facilities, and programs providing long-term care or other health services; and

iii. Governmental, planning, and funding agencies, such as the county's Agency on Aging, Planning Board, Board of Social Services, Long-Term Care Field Office, United Way, and Human Services Advisory Council.

2. All Long-Term Care Committee meetings shall be open to the public and shall provide opportunities for public comment.

3. All Long-Term Care Committee meetings shall be held in a handicap-accessible location within the county.

4. To the extent that data are available, the Local Advisory Board shall provide the most recent county-specific, LAB region-specific, and statewide long-term care and population data for consideration at the county Committee meetings.

(b) In each county where there is a projected need for new long-term care placements in accordance with the methodology specified in N.J.A.C. 8:33H–1.4, the Long-Term Care Committee shall formulate a proposal specifying the mix of options and the number of placements of each type that are to be developed in the county. Options shall be:

1. Alternate family care placements;

2. Home and community-based service waiver slots; that is, Community Care Program for the Elderly and Disabled (CCPED) and AIDS Community Care Assistance Program (ACCAP);

3. Comprehensive personal care homes;

4. Assisted living residences;

5. Nursing facility beds; and

6. Assisted living programs.

(c) The county Long-Term Care Committee shall be responsible for formulating or updating its placement mix proposal as described in (b) above by August 1 of each year.

1. The placement mix proposal shall be finalized by the county Committee by a majority vote, in which each Committee member shall have one independent vote.

2. At the time that the county Committee has voted on and finalized its placement mix proposal, including the desired number of placements for each option, the Local Advisory Board shall record the proposal in writing, including the Committee's stated rationale for selecting its mix of options.

(d) The Local Advisory Board shall make a determination as to whether each county's placement mix proposal and the process whereby it was developed by the county Long-Term Care Committee comply with all applicable requirements contained in this chapter.

1. When compliance with the requirements of this chapter has been determined, the Local Advisory Board shall accept the county's placement mix proposal and transmit it, along with the county Committee's rationale, to the Department so that implementation may be initiated. However, should the Department, in consultation with the State Health Planning Board, identify that a county placement mix proposal is not in compliance with the rules as they have been applied uniformly in reviewing all county placement mix proposals, the proposal will be returned to the Local Advisory Board for corrective action prior to implementation.

2. In the event that the Local Advisory Board determines noncompliance with the requirements of this chapter, the placement mix proposal shall be returned to the county Long-Term Care Committee, with a written statement identifying the reasons why it cannot be accepted. The county Long-Term Care Committee shall then revise or re-formulate the proposal for reconsideration by the LAB.

3. In the event that a county has not developed a placement mix proposal which is accepted by the Local Advisory Board within the time frame stipulated in (c) above, a "default" proposal shall be developed and implemented for the county by the State Health Planning Board. Options available in the default mix proposal shall be:

i. Alternate family care placements;

ii. Home and community-based service waiver slots; that is, Community Care Program for the Elderly and Disabled (CCPED) and AIDS Community Care Assistance Program (ACCAP);

iii. Comprehensive personal care homes;

iv. Assisted living residences; and

v. Assisted living programs.

(e) On an annual basis, the Department, in collaboration with the Departments of Human Services and Community Affairs, shall conduct education/information sharing sessions for Local Advisory Board staff, county Long-Term Care Committee members, and other interested individuals, regarding the various long-term care options, interpretation of long-term care data, and the formulation of county long-term care placement mix proposals.

(f) In proposing the desired mix of new long-term care options, county Long-Term Care Committees shall take into consideration local conditions, to the extent that data are available, as follows:

1. Waiting lists, utilization data, and availability of existing long-term care services, both non-institutional and institutional;

2. Potential capacity of services which have received Certificate of Need approval but which are not yet licensed and operational;

3. Demographic data, such as age-specific population projections and estimates;

4. Data regarding consumer preferences for long-term care options;

5. Health personnel supply and staffing and resource availability;

6. Financial, cultural, and geographical access barriers to existing services;

7. Land use availability for new facility-based long-term care services, including assisted living residences; and

8. Medicaid Pre-Admission Screening data.

(g) The county Long-Term Care Committee's placement mix proposal shall reflect consideration for area residents' diverse needs and preferences and shall promote consumer choice from a variety of options. Therefore, each placement mix proposal shall include at least two of the options specified in (b)1 through 6 above.

1. An exception may be made to (g) above in the event that a county has a need for fewer than 60 additional long-term care placements.

(h) The sum total of long-term care placements of all types proposed by each county Long-Term Care Committee shall not exceed the county's projected need for new long-term care placements in accordance with the formula in N.J.A.C. 8:33H–1.4.

(i) In recognition of the uncertainty about when new and expanded alternatives to nursing home care will become available, the Department shall assure the continued but controlled expansion of the nursing home bed supply in New Jersey.

1. The Department shall use two benchmarks to determine whether the number of new nursing home beds to be approved should be increased in 1993: a State legislature appropriation of Medicaid funds for initiation of the options identified in (a)1–5 beginning in 1994; and submission by the Department of Human Services of a Federal Medicaid waiver request for new home and community-based long-term care services, or, if a waiver is not required, an amendment to the Medicaid State Plan. In the event that the State legislature has not appropriated funds and the Department of Human Services has not submitted a Medicaid waiver request to the U.S. Health Care Financing Administration (or, if a waiver is not required, the Medicaid State Plan has not been amended) by July 31, 1993, county Long-Term Care Committees may request the approval of new nursing home beds as part of their placement mix proposals, provided that the number requested will not result in more than 10.0 nursing home beds per 100 population age 75 and over in each county, based on population projections for 1998. In the event that the aforementioned benchmarks are achieved, county Long-Term Care Committees may request the approval of new nursing home beds as part of their placement mix proposals, provided that the number requested will not result in more than 9.2 nursing home beds per 100 population age 75 and over in each county, based on population projections for 1998.

(j) County Long-Term Care Committees shall have the option of choosing to treat assisted living residences and comprehensive personal care homes interchangeably in their placement mix proposals. In this manner, Certificate of Need applications for either of these two residential services may be approved to meet the county's placement need, depending on the applications' merits.

(k) In the case of long-term placement options for which licensing, reimbursement, and planning standards have not yet been adopted, or where reimbursement has not yet been authorized by Medicaid, county Committees proposing a placement mix which includes such options shall have the requested number of placements set aside and reserved for them, until such time as the necessary standards and authorizations become effective.

1. On an annual basis, counties with set-aside and reserved placements shall have the option of reconsidering and revising their placement mix proposals, thereby re-allocating the reserved placements.

2. In the case that a county placement mix proposal contains a request for Medicaid-waivered home and community-based service slots in excess of the number which Medicaid subsequently finds it has the resources to authorize, the county Long-Term Care Committee may reconsider and revise its placement mix proposal, thereby reallocating the unauthorized placements.

(*l*) In the event that a State psychiatric hospital closes, the Department, in collaboration with the Department of Human Services, shall determine the number of additional placements which are imminently needed to accommodate the influx of long-term care patients who are discharged from these hospitals. The number of placements needed shall be determined for each county, based upon the county of origin of the discharged psychiatric patients. In affected counties, the Long-Term Care Committee shall formulate a placement mix proposal dedicated specifically for these patients.

(m) In counties where there is a need for long-term care placements in accordance with the placement methodology in N.J.A.C. 8:33H–1.4, the long-term care needs of persons who have AIDS or are HIV positive shall be met through the mix of options which are planned by the county Long-Term Committee. However, in counties where there is no long-term care placement need in accordance with the placement methodology in N.J.A.C. 8:33H–1.4, the Department recognizes that there could be special access problems for the growing number of HIV-infected people who require long-term care. Consequently, in the event that the Department determines there is an unmet need for nursing home beds or other long-term care services for persons with AIDS or HIV-infection, consideration shall be given to the approval of the necessary type of long-term care placements, which shall be dedicated for exclusive use by this patient population.

1. In counties that do not have a projected long-term care placement need in accordance with the methodology in N.J.A.C. 8:33H–1.4, applications which exclusively propose long-term care services dedicated for patients with AIDS or HIV infection may be submitted in any month when Certificate of Need applications are accepted for processing.

Amended by R.1993 d.671, effective December 20, 1993.
See: 25 N.J.R. 3719(a), 25 N.J.R. 6031(a).

Case Notes

Health advisory board; vote on applications for long-term care ventilator beds. Kingston Convalescent Center v. Mid-State Health Advisory Corp., 94 N.J.A.R.2d (HLT) 1.

8:33H–1.4 Projection of need for long-term care placements

(a) New long-term care placements shall only be approved in counties with a net need for placements, in accordance with the formula contained in (d) below.

1. The Department, in collaboration with the Department of Human Services, shall devise a formula to allow for the development of new long-term care options identified in 8:33H–1.3(b)1 through 5. in counties where the formula contained in (d) below projects an excess of long-term care placements.

(b) The projected need for long-term care placements shall be computed for each county, targeted five years into the future. The Department shall release updated projections by April 1 of each year, or as soon thereafter as the necessary data are available.

(c) The source of population data to be used in projecting the need for long-term care placements shall be the most recent official population projections which are published by the New Jersey State Department of Labor.

1. For target years between those years for which the New Jersey State Department of Labor has issued official projections, the population numbers to be used in the need formula shall be derived using linear interpolations as follows for each age group, where "Year X" precedes "Year Y" and where "n" is the number of years that must be added to "Year X" in order to arrive at the "Target Year":

Step 1: Projected Population for Year Y − Projected Population for Year X = A

Step 2: $\frac{A}{(\text{Year Y} - \text{Year X})} = B$

Step 3: Projected Population for Year X + (B × n) = Projected Population for Target Year

(d) The formula for computing the number of long-term care placements needed shall be as follows:

1. Sum 0.07 placements per 100 population age 20–64, plus 1.07 placements per 100 population age 65 to 74, plus 5.44 placements per 100 population age 75 to 84, plus 21.21 placements per 100 population age 85 and over;

2. From each county's total computed in (d)1 above, subtract the county's current inventory of long-term care placements, which shall include the following:

i. Licensed and Certificate of Need-approved general use long-term care beds, excluding pediatric long-term care beds and beds located in continuing care retirement communities and restricted admissions facilities;

ii. Home and community-based service waiver slots, including those currently available to the county and those which have been requested in the county's placement mix proposal, accepted in accordance with N.J.A.C. 8:33H–1.3(c)1;

iii. Twenty-five percent of licensed and Certificate of Need-approved adult day health care slots, which shall approximate the number of slots utilized by patients who are nursing home-eligible;

iv. Alternate family care placements, including those currently in use and those which have been requested in the county's placement mix proposal, accepted in accordance with N.J.A.C. 8:33H–1.3;

v. Licensed and Certificate of Need-approved assisted living residence beds;

vi. Licensed and Certificate of Need-approved comprehensive personal care beds; and

vii. Assisted living program placements, including those currently in use and those which have been requested in the county's placement mix proposal, accepted in accordance with N.J.A.C. 8:33H–1.3.

3. Based on the computation in (d)2 above, the remainder equals the net, projected, new placement need for the county, if the number is a positive one. A negative number shall represent a projected excess of placements for the county.

(e) On an annual basis, the Department shall review the need methodology contained in (d) above, along with other pertinent long-term care data, to determine whether there is a basis for amending the methodology in order to more accurately project future service requirements throughout the State.

Amended by R.1993 d.671, effective December 20, 1993.
See: 25 N.J.R. 3719(a), 25 N.J.R. 6031(a).

8:33H–1.5 Pediatric long-term care

(a) Because of their unique growth and development needs, children who require nursing facility placement should be able to receive care in an environment that is dedicated to addressing these needs. For this reason, the

Department shall give consideration to approving separate and distinct pediatric long-term care units in areas where they are needed.

(b) Because there are so few children who require nursing facility placement in New Jersey, pediatric long-term care units should be planned and developed to serve a regional need. For this purpose, the region shall be a Local Advisory Board region.

(c) The need for pediatric long-term care beds shall be determined in the following manner:

1. On a periodic basis (that is, at least once every two years), the Department, in collaboration with the Department of Human Services, shall conduct a survey of acute care hospitals, special hospitals, and other health care facilities at a particular point in time to identify all children who are medically ready for discharge and who require transfer to a pediatric long-term care facility. In addition, the number of children who are known to have been placed in long-term care facilities outside of New Jersey shall be counted;

2. The number of pediatric patients computed in (c)1 above shall be grouped according to their county and LAB region of origin;

3. The projected rate of growth in the population under age 20 in each LAB region shall be calculated using the most recent New Jersey Department of Labor population projections, covering the five year period from the time a Certificate of Need application is accepted for processing up to the target year. The number of patients in each LAB region requiring pediatric long-term care shall then be adjusted (that is, multiplied) by the aforementioned, region-specific population growth rate. The latter product shall then be added to the number of patients requiring pediatric long-term care in the LAB region;

4. The projected number of pediatric long-term care patients in each region requiring care as derived in (c)3 above, shall then be adjusted (that is, divided by a factor of .85) to allow for a projected occupancy rate of at least 85 percent.

Amended by R.1993 d.671, effective December 20, 1993.
See: 25 N.J.R. 3719(a), 25 N.J.R. 6031(a).

8:33H–1.6 Specialized long-term care

(a) For the purposes of this chapter, specialized long-term care shall include the following categories:

1. Ventilator care for adult patients; and

2. Care of patients with severe behavior management problems, such as combative, aggressive, and disruptive behaviors.

(b) A Certificate of Need shall be required for the establishment of a new specialized care program, including the conversion of general long-term care beds for specialized care use, or for the expansion of an existing specialized care program. The Certificate of Need applicant shall identify the type of specialized care patients who will be admitted to the proposed nursing facility beds in accordance with the categories identified in (a) above. Specialized care beds shall be dedicated for exclusive use by the type or types of specialized care patients identified in the approval letter.

1. Certificate of Need approval shall be required in the event that an applicant intends to occupy specialized care beds with patients who do not require specialized care or patients who do not require the type of specialized care which was identified in the applicant's Certificate of Need. An application for the conversion of specialized care beds for some other use shall comply with the requirements in N.J.A.C. 8:33H–1.13(g).

(c) Specialized care beds shall be approved to meet a regional need. The applicant shall identify the Local Advisory Board region to be served as defined in N.J.A.C. 8:33H–1.2 and shall document how access to the unit's services shall be assured for residents throughout the region.

(d) The number of new beds needed in each LAB region for long-term ventilator care shall be determined in the following manner:

1. On a periodic basis (that is, at least once every two years), the Department shall conduct a survey of acute care hospitals, special hospitals, and other health care facilities at a particular point in time to identify all patients who are medically ready for discharge and who are in need of transfer to a facility that provides long-term ventilator care;

2. Through the survey, the number of patients shall be counted for each LAB region;

3. The projected rate of growth in the population age 20 and over in each regional health systems area shall be calculated using the most recent New Jersey Department of Labor population projections, covering the four year period from the time a Certificate of Need application is accepted for processing up to the target year. The number of patients in each LAB region requiring ventilator care, as identified through the survey, shall then be adjusted (that is, multiplied) by the aforementioned, region-specific adult population growth rate. The latter product shall then be added to the number of patients in the regional service area requiring each type of specialized care:

Number of Patients Requiring Ventilator Care, Per Survey	×	Region-Specific Growth Rate, Population Age 20+	+	Number of Patients Requiring Ventilator Care, Per Survey;

4. The projected number of patients in each region requiring ventilator care as derived in (d)3 above, shall then be adjusted (that is, divided by a factor of .85) to allow for a projected occupancy rate of at least 85 percent, in accordance with (i) below.

(e) A formal methodology shall not be used to determine the number of beds needed for the specialized care of patients with severe behavior management problems. However, in the interest of promoting improved access to high quality care for these patients whose needs cannot safely and effectively be met in general long-term care facilities, the Commissioner shall give consideration to approving one model program in each LAB region. Model programs may be approved providing that the following requirements are met, in addition to all other applicable requirements of this chapter:

1. The applicant shall document to the satisfaction of the Department that the number of beds proposed is reasonable with respect to the need for specialized long-term care for patients with severe behavior management problems in the LAB region. However, no more than 32 beds in any one nursing home in each LAB region shall be approved for a model program. Protecting individuals' identities, the applicant shall provide patient-specific data to demonstrate that there is a sufficient number of individuals residing in the regional service area who could meet the model program's admission criteria at the time of application submission, in order to fill 85 percent of the proposed number of beds in the model program. Patient-specific data shall include each individual's age, sex, county of residence, diagnoses, functional impairments, current placement, and reasons why the current placement is inappropriate;

2. The facility shall develop and maintain a collaborative affiliation with at least one school of nursing which grants baccalaureate and/or master's degrees in nursing, one school of social work, and one medical school, for the purpose of providing ongoing clinical training and research on site in the specialized care unit;

3. The model program shall include a formal research and program evaluation component. The applicant shall describe in detail how patient care outcomes will be evaluated by an independent party or organization. A report of this evaluation shall be submitted to the Department within three years of licensure of the approved beds. In view of the fact that Medicaid does not reimburse for research-related expenses, the applicant shall identify funding sources and otherwise explain how the costs of research will be covered;

4. The application shall include admission and discharge criteria which assure that the most difficult-to-manage patients in the regional service area shall receive priority for placement in the model program;

5. The application shall include a detailed plan describing how continuity of care will be assured for patients who are admitted to and discharged from the model program. The facility in which the model program will be located shall have available at all times a reasonable number of beds in other nursing units within the facility in order to allow for the transfer of patients who are no longer in need of specialized care as it is offered in the model program. Furthermore, the applicant shall specify how other nursing homes throughout the region shall be involved in assuring continuity of care for patients who are admitted to and discharged from the model program;

6. The facility shall develop and maintain an ongoing program whereby designated staff members are available to offer other area health care facilities in the regional service area training, educational seminars, and technical assistance in the care of patients with severe behavior management problems;

7. The model program shall conduct multidisciplinary team meetings on a regular basis for the purpose of establishing and reviewing each patient's plan of care; the multidisciplinary team shall include staff members involved in direct patient care on the unit, such as physicians, nurses, social workers, psychologists, activities therapists, and so forth. The certificate of need application shall document how the multidisciplinary team will promote innovative approaches to care for patients with severe behavior management problems; and

8. The special care unit shall have a medical director with demonstrated expertise in the care of adult patients with behavior management problems.

(f) The establishment, addition, or conversion of beds for either types of specialized care shall be approved only in those cases where the facility will have one or more distinct and separate nursing units which treat exclusively patients who require the type of specialized care for which the facility receives Certificate of Need approval.

(g) All applicants for specialized care beds shall provide the following, to the satisfaction of the Department:

1. A detailed description of the services and program of care that will be provided;

2. Specific admission and discharge criteria for the proposed unit, which clearly identify the types of patients who will be treated in the specialized care beds;

3. A specific plan to provide inservice training for nursing staff and others who will work with specialized care patients, including an orientation program for new staff members, ongoing inservice education, and opportunities to pursue advanced education and certification in the appropriate clinical specialties;

4. A description of physical plant considerations and special architectural features of the proposed unit as well as an identification of any special equipment that will be installed in order to accommodate patients' needs;

5. A signed transfer agreement with at least one acute care hospital with a licensed capacity of at least 200 beds to which specialized care patients can be transferred within 30 minutes total travel time for the purpose of receiving emergency medical treatment, if the proposed specialized care unit will not be located within an acute care hospital. The applicant shall submit documentation of the reasons why a particular hospital was chosen for the transfer agreement, including a description of the hospital's resources and capability to address the needs of patients requiring the applicable type of specialized care; and

6. A specific plan to provide coordination and continuity of care for patients who may be discharged from the proposed specialized care beds when this is feasible and beneficial to the patient/family/significant other. Supporting documentation for the plan may include signed transfer agreements or referral arrangements with licensed home health agencies and other health care facilities in the nursing home's regional service area which maintain the resources and capability to offer follow-up specialized care.

(h) In the case of specialized care units proposing to treat ventilator dependent patients, the facility shall provide staffing for the nursing unit on which the ventilator beds are located that includes the 24 hour per day presence on the unit of at least one registered nurse and the 24 hour per day on-call availability of at least one respiratory therapist. In addition, the facility shall comply with licensure staffing requirements that are applicable to the care of ventilator-dependent patients.

(i) The minimum desired annual occupancy rate for specialized care units shall be 85 percent.

(j) In cases where there are two or more competing applications for specialized long-term care beds in the same health systems area, the prioritization criteria contained in N.J.A.C. 8:33H–1.19(e) shall be used in determining which applications should be approved or denied.

8:33H–1.7 Assisted living residences and assisted living programs

(a) The applicant for an assisted living residence or for an addition to an existing, licensed assisted living residence shall submit a Certificate of Need application for expedited review, in accordance with the applicable provisions of N.J.A.C. 8:33. Upon approval of a certificate of need, the applicant shall comply with the licensing requirements for assisted living residences at N.J.A.C. 8:36.

(b) The applicant for an assisted living program shall submit a Certificate of Need application for expedited review, in accordance with the applicable provisions of N.J.A.C. 8:33. Each licensed assisted living program office site may provide services in an area that covers no more than two contiguous counties. An applicant may establish and license sufficient sites to provide services for multiple counties, up to and including a Statewide service area. Upon approval of a certificate of need, the applicant shall comply with licensing requirements for assisted living programs at N.J.A.C. 8:36.

(c) Applicants who own, operate, or manage any licensed health care facilities in New Jersey or other states shall have their track record evaluated in accordance with the requirements in N.J.A.C. 8:33H–1.14.

(d) Certificate of Need applications submitted subsequent to the time that Medicaid reimbursement for assisted living residences becomes generally available beyond the limited number of slots authorized under the Medicaid waiver to section 1915(c) of the Social Security Act, 42 U.S.C. § 1396n shall include a statement of commitment to provide access and continuity of care for Medicaid-eligible patients, including former psychiatric patients, who need nursing home level care.

Repeal and New Rule, R.1993 d.671, effective December 20, 1993.
See: 25 N.J.R. 3719(a), 25 N.J.R. 6031(a).
Section was "Adult day health care programs".

8:33H–1.8 Hospital-based subacute long term care units

(a) The applicant for hospital-based subacute long term care unit or for an addition to an existing, licensed hospital-based subacute long term care unit shall submit a Certificate of Need application for expedited review, in accordance with the applicable provisions of N.J.A.C. 8:33. Upon approval of a certificate of need, the applicant shall comply with licensing requirements for long term care facilities at N.J.A.C. 8:39 and Federal Medicare certification requirements for long-term care beds (42 U.S.C. §§ 1395 et seq.), with reasonable waiver provisions as determined by the Commissioner or the Federal Health Care Financing Administration, as appropriate (see, respectively, N.J.A.C. 8:39–2.7 and 42 C.F.R. 488).

(b) The unit shall be comprised of not more than seven percent of the hospital's licensed medical-surgical bed capacity or 12 beds, whichever is greater.

(c) The hospital's license medical-surgical bed capacity shall be reduced, by the Commissioner, by the number of beds used to establish a hospital-based subacute long term care unit.

(d) Long-term care beds in a hospital-based subacute long term care unit shall not be transferred to, or combined with, a hospital-based subacute long term care unit in another hospital. Bed limitations for a hospital shall include both conversions of existing acute care beds and any purchases or other acquisitions or rentals of beds to be used by a hospital for the provision of subacute care.

(e) Hospital-based subacute long term care shall not be covered by the Medicaid program established pursuant to P.L. 1968, c.413 (N.J.S.A. 30:4D–1 et seq.)

8:33H–1.9 Size and occupancy of nursing homes and nursing units

(a) The targeted annual occupancy rate for nursing homes should be 90 percent.

1. Certificate of Need applicants proposing the addition of long-term care beds at nursing homes with an annual occupancy rate of less than 90 percent of the licensed bed capacity for the most recent calendar year shall not be approved.

(b) Nursing homes shall be designed and sized to promote a homelike environment, as opposed to a hospital-like environment, efficient facility operation, and a high quality of life and care.

(c) The Certificate of Need application for a new or expanding nursing home or for a long-term care bed addition to an existing facility shall state the number of long-term care beds which is proposed for each nursing unit. The maximum nursing unit size for long-term care shall be 64 beds.

(d) The applicant shall provide detailed documentation to show that each and every proposed nursing unit containing long-term care beds, regardless of its size, shall be staffed with at least one licensed nurse (that is, a registered nurse or licensed practical nurse) for each shift around the clock, and that there shall be at least two nursing personnel assigned to each nursing unit for each shift around the clock, and that the facility shall comply with or exceed all other applicable staffing requirements contained in N.J.A.C. 8:39, and that operation of the facility will be financially feasible thus staffed.

1. As a condition of Certificate of Need approval, the long-term care applicant shall agree to comply with the staffing requirements in (d) above, even if this necessitates exceeding the minimum staffing standards required for licensure, which are contained in N.J.A.C. 8:39.

(e) The maximum size of facilities receiving Certificate of Need approval for general or specialized long-term care beds shall be 240 beds.

1. An exception to the maximum size requirement in (e) above may be made in the case of existing facilities which are licensed for more than 240 long-term care beds, which propose to reduce their long-term care bed complement by at least 15 percent. Such facilities may be approved to maintain a licensed capacity which will exceed 240 long-term care beds at project completion, after a proposed number of long-term care beds has been eliminated, provided that all other applicable requirements of this chapter are met.

2. An exception to (e) above may be made in the case of Statewide restricted admissions facilities, which may be given consideration for an expansion which will result in a net capacity of more than 240 beds, provided that the facility meets the requirements of N.J.A.C. 8:33H–1.11 and all other applicable requirements of this chapter.

(f) A facility which is licensed for more than 240 general and/or specialized long-term care beds, which proposes to add long-term care beds, may receive Certificate of Need approval provided that the applicant designs the project to result in two or more separately licensed and staffed facilities, each in compliance with the maximum size requirement in (e) above. However, a facility which is licensed for more than 240 general and/or specialized long-term beds which proposes a replacement or renovation project without adding beds may be considered for Certificate of Need approval, provided that it complies with all other applicable requirements of this chapter.

(g) The maximum unit size for specialized long-term care beds shall be 32 beds.

Case Notes

Nursing home operator was entitled to use variance for construction of congregate care housing facility adjunctive to nursing home. Jayber, Inc. v. Municipal Council of Tp. of West Orange, 238 N.J.Super. 165, 569 A.2d 304 (A.D.1990), certification denied 122 N.J. 142, 584 A.2d 214, certification denied 122 N.J. 142, 584 A.2d 215.

It was reasonable to not recommend approval of application to add ventilator beds due to geographic distribution of beds. Linwood Convalescent Center v. State Health Planning Board, 94 N.J.A.R.2d (HLT) 11.

8:33H–1.10 Comprehensive personal care homes

(a) In order to improve the utilization of readily available residential health care and "Class C" boarding home beds, to give current residents of these facilities the opportunity to age in place, and to improve access to care for many hospitalized patients and others who need long-term care placements, the Department shall give consideration to the conversion of residential health care facilities and "Class C" boarding homes to comprehensive personal care homes. The Department aims to preserve and promote the residential atmosphere of these settings, while enhancing the level of care and services they may provide, in accordance with the licensure standards at N.J.A.C. 8:36. Furthermore, in the case of hospice, the Department aims to promote the establishment of comprehensive personal care homes to serve terminally ill persons who lack adequate caregiving support to meet their needs while residing at home.

(b) The applicant for a comprehensive personal care home shall submit a Certificate of Need application for expedited review, in accordance with the applicable provisions of N.J.A.C. 8:33.

(c) Eligibility for the construction of new comprehensive personal care beds shall be open exclusively to the following:

1. Existing comprehensive personal care homes and existing facilities proposing conversion to a comprehensive personal care home that wish to add a limited number of beds. Within any five year period commencing at the time of licensure, the new construction of no more than 20 beds as an addition to an existing or proposed comprehensive personal care home may be considered for Certificate of Need approval.

i. Applicants who wish to add more than 20 beds shall apply for approval as an assisted living residence.

2. Hospice programs which have been Medicare-certified for at least 12 consecutive months.

i. As a condition of Certificate of Need approval, the facility shall be occupied exclusively by patients who are eligible for hospice services in accordance with 42 C.F.R. 418 of the Medicare Hospice Manual.

(d) Applicants who own, operate, or manage any licensed health care facilities in New Jersey or other states shall have their track record evaluated in accordance with the requirements in N.J.A.C. 8:33H–1.14.

(e) Certificate of Need applications submitted subsequent to the time that Medicaid reimbursement for comprehensive personal care homes becomes generally available beyond the limited number of slots authorized under the current Medicaid waiver to section 1915(c) of the Social Security Act, 42 U.S.C. § 1396n, shall include a statement of commitment to provide access and continuity of care for Medicaid-eligible patients, including former psychiatric patients, who need nursing home level care.

(f) In converting to a comprehensive care home from a residential health care facility or Class C boarding home, the facility shall maintain its existing residents who are Supplemental Security Income-eligible recipients and former psychiatric patients. On an ongoing, annual basis, at least five percent of the facility's residents shall be Supplemental Security Income-eligible recipients, at least half of whom shall be former psychiatric patients. This percentage shall be computed based on the number of resident days per calendar year. The facility shall report this information to the Department's Long-Term Care Licensing Program by April 15 of each year for the prior calendar year.

1. In the event that the facility's Supplemental Security Income-eligible residents develop the need for nursing home level care, as defined at N.J.A.C. 8:33H–1.2 and determined by Medicaid's pre-admission screening process at N.J.A.C. 10:63, the facility shall maintain these residents in accordance with the licensing standards at N.J.A.C. 8:36, subject to the facility's discharge criteria in accordance with N.J.A.C. 8:36–4.1(d), provided that Medicaid reimbursement is available. However, if Medicaid reimbursement is not available, the facility shall make all necessary arrangements to transfer the person to a nursing home.

2. In the event that the Supplemental Security Income (SSI) payment rate for Comprehensive Personal Care Homes is set at a level below the SSI payment rate for Residential Health Care Facilities, the five percent occupancy requirement for SSI-eligible residents in (f) above shall not take effect. However, Comprehensive Personal Care Homes shall maintain their existing residents who are Supplemental Security Income-eligible, as required in (f) above.

Repeal and New Rule, R.1993 d.671, effective December 20, 1993.
See: 25 N.J.R. 3719(a), 25 N.J.R. 6031(a).
Section was "Continuing care retirement communities".

8:33H–1.11 Statewide restricted admissions facilities

(a) An applicant proposing a new or expanded nursing home which meets the definition of a Statewide restricted admissions facility in N.J.A.C. 8:33H–1.2 shall state this fact in the Certificate of Need application and shall provide documentation that the following criteria are met:

1. The facility's bylaws explicitly state that only members of the specified religious or fraternal organization and their immediate family members will be admitted to 100 percent of the long-term care beds; and

2. At least 50 percent of the facility's patients are from outside the LAB region in which the facility is located.

(b) An applicant proposing a new or expanded Statewide restricted admissions facility shall be exempt from the need methodology in N.J.A.C. 8:33H–1.4 and the county-based planning process in N.J.A.C. 8:33H–1.3, and may submit a Certificate of Need application for expedited review, in accordance with the applicable provisions of N.J.A.C. 8:33.

(c) An applicant proposing a long-term care bed addition to an existing Statewide restricted admissions facility shall provide a detailed patient origin breakdown of the facility's current patient population. The applicant shall identify the county (or State, for out-of-State patients) of prior residence for each patient, as well as for any patients on the facility's admission waiting list.

(d) The applicant for a Statewide restricted admissions facility shall agree to meet the applicable utilization criteria for Medicaid, SSI, and discharged psychiatric patients, as stated in N.J.A.C. 8:33H–1.15. Facilities that do not participate in the State's Medicaid program shall document how they will subsidize the care of patients who are Medicaid-eligible.

Case Notes

Prior to enactment of statute exempting religiously affiliated nursing homes from certificate of need requirements, Commissioner could recognize public need where facility operated by religious body applied for certificate and proposed nursing facilities would provide care and treatment of only applicant's members. New Jersey Ass'n of Health Care Facilities v. State, 284 N.J.Super. 347, 665 A.2d 399 (L.1995).

8:33H–1.12 Residential health care facilities

An applicant proposing a new residential health care facility shall submit a Certificate of Need application for expedited review, in accordance with the applicable provisions of N.J.A.C. 8:33. The applicant shall comply with the applicable utilization requirements for Supplemental Security Income recipients and former psychiatric patients, in accordance with N.J.A.C. 8:33H–1.15.

Amended by R.1993 d.671, effective December 20, 1993.
See: 25 N.J.R. 3719(a), 25 N.J.R. 6031(a).

8:33H–1.13 Conversion or elimination of licensed or Certificate of Need approved beds or services

(a) Applicants proposing to convert any licensed beds shall submit schematic plans with a floor layout of the facility, illustrating how the proposed conversion will be accomplished. In order to assure that the bed conversion can be implemented in accordance with health facility construction standards, it is recommended that applicants consult with the Department of Community Affairs, Health Care Plan Review Program, prior to submitting a certificate of need application. Applications for bed conversions that are submitted without schematic plans shall be deemed incomplete.

(b) Applicants for the conversion of residential health care beds to long-term care beds shall document a commitment to enabling current residents to continue occupying their assigned beds until or unless a permanent relocation placement is requested by the resident.

1. The mixing of residential health care and long-term care beds within one or more units as a consequence of implementing a Certificate of Need to convert or eliminate beds may be permitted if necessary in order to avoid relocating or discharging residents who do not wish to move.

(c) An applicant whose project entails the discharge or permanent relocation of patients in order to effect the conversion or elimination of licensed beds shall provide compelling documentation, to the satisfaction of the Commissioner, that a greater public benefit is to be obtained from the proposed conversion or elimination of beds than would be obtained if the existing licensed bed complement were maintained. This documentation shall be submitted not only by applicants who propose to discharge or permanently relocate a specified number of patients upon receiving Certificate of Need approval, but also by any applicant who has discharged or relocated more than 25 percent of the residents of the beds in question during the 12 month period prior to submission of the Certificate of Need application for a bed conversion or elimination. Compelling documentation of public benefit may include, but shall not be limited to, the following:

1. Letters supporting the discharge or relocation of patients which are submitted by the patients themselves, their family members or significant others, and/or the patients' health care providers;

2. Evidence that patients' quality of life and/or care would either deteriorate if they were permitted to remain in the facility, or that it would improve as a result of their being discharged or relocated to other facilities;

3. Evidence that the quality of life and/or care of those patients who will remain as residents in the facility would either deteriorate unless the proposed beds are converted or eliminated, or substantially improve as a result of eliminating or converting the beds in question; and

4. Evidence that the relocation will afford patients' family members and significant others convenient access for visitation purposes; that is, the facility to which most patients are expected to be relocated shall be situated in an area that has readily available public transportation and/or easy access to major roadways.

(d) An exception to the documentation requirement in (c) above may be granted by the Commissioner in the case where an applicant proposes to completely and permanently close the facility in question and/or to cease operating as any type of health care facility. The applicant shall nonetheless comply with the requirements in (f) below, to the extent that they are applicable.

(e) Certificate of Need applications proposing the conversion of residential health care beds to long-term care beds may be approved provided that the county in which the applicant's facility is located has a documented nursing home bed need in accordance with N.J.A.C. 8:33H–1.3(g) and consistent with the county Long-Term Care Committee's placement mix proposal.

1. Long-term care facilities located in Newark, Jersey City, Paterson, Atlantic City, Camden, Elizabeth, Trenton, Irvington, East Orange or Union City that were issued a certificate of need between January 20, 1987 and September 8, 1992 pursuant to the methodology contained in then existing N.J.A.C. 8:33H–3.3(b)3 may apply under the expedited review process to convert existing, on-site, licensed residential health care beds to long-term care beds as long as the residential health care beds were licensed on or before August 17, 1998.

2. Any CN application submitted pursuant to (e)1 above and approved by the Commissioner shall be subject to the following conditions:

i. The facility shall maintain a minimum of 50 percent bed occupancy by direct Medicaid-eligible patients, of which 10 percent shall be discharged psychiatric patients from State and county hospitals. The aforesaid 50 percent and 10 percent bed minimums shall be calculated using the entire licensed bed capacity for the facility, shall be achieved no later than one year from approval, and shall be maintained at all times thereafter.

ii. The conversion of residential health care beds to long-term care beds shall occur within the long-term care facility and the applicant and/or any successive owner shall not relocate all or any portion of the facility's total licensed long-term care capacity outside of the city limits.

(f) Certificate of Need applications proposing the conversion of residential health care beds to long-term care beds shall meet the following requirements:

1. If the project entails the relocation of patients from the facility, the applicant shall provide documentation of a transfer agreement with at least one other residential health care facility in the area that maintains admission policies, offers amenities, and charges fees which are similar to those of the applicant's residential health care facility. Furthermore, the applicant shall provide documentation that the residential health care facility which is the subject of the transfer agreement has the willingness and bed capacity to accommodate those patients who might be transferred from the applicant's facility, including Supplemental Security Income recipients and discharged psychiatric patients;

2. If the applicant's facility currently has patients occupying residential health care beds who may require or desire relocation, the applicant agrees to provide all necessary social service assistance to effect the relocation in a manner that maximizes consumer choice of placement alternatives. The applicant shall bear the cost of relocating patients as necessary and shall make arrangements for any residential health care resident at the facility who wishes to visit other residential health care facilities in the area, prior to making a relocation decision; and

3. The Certificate of Need application complies with all other applicable requirements in this chapter.

(g) The conversion of specialized care beds to general long-term care beds or to another specialized care use may be considered for approval, provided that the following conditions are met:

1. The applicant provides evidence, to the satisfaction of the Department, that good faith efforts have been made to implement the existing specialized care unit as it was originally approved, for a period of at least 18 months prior to submission of the Certificate of Need application for conversion. Evidence shall include:

i. Records of efforts to establish appropriate referral sources and transfer agreements;

ii. Records of efforts to negotiate reimbursement rates with third party payors including Medicaid; and

iii. Without disclosing names or otherwise publicly divulging individuals' identities, a verifiable listing of all patients referred for admission over the 12 month period prior to application submission. The listing shall include each patient's age, medical diagnoses, county of residence, payment source, and clinical care needs. For each patient, the applicant shall indicate whether the patient was admitted to the special care unit, and if not, the reason why admission was denied and the name of the facility where the patient was finally placed; and

iv. A description of all efforts to recruit and train staff for the unit.

(h) A Certificate of Need application proposing the conversion of acute care hospital beds to general or specialized long-term care beds may be approved provided that the following conditions are met:

1. The county in which the hospital is located has a documented nursing home bed need in accordance with N.J.A.C. 8:33H–1.3(g) and consistent with the county Long-Term Care Committee's placement mix proposal.

2. The project entails a permanent conversion of beds located on one or more distinct nursing units (that is the creation of so-called "swing beds" shall not be approved);

3. The applicant documents plans for providing a suitable, home like living environment for long-stay patients or agrees to adopt admission policies limiting utilization of the proposed long-term care beds to patients whose stays can reasonably be expected to be less than 100 days;

4. The capital cost of converting the acute care beds is less than that of new nursing facility construction; and

5. The Certificate of Need application complies with all other applicable requirements in this chapter.

Amended by R.1993 d.671, effective December 20, 1993.
See: 25 N.J.R. 3719(a), 25 N.J.R. 6031(a).
Amended by R.1998 d.430, effective August 17, 1998.
See: 30 N.J.R. 1702(a), 30 N.J.R. 3081(a).
In (e), added 1 and 2.

Case Notes

Nursing home operator was entitled to use variance for construction of congregate care housing facility adjunctive to nursing home, even though facility was to be run for profit. Jayber, Inc. v. Municipal Council of Tp. of West Orange, 238 N.J.Super. 165, 569 A.2d 304 (A.D.1990), certification denied 122 N.J. 142, 584 A.2d 214, certification denied 122 N.J. 142, 584 A.2d 215.

8:33H–1.14 Quality of care and licensure track record requirements for long-term care, assisted living residences, comprehensive personal care homes, and residential health care facilities

(a) The licensure "track record" of an applicant shall be evaluated by the Department to determine whether the applicant's proposed project may be approved. The criteria for this examination are set forth at N.J.A.C. 8:33.

Amended by R.1993 d.671, effective December 20, 1993.
See: 25 N.J.R. 3719(a), 25 N.J.R. 6031(a).

Case Notes

Regulation mandating rejection of county hospital's certificate of need application, based upon numerous federal "Level A" deficiencies in patient care, did not violate hospital's due process rights, despite pending appeal of deficiency assessment; state was responsible for assuring availability of highest quality health care services. In re Certificate of Need Granted to the Harborage, 300 N.J.Super. 363, 693 A.2d 133 (A.D.1997).

Application of subsidiary for certificate of need properly based on track record of other subsidiaries owned by parent corporation. Matter of Old Bridge Manor, 95 N.J.A.R.2d (HLT) 1.

Refusal to admit HIV-positive patient; denial of Certificate of Need sought by nursing center also owned by owner of center refusing admission to patient. Yihoshna, Inc., t/a Manahawkin Convalescent Center v. Department of Health. 93 N.J.A.R.2d (HLT) 9.

8:33H–1.15 Utilization requirements for Medicaid-eligible patients, Supplemental Security Income (SSI) recipients, and former psychiatric patients

(a) Applicants receiving certificate of need approval to add general or specialized long-term care beds to an existing facility or to construct a new nursing home or a replacement facility shall comply with the following utilization requirements:

1. Within one year from license issuance, a minimum of 36 percent of the total general long-term care bed complement shall be occupied by direct admission Medicaid-eligible patients, as defined in N.J.A.C. 8:33H–1.2. The facility shall continue to maintain at least 36 percent Medicaid-eligible direct admissions in its general long-term care beds annually thereafter.

2. Within one year from license issuance, a minimum of 36 percent of the total specialized long-term care bed complement shall be occupied by direct admission Medicaid-eligible patients, as defined in N.J.A.C. 8:33H–1.2. The facility shall continue to maintain at least 36 percent Medicaid-eligible direct admissions in its specialized long-term care beds annually thereafter.

3. A minimum of 45 percent of the total general long-term care bed complement shall be occupied by Medicaid-eligible patients who either have spent down to the level of Medicaid eligibility during their nursing home stay or who are directly admitted to the facility as Medicaid-eligible patients, as defined in N.J.A.C. 8:33H–1.2. The facility shall meet this 45 percent overall occupancy by Medicaid-eligible patients in its general long-term care beds by the end of the first year of licensure and continue meeting this percentage thereafter.

4. A minimum of 45 percent of the total specialized long-term care bed complement shall be occupied by Medicaid-eligible patients who either have spent down to the level of Medicaid eligibility during their nursing home stay or who are directly admitted to the facility as Medicaid-eligible patients, as defined in N.J.A.C. 8:33H–1.2. The facility shall meet this 45 percent overall occupancy by Medicaid-eligible patients in its specialized long-term care beds by the end of the first year of licensure and continue meeting this percentage thereafter.

5. As a condition of certificate of need approval, seven percent of the total number of long-term care beds shall be available for occupancy by persons in need of nursing home care who are present or former patients of State/county psychiatric hospitals or community inpatient psychiatric units.

i. Occupancy of beds by former psychiatric patients who are Medicaid-eligible may count toward the utilization requirements for Medicaid-eligible patients which are specified in (a) above, provided that the former psychiatric patient is Medicaid-eligible.

ii. At the time of initial licensure of any long-term care bed approved in accordance with this chapter, the nursing home shall sign and subsequently maintain a written transfer agreement with the Division of Mental Health Services (within the New Jersey Department of Human Services) or at least one county psychiatric hospital or a facility with a community inpatient psychiatric unit, for the purpose of complying with the percentage requirement specified in (a)5 above.

(b) Applicants receiving certificate of need approval to add residential health care beds to an existing facility or to construct a new residential health care facility or a replacement facility shall comply with the following utilization requirements:

1. A minimum of 10 percent of the total residential health care bed complement shall be occupied by direct admission Supplemental Security Income eligible recipients. This percentage shall be achieved within one year of license issuance and maintained on an annual basis thereafter.

2. A minimum of 50 percent of the Supplemental Security Income eligible recipient beds shall be dedicated for occupancy by persons in need of residential health care who are State, County, or designated psychiatric short-term care facility patients.

i. Occupancy of beds by former psychiatric patients who are recipients of Supplemental Security Income may count toward the utilization requirements for Supplemental Security Income recipients which are specified in (b)1 above.

ii. At the time of initial licensure of any residential health care bed approved in accordance with this chapter, the facility shall sign and subsequently maintain a written transfer agreement with either the Division of Mental Health Services (within the New Jersey Department of Human Services) or at least one county psychiatric hospital or designated psychiatric short-term care facility, for the purpose of complying with the percentage requirement specified in (b)2 above.

(c) A nursing home or residential health care facility that receives certificate of need approval for a change in cost or scope shall comply with either the applicable utilization percentages for Supplemental Security Income recipients and Medicare-to-Medicaid and Medicaid-eligible patients which were stated in the Commissioner's original certificate of need approval letter to that facility, or the utilization percentages which are outlined in this chapter, whichever percentages are higher.

(d) A certificate of need applicant proposing a new or expanded facility, or a change in cost or scope to a previously approved project, or a transfer of ownership of an existing facility with previous certificate of need conditions, who can produce documentation that the utilization percentage requirements in this section will cause a financial hardship may request a review of the feasibility of those percentages, which may result in a finding by the Department that a lower percentage is required for financial feasibility.

8:33H–1.16 Cost-efficiency and financial feasibility

(a) Applicants for a Certificate of Need shall demonstrate the financial feasibility of their projects. This analysis shall be based upon the projection of reasonable private pay and Medicaid charges, expenses of operation, and staffing patterns, relative to other facilities in the health systems area in which the proposed project will be located.

(b) Total project cost, construction cost per square foot, and cost per bed shall be taken into consideration in the review of Certificate of Need applications.

(c) Where projected construction and operating costs are considerably lower or higher than the average for the health systems area, as determined by the Department, the applicant shall provide an explanation at the request of the Department indicating factors contributing to said projections. This request for an explanation shall not be construed as an opportunity to change cost projections. Information regarding the most recent available facility costs in the health systems areas may be obtained from the Department of Community Affairs' Health Care Plan Review Program.

(d) Applicants shall describe their previous record of implementing Certificate of Need-approved long-term care projects, identifying each case in which a change in cost was requested in order to complete a project. All other things being equal, preference shall be given to approving applicants with a history of realistically projecting construction costs in their Certificate of Need applications, as reflected in the number and magnitude of previous requests for a change in cost.

(e) Applicants shall provide evidence in their financial projections that income generated by operation of the facility will be sufficient to provide care to the percentage of Medicaid-eligible or indigent patients specified in the application, or in accordance with N.J.A.C. 8:33H–1.15 whichever is greater.

(f) Applicants shall provide verification of the availability of at least 10 percent of the total project cost, including all financing and carrying costs, in the form of equity.

(g) As a condition of approval, applicants shall agree to make reasonable efforts to obtain the least cost financing available.

(h) Applicants proposing to add long-term care beds in an existing facility or to add long-term care beds in the course of replacing an existing facility shall provide documentation that the added beds will improve the efficient operation of the facility, reducing unit costs of care per patient.

8:33H–1.17 Environmental and physical plant considerations

(a) Health care facilities shall be designed and constructed in such a manner as to eliminate architectural barriers to care.

(b) Prior to submitting a Certificate of Need application, applicants proposing specialized long-term care beds shall consult with the Department of Community Affairs' Health Care Plan Review Program regarding the architectural design and construction of such projects. In addition to the standard construction requirements for nursing homes, the following shall be required:

1. Specialized care units approved for ventilator care shall have piped-in oxygen, suction equipment, emergency electrical outlets, and additional square footage for ventilator equipment and supplies;

2. Pediatric nursing home units shall include a play room or recreation room and suitable, adaptable space for educational uses such as tutoring; and

3. Specialized care units for patients with severe behavior management problems shall provide easy access to a protected outdoor area, such as a courtyard, patio, or garden.

8:33H–1.18 Location of facilities

(a) The applicant shall describe the proposed site of a project and the immediate surrounding community, identifying how the site is currently zoned and providing a timetable for securing any and all necessary zoning and land use approvals. The construction of new or replacement facilities proposed to be located on sites which are currently zoned for heavy industrial use shall not be approved.

1. Applicants should not enter into costly land use or zoning approval procedures prior to receiving an approved Certificate of Need.

(b) The applicant shall identify the proposed facility's access to public transportation. Where possible, each facility shall be located where access is easily obtained via low-cost public transportation.

(c) The applicant for a new facility shall describe the availability to the proposed site of all necessary utilities. Where utilities are not already available at the proposed site, the applicant shall provide a timetable and detail the costs for obtaining these utilities.

(d) The applicant shall identify the proposed facility's proximity to any potential source of adverse environmental conditions. Facilities shall be located so as to prevent exposure of residents to adverse environmental conditions which might hamper or interfere with their care, including excessive noise levels, offensive odors, or unsightly physical surroundings.

Amended by R.1993 d.671, effective December 20, 1993.
See: 25 N.J.R. 3719(a), 25 N.J.R. 6031(a).

8:33H–1.19 Prioritization criteria and recommended features for the approval of nursing home projects

(a) In the case where two or more applications propose to meet a limited nursing home bed need in a particular county, these applications shall be reviewed in competition with each other using the prioritization criteria contained herein.

(b) Preference shall be given to the Certificate of Need approval of those projects that receive the greatest number of points using the criteria enumerated below. Each criterion shall count for one point, except that the criteria at (b)1 and 2 below shall count for two points each. In this manner, the maximum possible score shall be 15. Criteria are as follows:

1. The applicant documents a commitment to occupy 55 percent or more of the facility's total long-term care bed complement with Medicaid-eligible patients within one year of licensure. This proportion shall include at least 45 percent occupancy of the total bed complement by direct-admission Medicaid-eligible patients and at least 10 percent occupancy by patients who convert from private pay status to Medicaid eligibility during their stay in the facility. Applicants may propose to accept higher percentages of Medicaid patients than those stated herein, however, no greater priority shall be given to applicants for such a commitment;

2. The applicant demonstrates a commitment to admit and maintain Medicaid-eligible "heavy care" or acuity patients in at least 20 percent of the proposed new beds (that is, patients who do not require specialized care, as it is defined in N.J.A.C. 8:33H–1.2, but who routinely require more than the 2.5 hours per day minimum amount of nursing care required in N.J.A.C. 8:39). In order to meet this criterion, the applicant is required to provide documentation from area hospital discharge planners or other appropriate resources to show that there is a need of the magnitude that would warrant 20 percent of the proposed beds being dedicated for heavy care;

3. Above and beyond meeting the requirements in N.J.A.C. 8:33–1.14, the applicant has a track record for consistently high quality patient care in nursing facilities owned or operated by the applicant, as demonstrated by a satisfactory record of compliance with licensure standards during the three year period prior to application submission and submission of an affidavit to that effect;

4. The applicant successfully operates at least one facility that is licensed for both residential health care and long-term care beds, and the facility has maintained an annual occupancy rate of at least 85 percent in its licensed residential health care beds during the most recent calendar year;

5. The facility will include a separate and distinct unit for young adult patients. The size of this unit should be proportionate to the county's need, taking into consideration the projected need for placements for individuals age 20 to 64 in accordance with the placement methodology in N.J.A.C. 8:33H–1.4, and the existence of other long-term care resources that are available for young adults in the area.

6. Within one year of licensure, the facility will be staffed with one or more full-time equivalent physician, or clinical nurse specialists who have received a master's degree in geriatric nursing or a related clinical field from a program accredited by the National League for Nursing;

7. The facility will provide tuition reimbursement and/or a career ladder program for facility personnel. The program and employee participation criteria shall be described in detail in the application. The facility will provide documentation to the Department on an annual basis to show that one or more employees have received college or training school tuition reimbursement each year as part of this program;

8. The project will result in the elimination of life safety code waivers at an existing facility;

9. The project entails the conversion of excess acute care hospital bed capacity to long-term care, in accordance with the requirements in N.J.A.C. 8:33H–1.13(i);

10. The applicant has a track record of implementing long-term care projects in New Jersey in an especially timely manner (that is, long-term care construction projects owned, operated, or managed by the applicant have been licensed within four years of Certificate of Need issuance);

11. The applicant has no more than one other Certificate of Need approved but not yet licensed long-term care facility in New Jersey at the time that the current application is accepted for processing;

12. Above and beyond meeting the requirements in N.J.A.C. 8:33H–1.14, the applicant has a track record for high quality patient care in nursing facilities owned or operated by the applicant in New Jersey, as demonstrated by compliance with five or more advisory standards contained in N.J.A.C. 8:39 at the time of the most recent annual licensing survey. Advisory standards which will be taken into consideration are: access to care, patient assessment and care plans, pharmacy, infection control and sanitation, patient activities, dietary services, medical services, nurse staffing, physical environment, and quality assurance. Substantial compliance refers to compliance with at least 65 percent of the components of each of the five advisory standards; and

13. The facility will promote not only a high quality of nursing and medical care but also a high quality of life for residents. Factors deemed to promote a high quality of life include, but are not limited to, the following:

i. Physical space inside the facility in excess of minimum construction requirements, designed for patients to meet privately with family and significant others;

ii. Year-round, easy access to protected, landscaped outdoor areas that are furnished with outdoor seating and tables; and

iii. Strategies to address the needs of patients with Alzheimer's Disease and related dementias, including, but not limited to, wandering tracks, behavior manage-

ment programs, family support groups, and ongoing special activities.

(c) In the event that an applicant receives Certificate of Need approval for proposing to meet any or all of the prioritization criteria in (b) above, the specified criteria shall be included as conditions of Certificate of Need approval. Failure to comply with the conditions may result in licensure fines or other penalties.

(d) In the case where an applicant states a commitment to meet any or all of the prioritization criteria in (b) above, the applicant shall provide documentation that the costs of meeting the specified criteria have been factored into the applicant's financial feasibility analysis, in accordance with N.J.A.C. 8:33H–1.16.

(e) In Local Advisory Board regions where there is a need for specialized long-term care beds, priority shall be given to the approval of certificate of need applications for projects which are in compliance with all applicable requirements of this chapter and which meet the greatest number of the following criteria:

1. The facility will be centrally located in a geographically accessible location which is conveniently reached by public and private transportation by residents of all parts of the LAB region;

2. The facility has the physical space, bed capacity and architectural layout to accommodate an addition of specialized care beds in a timely manner in the future, should there be a need for more beds in accordance with N.J.A.C. 8:33H–1.6; and

3. The applicant documents a commitment to occupy 55 percent or more of the facility's specialized care bed complement with Medicaid-eligible patients within one year of licensure. This proportion shall include at least 45 percent occupancy by direct-admission Medicaid-eligible patients and at least 10 percent occupancy by patients who convert from private pay status to Medicaid eligibility during their stay in the facility. Applicants may propose to accept higher percentages of Medicaid patients than those stated herein, however, no greater priority shall be given to applicants for such a commitment.

Law Review and Journal Commentaries

Certificates of Need—Appeals. P.R. Chenoweth, 138 N.J.L.J. No. 14, 72 (1994).

Case Notes

There is right to "on the merits" assessment of proposals. In re Certificate of Need Application of Arnold Walter Nursing Home, 277 N.J.Super. 472, 649 A.2d 1319 (A.D.1994).

Health Commissioner has obligation to provide fuller explanation for rejecting appraisals than mere statement that prioritization criteria outweigh recommendations. In re Certificate of Need Application of Arnold Walter Nursing Home, 277 N.J.Super. 472, 649 A.2d 1319 (A.D.1994).

Rationale for denial of application for certificate of need was insufficient. In re Certificate of Need Application of Arnold Walter Nursing Home, 277 N.J.Super. 472, 649 A.2d 1319 (A.D.1994).

Denial of certificate of need upheld when applicant cited for four Level A violations. Bergen Pines County Hospital v. State Health Planning Board, 96 N.J.A.R.2d (HLT) 45.

Applicant's violations of state and federal standards justify denial of certificate of need. In the Matter of the Application of the Raritan Bay Long Term Care Pavilion, 96 N.J.A.R.2d (HLT) 1.

Denial of Certificate of Need for construction of new long-term care facility was not arbitrary and capricious. In Matter of Application of Mediplex of Voorhees for Certificate of Need. 93 N.J.A.R.2d (HLT) 37.

8:33H–1.20 Relationship between licensure and certificate of need requirements

The provisions of N.J.A.C. 8:39, Licensing Standards for Long-Term Care Facilities, N.J.A.C. 8:43, Manual of Standards for Licensure of Residential Health Care Facilities, and N.J.A.C. 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs, and N.J.A.C. 8:43B, Standards for Licensure of Alternate Family Care Sponsor Agencies are hereby incorporated by reference. Applicants receiving certificate of need approval under the provisions of this chapter shall comply with all applicable licensing requirements of N.J.A.C. 8:39, 8:36, 8:43, and 8:43B.

Amended and Recodified by R.1993 d.671, effective December 20, 1993.
See: 25 N.J.R. 3719(a), 25 N.J.R. 6031(a).