Appendix 8.5: FINAL SUBCOMMITTEE REPORTS

Subcommittee Report 5: Regulatory and Legal Reform

Introduction

The New Jersey Commission on Rationalizing Health Care Resources was established to advise the Governor on issues related to maintaining a system of high-quality, affordable, and accessible health care. The Commission in particular was charged with examining the New Jersey acute care hospital system. The evolution of health care in the United States and in New Jersey has presented challenges to New Jersey's hospitals. Hospitals are faced with severe fiscal strains, the people of New Jersey are faced with reductions in the availability of care, and the State is presented with the challenge of whether, and in what manner, to intervene to serve the public good.

The Commission acknowledged in its June 29, 2007 Interim Report the fiscal pressures faced by hospitals, and made some preliminary recommendations regarding funding. It noted, however, that other factors must be considered in fulfilling its charge. The Commission charged the Regulatory and Legal Reform Subcommittee with those issues concerning the regulatory structure within which hospitals operate. The Subcommittee met six times. It was chaired by Commission Member Joel Cantor, and included Commission Members Debra DiLorenzo and Steven Goldman, and twenty experts on New Jersey health care law and regulation.[1]

A primary recommendation of this Subcommittee is that the systematic under-funding of acute care hospitals in this State must be addressed. While other recommendations can and should be made, it is the belief of this Subcommittee that until the underpayment issues are addressed, the acute care hospital industry in New Jersey will continue to struggle. This is evidenced by the 17 closures in the past decade and five bankruptcies in the past 18 months.

I. Subcommittee Charge

The Commission charged six Subcommittees to address particular issues to advance the overall project of the Commission. The Commission charged the Regulatory and Legal Reform Subcommittee as follows:

> To gather and review background information about current statutory and regulatory requirements governing health care facilities specifically in regards to licensing, certificate of need, and oversight through reporting of administrative, financial, and quality data; identify and review issues pertaining to the Certificate of Need Program including impact of trends in health care delivery, issues related to the implementation of the Certificate of Need Program, and recommendations; identify and review issues related to licensure and health care delivery; recommend revisions in statutes, administrative rules and programs; and serve as liaison to Commission subcommittees to assess necessity for legislative reforms.

II. Overview of Subcommittee Process

The Subcommittee met six times from August to December 2007. Rutgers' Center for State Health Policy in New Brunswick generously hosted the meetings. Before the meetings, staff circulated material describing New Jersey's statutory and regulatory structure, particularly as it pertains to Certificate of Need ("CON") and licensure. Staff also circulated materials on other states' regulatory structures, and materials produced from non-governmental sources such as the American Health Lawyers Association and the Joint Commission. The Subcommittee requested and received copies of reports of two Commission subcommittees: Benchmarking for Efficiency & Quality and Reimbursements/Payers.

[1] See Appendix 8.5A for full roster of Subcommittee members.

The deliberations focused on CON matters associated with the closure of hospitals and alternatives to the existing statutory process for closure, including, but not limited to, the development of an early warning system for distressed hospitals. Additionally, deliberations focused on licensure matters, particularly those concerning the interrelationship of hospitals and ambulatory care facilities and those concerning the governance structure of hospitals. The deliberations were informed by the proceedings of other committees and the Commission activities generally. There was robust discussion, sometimes disagreement, but ultimately the consensus of the subcommittee reached a number of recommendations.

III. General Approach to the Issues

Deliberations focused on several clusters of issues, to which the members returned regularly. These cross-cutting concerns arose in discussion of CON structure, licensure, and other statutory and regulatory issues:

- Adequacy of hospital reimbursement. Members recognized that other Subcommittees were primarily responsible for this issue, but asserted forcefully that the under-funding of acute care hospitals in this State must be addressed. It is the belief of this subcommittee that until the underpayment issues are addressed, the acute care hospital industry in New Jersey will continue to struggle
- Planning. Members recommended several steps to improve the function of health planning.
    - The State of New Jersey, through both the Department of Health and Senior Services (the Department) and the Health Care Facilities Financing Authority (the HCFFA), has data that can be used to create an "early warning system."
    - CON regulations should be reviewed regularly to assure that they are consistent with industry and regulatory practice.
    - Prospective health planning should be employed to rationalize health care (particularly hospital) delivery when market forces drive the closure of hospitals. In particular, local and market area health planning was advocated as a means to avoid problems that arise when market forces, rather than prospective planning, are allowed to drive the closure of hospitals.
    - The CON process should be comprehensively reviewed to respond to the unacceptable consequences of market forces, which limit access to essential health care services.
    - In particular, the CON process for hospital closure should be modified to recognize the realities of the process of the winding down of a failing hospital.
- "Leveling the playing field." The mixture of regulation and markets in New Jersey leads to some discontinuities disadvantageous to hospitals. Areas of focus included,
    - The imbalance between the regulatory burden on hospitals and ambulatory care facilities, particularly in terms of hours of operation and obligations to accept all patients.
    - The imbalance in the regulatory attention paid to hospitals and ambulatory care facilities, particularly in terms of monitoring quality and reporting of utilization, quality measures, and payer data.
- Governance. Although much of the distress suffered by New Jersey hospitals has resulted from outside forces, members considered possible changes in the regulation of hospital boards. Discussion focused on two issues:
    - Best practices, including some drawn from the application of Sarbanes-Oxley to non-profit boards, should be included in licensure regulations.
    - The Department of Health and Senior Services role should be to improve the ability of governing bodies to respond to changing market conditions. In particular,
        - Board members should receive appropriate training, which is already mandated for new board members by the Hospital Trustee Education law, P.L.2007, c 74 . The Department is in the process of promulgating regulations to implement this new law.
        - The Department should provide "early warning" information to boards to allow them to make informed decisions well in advance of times of distress.
- Other legal/regulatory issues. Two additional concerns were the subject of substantial discussion:
    - New Jersey's physician self-referral law (the "Codey law") has been interpreted by the Board

of Medical Examiners to permit physicians to operate ambulatory care facilities in a manner that creates challenges to hospitals.

A Superior Court decision (*Garcia v. Health* Net) recently adopted an interpretation of the Codey law that appears to be substantially narrower than that articulated by the Board of Medical Examiners. Some members of the Subcommittee advocated a narrower interpretation of the Codey Law to reduce this competitive pressure.

- The competitive relationship between physicians and hospitals raises concerns, some of which are addressed by other Subcommittees. Two in particular were raised:
  - Hospitals and physicians experience conflicting incentives with respect to the intensity of services provided inpatients; some realignment is called for.
  - The fiscal pressures experienced by physicians, combined with the sometimes competitive nature of the relationship between hospitals and physicians, have resulted in hospitals experiencing difficulty in providing physician coverage for essential services.

IV. Findings and Recommendations

A. Reimbursement shortfalls drive many of the problems in New Jersey's hospital industry.

A major factor that must be taken into consideration in examining the distress experienced by New Jersey's hospitals is the level of reimbursement paid by governmental payers. In particular, Medicaid and Charity Care reimburse most hospitals for most procedures at a level below hospitals' costs, and below the level of Medicare and private payers. Hospitals can no longer cost-shift to make up the difference.

Recommendation:

Governmental payers' practices must be reviewed to ensure that adequate reimbursement is provided to hospitals and healthcare providers who provide services to beneficiaries of public programs and to the under-insured and uninsured.

B. New Jersey's health planning process at times does not match with the evolving needs of the health care delivery system.

New Jersey's health care system is subject to both market pressure and State regulation. Market conditions can change more quickly than regulatory systems. Health planning regulations should be reexamined to make sure that they perform their intended functions in this mixed economy.

B.1. Planning regulations sometimes fall out of date, and are eclipsed by practice.

Recommendation:

The Department should review its CON regulations and update those that are no longer reflective of practice, and discard those that are no longer used by the Department.

B.2. CON regulation of hospital and other health care services clashes at times with the market-driven pressures to which health care providers are also subjected, but proper CON regulation may help to rationalize New Jersey's health care services.

The Health Care Facilities Planning Act, N.J.S.A. 26:2H-1 et seq., established the CON process to ensure "that hospital and health care services of the highest quality, of demonstrated need, efficiently provided, and properly utilized at a reasonable cost are of vital concern to the public health." The original purpose of the Act was to encourage highly centralized regional planning. See N.J.S.A. 26:2H-6.1. This process has largely been supplanted by a regulatory process that maintains the structure of planning while becoming largely reactive to market forces rather than prospectively identifying need. Reestablishment of comprehensive State health planning could be problematic because the speed of market changes tends to render regulations quickly obsolete. In addition, the resources that would be needed to maintain a comprehensive planning process are not likely to be readily available to the Department. The Subcommittee agreed, however, that continued State health planning in some form – some argued in a very robust form – is necessary to maintain rationality in the health care delivery market.

The time constraints on the Subcommittee process prevented the full review of this issue that is warranted. The Department should convene a workgroup to review New Jersey's CON process.

B.3. In some areas of the State, some reconfiguration of hospitals will take place, through market forces or otherwise. The State currently approaches these problems on a hospital-by-hospital basis, and tends to intervene only when a hospital has failed. This process is unnecessarily disruptive to the communities served in these areas.

Recommendation:

The State health planning process should undertake a review of a troubled hospital's market area to permit a more rational hospital closure and realignment process than results from market forces and the bankruptcy process.

In addition, the Subcommittee strongly recommends that the State of New Jersey create an "Early Warning System" under which representatives of the State, including the Commissioner of Health and Senior Services, a Deputy Commissioner of Health and Senior Services, and the Executive Director of HCFFA (or a senior member of HCFFA), would meet with any hospital CEO and Board of a hospital whose financial indicators moving in the wrong direction early in the process when the hospital might still be able to turn things around. While the Subcommittee did not definitively agree upon the financial indicators to be utilized and instead deferred this to the appropriate Commission subcommittee, we discussed indicators such as "days cash-on-hand, total margin of facility, occupancy, and period of time in which bills are paid. The concept of the Early Warning System is that the State has much data that it receives that shows early signs of hospital distress. Since some members of the Subcommittee expressed concern that hospital boards are not always kept apprised of such distress, this Early Warning System would be utilized to alert the CEO and the Executive Committee of the Board (who can then alert the full board) that the State sees signs of trouble, and give the facility time enough to work on a turn around plan. The feeling of the Subcommittee is that State officials are often involved in a situation of financial distress when it is too late in the process, and since they end up spending enormous amounts of time with distressed facilities prior to closing, this would be time well spent by all involved.

B.4. The current closure process is unwieldy and too narrowly focused on the hospital itself. If a hospital must be closed, the process should be well coordinated to minimize adverse effects on available health care services within the community, and facilitate the continuation of services in the most effective settings possible.

CON applications for closure authorization usually come when closure is a foregone conclusion. The applications, then, become applications for assistance in maintenance of continued operation of surviving services and in ensuring access to other facilities' resources until shutdown. Problems with cash shortages, labor shifts, and loss of control over the availability of community services can be exacerbated if a bankruptcy court is involved. On the positive side, the CON closure process allows for public involvement and input and often highlights issues related to disposition of employee benefits and essential health care services needs. In limited circumstances, the CON closure process allows the Commissioner to establish conditions for services to continue in a new setting to maintain community access.

The Subcommittee discussed the possibly of shortening the length of time it takes to allow a financially troubled hospital to close, including shortening the completeness review to a specific number of days from application filing. The subcommittee also discussed the coordination of hearing processes required by the State Health Planning Board (SHPB) and the Office of the Attorney General, in order to avoid duplication while protecting the community's interests.

The Subcommittee advocates a revision in the CON statute to emphasize the need, during the closure process, for maintaining and coordinating the continuation of needed services as a facility is closed. The statutory process should focus on the need for the hospital and the Department to plan for a closure, with the goal of facilitating community

notification and input, and supporting the creation of alternative health care services and provision of essential resources, rather than the simple unwinding of the failed hospital business.

Recommendation:

There should be a specific deadline for the Department completeness review of hospital closure applications, along with the Commissioner of Health and Senior Service's final determination. The Department's completeness review should not exceed 60 days, which will allow time for the Department's initial review, submission of questions to the hospital if the additional information is needed and consideration of the hospital's response. Final approval by the Commissioner should occur within 30 days of receiving recommendations from the SHPB.

The public hearing held by the Office of Attorney General pursuant to the Community Health Assets Protection Act and the public hearing held by the SHPB for a CN Closure should be coordinated to occur on one hearing date.

C. Ambulatory care facilities have expanded in New Jersey, as elsewhere. In many cases, for example, ambulatory surgery centers, the facilities compete directly with hospitals. The competitive playing field, however, is not level, as hospitals retain obligations that have not been imposed on ambulatory care facilities.

New Jersey has partially deregulated health care facilities in recent years. Following this deregulation, ambulatory care facilities have increased throughout the State. *See* Appendices 8.5B and 8.5C. This deregulation, in addition to being partial, is also uneven in its application. For example, ambulatory care facilities, unlike hospitals, are no longer subject to CON requirements, although they are subject to licensing regulations. *See* P.L. 1998, c. 43. For example, hospitals are required by law to provide "charity care" access for all medically necessary treatments, although the State's reimbursement for those services is in many cases far short of the hospital's cost of providing those treatments. In contrast, ambulatory care facilities have no such obligation, even in those circumstances, such as outpatient surgery, where the hospitals and ambulatory facilities are in direct competition.

Hospitals face hurdles not faced by the ambulatory care facilities in addition to the incompletely reimbursed costs of charity care. For example, most hospital facilities must be available 24/7 in order to serve the needs of emergency departments. In addition, hospitals assert that the ambulatory care facilities with which they are in competition "cherry pick" the less intense cases as well as the insured cases, leaving the more complex and under-insured or uninsured (and therefore more expensive) cases for the hospitals. Finally, hospitals assert that the entrepreneurial nature of modern practice reduces the availability of physician coverage for hospitals, including hospital emergency departments – in part because the charity care system does not pay physicians for their services.

Some of these tensions are the inevitable result of shift in medical practice, as more and more services may appropriately and conveniently be provided in ambulatory settings away from the hospital. The Subcommittee determined, however, that the uneven application of regulations to the two settings exacerbates the effect of this shift, harming hospitals and creating windfalls for ambulatory care providers. The Subcommittee considered two types of regulations in this context: those that mandate the provision of services, and those by which the State engages in oversight, data collection, and quality control.

As to the former, the solutions are somewhat uncertain. The burden of providing charity care, focused as it is solely on hospitals, might be extended to some categories of ambulatory care facilities. For example, New Jersey recently enacted a law that requires outpatient renal dialysis facilities to provide a limited amount of free care. *See* P.L. 2007, c. 79. In addition, many ambulatory care facilities are required to pay assessments in lieu of providing free care.[2] The funds derived from this assessment during the 2005 – 2007 period is significant, but many of the Subcommittee believed it was not adequate to fairly offset the cost of charity care provided by hospitals during that time. Some members suggested that a careful study is

[2] NJSA 26:2H-18.57 establishes the ambulatory care facility assessment. It requires facilities with gross receipts of at least $300,000 and licensed to provide one or more of the following services to pay a gross receipts assessment: ambulatory surgery, computerized axial tomography, comprehensive outpatient rehabilitation, extracorporeal shock wave lithotripsy, magnetic resonance imaging, megavoltage radiation oncology, positron emission tomography, orthotripsy, and sleep disorder.

Number of Facilities	State Fiscal Year	Total fees collected
287	2005	$24,100,628
288	2006	$23,426,868
307	2007	$26,554,395

necessary to assess the burdens of providing charity care and the impact on hospitals and ambulatory care facilities to determine an equitable and appropriate assessment.

With respect to data collection and quality assurance, the Subcommittee was able to reach concrete recommendations. The Subcommittee determined that the licensure regulations for ambulatory care facilities should be amended to require forms of data reporting and quality control at a level similar to those applied to hospitals, while taking into account the differences between the forms of operation.

C.1. The current structure of health delivery results in direct competition between hospitals and ambulatory care facilities for many services, but the regulatory burden on hospitals to operate emergency departments and to provide care to all regardless of ability to pay or source of payment imposes an imbalance that should be addressed.

Recommendation:

The State should remedy the competitive imbalance between hospitals and ambulatory care facilities to the extent the imbalance is exacerbated by State regulation. If charity care continues to be required to be provided by hospitals across all hospital settings (emergency room, inpatient care, surgery, outpatient care, etc.), the State must take steps to assure that the burden of charity care does not unfairly disadvantage hospitals in their competition with ambulatory care facilities. Similarly, the requirement that hospitals, but not ambulatory care facilities, accept Medicaid and other public forms of insurance suggests that the State should act so as to avoid this requirement from creating unfair competitive imbalance.

C.2. The migration of increasingly complex services to ambulatory care facilities has not been matched by proportionate regulatory oversight of these facilities. As a result, the State may not adequately monitor the service quality, payer mix, and administrative structure of these facilities.

Recommendation:

The Department of Health and Senior Services should review the reporting requirements of ambulatory care facilities to ensure that it receives appropriate information to permit it to monitor the quality of the care provided, and to ensure it receives appropriate data on utilization, payer sources, cost reporting, and the identity and number of practitioners participating in care. The gathering of these data could be provided through the use of uniform bills and other reporting mechanisms now employed to gather information from hospitals.

The Department should examine whether it can adopt the standards employed by such organizations as the Accreditation Association for Ambulatory Health Care (AAAHC) or the American Association for the Accreditation of Ambulatory Surgery Facilities (AAAASF) for these purposes. Adopting approval by these oversight entities as "deemed

status" for at least some purposes could streamline the regulatory process for both the Department and the facilities.

C.3. The Department should develop reporting mechanisms and implement reporting requirements for ambulatory care facilities to provide complete data regarding utilization, patient visits by payment source, number of visits, number of practitioners, cost reporting and quality measures. In addition freestanding ambulatory care centers must issue a uniform bill (UB04) for all patients so volumes and referrals may be tracked. Ambulatory care centers should have to comply with all aspects of the Patient Safety Act, and be subject to the same reporting and quality requirements as hospitals. Physician specific data should be unblended so that physician referral patterns may be tracked and evaluated.

D. The governance of non-profit hospitals in New Jersey is accomplished through the leadership and/or contributions of volunteer directors and trustees. The structure of this governance and the regulation of non-profit boards have changed little during the decades in which the operation of hospitals has grown increasingly complex. The regulation of these boards and the recommendation of best practices to their members should be reviewed and brought up to date.

Non-profit hospitals rely on their boards to oversee the hospital's management, and to ensure that the hospital operates in a way that is consistent with the needs of the community. Those boards are populated by volunteers, often people from the community with little experience in the oversight of entities operating on the scale of modern hospitals, and frequently with little familiarity with hospital operations. This community source and orientation of board members has remained unchanged as hospitals have become more complex.

Several national organizations have examined the role, structure and regulation of non-profit boards, including the boards of non-profit hospitals in recent years. The Joint Commission, the American Law Institute, and the American Health Lawyers Association are all engaged in such reviews.

D.1. Board members need appropriate education on their obligations, their hospital's mission, and the operations of non-profit hospitals. Orientation of new members is particularly important.

Recommendation:

The law requiring new hospital board members to attend orientation sessions should be implemented to maximize new members' ability to engage in appropriate oversight. N.J.S.A. 26:2H-12.34.

D.2. New Jersey law vests with the Attorney General the responsibility of overseeing the conduct of the boards of not for profit corporations. This oversight is particularly important as not for profit corporations, unlike for-profit corporations do not have shareholders with an interest and the ability to monitor the corporation's conduct. The Attorney General is charged by law with filling this void by exercising appropriate oversight of board conduct.

Recommendation:

The New Jersey Attorney General should respond appropriately to information, from whatever source, tending to show that the board of a non-profit hospital is derelict in its obligations to carefully oversee the management of the hospital. It should investigate promptly to determine if board misconduct or inattentiveness imperils the hospital. The Department, as the regulatory agency most intimately familiar with hospital operations, should in appropriate cases make referrals to the Attorney General for such purposes. The Attorney General should intrude into board affairs only when necessary to preserve the hospital's community mission.

D.3. The Subcommittee recognizes concerns that board members are sometimes unaware of a hospital's financial difficulties until too late, and that they are sometimes not provided by

hospital management with adequate information to respond to financial crises.

Recommendation:

Hospital management should be encouraged to share appropriate financial information with board members on a timely basis. The Department should work with hospital management, boards, and the HCFFA to ensure that boards are aware of financial crises as well as the options available to salvage the hospital's resources and health care mission, on a timely basis. Sale and closure should not occur in circumstances of extreme crisis, and should be initiated well before significant dissipation of assets and allow conversion of resources to sustainable uses that are mission-consistent.

D.4. Information regarding the makeup of hospital boards, even including the names of the people who serve as directors or trustees, is often not available to the people of the community. Hospitals are important community assets, and the governance of boards should be approached with an eye toward transparency.

Recommendation:

Information regarding the governance of hospitals should be available to the people of the community. While dated, much of the information is available on the Internet for those who know where to find it at locations such as www.guidestar.com.] Some Subcommittee members believed Hospital Boards should place information on the hospital's website, including their Form 990, an information return that most secular exempt organizations with incomes above $25,000 are required to file annually with the IRS, to permit easy access for the public.

D.5. Board governance in the for-profit sector has been rocked by repeated scandals in recent years, as board members and management have intentionally flouted their responsibilities to their shareholders and the public. One result was the passage of the American Competitiveness and Corporate Accountability Act of 2002 (the "Sarbanes-Oxley Act"), which mandated certain corrective steps in corporate governance. Many of the steps mandated for commercial firms have been recommended for adoption by non-profit firms.

Recommendation:

The Department should mandate the adoption of suitable portions of the Sarbanes-Oxley requirements by non-profit healthcare facilities. It should be noted that time constraints prevented the subcommittee from identifying which provisions of Sarbanes-Oxley should be extended to non-profit providers in New Jersey.

E. The relationship between hospitals and their physicians is sometimes not harmonious, and instead creates competitive tensions. As is described above, ambulatory care facilities are in direct competition with hospitals for some services, and those facilities are often operated by the hospital's own physicians. In addition, hospitals and physicians can experience conflict on the management of patients within the hospital, and can disagree on the obligations of physicians to cover needed patient care services within the hospital.

Several developments in health finance have combined to complicate the relationship between hospitals and physicians. As is noted above, hospitals have contended increasingly with competition from ambulatory care facilities. Those facilities are typically owned by physicians. The physician-owners perform procedures in these ambulatory care facilities that they had previously performed in the hospitals with which they now compete.

New Jersey and federal law limit the ability of physicians to refer patients to facilities in which they have an ownership interest. *See* 42 U.S.C. 1395NN (the "Stark Act") and N.J.S.A. 45:9-22.4 *et seq*. (the "Codey law"). There is currently conflicting authority on the proper interpretation of the Codey law. The Board of Medical Examiners has described an interpretation of the Codey law that permits physicians to refer to ambulatory care facilities in which they have

an ownership interest, while a recent Superior Court decision has articulated a narrower interpretation. Several members of the Subcommittee urged that the law is most properly interpreted narrowly to restrict many of the forms of ownership and referral currently permitted under decisions of the New Jersey Board of Medical Examiners.

In addition, the Subcommittee considered the tensions that distort hospital finances when payers – particularly but not exclusively Medicare – create incentives for hospitals to economize on patient care and simultaneously for physicians to practice expansively within the hospital. As it is physicians and not hospitals that control admission, management, and discharge of patients, this conflict is difficult for hospitals to manage. This issue, as the Subcommittee was informed, is within the charge of another Subcommittee.

Finally, the changing economic pressures and incentives experienced by physicians interfere with a cooperative relationship by which hospitals have historically staffed necessary services such as emergency departments. Physicians are under increased pressure to stay in their offices, seeing patients, rather than taking call at hospitals. In addition, some of the call services are in direct conflict with the activities of some of these physicians within their outside ambulatory care facilities.

E.1. Hospitals, physicians, and proprietors of ambulatory care facilities disagree on the proper scope of self-referral laws, particularly the Codey law. It is in New Jersey's interest to have this conflict resolved quickly.

Recommendation:

The Department, in conjunction with the Office of the Attorney General, Division of Consumer Affairs and the Board of Medical Examiners, should take measures to ensure that the self-referral provisions of federal and state law are properly enforced.

E.2. Hospitals and physicians are subject to conflicting pressures with respect to the management of hospital patients. This conflict distorts the management of hospitals, and limits the ability of hospitals to manage patient care consistently and appropriately.

Recommendation:

The Department should examine methods to align the incentives of hospitals and physicians in the management of patients, consistent with appropriate patient protection standards.

E.3. Changes in physician practice has eroded the ability of hospitals to rely on voluntary staffing by physicians of necessary hospital services.

Recommendation:

The Department should undertake a comprehensive review of this problem in conjunction with hospitals and physicians. To the extent it can be addressed cooperatively by accommodating the needs of all parties, such cooperative solutions should be favored.

Appendix 8.5A
Regulatory and Legal Reform Subcommittee Members

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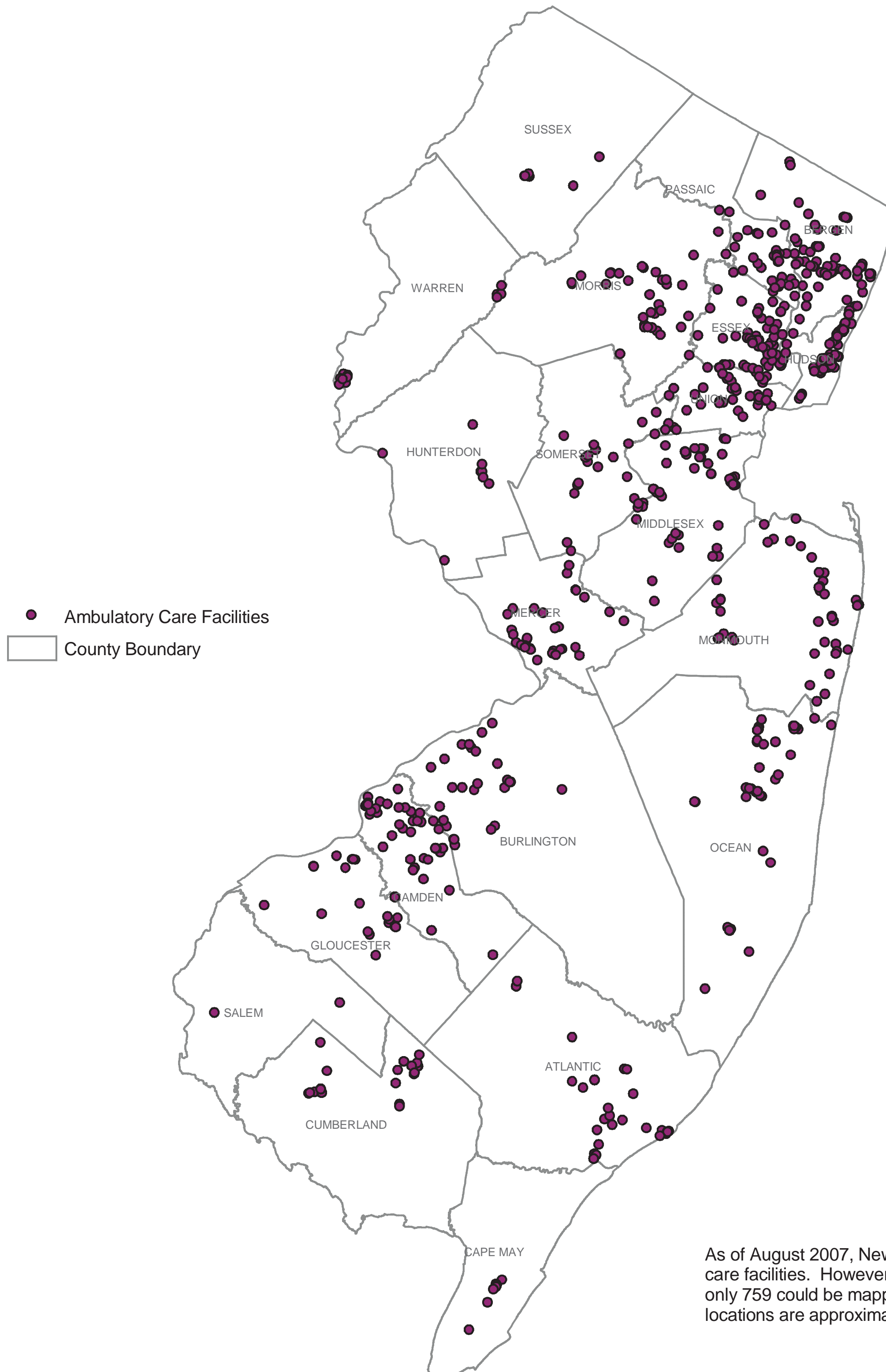
Appendix 8.5B

Ambulatory Care Facilities, New Jersey



As of August 2007, New Jersey has 766 ambulatory care facilities. However, due to geocoding limitations, only 759 could be mapped, and several facility locations are approximate.

Appendix 8.5C
Ambulatory Care Facilities, New Jersey