Home Health Agency Certificate of Need
Application Packet

Contents:

Application submission must include:

- One electronic copy of your application, including any applicable addendum – no paper copy is required.
- A check or money order for the review fee of **$24,666** payable to **Department of Health.**

Include copy of the signed cover sheet with the fee if you submit the application and fee separately. This allows us to connect your application to your fee. We also strongly encourage sending payment with a tracking number.

- Mail or deliver the application and review fee to:

Mailing Address:	**Other Than By Mail:**
Department of Health Certificate of Need Program P O Box 47852 Olympia, Washington 98504-7852	Department of Health Certificate of Need Program 111 Israel Road SE Tumwater, Washington 98501

Contact Us:
Certificate of Need Program Office 360-236-2955 or FSLCON@doh.wa.gov.

Application Instructions

The Certificate of Need Program will use the information in your application to determine if your project meets the applicable review criteria. These criteria are included in state law and rules. Revised Code of Washington (RCW) 70.38 and Washington Administrative Code (WAC) 246-310.

General Instructions:

- Include a table of contents for application sections and appendices/exhibits
- Number **all** pages consecutively
- Make the narrative information complete and to the point.
- Cite all data sources.
- Provide copies of articles, studies, etc. cited in the application.
- Place extensive supporting data in an appendix.
- **Provide a detailed listing of the assumptions you used for all of your utilization and financial projections, as well as the bases for these assumptions.**
- Under no circumstance should your application contain any patient identifying information.
- Use **non-inflated** dollars for **all** cost projections
- **Do not** include a general inflation rate for these dollar amounts.
- **Do** include current contract cost increases such as union contract staff salary increases. You must identify each contractual increase in the description of assumptions included in the application.
- **Do not** include a capital expenditure contingency.
- If any of the documents provided in the application are in draft form, a draft is only acceptable if it includes the following elements:
  a. identifies all entities associated with the agreement,
  b. outlines all roles and responsibilities of all entities,
  c. identifies all costs associated with the agreement,
  d. includes all exhibits that are referenced in the agreement, and
  e. any agreements in draft form must include a document signed by both entities committing to execute the agreement as submitted following CN approval.

Do not skip any questions in this application. If you believe a question is not applicable to your project, explain why it is not applicable.

Answer the following questions in a manner that makes sense for your project. In some cases, a table may make more sense than a narrative. The department will follow up in screening if there are questions.

Program staff members are available to provide technical assistance (TA) at no cost to you before submitting your application. While TA isn't required, it's highly recommended and can make any required review easier. To request a TA meeting, call 360-236-2955 or email us at FSLCON@doh.wa.gov.

Washington State Department of Health

Certificate of Need Application
Home Health Agency

Certificate of Need applications must be submitted with a fee in accordance with Washington Administrative Code (WAC) 246-310-990.

Application is made for a Certificate of Need in accordance with provisions in Revised Code of Washington (RCW) 70.38 and WAC 246-310, rules and regulations adopted by the Washington State Department of Health. I attest that the statements made in this application are correct to the best of my knowledge and belief.

Signature and Title of Responsible Officer Email Address	Date Telephone Number
Legal Name of Applicant Address of Applicant	Provide a brief project description ☐ New Agency ☐ Expansion of Existing Agency ☐ Other: _____ Estimated capital expenditure: $_____
Identify the county proposed to be served for this project. Note: Each home health application must be submitted for one county only. If an applicant intends to obtain a Certificate of Need to serve more than one county, then an application must submitted for each county separately. _____	

Applicant Description

Answers to the following questions will help the department fully understand the role of the applicant(s). Your answers in this section will provide context for the reviews under Financial Feasibility (WAC 246-310-220) and Structure and Process of Care (WAC 246-310-230).

1. Provide the legal name(s) and address(es)of the applicant(s).
   Note: The term "applicant" for this purpose includes any person or individual with a ten percent or greater financial interest in the partnership or corporation or other comparable legal entity as defined in WAC 246-310-010(6).

2. Identify the legal structure of the applicant (LLC, PLLC, etc.) and provide the Unified Business Identifier (UBI).

3. Provide the name, title, address, telephone number, and email address of the contact person for this application.

4. Provide the name, title, address, telephone number, and email address of the consultant authorized to speak on your behalf related to the screening of this application (if any).

5. Provide an organizational chart that clearly identifies the business structure of the applicant(s).

6. Identify all healthcare facilities and agencies owned, operated by, or managed by the applicant or its affiliates with overlapping decision-makers. This should include all facilities in Washington State as well as out-of-state facilities. The following identifying information should be included:
   - Facility and Agency Name(s)
   - Facility and Agency Location(s)
   - Facility and Agency License Number(s)
   - Facility and Agency CMS Certification Number(s)
   - Facility and Agency Accreditation Status
   - If acquired in the last three full calendar years, list the corresponding month and year the sale became final
   - Type of facility or agency (home health, hospice, other)

Project Description

1. Provide the name and address of the existing agency, if applicable.

2. If an existing Medicare and Medicaid certified home health agency, explain how this proposed project will be operated in conjunction with the existing agency.

3. Provide the name and address of the proposed agency. If an address is not yet assigned, provide the county parcel number and the approximate timeline for assignment of the address.

4. Provide a detailed description of the proposed project.

5. Confirm that this agency will be available and accessible to the entire geography of the county proposed to be served.

6. With the understanding that the review of a Certificate of Need application typically takes at least six to nine months, provide an estimated timeline for project implementation, below:

Event	Anticipated Month/Year
CN Approval	
Design Complete (if applicable)	
Construction Commenced* (if applicable)	
Construction Completed* (if applicable)	
Agency Prepared for Survey	
Agency Providing Medicare and Medicaid hospice services in the proposed county.	

* If no construction is required, commencement of the project is project completion, commencement of the project is defined in WAC 246-310-010(13) and project completion is defined in WAC 246-310-010(47).

7. Identify the home health services to be provided by this agency by checking all applicable boxes below. For home health agencies, at least two of the services identified below must be provided.

□Skilled Nursing	□Occupational Therapy
□Home Health Aide	□Nutritional Counseling
□Durable Medical Equipment	□Bereavement Counseling
□Speech Therapy	□Physical Therapy
□Respiratory Therapy	□IV Services
□Medical Social Services	□Applied Behavioral Analysis
□ Other (please describe)	

8. If this application proposes expanding the service area of an existing home health agency, clarify if the proposed services identified above are consistent with the existing services provided by the agency in other planning areas.

9. If this application proposes expanding an existing home health agency, provide the county(ies) already served by the applicant and identify whether Medicare and Medicaid services are provided in the existing county(ies).

10. Provide a general description of the types of patients to be served by the agency at project completion (age range, diagnoses, etc.).

11. Provide a copy of the applicable letter of intent that was submitted according to WAC 246-310-080.

12. Confirm that the agency will be licensed and certified by Medicare and Medicaid. If this application proposes the expansion of an existing agency, provide the existing agency's license number and Medicare and Medicaid numbers.

    IHS.FS._____

    Medicare #:_____

    Medicaid #:_____

Certificate of Need Review Criteria

A. Need (WAC 246-310-210)

WAC 246-310-210 provides general criteria for an applicant to demonstrate need for healthcare facilities or services in the planning area. Documentation provided in this section must demonstrate that the proposed agency will be needed, available, and accessible to the community it proposes to serve. Some of the questions below only apply to existing agencies proposing to expand. For any questions that are not applicable to your project, explain why.

1. List all home health providers currently operating in the planning area.

2. Complete the numeric methodology.

3. If applicable, provide a discussion identifying which agencies identified in response to Question 1 should be excluded from the numeric need methodology and why. Examples for exclusion could include but are not limited to: not serving the entire geography of the planning area, being exclusively dedicated to DME, infusion, or respiratory care, or only serving limited groups.

4. Explain why this application is not considered an unnecessary duplication of services for the proposed planning area. Provide any documentation to support the response.

5. For existing agencies, using the table below, provide the home health agency's historical utilization broken down by county for the last three full calendar years.

County	Identify Year	Identify Year	Identify Year
Total number of admissions			
Total number of visits			
Average number of visits/patient			

6. Provide the projected utilization for the proposed agency for the first three full years of operation. For existing agencies, also provide the intervening years between historical and projected. Include all assumptions used to make these projections.

County	Identify Year	Identify Year	Identify Year
Total number of admissions			
Total number of visits			
Projected number of visits/patient			

7. Identify any factors in the planning area that could restrict patient access to home health services.

8. Explain why this application is not considered an unnecessary duplication of services for the proposed planning area. Provide any documentation to support the response.

9. Confirm the proposed agency will be available and accessible to the entire planning area.

10. Identify how this project will be available and accessible to underserved groups.

11. Provide a copy of the following policies:
    - Admissions policy
    - Charity care or financial assistance policy
    - Patient Rights and Responsibilities policy
    - Non-discrimination policy
    - Any other policies directly related with patient access (involuntary discharge)

B. Financial Feasibility (WAC 246-310-220)

Financial feasibility of a home health project is based on the criteria in WAC 246-310-220.

1. Provide documentation that demonstrates the immediate and long-range capital and operating costs of the project can be met. This should include but is not limited to:
    - Utilization projections. These should be consistent with the projections provided under the Need section. **Include all assumptions.**
    - Pro Forma revenue and expense projections for at least the first three full calendar years of operation using at a minimum the following Revenue and Expense categories identified at the end of this question**. Include all assumptions.**
    - Pro Forma balance sheet for the current year and at least the first three full calendar years of operation. **Include all assumptions.**
    - For existing agencies proposing addition of another county, provide historical revenue and expense statements, including the current year.

Ensure these are in the same format as the pro forma projections. For incomplete years, identify whether the data is annualized.

Revenue	**Expenses**
Medicare, including Managed Care	Advertising
Medicaid, including Managed Care	Allocated Costs
Private Pay	B & O Taxes
Other, [TriCare, Veterans, LNI, etc.] detail what is included	Depreciation and Amortization
Non-operating revenue	Dues and Subscriptions
	Education and Training
	Employee Benefits
	Equipment Rental
	Information Technology/Computers
Deductions from Revenue:	Insurance
(Charity)	Interest
(Provision for Bad Debt)	Legal and Professional
(Contractual Allowances)	Licenses and Fees
	Medical Supplies
	Payroll Taxes
	Postage
	Purchased Services (utilities, other)
	Rental/Lease
	Repairs and Maintenance
	Salaries and Wages (DNS, RN, OT, clerical, etc.)
	Supplies
	Telephone/Pagers
	Travel (patient care, other)
	Other, detail what is included

2. Provide the following agreements/contracts:
    - Management agreement.
    - Operating agreement
    - Medical director agreement
    - Joint Venture agreement

    Note, all agreements above must be valid through at least the first three full years following completion or have a clause with automatic renewals. **Any agreements in draft form must include a document signed by both entities committing to execute the agreement as submitted following CN approval.**

3. Provide documentation of site control. This could include either a deed to the site or a lease agreement for the site.

   If this is an existing home health agency and the proposed services would be provided from an existing main or branch office, provide a copy of the deed or lease agreement for the site. If a lease agreement is provided, the agreement must extend through at least the third full year following the completion of the project. Provide any amendments, addenda, or substitute agreements to be created as a result of this project to demonstrate site control.

   If this is a **new** home health agency site, documentation of site control includes one of the following:

   a. An **executed** purchase agreement or deed for the site.
   b. A **draft** purchase agreement for the site. The draft agreement must include a document signed by both entities committing to execute the agreement as submitted following CN approval.
   c. An **executed** lease agreement for at least three years with options to renew for not less than a total of two years.
   d. A draft lease agreement. For Certificate of Need purposes, draft agreements are acceptable if the draft identifies all entities entering into the agreement, outlines all roles and responsibilities of the entities, identifies all costs associated with the agreement, includes all exhibits referenced in the agreement. The draft agreement must include a document signed by both entities committing to execute the agreement as submitted following CN approval.

4. Complete the table below with the estimated capital expenditure associated with this project. Capital expenditure is defined under WAC 246-310-010(10). If you have other line items not listed below, include the definition of the line item. Include all assumptions used to create the capital expenditure estimate

Item	Cost
a. Land Purchase	$
b. Utilities to Lot Line	$
c. Land Improvements	$
d. Building Purchase	$
e. Residual Value of Replaced Facility	$
f. Building Construction	$
g. Fixed Equipment (not already included in the construction contract)	$
h. Movable Equipment	$
i. Architect and Engineering Fees	$
j. Consulting Fees	$
k. Site Preparation	$
l. Supervision and Inspection of Site	$
m. Any Costs Associated with Securing the Sources of Financing (include interim interest during construction)	
1. Land	$
2. Building	$
3. Equipment	$
4. Other	$
n. Washington Sales Tax	$
Total Estimated Capital Expenditure	**$**

5. Identify the entity responsible for the estimated capital costs identified above. If more than one entity is responsible, provide breakdown of percentages and amounts for each
.
6. Identify the amount of start-up costs expected to be needed for this project. Include any assumptions that went into determining the start-up costs. Start-up costs should include any non-capital expenditure expenses incurred prior to the facility opening or initiating the proposed service. If no start-up costs are expected, explain why.

7. Identify the entity responsible for the start-up costs. If more than one entity is responsible, provide a breakdown of percentages and amounts for each.

8. Explain how the project would or would not impact costs and charges for healthcare services in the planning area.

9. Explain how the costs of the project, including any construction costs, will not result in an unreasonable impact on the costs and charges for healthcare services in the planning area.

10. Provide the projected payer mix by revenue and by patients by county as well as for the entire agency using the example table below. Medicare and Medicaid managed care plans should be included within the Medicare and Medicaid lines, respectively. If "other" is a category, define what is included in "other."

Payer Mix	Percentage of Gross Revenue	Percentage by Patient
Medicare		
Medicaid		
Other Payers (list in individual lines)		
Total		

11. If this project proposes the addition of a county for an existing agency, provide the historical payer mix by revenue and patients for the existing agency. The table format should be consistent with the table shown above.

12. Provide a listing of equipment proposed for this project. The list should include estimated costs for the equipment. If no equipment is required, explain.

13. Identify the source(s) of financing (loan, grant, gifts, etc.) and provide supporting documentation from the source. Examples of supporting documentation include: a letter from the applicant's CFO committing to pay for the project or draft terms from a financial institution.

14. If this project will be debt financed through a financial institution, provide a repayment schedule showing interest and principal amount for each year over which the debt will be amortized.

15. Provide the most recent audited financial statements for:
    - The applicant, and
    - Any parent entity responsible for financing the project.

C. Structure and Process (Quality) of Care (WAC 246-310-230)

Projects are evaluated based on the criteria in WAC 246-310-230 for staffing availability, relationships with other healthcare entities, relationships with ancillary and support services, and compliance with federal and state requirements. Some of the questions within this section have implications on financial feasibility under WAC 246-310-220.

1. Provide a table that shows FTEs [full time equivalents] by category for the county proposed in this application. All staff categories should be defined.

2. If this application proposes the expansion of an existing agency into another county, provide an FTE table for the entire agency, including at least the most recent three full years of operation, the current year, and the first three full years of operation following project completion. There should be no gaps in years. All staff categories should be defined.

3. Provide the assumptions used to project the number and types of FTEs identified for this project.

4. Provide a detailed explanation of why the staffing for the agency is adequate for the number of patients and visits projected.

5. If you intend to have a medical director, provide the name and professional license number of the current or proposed medical director. If not already disclosed under 210(1) identify if the medical director is an employee or under contract.

6. If the medical director is/will be an employee rather than under contract, provide the medical director's job description.

7. Identify key staff by name and professional license number, if known. If not yet known, provide a timeline for staff recruitment and hiring (nurse manager, clinical director, etc.)

8. For existing agencies, provide names and professional license numbers for current credentialed staff.

9. Describe your methods for staff recruitment and retention. If any barriers to staff recruitment exist in the planning area, provide a detailed description of your plan to staff this project.

10. Identify your intended hours of operation and explain how patients will have access to services outside the intended hours of operation.

11. For **existing** agencies, clarify whether the applicant currently has a method for assessing customer satisfaction and quality improvement for the home health agency.

12. For **existing** agencies, provide a listing of ancillary and support service vendors already in place.

13. Identify whether any of the existing ancillary or support agreements are expected to change as a result of this project.

14. For **new** agencies, provide a listing of ancillary and support services that will be established.

15. For **existing** agencies, provide a listing of healthcare facilities with which the home health agency has documented working relationships.

16. Clarify whether any of the existing working relationships would change as a result of this project.

17. For a **new** agency, provide the names of healthcare facilities with which the home health agency anticipates it would establish working relationships.

18. Identify whether any facility or practitioner associated with this application has a history of the actions listed below. If so, provide evidence that the proposed or existing facility can and will be operated in a manner that ensures safe and adequate care to the public and conforms to applicable federal and state requirements. WAC 246-310-230(3) and (5)
    a. A criminal conviction which is reasonably related to the applicant's competency to exercise responsibility for the ownership or operation of a health care facility; or
    b. A revocation of a license to operate a healthcare facility; or
    c. A revocation of a license to practice as a health profession; or
    d. Decertification as a provider of services in the Medicare or Medicaid program because of failure to comply with applicable federal conditions of participation.

19. Provide a discussion explaining how the proposed project will promote continuity in the provision of health care services in the planning area, and not result in an unwarranted fragmentation of services. WAC 246-310-230

20. Provide a discussion explaining how the proposed project will have an appropriate relationship to the service area's existing health care system as required in WAC 246-310-230.

21. The department will complete a quality of care analysis using publicly available information from CMS. If any facilities or agencies owned or operated by the applicant reflect a pattern of condition -level findings, provide applicable plans of correction identifying the facilities current compliance status.

22. If information provided in response to the question above show a history of condition-level findings, provide clear, cogent and convincing evidence that the applicant can and will operate the proposed project in a manner that ensures safe and adequate care and conforms to applicable federal and state requirements.

D. Cost Containment (WAC 246-310-240)

Projects are evaluated based on the criteria in WAC 246-310-240 in order to identify the best available project for the planning area.

1. Identify all alternatives considered prior to submitting this project. At a minimum include a brief discussion of this project versus no project.

2. Provide a comparison of the project with alternatives rejected by the applicant. Include the rationale for considering this project to be superior to the rejected alternatives. Factors to consider can include, but are not limited to: patient access to healthcare services, capital cost, legal restrictions, staffing impacts, quality of care, and cost or operation efficiency.

3. If the project involves construction, provide information that supports conformance with WAC 246-310-240(2):
   - The costs, scope, and methods of construction and energy conservation are reasonable; and
   - The project will not have an unreasonable impact on the costs and charges to the public of providing health services by other persons.

4. Identify any aspects of the project that will involve appropriate improvements or innovations in the financing and delivery of health services which foster cost containment and which promote quality assurance and cost effectiveness.

Home Health Agency Tie Breakers (1987 State Health Plan, Volume II, pages B35-36)

If two or more applicants meet all applicable review criteria and there is not enough need projected for all applications to be approved, the department will approve the agency that better improves patient care, reduces costs, and improves population health through increased access to services in the planning area. Ensure that sufficient documentation and discussion of these items is included throughout the application under the relevant sections.

Certificate of Need Program Revised Code of Washington (RCW) and Washington Administrative Code (WAC)

Certificate of Need Program laws RCW 70.38

Certificate of Need Program rules WAC 246-310

Certificate of Need Program 'Frequently Asked Questions'

Commonly Referenced Rules for Home Health Projects:

WAC Reference	Title/Topic
246-310-010	Certificate of Need Definitions
246-310-200	Bases for findings and action on applications
246-310-210	Determination of Need
246-310-220	Determination of Financial Feasibility
246-310-230	Criteria for Structure and Process of Care
246-310-240	Determination of Cost Containment

Certificate of Need Contact Information:
Certificate of Need Program Web Page
Phone: (360) 236-2955
Email: FSLCON@doh.wa.gov

Licensing Resources:
In-Home Services Agencies Laws, RCW 70.127
In-Home Services Agencies Rules, WAC 246-335
Home Health Agencies Program Web Page