Lakeland Care District

www.lakelandltcdistrict.org

TO: **Service Providers**

FROM: **Jill Burdette**

DATE: **September 30, 2009**

RE: **2010 Contract Service Rates**
Home Health (SPC 105)

On January 1, 2010, Creative Care Options of Fond du Lac County will become a new Family Care entity that will be called the Lakeland Care District (LCD). Later in 2010, Manitowoc County and Winnebago County will join LCD. This memo and the enclosed application are being sent to prospective LCD Supportive Home Care providers to solicit rate and service proposals for 2010 LCD contracts.

LCD will review application and rate proposals for Home Health using the following criteria:

1. Applications completed, signed, and returned by the deadline indicated below.
2. Provider's application and related material in relation to applicable contractual and regulatory criteria for reimbursement as indicated in the Department of Health Services contract.

Please complete, sign, and return the enclosed application material by **October 23 2009**. Please send me an email if you would like the attachments sent electronically. I can be reached at (920) 906-5127 or jill.burdette@fdlco.wi.gov for questions.

Enclosed with this memo you will find the following form(s):

1. 2010 Home Health LCD Application

If you wish to receive an electronic version of this application, please contact me at the above phone or e-mail address.

Mail or return electronically completed applications by October 23, 2009, to:

Attn. Jill Burdette
Creative Care Options
50 N Portland St
Fond du Lac, WI 54935

2010 Home Heath
Annual Application & Rate Proposal Information

Section I Contact Information

(Agency Name)

(Tax ID Number or SSN) (NPI# for Medical Providers)

(WI Medicaid # for Medical Providers) (Medicare # for Medical Providers)

(Contract Administrator) (Email)

(Mailing address for Contract correspondence)

(Phone—including area code) (Fax—including area code)

(Contact for Billing) (Email)

(Mailing address for Billing)

(Phone—including area code) (Fax—including area code)

(Contact for Referrals and Services) (Email)

(Mailing address for Referrals and Services)

(Phone—including area code) (Fax—including area code)

Section II Rate Proposal

Column I	Column II	Column III	Column IV	Column V
Service Category	**2009 Unit MCHSD Contracted Rate**	**2010 Unit LCD Proposed Rate**	**Days Service Available**	**Hours of Day Service is Available**
EXAMPLE: 105	MA Rates	MA Rates	M-R, no holidays	7 a.m. – 5 p.m.
105.11 – (1050) Home Health Care - PT				
105.12 – (1051) Home Health Care – OT				
105.13 – (1052) Home Health Care - SP				
105.20 – (105) Home Health Nurse Initial Visit				
105.20 – (1053) Home Health Nurse, Subsequent Visit				
105.21 – (1054) HHA Initial Visit				
105.21 – (1505) HHA Subsequent Visit				
105.22 - (1056) RN Supervision of PCW 50-60 days				
105.24 - (1500) HHC-Respiratory Care RN				

Section II Instructions

Column I List each service code category proposed

Column II Indicate your LCD contracted 2009 rate for this service category.

Column III Indicate your LCD proposed 2010 rate for this service category.

Column IV Indicate the days of the week the service is available. Note whether these days are applicable on holidays.

(Ex. 7 days a week, including holidays or 5 days a week (M-F) excluding holidays)

Column V Indicate the times during each operating day the service is available.

(Ex. 24 hours a day or 8 am- 6 pm.)

Section III Costs

Please provide an overview of the costs that contribute to your proposed rate for the proposed services. Include administrative allocations, salary and benefits information, travel, training, etc.
The total for all costs should add up to your proposed rate on line f.

Cost	Description	Rate
a.) Administrative		

b.) Staff Salary		
c.) Benefits		
d.) Other Describe____________		
e.) Other Describe_____________		
f.) Total Hourly Rate		

Section IV Service Assessment Information

1. To what target groups does your agency provider these services? Please indicate all that apply.
   - ❑ Developmentally Disabled
   - ❑ Frail Elderly
   - ❑ Physically Disabled
   - ❑ Mentally Ill

2. In which counties will you provide services?
   - ❑ Fond du Lac County
   - ❑ Manitowoc County
   - ❑ Winnebago County
   - ❑ Other ____

3. What radius/area do you cover?
   - ❑ All of Fond du Lac County
   - ❑ Specific Cities.
     - Please list by Area
       - o __________
       - o __________
       - o __________
       - o __________
4. What radius/area do you cover?
   - ❑ All of Manitowoc County
   - ❑ Specific Cities.
     - Please list by Area
       - o __________
       - o __________
       - o __________
       - o __________
5. What radius/area do you cover?
   - ❑ All of Winnebago County
   - ❑ Specific Cities.
     - Please list by Area
       - o __________
       - o __________
       - o __________
       - o __________

6. Is your facility (where members would come to receive services) handicap accessible for the following?
   - ❑ Physically Disabled (in wheelchair) Yes ☐ No ☐ N/A ☐
   - ❑ Visually Impaired Yes ☐ No ☐ N/A ☐
   - ❑ Hearing Impaired Yes ☐ No ☐ N/A ☐
   - ❑ Other __________________________________

- ❑ N/A (Members don't come to facility)

7. LCD contracted providers are prohibited from establishing restrictions limiting access to contracted services for LCD Members. Outside of restricted practices do you have any universally applicable limits for the provision of the services you are proposing?

- ❑ Yes. Please attach narrative description of limits.
- ❑ No.

Section V Capacity

Capacity: LCD is required to report to the Department of Health Services (DHS) that it has adequate capacity within its network to meet the needs of current and prospective members. The information indicated here from Supportive Home Care providers assists LCD in determining whether it needs additional Supportive Home Care providers in our network.

Describe how your agency determines adequate capacity. For example, do you frequently inquire whether employees want additional hours? Do you turn down referrals? What is your current capacity?

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Section VI Service Description Narrative

Service Description. Please indicate which services your narrative applies to. Make copies and complete different narratives if the service descriptions are different. This narrative will be made available to staff, and to members upon request, when asking for information related to choosing a provider. It is important that this description be inclusive and relatively brief, as staff will be reviewing this section when determining which vendors can meet specific member's needs. If you produce written brochures/materials describing your contracted services, that information may be attached in lieu of a written description.

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Section VII Procedures

1. Does your agency prioritize services to determine which services may be missed in a day if staff is ill or overbooked?
   - ❑ Yes
   - ❑ No
   - ❑ N/A

If yes, how____

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2. Do employees have an emergency contact number?
   - ❑ Yes.
     - o Indicate # ________________
   - ❑ No
   - ❑ N/A

2a. Is this contact available 24 hours a day?

- ❑ Yes
- ❑ No
- ❑ N/A
- ❑

3. Do members have a number to call when staff does not show up?
   - ❑ Yes
     - o Indicate #_________________________
   - ❑ No
   - ❑ N/A

4. Does your agency have personnel within your organization or available to your organization to accommodate non-English speaking members?
   - ❑ Yes, please list languages :__________, _______________, ___________________, _______________
   - ❑ No
   - ❑ N/A

Section VIII Transportation

1. Does your agency allow employees to transport members in their personal vehicles?
   - ❑ Yes
   - ❑ No
   - ❑ N/A

2. Does your agency pay your employees mileage or travel reimbursement?
   - ❑ Yes, explain which _______________________________________
   - ❑ No
   - ❑ N/A

3. Does your agency have a policy related to transportation of members, such as limiting the number of miles, distance, etc.?
   - ❑ Yes
   - ❑ No
   - ❑ N/A

If yes, please summarize that policy here.____

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Section IX Signature

Completion of this application packet is necessary for contracting for Supportive Home Care services with LCD. Responses and information contained herein will be used for contractual expectations for your organization's 2010 agreement with LCD.

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Print Name and Title of Agency Representative

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Signature of Authorized Agency Representative Date