IDAHO DEPARTMENT OF
HEALTH & WELFARE

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March 8, 2016

MEDICAID INFORMATION RELEASE MA16-03

To: All Nursing Facility and ICF/ID Administrators

From: Lisa Hettinger, Administrator

Subject: Information Request Related To Wage Determination

Each year the Idaho Department of Health and Welfare gathers information from all nursing facilities (including hospital-based facilities) and intermediate care facilities for persons with intellectual disabilities (ICF/ID) to determine wage data for select employees in the nursing home industry.*

If you were a Medicaid provider on or before March 15, 2016, you must complete the attached certification according to the attached instructions and return the required information to:

Myers and Stauffer LC
8555 West Hackamore Drive, Suite 100
Boise, ID 83709-1693
Fax: (208) 378-0660

You must respond by April 15, 2016.

Submission instructions are shown on page 3. If you have questions, please contact Myers and Stauffer at (800) 336-7721. Thank you for participating in Idaho Medicaid.

LH/dk

Attachments
* *IDAPA 16.03.10.281.02 and IDAPA 16.03.10.603.02*

INFORMATION REQUEST INSTRUCTIONS

(Please read carefully as strict adherence to these standards is required)

As of March 15, 2016, we are requesting the following information regarding select staff at all nursing facilities (including hospital-based facilities) and intermediate care facilities for individuals with intellectual disabilities (ICF/ID).*

You must submit the following information in an Excel format to Myers and Stauffer no later than April 15, 2016.* Early submissions are greatly appreciated. **Please see below for additional requirements for email submissions.**

- Employee Name: Include only the name or identifier for each employee (e.g., ID number). Do not include employee social security numbers.

- Employment Class: Do not send information for staff who are not involved in the routine, direct care of residents who receive long-term care (e.g., physical therapy, occupational therapy, speech therapy, restorative aides, staff development, social service, activities, health information, administration, or ward clerks).

- Include and assign only the staff that fall into these categories (do not include outside contract labor):

  - RN - Registered Nurses (indicate Director of Nursing, Mini Data Set (MDS) Staff, Care Manager, etc.)
  - LPN - Licensed Practical Nurses
  - CNA - Certified Nurse Aides
  - NA - Nurse Aides
  - Dietary Aide
  - Housekeeping Aide
  - Laundry Aide
  - QIDP - Qualified Intellectual Disabilities Professional (ICF/IDs only)
  - THT - Therapy Technicians (ICF/IDs only)

- Hourly Wage: Include only the hourly wage. If the individual is paid a salary, please convert it to an hourly wage (full time = 2,080 hours/year).

- Weekly Hours: Include the number of hours that the individual works in an average work week and round figures to the nearest hour. Include Pro Re Nata (PRN) staff only if a weekly average can be determined.

- Time Frame: The wage data must be the rate paid as of March 15, 2016. Do not include personnel hired after this date.

* According to *IDAPA 16.03.10.281.02 and IDAPA 16.03.10.603.02*

- Format: **All providers are now required to use the standardized reporting form, WAHR Survey Form 2016.** The form is available for download at http://www.mslc.com/Idaho. Navigate to the download folder and select the "WAHRS" folder.

- Submission Requirements: Electronic files that can be sent through a **secured** email system should be sent directly to IDWAHRS@mslc.com. If you do not have access to this type of program, the information should be saved to a CD or other electronic media and mailed to Myers and Stauffer LC at the address shown on page 1.

- Certification: The cover sheet/certification page below must be completed, signed, and included with the information requested above.

STATE OF IDAHO
DEPARTMENT OF HEALTH AND WELFARE
* * *
PERSONNEL LISTING WITH WAGE DATA
* * *
REQUESTED TO COMPLY WITH
IDAPA 16.03.10.281.02 and IDAPA 16.03.10.603.02
* * *
AS OF MARCH 15, 2016

_____
Name of Facility

_____
Address

_____
City, State Zip

_____
Medicaid Provider Number

I certify that, to the best of my knowledge, the information reflected herein is an accurate representation of the facts.

_____
Administrator Signature

_____
Print or Type Name

_____
Date

_____
Phone Number

IDAHO MEDICAID
MIR MA16-03 REQUESTED WAGE & HOUR INFORMAITON
(as of March 15, 2016)

Provider Name: _____

Provider Type: _____

Medicaid Number: _____

Employee ID	Employment Class	Job Title (DON, MDS, etc)	Wage per Hour	Average Hours per Week