IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

MATT WIMMER - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

December 16, 2016

MEDICAID INFORMATION RELEASE MA16-19

To: All Nursing Facility and ICF/ID Administrators

From: Matt Wimmer, Administrator *Matt Wimmer*

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 **February 1, 2017**, you must complete the certification according to the instructions (both the certification and instructions are attached) 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 February 28, 2017.

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.

MW/kl

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

As of February 1, 2017, 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 February 28, 2017. 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). Don't include employee social security numbers.

- Employment Class: Don't send information for staff who aren't 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 (don't 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 February 1, 2017. Don't include personnel hired after this date.

- Format: **All providers are now required to use the standardized reporting form, WAHR Survey Form 2017.** 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 don't have access to this type of program, the information can be submitted through the Myers and Stauffer LC Secure File Transfer Portal (SFTP). If you don't have an account, please contact Pamela Perry of Myers and Stauffer LC at (800) 336-7721 to request access to the SFTP.

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

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 FEBRUARY 1, 2017

____
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

____
Email Address