



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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March 22, 2011

MEDICAID INFORMATION RELEASE 2011-03

To: All Nursing Facility and ICF/ID Administrators
From: Leslie M. Clement, 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.* You must respond according to the attached instructions and complete the attached certification.

If you were a Medicaid provider on or before March 15, 2011, **you must respond by April 27, 2011.**

Please return the required information as soon as possible to:

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

If you have questions, please contact Myers and Stauffer at (800) 336-7721. Thank you for participating in Idaho Medicaid.

LMC/rs

Attachments

* According to *Idaho Code, Section 39-5606, 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, 2011, 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 to Myers and Stauffer no later than April 27, 2011.* Early submissions are greatly appreciated.

- 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 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, admin or ward clerks). Include and assign only the staff that fall into these categories (please notice the new employment categories this year):
 - Registered Nurses (indicate Director of Nursing, Mini Data Set (MDS) staff, Care Manager, etc.)
 - Licensed Practical Nurses
 - Qualified Mental Retardation Professional (ICF/IDs only)
 - Certified Nurse Aides
 - Nurse Aides
 - Therapy Technicians (ICF/IDs only)
 - Dietary Aide – NEW
 - Housekeeping Aide – NEW
 - Laundry Aide – NEW
- 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 Na (PRN) staff only if a weekly average can be determined.
- Time Frame: The wage data must be the rate paid as of March 15, 2011. Do not include personnel hired after this date.

* According to *Idaho Code, Section 39-5606, IDAPA 16.03.10.281.02, and IDAPA 16.03.10.603.02*

- **Format:** Electronic files must be in a standard spreadsheet format. Fax or mail a printout of the file, which must include the signed certification page below, to Myers and Stauffer LC. In addition, please email electronic files directly to valc@mslc.com or submit them on another electronic media. No subtotals or summarizations are necessary. A sample printout is included for your reference.

Note: a payroll schedule will not satisfy the requirements of this request.

Design your printed report according to the following layout:

<u>Employee Name</u>	<u>Employment Class</u>	<u>Hourly Wage</u>	<u>Avg. Weekly Hours</u>
John Doe	Certified Nurse Aide	\$9.37	32

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

STATE OF IDAHO
DEPARTMENT OF HEALTH AND WELFARE

PERSONNEL LISTING WITH WAGE DATA

REQUESTED TO COMPLY WITH
IDAHO CODE, SECTION 39-5606
(Medicaid Information Release)

AS OF MARCH 15, 2011

(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

