

COURT OF APPEALS  
DIVISION II  
OF THE STATE OF WASHINGTON

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LIFE CARE CENTERS OF AMERICA, INC., et al.,

Appellants

vs.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES, STATE OF  
WASHINGTON,

Respondent.

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COURT OF APPEALS  
DIVISION II  
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**REPLY BRIEF OF APPELLANTS**

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## I. INTRODUCTION

The case mix system that the Department uses to establish direct care component rates for Medicaid-participating nursing facilities is complex, but its purpose is simple: to more closely align the direct care component rate to the needs of nursing facility Medicaid residents. RP 15. But the Department's position here frustrates the purpose of the case mix system, ignores the plain language of the applicable statutes, and does not make sense.

The case mix system determines the cost of caring for Medicaid residents through a formula that begins by assigning to each nursing facility resident a "case mix weight" that is based upon the acuity level of the resident. RP 15-16. The case mix weights are determined based upon wage ratio data and factor in how much of a resident's care needs require the services of an RN as opposed to an LPN or a nurse's aide. Id.

From the case mix weights, the Department calculates two average case mix indexes for each nursing facility: (i) a Medicaid average case mix index ("MACMI"), which is the case mix index for all of the facility's Medicaid residents; and (ii) a facility average case mix index ("FACMI"), which is the case mix index for all of the facility's

residents – including its Medicaid and non-Medicaid residents. RP 17; see, also, RCW 74.46.501(1).

The nursing facility’s adjusted direct care costs are divided by the FACMI to determine the facility’s “allowable direct care cost per case mix unit.” AR 563 (Item 45); see, also, RCW 74.46.506(5)(d).<sup>1</sup> This is what it generally costs to provide one day of direct care to the average resident of the nursing facility.

To determine the direct care cost that is specific to the facility’s Medicaid residents, the allowable direct care cost per case mix unit, subject to certain limits or corridors, is then multiplied by the facility’s MACMI. The result is the facility’s direct care rate. Id. (Items 48 and 49). Thus, the direct care rate is essentially the result of the following formula: (Adjusted allowable direct care costs/FACMI) x MACMI.

The problem presented in this case is that the Department used different base year data in setting the Appellants’ (the “Facilities”) July 1, 2007 direct care rates. Specifically, the Department used wage data from 1999 for the FACMI, but wage data from 2005 for the MACMI. So the Department’s calculation of the Facilities’ July 1, 2007

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<sup>1</sup> Citations to the administrative record below are identified as “AR.”

direct care rates followed a disjointed formula that divided 2005 adjusted allowable direct care costs per patient day (which are based on 2005 patient days and 2005 allowable costs) by a FACMI that is based upon case mix weights from 1999. The result was then multiplied by a MACMI that is based upon 2005 case mix weights.

The Department makes a convoluted argument to rationalize its use of wage data from 1999 for the FACMI when updated 2005 wage data was available and was used in the MACMI. But the Department makes no attempt to explain how its mismatching of data: (i) is consistent with the purpose of the case mix system; (ii) complies with the requirement in RCW 74.46.431(4)(a) to set the July 1, 2007, rate based upon 2005 costs; or (iii) complies with the requirement in RCW 74.46.496(4) and (5) to revise the case mix weights when the rate is cost-rebased.

## II. ARGUMENT

1. The Department's current interpretation of RCW 74.46.431(4)(a) is inconsistent with both the statute's plain language and the Department's previous application of the statute.

RCW 74.46.431(4)(a) requires that the Department use adjusted cost data from 2005 in setting the Facilities' July 1, 2007 Medicaid direct care rates. RCW 74.46.431(4)(a) provides, in part, as follows:

Direct care component rate allocations shall be established using adjusted cost report data covering at least six months. . . . Adjusted cost report data from 2005 will be used for July 1, 2007, through June 30, 2009, direct care component rate allocations. . . .

The Department used 2005 adjusted cost report data in every step of the July 1, 2007, rate calculation (patient days, allowable costs, the MACMI calculation, etc.) *except for the FACMI calculation*. Unlike every other step of the rate calculation, the case mix weights used in the FACMI step were not updated with 2005 adjusted cost report data but continued to be based upon 1999 adjusted cost report data. RP 65.

The Department argues that its continued use of case mix weights based upon 1999 cost data is consistent with RCW 74.46.431(4)(a) because it is using a 2005 FACMI, even if that 2005 FACMI is based

upon 1999 cost data. But this is not how the Department previously construed RCW 74.46.431(4)(a) or how the Department construes the statute for purposes of the MACMI. Furthermore, the FACMI itself, as opposed to the cost data that goes into the case mix weights, is not part of the cost report so it cannot be considered “cost report data.”

The Department explains on page 18 of the Brief of Respondent that it used 1999 case mix weights in the FACMI for five years (from July 1, 2001, through June 30, 2006) because RCW 74.46.431(4)(a) required that “adjusted cost report data from 1999 will be used for the July 1, 2001, through June 30, 2006, direct care component rate allocations.” But the cost report base period was updated for the July 1, 2006, and the July 1, 2007 rates, and yet the Department continues to use 1999 case mix weights in the FACMI.

Specifically, RCW 74.46.431(4)(a) requires that “adjusted cost report data from 2003” be used to set the July 1, 2006, rate. Further, RCW 74.46.431(4)(a) requires that “adjusted cost report data from 2005” be used to set the July 1, 2007, rate. Nevertheless, the Department continued to use 1999 case mix weights in the FACMI for the July 1, 2006, and the July 1, 2007 rates. So although the base period

has changed twice since the July 1, 2001, through June 30, 2006 period, the Department continues to use 1999 case mix weights in the rate calculation.

If RCW 74.46.431(4)(a) is to be construed consistent with how the Department construed the statute from July 1, 2001, through June 30, 2006, then the Department should have used the 2003 case mix weights for the FACMI in the July 1, 2006 rate calculation, and it must be required to use the 2005 case mix weights for the FACMI in the July 1, 2007, rate calculation. Whereas the Department's treatment of the FACMI for periods prior to June 30, 2006, has followed the requirement in RCW 74.46.431(4)(a) that "adjusted cost report data from 1999 will be used for the July 1, 2001, through June 30, 2006" direct care rates; its subsequent treatment of the FACMI fails to follow the statutes' requirement that "adjusted cost report data from 2003" be used for the July 1, 2006 direct care rate, and "adjusted cost report data from 2005" be used for the July 1, 2007 direct care rate.

No deference should be afforded to the Department's conflicting interpretation of RCW 74.46.431(4)(a). Waste Management vs. WUTC, 123 Wn.2d 621, 628, 869 P.2d 1034 (1994) (citing Cowiche Canyon

Conservancy v. Bosely, 118 Wn.2d 801, 813-814, 828 P.2d 549 (1992)). Rather, because RCW 74.46.431(4)(a) is clear and unambiguous, the Court must determine the Legislature's intent from the language of the statute alone. Waste Management, 123 Wn.2d at 629 (citations omitted).

In sum, no statute or regulation authorizes the Department to use 1999 adjusted cost data in setting the Facilities' July 1, 2007, direct care rates. RCW 74.46.431(4)(a) only authorizes the use of 1999 adjusted cost data for the rates effective from July 1, 2001, through June 30, 2006. The statute clearly requires the use of 2005 adjusted cost data in setting the July 1, 2007, Medicaid rates.

**2. The Department's failure to revise the case mix weights in the FACMI is also contrary to the plain language of RCW 74.46.496(4) and (5).**

The Department makes no attempt to reconcile its refusal to update the case mix weights used in the FACMI with RCW 74.46.496(4) and (5), which provide as follows:

(4) The case mix weights in this state may be revised if the health care financing administration updates its nursing facility staff time measurement studies. *The case mix weights shall be revised, but only when direct care component rates are cost-*

*rebased as provided in subsection (5) of this section, to be effective on the July 1st effective date of each cost-rebased direct care component rate.* However, the department may revise case mix weights more frequently if, and only if, significant variances in wage ratios occur among direct care staff in the different caregiver classifications identified in this section.

*(5) Case mix weights shall be revised when direct care component rates are cost rebased as provided in RCW 74.46.431(4).*  
(Emphasis added.)

RCW 74.46.496(4) and (5) unequivocally require the Department to revise the case mix weights when the direct care component rates are cost rebased. The Department concedes that it normally revises the case mix weights when a rebasing occurs. RP 16. Although the direct care component rates were rebased in both the July 1, 2006 and the July 1, 2007 rate settings, the Department did not revise the case mix weights for the FACMI. Instead, the Department continues to use the old 1999 case mix weights for the FACMI in the July 1, 2007 rate setting. RP 39, 45, 48, and 56. The Department again ignores the Legislature's clear directive to revise the case mix weights.

3. Unlike the FACMI, the Department revised the case mix weights used in the MACMI even though the applicable MACMI was originally set using case mix weights from 2003, and not 2005.

The Department acknowledges that it has treated the case mix weights for the MACMI differently than it did for the FACMI in the July 1, 2007 rate setting. RP 50 and 56. The Department rationalizes its use of different case mix weights in the MACMI (2005 case mix weights) than the FACMI (1999 case mix weights) based on RCW 74.46.501(7)(a) and (c), which requires the Department to use the “First Quarter MACMI Score in Calculating The July 1, 2007 Medicaid Payment Rates.” See, Respondent’s Brief, p. 22. But a closer look at how the First Quarter MACMI was calculated reveals the flawed inconsistency in the Department’s argument.

The Department did not just take the MACMI from the first quarter of 2007 to calculate the July 1, 2007 rates, as it implies. Rather, the Department took the additional step of updating the MACMI from the first quarter of 2007 with the 2005 revised case mix weights. RP 56.

This additional step was necessary because, as the Department neglects to mention, the MACMI from the first quarter of 2007 was originally determined based upon case mix weights from 2003, and not

based upon the 2005 revised case mix weights. The reason that 2003 case mix weights were originally used in the first quarter 2007 MACMI is because RCW 74.46.431(4)(a) required that 2003 cost data be used for the July 1, 2006 rate, and the July 1, 2006 rate encompassed the first quarter of 2007. So if the Department were to have simply used the MACMI from the first quarter of 2007 in the July 1, 2007 rate calculation, as it claims it did, then the Department would have used a MACMI that was based upon 2003 case mix weights, and not one that incorporated the 2005 revised case mix weights.

But the Department clearly took the additional step of updating the MACMI from the first quarter of 2007 to incorporate the revised case mix weights from 2005. Brief of Respondent, page 23; and RP 46 and 56. RCW 74.46.496(4) and (5) clearly require that this same adjustment be made to the FACMI. In other words, while the Department is to start with the FACMI from the four quarters of 2005, as RCW 74.46.501(7)(b)(iii) requires, the Department must then update that FACMI using the revised case mix weights from 2005.

The Department's witness, Ken Callaghan, explains the additional adjustment that the Department made to the MACMI as follows:

Q Okay. And did the Department take the MACMI from the first quarter of 2007 in that July 1, 2007, rate calculation?

A Yes.

Q Okay. But the Department went one step further with that MACMI and it recalibrated the case mix weights?

A Yes.

Q So not only did the Department take the MACMI from the first quarter of 2007, but the Department also recalibrated the wage rates - I'm sorry - the case mix weights up to 2005 cost; is that correct?

A For July, yes.

RP 46; see, also, RP 56.

The Department argues that “the law required the Department to look to two different periods in time in determining which FACMI and which MACMI to use in calculating the July 1, 2007, rates.” Brief of Respondent, pp. 23-24. But the Department’s additional adjustment to the MACMI shows that its argument is nothing more than misdirection. Neither of the “two different time periods” originally incorporated the revised 2005 case mix weights.

The issue is not the year from which the index is derived, but whether the case mix weights in the index should be revised. The

Department answers this question in the affirmative for the MACMI by revising the case mix weights based upon 2005 cost data. RP 23, 45 and 56. There is no support for the Department's refusal to do the same for the FACMI.

In short, although RCW 74.46.501 provides that the MACMI and the FACMI are derived from two different time periods, it does not support the Department's updating the case mix weights for the MACMI but not for the FACMI. Contrary to the Department's position, RCW 74.46.496 specifically requires the Department to revise the case mix weights when the rates are cost rebased, and it does not say that the Department is to do this for the MACMI but not the FACMI.

The Department essentially seeks to add a condition to the statute to allow it to revise the case mix weights for the MACMI but not for the FACMI. This is despite the Department acknowledgement that RCW 74.46.496 does not permit it to treat the MACMI any different than the FACMI. RP 50. Instead of adding terms to the statute, the Department must give effect to its plain meaning as an expression of legislative intent. State ex. rel. Citizens vs. Murphy, 151 Wn.2d 226, 242, 88 P.3d 375 (2004).

4. **RCW 74.46.496(4) requires that the case mix weights be revised effective July 1, 2007, and not July 1, 2009.**

The Department asserts that it has updated the case mix weights used in the FACMI, but that the update will not take effect until July 1, 2009. Brief of Respondent, page 24. As the Department's presiding officer put it in Conclusion of Law 9:

Contrary to the Appellant's position, RCW 74.46.496(4) and (5) do not specifically state that the case mix weights shall be revised so as to affect the July 1 Medicaid rate within the year of the revision. . . . [T]he revision will be 'effective' in recalculating the FACMIs for the last two quarters of 2007 which, pursuant to RCW 74.46.501(7)(b)(iii), does not affect the July 1, 2007 Medicaid rates, but will be used in determination of the July 1, 2009 Medicaid rates.

As a result, the Department's position is that the effective date is July 1, 2007 for the MACMI, but July 1, 2009 for the FACMI. Once again, the Department construes RCW 74.46.496(4) differently for the MACMI than it does for the FACMI. This disparate treatment again has nothing to do with the time period from which the indices are derived, but when the revision to the case mix weights is to take effect.

Contrary to the Department's position, RCW 74.46.496(4) specifies one effective date which applies to both the FACMI and the

MACMI. RCW 74.46.496(4) makes it clear that the revised case mix weights are “to be effective on the July 1 effective date of each cost rebased direct care component rate.” For purposes of the July 1, 2007 Medicaid rate, which is a cost rebased rate, the July 1 effective date is *July 1, 2007*, and not July 1, 2009. This is because July 1, 2007 is the “July 1 effective date of each cost rebased direct care component rate.” See, RCW 74.46.496(4).

5. **RCW 74.46.501(7)(b)(iii) should not be construed so that it conflicts with the express requirements of RCW 74.46.431(4)(a) and RCW 74.46.496(4) and (5).**

The Department contends that RCW 74.46.501(7)(b)(iii) somehow excuses it from revising the case mix weights for the FACMI despite the express requirements to the contrary in RCW 74.46.496(4) and (5), and RCW 74.46.431(4)(a). But RCW 74.46.501(7)(b)(iii) provides no such exception. In fact, the statute does not even address what cost data is to be used in the rate calculation. The Department's presiding officer even acknowledged that RCW 74.46.501 does not state that the Department is to continue to use the old 1999 case mix weights in the July 1, 2007, rate setting. RP 42.

The Department's conflicting interpretations of the statutory scheme runs afoul of several maxims of statutory construction, including: that statutes which relate to the same subject matter must be read "as a unified whole to the end that a harmonious statutory scheme evolves which maintains the integrity of the respective statutes (Anderson vs. Dep't of Corr., 159 Wn.2d 849, 861, 154 P.3d 220 (2007), and Employco Pers. Servs., Inc. vs. City of Seattle, 117 Wn.2d 606, 614, 817 P.2d 1373 (1991)); the presumption that the Legislature does not intend to create an inconsistency (State ex. rel. Citizens vs. Murphy, 151 Wn.2d 226, 245, 88 P.3d 375 (2004)); and that the Department may not treat similar situations in different ways (Appren. Comm. v. Training Council, 131 Wn. App. 862, 879, 129 P.2d 838 (2006), *citing* Vergeyle vs. Employment Sec. Dep't., 28 Wn. App. 399, 404, 623 P.2d 736 (1981), *overruled on other grounds in* Davis vs. Employment Sec. Dep't., 108 Wn.2d 272, 276, 737 P.2d 1262 (1987)).

The statutory scheme here can be construed in a harmonious fashion by construing it to require the Department to make the same adjustment for the FACMI as it has for the MACMI. Thus, the Department would start with the FACMI from the four quarters of 2005

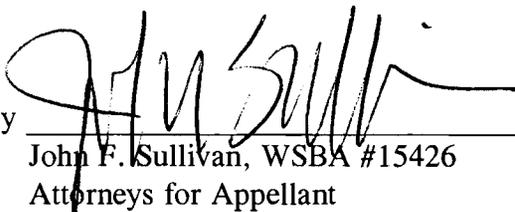
and then update it using the 2005 revised case mix weights. The result would satisfy RCW 74.46.501(7)(b)(iii) by using a FACMI from the four quarters of 2005, and it would also meet the requirements of RCW 74.46.496(4) and (5) to revise the case mix weights. As discussed above, this is precisely how the Department construed the statutory scheme with respect to the MACMI. RP 46 and 56.

### III. CONCLUSION

The Facilities request that the determinations below on the FACMI issue be reversed. The Department must be ordered to comply with RCW 74.46.496(4) and (5) and apply the 2005 revised case mix weights in the FACMI for purposes of calculating the Facilities' July 1, 2007, direct care rates.

RESPECTFULLY SUBMITTED this 22<sup>nd</sup> of October, 2010.

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## **APPENDIX**

- A. RCW 74.46.431
- B. RCW 74.46.496
- C. RCW 74.46.501

RCW 74.46.431

Nursing facility medicaid payment rate allocations — Components — Minimum wage — Rules.

## \*\*\* CHANGE IN 2010 \*\*\* (SEE 6872-S.SL) \*\*\*

(1) Effective July 1, 1999, nursing facility medicaid payment rate allocations shall be facility-specific and shall have seven components: Direct care, therapy care, support services, operations, property, financing allowance, and variable return. The department shall establish and adjust each of these components, as provided in this section and elsewhere in this chapter, for each medicaid nursing facility in this state.

(2) Component rate allocations in therapy care, support services, variable return, operations, property, and financing allowance for essential community providers as defined in this chapter shall be based upon a minimum facility occupancy of eighty-five percent of licensed beds, regardless of how many beds are set up or in use. For all facilities other than essential community providers, effective July 1, 2001, component rate allocations in direct care, therapy care, support services, and variable return shall be based upon a minimum facility occupancy of eighty-five percent of licensed beds. For all facilities other than essential community providers, effective July 1, 2002, the component rate allocations in operations, property, and financing allowance shall be based upon a minimum facility occupancy of ninety percent of licensed beds, regardless of how many beds are set up or in use. For all facilities, effective July 1, 2006, the component rate allocation in direct care shall be based upon actual facility occupancy. The median cost limits used to set component rate allocations shall be based on the applicable minimum occupancy percentage. In determining each facility's therapy care component rate allocation under RCW 74.46.511, the department shall apply the applicable minimum facility occupancy adjustment before creating the array of facilities' adjusted therapy costs per adjusted resident day. In determining each facility's support services component rate allocation under RCW 74.46.515(3), the department shall apply the applicable minimum facility occupancy adjustment before creating the array of facilities' adjusted support services costs per adjusted resident day. In determining each facility's operations component rate allocation under RCW 74.46.521(3), the department shall apply the minimum facility occupancy adjustment before creating the array of facilities' adjusted general operations costs per adjusted resident day.

(3) Information and data sources used in determining medicaid payment rate allocations, including formulas, procedures, cost report periods, resident assessment instrument formats, resident assessment methodologies, and resident classification and case mix weighting methodologies, may be substituted or altered from time to time as determined by the department.

(4)(a) Direct care component rate allocations shall be established using adjusted cost report data covering at least six months. Adjusted cost report data from 1996 will be used for October 1, 1998, through June 30, 2001, direct care component rate allocations; adjusted cost report data from 1999 will be used for July 1, 2001, through June 30, 2006, direct care component rate allocations. Adjusted cost report data from 2003 will be used for July 1, 2006, through June 30, 2007, direct care component rate allocations. Adjusted cost report data from 2005 will be used for July 1, 2007, through June 30, 2009, direct care component rate allocations. Effective July 1, 2009, the direct care component rate allocation shall be rebased biennially, and thereafter for each odd-numbered year beginning July 1st, using the adjusted cost report data for the calendar year two years immediately preceding the rate rebase period, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, 2011, and so forth.

(b) Direct care component rate allocations based on 1996 cost report data shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. A different economic trends and conditions adjustment factor or factors may be defined in the biennial appropriations act for facilities whose direct care component rate is set equal to their adjusted June 30, 1998, rate, as provided in RCW 74.46.506(5)(i).

(c) Direct care component rate allocations based on 1999 cost report data shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. A different economic trends and conditions adjustment factor or factors may be defined in the biennial appropriations act for facilities whose direct care component rate is set equal to their adjusted June 30, 1998, rate, as provided in RCW 74.46.506(5)(i).

(d) Direct care component rate allocations based on 2003 cost report data shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. A different economic trends and conditions adjustment factor or factors may be defined in the biennial appropriations act for facilities whose direct care component rate is set equal to their adjusted June 30, 2006, rate, as provided in RCW 74.46.506(5)(i).

(e) Direct care component rate allocations established in accordance with this chapter shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. The economic trends and conditions factor or factors defined in the biennial appropriations act shall not be compounded with the economic trends and conditions factor or factors defined in any other biennial appropriations acts before applying it to the direct care component rate allocation established in accordance with this chapter. When no economic trends and conditions factor or factors for either fiscal year are defined in a biennial appropriations act, no economic trends and conditions factor or factors defined in any earlier biennial appropriations act shall be applied solely or compounded to the direct care component rate allocation established in accordance with this chapter.

(5)(a) Therapy care component rate allocations shall be established using adjusted cost report data covering at least six

months. Adjusted cost report data from 1996 will be used for October 1, 1998, through June 30, 2001, therapy care component rate allocations; adjusted cost report data from 1999 will be used for July 1, 2001, through June 30, 2005, therapy care component rate allocations. Adjusted cost report data from 1999 will continue to be used for July 1, 2005, through June 30, 2007, therapy care component rate allocations. Adjusted cost report data from 2005 will be used for July 1, 2007, through June 30, 2009, therapy care component rate allocations. Effective July 1, 2009, and thereafter for each odd-numbered year beginning July 1st, the therapy care component rate allocation shall be cost rebased biennially, using the adjusted cost report data for the calendar year two years immediately preceding the rate rebase period, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, 2011, and so forth.

(b) Therapy care component rate allocations established in accordance with this chapter shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. The economic trends and conditions factor or factors defined in the biennial appropriations act shall not be compounded with the economic trends and conditions factor or factors defined in any other biennial appropriations acts before applying it to the therapy care component rate allocation established in accordance with this chapter. When no economic trends and conditions factor or factors for either fiscal year are defined in a biennial appropriations act, no economic trends and conditions factor or factors defined in any earlier biennial appropriations act shall be applied solely or compounded to the therapy care component rate allocation established in accordance with this chapter.

(6)(a) Support services component rate allocations shall be established using adjusted cost report data covering at least six months. Adjusted cost report data from 1996 shall be used for October 1, 1998, through June 30, 2001, support services component rate allocations; adjusted cost report data from 1999 shall be used for July 1, 2001, through June 30, 2005, support services component rate allocations. Adjusted cost report data from 1999 will continue to be used for July 1, 2005, through June 30, 2007, support services component rate allocations. Adjusted cost report data from 2005 will be used for July 1, 2007, through June 30, 2009, support services component rate allocations. Effective July 1, 2009, and thereafter for each odd-numbered year beginning July 1st, the support services component rate allocation shall be cost rebased biennially, using the adjusted cost report data for the calendar year two years immediately preceding the rate rebase period, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, 2011, and so forth.

(b) Support services component rate allocations established in accordance with this chapter shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. The economic trends and conditions factor or factors defined in the biennial appropriations act shall not be compounded with the economic trends and conditions factor or factors defined in any other biennial appropriations acts before applying it to the support services component rate allocation established in accordance with this chapter. When no economic trends and conditions factor or factors for either fiscal year are defined in a biennial appropriations act, no economic trends and conditions factor or factors defined in any earlier biennial appropriations act shall be applied solely or compounded to the support services component rate allocation established in accordance with this chapter.

(7)(a) Operations component rate allocations shall be established using adjusted cost report data covering at least six months. Adjusted cost report data from 1996 shall be used for October 1, 1998, through June 30, 2001, operations component rate allocations; adjusted cost report data from 1999 shall be used for July 1, 2001, through June 30, 2006, operations component rate allocations. Adjusted cost report data from 2003 will be used for July 1, 2006, through June 30, 2007, operations component rate allocations. Adjusted cost report data from 2005 will be used for July 1, 2007, through June 30, 2009, operations component rate allocations. Effective July 1, 2009, and thereafter for each odd-numbered year beginning July 1st, the operations component rate allocation shall be cost rebased biennially, using the adjusted cost report data for the calendar year two years immediately preceding the rate rebase period, so that adjusted cost report data for calendar year 2007 is used for July 1, 2009, through June 30, 2011, and so forth.

(b) Operations component rate allocations established in accordance with this chapter shall be adjusted annually for economic trends and conditions by a factor or factors defined in the biennial appropriations act. The economic trends and conditions factor or factors defined in the biennial appropriations act shall not be compounded with the economic trends and conditions factor or factors defined in any other biennial appropriations acts before applying it to the operations component rate allocation established in accordance with this chapter. When no economic trends and conditions factor or factors for either fiscal year are defined in a biennial appropriations act, no economic trends and conditions factor or factors defined in any earlier biennial appropriations act shall be applied solely or compounded to the operations component rate allocation established in accordance with this chapter. A different economic trends and conditions adjustment factor or factors may be defined in the biennial appropriations act for facilities whose operations component rate is set equal to their adjusted June 30, 2006, rate, as provided in RCW 74.46.521(4).

(8) For July 1, 1998, through September 30, 1998, a facility's property and return on investment component rates shall be the facility's June 30, 1998, property and return on investment component rates, without increase. For October 1, 1998, through June 30, 1999, a facility's property and return on investment component rates shall be rebased utilizing 1997 adjusted cost report data covering at least six months of data.

(9) Total payment rates under the nursing facility medicaid payment system shall not exceed facility rates charged to the general public for comparable services.

(10) Medicaid contractors shall pay to all facility staff a minimum wage of the greater of the state minimum wage or the federal minimum wage.

(11) The department shall establish in rule procedures, principles, and conditions for determining component rate allocations for facilities in circumstances not directly addressed by this chapter, including but not limited to: The need to prorate inflation for partial-period cost report data, newly constructed facilities, existing facilities entering the medicaid program for the first time or after a period of absence from the program, existing facilities with expanded new bed capacity, existing medicaid facilities following a change of ownership of the nursing facility business, facilities banking beds or converting beds back into service, facilities temporarily reducing the number of set-up beds during a remodel, facilities having less than six months of either resident assessment, cost report data, or both, under the current contractor prior to rate setting, and other circumstances.

(12) The department shall establish in rule procedures, principles, and conditions, including necessary threshold costs, for adjusting rates to reflect capital improvements or new requirements imposed by the department or the federal government. Any such rate adjustments are subject to the provisions of RCW 74.46.421.

(13) Effective July 1, 2001, medicaid rates shall continue to be revised downward in all components, in accordance with department rules, for facilities converting banked beds to active service under chapter 70.38 RCW, by using the facility's increased licensed bed capacity to recalculate minimum occupancy for rate setting. However, for facilities other than essential community providers which bank beds under chapter 70.38 RCW, after May 25, 2001, medicaid rates shall be revised upward, in accordance with department rules, in direct care, therapy care, support services, and variable return components only, by using the facility's decreased licensed bed capacity to recalculate minimum occupancy for rate setting, but no upward revision shall be made to operations, property, or financing allowance component rates. The direct care component rate allocation shall be adjusted, without using the minimum occupancy assumption, for facilities that convert banked beds to active service, under chapter 70.38 RCW, beginning on July 1, 2006. Effective July 1, 2007, component rate allocations for direct care shall be based on actual patient days regardless of whether a facility has converted banked beds to active service.

(14) Facilities obtaining a certificate of need or a certificate of need exemption under chapter 70.38 RCW after June 30, 2001, must have a certificate of capital authorization in order for (a) the depreciation resulting from the capitalized addition to be included in calculation of the facility's property component rate allocation; and (b) the net invested funds associated with the capitalized addition to be included in calculation of the facility's financing allowance rate allocation.

[2009 c 570 § 1; 2008 c 263 § 2; 2007 c 508 § 2; 2006 c 258 § 2; 2005 c 518 § 944; 2004 c 276 § 913; 2001 1st sp.s. c 8 § 5; 1999 c 353 § 4; 1998 c 322 § 19.]

**Notes:**

**Effective date – 2009 c 570:** "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [May 19, 2009]." [2009 c 570 § 3.]

**Effective date -- 2007 c 508:** See note following RCW 74.46.410.

**Effective date – 2006 c 258:** See note following RCW 74.46.020.

**Severability – Effective date – 2005 c 518:** See notes following RCW 28A.500.030.

**Severability – Effective date – 2004 c 276:** See notes following RCW 43.330.167.

**Severability – Effective dates – 2001 1st sp.s. c 8:** See notes following RCW 74.46.020.

**Effective dates -- 1999 c 353:** See note following RCW 74.46.020.

RCW 74.46.496

Case mix weights — Determination — Revisions.

**\*\*\* CHANGE IN 2010 \*\*\* (SEE 6872-S.SL) \*\*\***

(1) Each case mix classification group shall be assigned a case mix weight. The case mix weight for each resident of a nursing facility for each calendar quarter shall be based on data from resident assessment instruments completed for the resident and weighted by the number of days the resident was in each case mix classification group. Days shall be counted as provided in this section.

(2) The case mix weights shall be based on the average minutes per registered nurse, licensed practical nurse, and certified nurse aide, for each case mix group, and using the health care financing administration of the United States department of health and human services 1995 nursing facility staff time measurement study stemming from its multistate nursing home case mix and quality demonstration project. Those minutes shall be weighted by statewide ratios of registered nurse to certified nurse aide, and licensed practical nurse to certified nurse aide, wages, including salaries and benefits, which shall be based on 1995 cost report data for this state.

(3) The case mix weights shall be determined as follows:

(a) Set the certified nurse aide wage weight at 1.000 and calculate wage weights for registered nurse and licensed practical nurse average wages by dividing the certified nurse aide average wage into the registered nurse average wage and licensed practical nurse average wage;

(b) Calculate the total weighted minutes for each case mix group in the resource utilization group III classification system by multiplying the wage weight for each worker classification by the average number of minutes that classification of worker spends caring for a resident in that resource utilization group III classification group, and summing the products;

(c) Assign a case mix weight of 1.000 to the resource utilization group III classification group with the lowest total weighted minutes and calculate case mix weights by dividing the lowest group's total weighted minutes into each group's total weighted minutes and rounding weight calculations to the third decimal place.

(4) The case mix weights in this state may be revised if the health care financing administration updates its nursing facility staff time measurement studies. The case mix weights shall be revised, but only when direct care component rates are cost-rebased as provided in subsection (5) of this section, to be effective on the July 1st effective date of each cost-rebased direct care component rate. However, the department may revise case mix weights more frequently if, and only if, significant variances in wage ratios occur among direct care staff in the different caregiver classifications identified in this section.

(5) Case mix weights shall be revised when direct care component rates are cost-rebased as provided in RCW 74.46.431 (4).

[2006 c 258 § 4; 1998 c 322 § 23.]

Notes:

**Effective date -- 2006 c 258:** See note following RCW 74.46.020.

RCW 74.46.501

Average case mix indexes determined quarterly — Facility average case mix index — Medicaid average case mix index.

\*\*\* CHANGE IN 2010 \*\*\* (SEE 6872-S.SL) \*\*\*

(1) From individual case mix weights for the applicable quarter, the department shall determine two average case mix indexes for each medicaid nursing facility, one for all residents in the facility, known as the facility average case mix index, and one for medicaid residents, known as the medicaid average case mix index.

(2)(a) In calculating a facility's two average case mix indexes for each quarter, the department shall include all residents or medicaid residents, as applicable, who were physically in the facility during the quarter in question based on the resident assessment instrument completed by the facility and the requirements and limitations for the instrument's completion and transmission (January 1st through March 31st, April 1st through June 30th, July 1st through September 30th, or October 1st through December 31st).

(b) The facility average case mix index shall exclude all default cases as defined in this chapter. However, the medicaid average case mix index shall include all default cases.

(3) Both the facility average and the medicaid average case mix indexes shall be determined by multiplying the case mix weight of each resident, or each medicaid resident, as applicable, by the number of days, as defined in this section and as applicable, the resident was at each particular case mix classification or group, and then averaging.

(4)(a) In determining the number of days a resident is classified into a particular case mix group, the department shall determine a start date for calculating case mix grouping periods as follows:

(i) If a resident's initial assessment for a first stay or a return stay in the nursing facility is timely completed and transmitted to the department by the cutoff date under state and federal requirements and as described in subsection (5) of this section, the start date shall be the later of either the first day of the quarter or the resident's facility admission or readmission date;

(ii) If a resident's significant change, quarterly, or annual assessment is timely completed and transmitted to the department by the cutoff date under state and federal requirements and as described in subsection (5) of this section, the start date shall be the date the assessment is completed;

(iii) If a resident's significant change, quarterly, or annual assessment is not timely completed and transmitted to the department by the cutoff date under state and federal requirements and as described in subsection (5) of this section, the start date shall be the due date for the assessment.

(b) If state or federal rules require more frequent assessment, the same principles for determining the start date of a resident's classification in a particular case mix group set forth in subsection (4)(a) of this section shall apply.

(c) In calculating the number of days a resident is classified into a particular case mix group, the department shall determine an end date for calculating case mix grouping periods as follows:

(i) If a resident is discharged before the end of the applicable quarter, the end date shall be the day before discharge;

(ii) If a resident is not discharged before the end of the applicable quarter, the end date shall be the last day of the quarter;

(iii) If a new assessment is due for a resident or a new assessment is completed and transmitted to the department, the end date of the previous assessment shall be the earlier of either the day before the assessment is due or the day before the assessment is completed by the nursing facility.

(5) The cutoff date for the department to use resident assessment data, for the purposes of calculating both the facility average and the medicaid average case mix indexes, and for establishing and updating a facility's direct care component rate, shall be one month and one day after the end of the quarter for which the resident assessment data applies.

(6) A threshold of ninety percent, as described and calculated in this subsection, shall be used to determine the case mix index each quarter. The threshold shall also be used to determine which facilities' costs per case mix unit are included in determining the ceiling, floor, and price. For direct care component rate allocations established on and after July 1, 2006, the threshold of ninety percent shall be used to determine the case mix index each quarter and to determine which facilities' costs per case mix unit are included in determining the ceiling and price. If the facility does not meet the ninety percent threshold, the department may use an alternate case mix index to determine the facility average and medicaid average case mix indexes for the quarter. The threshold is a count of unique minimum data set assessments, and it shall include resident assessment instrument tracking forms for residents discharged prior to completing an initial assessment. The threshold is calculated by dividing a facility's count of residents being assessed by the average census for the facility. A daily census shall be reported by each nursing facility as it transmits assessment data to the department. The department shall compute a quarterly average census based on the daily census. If no census has been reported by a facility during a specified quarter, then the department

shall use the facility's licensed beds as the denominator in computing the threshold.

(7)(a) Although the facility average and the medicaid average case mix indexes shall both be calculated quarterly, the facility average case mix index will be used throughout the applicable cost-rebasing period in combination with cost report data as specified by RCW 74.46.431 and 74.46.506, to establish a facility's allowable cost per case mix unit. A facility's medicaid average case mix index shall be used to update a nursing facility's direct care component rate quarterly.

(b) The facility average case mix index used to establish each nursing facility's direct care component rate shall be based on an average of calendar quarters of the facility's average case mix indexes.

(i) For October 1, 1998, direct care component rates, the department shall use an average of facility average case mix indexes from the four calendar quarters of 1997.

(ii) For July 1, 2001, direct care component rates, the department shall use an average of facility average case mix indexes from the four calendar quarters of 1999.

(iii) Beginning on July 1, 2006, when establishing the direct care component rates, the department shall use an average of facility case mix indexes from the four calendar quarters occurring during the cost report period used to rebase the direct care component rate allocations as specified in RCW 74.46.431.

(c) The medicaid average case mix index used to update or recalibrate a nursing facility's direct care component rate quarterly shall be from the calendar quarter commencing six months prior to the effective date of the quarterly rate. For example, October 1, 1998, through December 31, 1998, direct care component rates shall utilize case mix averages from the April 1, 1998, through June 30, 1998, calendar quarter, and so forth.

[2006 c 258 § 5; 2001 1st sp.s. c 8 § 9; 1998 c 322 § 24.]

Notes:

**Effective date – 2006 c 258:** See note following RCW 74.46.020.

**Severability – Effective dates – 2001 1st sp.s. c 8:** See notes following RCW 74.46.020.





SUBSCRIBED AND SWORN TO before me this 22<sup>nd</sup> day of  
October, 2010.



*Karen L. Torgerson*  
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(Print Name)

Notary Public in and for the  
State of Washington

Commission Expires: 10/30/12