

WSR 25-05-014
EMERGENCY RULES
HEALTH CARE AUTHORITY

[Filed February 7, 2025, 9:21 a.m., effective February 7, 2025, 9:21 a.m.]

Effective Date of Rule: Immediately upon filing.

Purpose: The health care authority (agency) is developing rules under ESSB 5187, section 211(83), 68th legislature, 2023 regular session. This legislation directed the agency to implement a program that began on July 1, 2024, with coverage comparable to the categorically needy medicaid program for certain adults age 19 and older who: (a) Have an immigration status making them ineligible for medicaid or federal subsidies through the health benefit exchange; and (b) are not eligible for another full scope federally funded medical assistance program.

Citation of Rules Affected by this Order: New chapters 182-525, 182-525A, and 182-525B WAC; and amending WAC 182-500-0120, 182-501-0060, 182-501-0065, 182-503-0510, 182-503-0515, 182-503-0535, 182-509-0220, and 182-526-0005.

Statutory Authority for Adoption: RCW 41.05.021 and 41.05.160.

Other Authority: ESSB 5187, section 211(83), 68th legislature, regular session.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: These rules are necessary to implement the agency's apple health expansion program, as directed in ESSB 5187, to provide health care coverage for adults who qualify. The program took effect on July 1, 2024.

The agency previously filed emergency rules: Under WSR 24-13-067 on June 14, 2024; under WSR 24-21-064 on October 11, 2024; and under WSR 25-02-112 on December 31, 2024, to amend two additional rules applicable to the apple health expansion program.

The rules filed under WSR 24-21-064 are expiring. The current filing continues the emergency rules while the permanent rule process is completed. The agency is also including the rules filed under WSR 25-02-112 into this filing to combine all rules related to this rule making into one filing. The text of these emergency rules has not changed.

The agency shared two versions of the draft rules with interested parties in February and May of 2024, and received substantial comments on each of the drafts. After the agency filed the emergency rules, staff subsequently asked stakeholders to comment on a permanent enrollment process for the apple health expansion program. The agency has created a draft policy, based on stakeholders' input, and staff are preparing proposed rules that include the permanent enrollment process.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 30, Amended 8, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 30, Amended 8, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: February 7, 2025.

Wendy Barcus
Rules Coordinator

OTS-5177.3

AMENDATORY SECTION (Amending WSR 13-14-019, filed 6/24/13, effective 7/25/13)

WAC 182-500-0120 Medical assistance definitions—W. "Washington apple health" means the public health insurance programs for eligible Washington residents. Washington apple health is the name used in Washington state for medicaid, the children's health insurance program (CHIP), and state-only funded health care programs.

"Washington apple health expansion" means the state-funded health care program for individuals age 19 and older who do not meet the citizenship or immigration requirements to receive benefits under federally funded programs. Eligibility for this program is limited and is subject to available funds.

"Washington Healthplanfinder" is a marketplace for individuals, families, and small businesses in Washington state to compare and enroll in health insurance coverage and gain access to premium tax credits, reduced cost sharing, and public programs such as Washington apple health. Washington Healthplanfinder is administered by the Washington health benefit exchange.

OTS-5178.3

AMENDATORY SECTION (Amending WSR 23-07-132, filed 3/22/23, effective 4/22/23)

WAC 182-501-0060 Health care coverage—Program benefit packages—Scope of service categories. (1) This rule provides a table that lists:

- (a) The following Washington apple health programs:
 - (i) The alternative benefits plan (ABP) medicaid;
 - (ii) Categorically needy (CN) medicaid;
 - (iii) Medically needy (MN) medicaid; (~~and~~)
 - (iv) Medical care services (MCS) programs (includes incapacity-based and aged, blind, and disabled medical care services), as described in WAC 182-508-0005; and

(v) Washington apple health expansion (AHE); and

(b) The benefit packages showing what service categories are included for each program.

(2) Within a service category included in a benefit package, some services may be covered and others noncovered.

(3) Services covered within each service category included in a benefit package:

(a) Are determined in accordance with WAC 182-501-0050 and 182-501-0055 when applicable.

(b) May be subject to limitations, restrictions, and eligibility requirements contained in agency rules.

(c) May require prior authorization (see WAC 182-501-0165), or expedited prior authorization when allowed by the agency.

(d) Are paid for by the agency or the agency's designee and subject to review both before and after payment is made. The agency or the client's managed care organization may deny or recover payment for such services, equipment, and supplies based on these reviews.

(4) The agency does not pay for covered services, equipment, or supplies that:

(a) Require prior authorization from the agency or the agency's designee, if prior authorization was not obtained before the service was provided;

(b) Are provided by providers who are not contracted with the agency as required under chapter 182-502 WAC;

(c) Are included in an agency or the agency's designee waiver program identified in chapter 182-515 WAC; or

(d) Are covered by a third-party payor (see WAC 182-501-0200), including medicare, if the third-party payor has not made a determination on the claim or has not been billed by the provider.

(5) Programs not addressed in the table:

(a) Medical assistance programs for noncitizens (see chapter 182-507 WAC); and

(b) Family planning only programs (see WAC 182-532-500 through 182-532-570);

(c) Postpartum and family planning extension (see WAC 182-523-0130(4) and 182-505-0115(5));

(d) Eligibility for pregnant minors (see WAC 182-505-0117); and

(e) Kidney disease program (see chapter 182-540 WAC).

(6) Scope of service categories. The following table lists the agency's categories of health care services.

(a) Under the ABP, CN, and MN headings, there are two columns. One addresses clients 20 years of age and younger, and the other addresses clients 21 years of age and older.

(b) The letter "Y" means a service category is included for that program. Services within each service category are subject to limitations and restrictions listed in the specific medical assistance program rules and agency issuances.

(c) The letter "N" means a service category is not included for that program.

(d) Refer to WAC 182-501-0065 for a description of each service category and for the specific program rules containing the limitations and restrictions to services.

Service Categories	ABP 20-	ABP 21+	CN ¹ 20-	CN 21+	MN 20-	MN 21+	MCS	<u>AHE</u>
Ambulance (ground and air)	Y	Y	Y	Y	Y	Y	Y	<u>Y</u>
Applied behavior analysis (ABA)	Y	Y	Y	Y	Y	Y	N	<u>Y</u>

Service Categories	ABP 20-	ABP 21+	CN ¹ 20-	CN 21+	MN 20-	MN 21+	MCS	AHE
Behavioral health services	Y	Y	Y	Y	Y	Y	Y	<u>Y</u>
Blood/blood products/related services	Y	Y	Y	Y	Y	Y	Y	<u>Y</u>
Dental services	Y	Y	Y	Y	Y	Y	Y	<u>Y</u>
Diagnostic services (lab and X-ray)	Y	Y	Y	Y	Y	Y	Y	<u>Y</u>
Early and periodic screening, diagnosis, and treatment (EPSDT) services	Y	N	Y	N	Y	N	N	<u>N</u>
Enteral nutrition program	Y	Y	Y	Y	Y	Y	Y	<u>Y</u>
Habilitative services	Y	Y	N	N	N	N	N	<u>N</u>
Health care professional services	Y	Y	Y	Y	Y	Y	Y	<u>Y</u>
Health homes	Y	Y	Y	Y	N	N	N	<u>N</u>
Hearing evaluations	Y	Y	Y	Y	Y	Y	Y	<u>Y</u>
Hearing aids	Y	Y	Y	Y	Y	Y	Y	<u>Y</u>
Home health services	Y	Y	Y	Y	Y	Y	Y	<u>Y</u>
Home infusion therapy/parenteral nutrition program	Y	Y	Y	Y	Y	Y	Y	<u>Y</u>
Hospice services	Y	Y	Y	Y	Y	Y	N	<u>Y</u>
Hospital services Inpatient/outpatient	Y	Y	Y	Y	Y	Y	Y	<u>Y</u>
Intermediate care facility/services for persons with intellectual disabilities	Y	Y	Y	Y	Y	Y	Y	<u>N</u>
Maternity care and delivery services	Y	Y	Y	Y	Y	Y	Y	<u>Y</u>
Medical equipment, supplies, and appliances	Y	Y	Y	Y	Y	Y	Y	<u>Y</u>
Medical nutrition therapy	Y	Y	Y	Y	Y	Y	Y	<u>Y</u>
Nursing facility services	Y	Y	Y	Y	Y	Y	Y	<u>Y*</u>
Organ transplants	Y	Y	Y	Y	Y	Y	Y	<u>Y</u>
Orthodontic services	Y	N	Y	N	Y	N	N	<u>Y**</u>
Out-of-state services	Y	Y	Y	Y	Y	Y	N	<u>Y</u>
Outpatient rehabilitation services (OT, PT, ST)	Y	Y	Y	Y	Y	(N) <u>Y</u>	Y	<u>Y</u>
Personal care services	Y	Y	Y	Y	N	N	N	<u>N</u>
Prescription drugs	Y	Y	Y	Y	Y	Y	Y	<u>Y</u>
Private duty nursing	Y	Y	Y	Y	Y	Y	N	<u>N</u>
Prosthetic/orthotic devices	Y	Y	Y	Y	Y	Y	Y	<u>Y</u>
Reproductive health services	Y	Y	Y	Y	Y	Y	Y	<u>Y</u>
Respiratory care (oxygen)	Y	Y	Y	Y	Y	Y	Y	<u>Y</u>
School-based medical services	Y	N	Y	N	Y	N	N	<u>Y**</u>
Vision care Exams, refractions, and fittings	Y	Y	Y	Y	Y	Y	Y	<u>Y</u>
Vision hardware Frames and lenses	Y	N	Y	N	Y	N	N	<u>Y**</u>

¹ Clients enrolled in the Washington apple health for kids and Washington apple health for kids with premium programs, which includes the children's health insurance program (CHIP), receive CN-scope of health care services.

* Medically necessary nursing facility services are covered when the enrollee's condition meets the criteria for rehabilitative or skilled care.

** Only for age 20 and younger.

OTS-6057.2

AMENDATORY SECTION (Amending WSR 24-10-081, filed 4/30/24, effective 7/1/24)

WAC 182-501-0065 Health care coverage—Description of service categories. This rule provides a brief description of the medical, dental, mental health, and substance use disorder (SUD) service categories listed in the table in WAC 182-501-0060. The description of services under each category is not intended to be all inclusive.

(1) For alternative benefits plan (ABP), categorically needy (CN), medically needy (MN), ~~((and))~~ medical care services (MCS), and apple health expansion, refer to the WAC citations listed in the following descriptions for specific details regarding each service category.

(2) The following service categories are subject to the exclusions, limitations, restrictions, and eligibility requirements contained in agency rules:

(a) **Ambulance** - Emergency medical transportation and ambulance transportation for nonemergency medical needs. (WAC 182-546-0001 through 182-546-4000.)

(b) **Applied behavior analysis (ABA)** - (Chapter 182-531A WAC.)

(c) **Behavioral health services** - (Chapter 182-538D WAC, Behavioral health services, WAC 182-531-1400 Psychiatric physician-related services and other professional mental health services, and chapter 246-341 WAC, Behavioral health services administrative requirements.)

(d) **Blood, blood products, and related services** - Blood and/or blood derivatives, including synthetic factors, plasma expanders, and their administration. (WAC 182-550-1400 and 182-550-1500.)

(e) **Community behavioral health support services (CBHS)** - (Chapter 182-561 WAC.)

(f) **Dental services** - Diagnosis and treatment of dental problems including emergency treatment and preventive care. (Chapters 182-535 and 182-535A WAC.)

(g) **Diagnostic services** - Clinical testing and imaging services. (WAC 182-531-0100; WAC 182-550-1400 and 182-550-1500.)

(h) **Early and periodic screening, diagnosis, and treatment (EPSDT)** - (Chapter 182-534 WAC and WAC 182-501-0050(10).)

(i) **Enteral nutrition program** - Enteral nutrition products, equipment, and related supplies. (Chapter 182-554 WAC.)

(j) **Habilitative services** - (Chapter 182-545 WAC.)

(k) **Health care professional services** - The following services found in chapter 182-531 WAC:

(i) Office visits and vaccinations;

(ii) Screening/brief intervention/referral to treatment (SBIRT), emergency room, and nursing facility services;

(iii) Home-based and hospital-based services;

(iv) Surgery, anesthesia, pathology, radiology, and laboratory services;

(v) Obstetric services;

(vi) Kidney dialysis and renal disease services;

(vii) Advanced registered nurse practitioner, naturopathy, osteopathy, podiatry, physiatry, and pulmonary/respiratory services; and

(viii) Allergen immunotherapy services.

(l) **Health homes** - (Chapter 182-557 WAC.)

(m) **Hearing evaluations** - The following services found in WAC 182-531-0375:

(i) Audiology;

(ii) Diagnostic evaluations; and

(iii) Hearing exams and testing.

(n) **Hearing aids** - (Chapter 182-547 WAC.)

(o) **Home health services** - Intermittent, short-term skilled nursing care, occupational therapy, physical therapy, speech therapy, home infusion therapy, and health aide services, provided in the home. (WAC 182-551-2000 through 182-551-2220.)

(p) **Home infusion therapy/parenteral nutrition program** - Supplies and equipment necessary for parenteral infusion of therapeutic agents. (Chapter 182-553 WAC.)

(q) **Hospice services** - Physician services, skilled nursing care, medical social services, counseling services for client and family, drugs, medications (including biologicals), medical equipment and supplies needed for palliative care, home health aide, homemaker, personal care services, medical transportation, respite care, and brief in-patient care. This benefit also includes services rendered in a hospice care center and pediatric palliative care services. (WAC 182-551-1210 through 182-551-1850.)

(r) **Hospital services—Inpatient/outpatient** - Emergency room; hospital room and board (includes nursing care); inpatient services, supplies, equipment, and prescription drugs; surgery, anesthesia; diagnostic testing, laboratory work, blood/blood derivatives; radiation and imaging treatment and diagnostic services; and outpatient or day surgery, and obstetrical services. (Chapter 182-550 WAC.)

(s) **Intermediate care facility/services for persons with intellectual disabilities** - Habilitative training, health-related care, supervision, and residential care. (Chapter 388-835 WAC.)

(t) **Maternity care and delivery services** - Community health nurse visits, nutrition visits, behavioral health visits, midwife services, birth doula services, maternity and infant case management services, family planning services, and community health worker visits. ((~~WAC 182-533-0330~~) Chapter 182-533 WAC.)

(u) **Medical equipment, supplies, and appliances** - Medical equipment and appliances, including wheelchairs, hospital beds, respiratory equipment; casts, splints, crutches, trusses, and braces. Medical supplies, including antiseptics, germicides, bandages, dressings, tape, blood monitoring/testing supplies, braces, belts, supporting devices, decubitus care products, ostomy supplies, syringes, needles, and urological supplies. (Chapter 182-543 WAC.)

(v) **Medical nutrition therapy** - Outpatient medical nutrition therapy and associated follow-ups. (Chapter 182-555 WAC.)

(w) **Nursing facility services** - Nursing, therapies, dietary, and daily care services delivered in a licensed nursing facility. (Chapter 388-97 WAC.)

(x) **Organ transplants** - Solid organs, e.g., heart, kidney, liver, lung, pancreas, and small bowel; bone marrow and peripheral stem cell; skin grafts; and corneal transplants. (WAC 182-550-1900 and 182-556-0400.)

(y) **Orthodontic services** - (Chapter 182-535A WAC.)

(z) **Out-of-state services** - (WAC 182-502-0120.)

(aa) **Outpatient rehabilitation services (OT, PT, ST)** - Evaluations, assessments, and treatment. (WAC 182-545-200.)

(bb) **Personal care services** - Assistance with activities of daily living (e.g., bathing, dressing, eating, managing medications) and routine household chores (e.g., meal preparation, housework, essential shopping, transportation to medical services). (Chapters 388-106 and 388-845 WAC.)

(cc) **Prescription drugs** - Outpatient drugs (including in nursing facilities), both generic and brand name; drug devices and supplies; some over-the-counter drugs; oral, topical, injectable drugs; vaccines, immunizations, and biologicals; and family planning drugs, devices, and supplies. (WAC 182-530-2000.) Additional coverage for medi-

cations and prescriptions is addressed in specific program WAC sections.

(dd) **Private duty nursing** - Continuous skilled nursing services provided in a private residence, including client assessment, administration of treatment, and monitoring of medical equipment and client care. For benefits for clients age 17 and younger, see WAC 182-551-3000 through 182-551-3400. For benefits for clients age 18 and older, see WAC 388-106-1000 through 388-106-1055.

(ee) **Prosthetic/orthotic devices** - Artificial limbs and other external body parts; devices that prevent, support, or correct a physical deformity or malfunction. (WAC 182-543-5000.)

(ff) **Reproductive health services** - Gynecological exams; contraceptives, drugs, and supplies, including prescriptions; sterilization; screening and treatment of sexually transmitted diseases; and educational services. (WAC 182-532-001 through 182-532-140.)

(gg) **Respiratory care (oxygen)** - All services, oxygen, equipment, and supplies related to respiratory care. (Chapter 182-552 WAC.)

(hh) **School-based health care services** - Early intervention services or special education health-related services provided in schools to medicaid-eligible children ages birth through 20 who have an individualized education program (IEP) or individualized family service plan (IFSP). (Chapter 182-537 WAC.)

(ii) **Vision care** - Eye exams, refractions, fittings, visual field testing, vision therapy, ocular prosthetics, and surgery. (WAC 182-531-1000.)

(jj) **Vision hardware** - Frames and lenses. (Chapter 182-544 WAC.)

OTS-5179.5

AMENDATORY SECTION (Amending WSR 23-11-007, filed 5/4/23, effective 6/4/23)

WAC 182-503-0510 Washington apple health—Program summary. (1)

The agency categorizes Washington apple health programs into three groups based on the income methodology used to determine eligibility:

(a) Those that use a modified adjusted gross income (MAGI)-based methodology described in WAC 182-509-0300, called MAGI-based apple health programs;

(b) Those that use an income methodology other than MAGI, called non-MAGI-based apple health programs, which include:

(i) Supplemental security income (SSI)-related apple health programs;

(ii) Temporary assistance for needy families (TANF)-related apple health programs; and

(iii) Other apple health programs not based on MAGI, SSI, or TANF methodologies.

(c) Those that provide coverage based on a specific status or entitlement in federal rule and not on countable income, called deemed eligible apple health programs.

(2) MAGI-based apple health programs include the following:

(a) Apple health parent and caretaker relative program described in WAC 182-505-0240;

(b) MAGI-based apple health adult medical program described in WAC 182-505-0250, for which the scope of coverage is called the alternative benefits plan (ABP) described in WAC 182-500-0010;

(c) Apple health (~~(for pregnant women program)~~) pregnancy and after-pregnancy coverage described in WAC 182-505-0115;

(d) Apple health for kids program described in WAC 182-505-0210 (3) (a);

(e) Premium-based apple health for kids described in WAC 182-505-0215;

(f) Apple health long-term care for children and adults described in chapter 182-514 WAC; (~~and~~)

(g) Apple health alien emergency medical program described in WAC 182-507-0110 through 182-507-0125 when the person is eligible based on criteria for a MAGI-based apple health program; and

(h) Apple health expansion program for people who are age 64 or younger as described in chapter 182-525 WAC.

(3) Non-MAGI-based apple health programs include the following:

(a) SSI-related programs which use the income methodologies of the SSI program (except where the agency has adopted more liberal rules than SSI) described in chapter 182-512 WAC to determine eligibility:

(i) Apple health for workers with disabilities (HWD) described in chapter 182-511 WAC;

(ii) Apple health SSI-related programs described in chapters 182-512 and 182-519 WAC;

(iii) Apple health long-term care and hospice programs described in chapters 182-513 and 182-515 WAC;

(iv) Apple health medicare savings programs described in chapter 182-517 WAC; (~~and~~)

(v) Apple health alien emergency medical (AEM) programs described in WAC 182-507-0110 and 182-507-0125 when the person meets the age, blindness or disability criteria specified in WAC 182-512-0050; and

(vi) Apple health expansion program for people who are age 65 and older as described in chapter 182-512 WAC.

(b) TANF-related programs which use the income methodologies based on the TANF cash program described in WAC 388-450-0170 to determine eligibility, with variations as specified in WAC 182-509-0001(5) and program specific rules:

(i) Refugee medical assistance (RMA) program described in WAC 182-507-0130; and

(ii) Apple health medically needy (MN) coverage for pregnant (~~women~~) people and children who do not meet SSI-related criteria.

(c) Other programs:

(i) Breast and cervical cancer program described in WAC 182-505-0120;

(ii) Family planning only programs described in chapter 182-532 WAC;

(iii) Medical care services described in WAC 182-508-0005;

(iv) Apple health for pregnant minors described in WAC 182-505-0117;

(v) Kidney disease program described in chapter 182-540 WAC; and

(vi) Tailored supports for older adults described in WAC 182-513-1610.

(4) Deemed eligible apple health programs include:

(a) Apple health SSI medical program described in chapter 182-510 WAC, or a person who meets the medicaid eligibility criteria in 1619b of the Social Security Act;

- (b) Newborn medical program described in WAC 182-505-0210(2);
- (c) Foster care program described in WAC 182-505-0211;
- (d) Medical extension program described in WAC 182-523-0100; and
- (e) Family planning extension described in WAC 182-505-0115(5).

(5) A person is eligible for categorically needy (CN) health care coverage when the household's countable income is at or below the categorically needy income level (CNIL) for the specific program.

(6) If income is above the CNIL, a person is eligible for the MN program if the person is:

- (a) A child;
- (b) A pregnant (~~woman~~) person; or
- (c) SSI-related (aged 65, blind or disabled).

(7) MN health care coverage is not available to parents, caretaker relatives, or adults unless they are eligible under subsection (6) of this section.

(8) A person who is eligible for the apple health MAGI-based adult program listed in subsection (2)(b) of this section is eligible for ABP health care coverage as defined in WAC 182-500-0010. Such a person may apply for more comprehensive coverage through another apple health program at any time.

(9) For the other specific program requirements a person must meet to qualify for apple health, see chapters 182-503 through 182-527 WAC.

AMENDATORY SECTION (Amending WSR 21-19-142, filed 9/22/21, effective 10/23/21)

WAC 182-503-0515 Washington apple health—Social Security number requirements. (1) To be eligible for Washington apple health (medicaid), or tailored supports for older adults (TSOA) described in WAC 182-513-1610, you (the applicant or recipient) must provide your valid Social Security number (SSN) or proof of application for an SSN to the medicaid agency or the agency's designee, except as provided in subsections (2) and (6) of this section.

(2) An SSN is not required if you are:

- (a) Not eligible to receive an SSN or may only be issued an SSN for a valid nonwork reason described in 20 C.F.R. 422.104;
- (b) A household member who is not applying for apple health coverage, unless verification of that household member's resources is required to determine the eligibility of the client;
- (c) Refusing to obtain an SSN for well-established religious objections as defined in 42 C.F.R. 435.910 (h)(3); or
- (d) Not able to obtain or provide an SSN because you are a victim of domestic violence.

(3) If you are receiving coverage because you meet an exception under either subsection (2)(c) or (d) of this section, we (the agency) will confirm with you at your apple health renewal, consistent with WAC 182-503-0050, that you still meet the exception.

(4) If we ask for confirmation that you continue to meet an exception in subsection (2) of this section and you do not respond in accordance with subsection (3) of this section, or if you no longer meet an exception and do not provide your SSN, we will terminate your apple health coverage according to WAC 182-518-0025.

(5) If you are not able to provide your SSN, either because you do not know it or it has not been issued, you must provide:

(a) Proof from the Social Security Administration (SSA) that you turned in an application for an SSN; and

(b) The SSN when you receive it.

(i) Your apple health coverage will not be delayed, denied, or terminated while waiting for SSA to send you your SSN. If you need help applying for an SSN, assistance will be provided to you.

(ii) We will ask you every 90 days if your SSN has been issued.

(6) An SSN is not required for the following apple health programs:

(a) Refugee medical assistance program described in WAC 182-507-0130;

(b) Alien medical programs described in WAC 182-507-0115, 182-507-0120, and 182-507-0125;

(c) Newborn medical program described in WAC 182-505-0210 (2)(a);

(d) Foster care program for a child age 18 and younger as described in WAC 182-505-0211(1);

(e) Medical programs for children and pregnant women who do not meet citizenship or immigration status described in WAC 182-503-0535 (2)(e)(ii) and (iii); (~~(e)~~)

(f) Family planning only program described in WAC 182-532-510 if you do not meet citizenship or immigration status for Washington apple health or you have made an informed choice to apply for family planning services only; or

(g) Washington apple health expansion program described in chapter 182-525 WAC.

(7) If you are required to provide an SSN under this section, and you do not meet an exception under subsection (2) of this section, failure to provide your SSN may result in:

(a) Denial of your application or termination of your coverage because we cannot determine your household's eligibility; or

(b) Inability to apply the community spouse resource allocation (CSRA) or monthly maintenance needs allowance (MMNA) for a client of long-term services and supports (LTSS).

OTS-6058.1

AMENDATORY SECTION (Amending WSR 24-22-006, filed 10/23/24, effective 11/23/24)

WAC 182-503-0535 Washington apple health—Citizenship and immigration status. (1) Definitions.

(a) **Nonqualified alien** means someone who is lawfully present in the United States (U.S.) but who is not a qualified alien, a U.S. citizen, a U.S. national, or a qualifying American Indian born abroad.

(b) **Qualified alien** means someone who is lawfully present in the United States and who is one or more of the following:

(i) A person lawfully admitted for permanent residence (LPR).

(ii) An abused spouse or child, a parent of an abused child, or a child of an abused spouse who no longer resides with the person who committed the abuse, and who has one of the following:

(A) A pending or approved I-130 petition or application to immigrate as an immediate relative of a U.S. citizen or as the spouse of an unmarried LPR younger than 21 years of age.

(B) Proof of a pending application for suspension of deportation or cancellation of removal under the Violence Against Women Act (VAWA).

(C) A notice of prima facie approval of a pending self-petition under VAWA. An abused spouse's petition covers his or her child if the child is younger than 21 years of age. In that case, the child retains qualified alien status even after he or she turns 21 years of age.

(iii) A person who has been granted parole into the U.S. for one year or more, under the Immigration and Nationality Act (INA) Section 212 (d) (5), including public interest parolees.

(iv) A member of a Hmong or Highland Laotian tribe that rendered military assistance to the U.S. between August 5, 1964, and May 7, 1975, including the spouse, unremarried widow or widower, and unmarried dependent child of the tribal member.

(v) A person who was admitted into the U.S. as a conditional entrant under INA Section 203 (a) (7) before April 1, 1980.

(vi) A person admitted to the U.S. as a refugee under INA Section 207.

(vii) A person who has been granted asylum under INA Section 208.

(viii) A person granted withholding of deportation or removal under INA Section 243(h) or 241 (b) (3).

(ix) A Cuban or Haitian national who was paroled into the U.S. or given other special status.

(x) An Amerasian child of a U.S. citizen under 8 C.F.R. Section 204.4(a).

(xi) A person from Iraq or Afghanistan who has been granted one of the following:

(A) Special immigrant status under INA Section 101 (a) (27);

(B) Special immigrant conditional permanent resident; or

(C) Parole under Section 602 (b) (1) of the Afghan Allies Protection Act of 2009 or Section 1059(a) of the National Defense Authorization Act of 2006.

(xii) An Afghan who, under Section 2502 of the Extending Government Funding and Delivering Emergency Assistance Act of 2021, is evaluated as a qualified alien until March 31, 2023, or the end of their parole term, whichever is later, when granted parole:

(A) Between July 31, 2021, and September 30, 2023; or

(B) After September 30, 2022, and is:

(I) Their spouse or child; or

(II) The parent or guardian of an unaccompanied minor described under this subsection.

(xiii) A citizen or national of Ukraine (or a person who last habitually resided in Ukraine) who, under section 401 of the Additional Ukraine Supplemental Appropriations Act, 2022 (AUSAA) and the Ukraine Security Supplemental Appropriations Act, 2024 (USSAA), is evaluated as a qualified alien until the end of their parole term when:

(A) Granted parole into the United States between February 24, 2022, and September 30, 2024; or

(B) Granted parole into the United States after September 30, 2024, and is:

(I) The spouse or child of a person described in (b) (xiii) (A) of this subsection; or

(II) The parent, legal guardian, or primary caregiver of a person described in (b) (xiii) (A) of this subsection who is determined to be

an unaccompanied child under section 462 (g) (2) of the Homeland Security Act of 2002 or section 412 (d) (2) (B) of the Immigration and Nationality Act.

(xiv) A person who has been certified or approved as a victim of trafficking by the federal office of refugee resettlement, or who is:

(A) The spouse or child of a trafficking victim of any age; or

(B) The parent or minor sibling of a trafficking victim who is younger than 21 years of age.

(xv) A person from the Federated States of Micronesia, the Republic of Palau, or the Republic of the Marshall Islands living in the United States in accordance with the Compacts of Free Association.

(c) **U.S. citizen** means someone who is a United States citizen under federal law.

(d) **U.S. national** means someone who is a United States national under federal law.

(e) **Undocumented person** means someone who is not lawfully present in the U.S.

(f) **Qualifying American Indian born abroad** means someone who:

(i) Was born in Canada and has at least 50 percent American Indian blood, regardless of tribal membership; or

(ii) Was born outside of the United States and is a member of a federally recognized tribe or an Alaska Native enrolled by the Secretary of the Interior under the Alaska Native Claims Settlement Act.

(2) **Eligibility.**

(a) A U.S. citizen, U.S. national or qualifying American Indian born abroad may be eligible for:

(i) Apple health for adults;

(ii) Apple health for kids;

(iii) Apple health for pregnant women; or

(iv) Classic medicaid.

(b) A qualified alien who meets or is exempt from the five-year bar may be eligible for:

(i) Apple health for adults;

(ii) Apple health for kids;

(iii) Apple health for pregnant women; or

(iv) Classic medicaid.

(c) A qualified alien who neither meets nor is exempt from the five-year bar may be eligible for:

(i) Alien medical programs;

(ii) Apple health for kids;

(iii) Apple health for pregnant women; or

(iv) Medical care services.

(d) A nonqualified alien may be eligible for:

(i) Alien medical programs;

(ii) Apple health for kids;

(iii) Apple health for pregnant women; or

(iv) Medical care services.

(e) An undocumented person may be eligible for:

(i) Alien medical programs;

(ii) State-only funded apple health for kids; ((~~or~~))

(iii) State-only funded apple health for pregnant women; or

(iv) State-only funded apple health expansion.

(3) **The five-year bar.**

(a) A qualified alien meets the five-year bar if he or she:

(i) Continuously resided in the U.S. for five years or more from the date he or she became a qualified alien; or

(ii) Entered the U.S. before August 22, 1996, and:

(A) Became a qualified alien before August 22, 1996; or
 (B) Became a qualified alien on or after August 22, 1996, and has continuously resided in the U.S. between the date of entry into the U.S. and the date he or she became a qualified alien.

(b) A qualified alien is exempt from the five-year bar if he or she is:

(i) A qualified alien as defined in subsection (1)(b)(vi) through (xv) of this section;

(ii) An LPR, parolee, or abused person, who is also an armed services member or veteran, or a family member of an armed services member or veteran, as described below:

(A) An active-duty member of the U.S. military, other than active-duty for training;

(B) An honorably discharged U.S. veteran;

(C) A veteran of the military forces of the Philippines who served before July 1, 1946, as described in Title 38 U.S.C. Section 107; or

(D) The spouse, unremarried widow or widower, or unmarried dependent child of an honorably discharged U.S. veteran or active-duty member of the U.S. military.

OTS-5234.3

AMENDATORY SECTION (Amending WSR 24-03-050, filed 1/10/24, effective 2/10/24)

WAC 182-509-0220 Washington apple health—How resources are considered. (1) A resource is any cash, other personal property, or real property that a person:

(a) Owns;

(b) Has the right, authority, or power to convert to cash (if not already cash); and

(c) Has the legal right to use for (~~his or her~~) their support and maintenance.

(2) There is no resource limit for an applicant or recipient of the following Washington apple health (medicaid) programs:

(a) Apple health for workers with disabilities (HWD) program, as described in chapter 182-511 WAC;

(b) Apple health foster care program (see WAC 182-505-0211);

(c) Medicare savings programs (see WAC 182-517-0100);

(d) All programs that are based on modified adjusted gross income (MAGI) methodologies, as described in WAC 182-503-0510. This includes the following:

(i) Apple health for parents and caretaker relatives (see WAC 182-505-0240);

(ii) Apple health pregnancy coverage (see WAC 182-505-0115);

(iii) Apple health for kids (see WAC 182-505-0210);

(iv) Premium-based apple health for kids (see WAC 182-505-0215);

(v) Apple health long-term care for children and adults (see WAC 182-514-0230);

(vi) Apple health for MAGI-based adult coverage (see WAC 182-505-0250); (~~and~~)

(vii) Apple health MAGI-based adult alien emergency medical (see WAC 182-507-0110); and

(viii) Apple health expansion coverage.

(3) For all other apple health programs, the resource limits and exclusions can be found in the following chapters:

(a) Apple health SSI-related medical (see chapter 182-512 WAC) with the exception of programs listed in subsection (2) of this section;

(b) Apple health long-term care (see chapters 182-513 and 182-515 WAC);

(c) SSI-related apple health alien medical program (see chapter 182-507 WAC);

(d) Apple health for refugees (see WAC 182-507-0130); and

(e) Medical care services (see WAC 182-508-0005).

(4) The agency or its designee determines how trusts, annuities and life estates affect eligibility for apple health coverage for the programs listed in subsection (3)(a) through (e) of this section by following the rules described in chapter 182-516 WAC.

(5) Receipt of money by a member of a federally recognized tribe from exercising federally protected rights or extraction of protected resources, such as fishing, shell-fishing, or selling timber, is considered conversion of an exempt resource during the month of receipt. Any amounts remaining from the conversion of this exempt resource on the first of the month after the month of receipt will remain exempt if the funds were used to purchase another exempt resource. Any amounts remaining in the form of countable resources (such as in checking or savings accounts) on the first of the month after receipt, will be added to other countable resources for eligibility determinations when a resource determination is required by the specific apple health program. If no resource determination is required by the specific apple health program, eligibility is not affected.

OTS-5226.7

Chapter 182-525 WAC

WASHINGTON APPLE HEALTH EXPANSION—COVERAGE BENEFITS

NEW SECTION

WAC 182-525-0100 Overview. This program began on July 1, 2024.

(1) The rules in this chapter and in chapters 182-525A and 182-525B WAC are specific to Washington apple health expansion and govern the administration of apple health expansion benefits.

(2) Apple health expansion benefits are state-funded physical and behavioral health services identified as covered in WAC 182-501-0060 and 182-525-0700.

(a) Coverage of apple health expansion services may be limited or modified based on program rules relating to those services. Informa-

tion related to noncovered or excluded services may be contained in the program rules applicable to apple health expansion.

(b) An apple health expansion enrollee may receive only those apple health expansion services that are specifically identified as a covered benefit in the apple health expansion program rules.

(c) Services administered or authorized by the department of social and health services are not covered under the apple health expansion benefit package.

(d) The exception to rule process in WAC 182-501-0160 applies only to services that are specified as part of the apple health expansion benefit package in WAC 182-501-0060 and pursuant to the rules of this chapter, and chapters 182-525A and 182-525B WAC.

(3) Health plans, as defined in WAC 182-525-0400, administer apple health expansion benefits under the apple health expansion contract based on the rules in this chapter and chapters 182-525A and 182-525B WAC.

(4) If a service is covered under the apple health expansion program but excluded from administration under the apple health expansion contract, the service is administered by the agency on a fee-for-service basis according to the agency rules for that service.

(5) In order to provide services and receive payments, an apple health expansion provider must be an enrolled provider in accordance with chapter 182-502 WAC and meet the requirements of this chapter and other applicable program rules.

(6) The agency deems that providers enrolled in apple health under chapter 182-502 WAC are enrolled providers for purposes of apple health expansion.

NEW SECTION

WAC 182-525-0200 Applying for the program and income limits.

(1) **How to apply.** A person may apply for Washington apple health expansion coverage by following the process described in WAC 182-503-0005.

(2) **Income.** The agency follows the modified adjusted gross income (MAGI) rules in chapter 182-509 WAC to determine a person's apple health expansion eligibility for people age 19 through 64. For people age 65 and older, the agency follows the non-MAGI rules in chapter 182-512 WAC, with the following exceptions:

(a) The person must have a countable income equal to or below 138 percent of the federal poverty level; and

(b) A resource or asset test is not required.

(3) **Insurance affordability programs.** A person may apply for the insurance affordability programs offered through the agency as described in WAC 182-503-0001.

NEW SECTION

WAC 182-525-0300 Available resources exhausted. (1) Unlike the medicaid program under Title XIX of the Social Security Act and chapter 74.09 RCW, Washington apple health expansion is not an entitlement program with an open-ended right to services and benefits. The provision of services and benefits under apple health expansion is strictly

limited by the funding that the legislature appropriates to the agency for the program.

(2) The agency does not have the legal right to spend money on apple health expansion coverage or benefits unless specifically appropriated by the legislature.

(3) The agency determines, in its sole discretion, if and when the available funding for apple health expansion has been or will be exhausted. Upon making any such determination, the agency notifies enrollees, providers, health plans, and the general public through a posting on its website or in any other manner that the agency considers appropriate. The notice will specify the date on which available funding has been or will be exhausted.

(4) A determination by the agency that available funding for apple health expansion is exhausted results in the automatic termination of any authorization, appeals process, independent review, or agency administrative hearing process related to a request to authorize a service or benefit. This is because services and benefits cannot be authorized or paid for without available funding, regardless of medical necessity.

NEW SECTION

WAC 182-525-0400 Definitions. The definitions from chapters 182-500 and 182-538 WAC apply to Washington apple health expansion, along with the following definitions:

- "Enrollment cap" - means the maximum number of people who may be enrolled in apple health expansion.
- "Health plan" - means the same as the term "managed care organization" in WAC 182-538-050.

NEW SECTION

WAC 182-525-0500 Enrollment cap for services. (1) Enrollment in Washington apple health expansion is subject to available funds, as described in this section and in WAC 182-525-0300.

(2) The agency caps apple health expansion enrollment if it determines that accepting additional enrollees would exceed funding appropriated by the legislature. Once the enrollment cap is reached, all applications for apple health expansion will be denied.

(3) If the agency denies a person apple health expansion coverage due to an enrollment cap, that person will be considered for other apple health programs. The person may be eligible for other programs if they:

(a) Meet immigration requirements for other apple health programs;

(b) Qualify due to pregnancy as identified in WAC 182-505-0115;
or

(c) Have a qualifying medical emergency for which federal funding is available.

(4) If apple health expansion enrollment closes due to a cap on enrollment, the agency notifies applicants that their applications are denied.

(5) Applicants who are denied based on the enrollment cap may not appeal the agency's decision to apply the enrollment cap.

(6) (a) If the agency reopens apple health expansion enrollment because enrollment has fallen below the cap and funding is available, the agency fills the available openings as described in (b) and (c) of this subsection.

(b) If the agency determines that additional individuals can be enrolled into apple health expansion, the agency will identify the number of openings available. To fill the available number of openings, the agency selects from the following categories:

(i) Individuals who submitted a completed application and were denied enrollment due to the cap;

(ii) Individuals who were enrolled in the children's health program (CHP), alien emergency medical (AEM), or after-pregnancy coverage programs who met eligibility requirements for apple health expansion and whose coverage ended while the cap was in effect; and

(iii) Individuals who are enrolled in a qualified health plan under the health benefit exchange's section 1332 waiver.

(c) The agency randomly selects individuals from (b) of this subsection to fill the openings, striving to ensure that 90 percent of these individuals are eligible under modified adjusted gross income (MAGI) standards, and 10 percent are non-MAGI.

(d) If the agency is unable to fill the openings available based on (b) and (c) of this subsection, the agency conducts outreach efforts to inform the public of the opportunity to apply.

NEW SECTION

WAC 182-525-0600 Termination of enrollees based on available funds. (1) (a) When the agency determines that available funds are exhausted as described in WAC 182-525-0300, the agency terminates Washington apple health expansion coverage of all enrollees.

(b) The agency sends notice to enrollees in accordance with WAC 182-518-0025 (1), (2), and (3). Continued coverage of apple health expansion benefits is not available.

(2) (a) When the agency determines that available funds are at risk of being exhausted, the agency terminates coverage of enrollees necessary to maintain funding for the program until the number of enrollees receiving coverage is sustainable based on the appropriated funds. The agency terminates apple health expansion enrollees beginning with the people most recently enrolled in apple health expansion, based on the date the agency approved a person for enrollment.

(b) The agency sends notice to enrollees in accordance with WAC 182-518-0025 (1), (2), and (3). Continued coverage of apple health expansion benefits is not available.

(3) Applicants who are denied based on the enrollment cap may not appeal the agency's decision to apply the enrollment cap.

(4) If the cap has been met and the agency denies enrollment due to agency error, the agency may choose not to apply the enrollment cap and enroll or provide coverage if there are available funds.

(5) If the cap has been met and the agency terminates an enrollee due to their failure to submit a completed renewal, the agency may choose not to apply the cap if:

(a) There are available funds to reinstate the enrollee's coverage; and

(b) The enrollee completes their renewal within 90 calendar days of their coverage end date.

NEW SECTION

WAC 182-525-0700 Washington apple health rules applicable to Washington apple health expansion. Agency rules applicable to other Washington apple health programs may also be applicable to Washington apple health expansion. The following agency rules apply to apple health expansion, with any modifications or exceptions as noted:

- (1) Chapter 182-500 WAC;
- (2) Chapter 182-501 WAC, except that the rules relating to early periodic screening, diagnosis, and treatment (EPSDT) services do not apply to apple health expansion.
- (3) Chapter 182-512 WAC, with the exception of WAC 182-512-0600 and 182-512-0960;
- (4) WAC 182-501-0165 applies only to the fee-for-service benefits available under apple health expansion and as noted in the apple health expansion contract.
- (5) Chapter 182-502 WAC, except that WAC 182-525-1100 replaces WAC 182-502-0160;
- (6) Chapter 182-502A WAC;
- (7) Chapter 182-503 WAC, except that the general eligibility requirements in WAC 182-503-0505 and 182-503-0055 do not apply to apple health expansion. (See WAC 182-525-0900.)
- (8) Chapter 182-504 WAC, except that WAC 182-504-0015 does not apply regarding the certification period for apple health expansion.
- (9) Chapter 182-505 WAC;
- (10) Chapter 182-506 WAC;
- (11) Chapter 182-509 WAC;
- (12) Chapter 182-518 WAC, except as otherwise noted in the apple health expansion rules;
- (13) Chapter 182-520 WAC;
- (14) Chapter 182-523 WAC;
- (15) Chapter 182-525 WAC;
- (16) Chapter 182-525A WAC;
- (17) Chapter 182-525B WAC;
- (18) Chapter 182-526 WAC;
- (19) Chapter 182-530 WAC does not apply to apple health expansion, except for the definitions from WAC 182-530-1050 that are incorporated by reference into chapter 182-525B WAC as identified in WAC 182-525B-0300. See chapter 182-525B WAC for the apple health expansion pharmacy benefit and outpatient drug program rules; and
- (20) Chapters 182-531 through 182-537 WAC and chapters 182-539 through 182-560 WAC may be applicable to apple health expansion if the services are provided on a fee-for-service basis or if incorporated by reference in the apple health expansion contract.

NEW SECTION

WAC 182-525-0800 Certification period. (1) A certification period is the length of time the agency determines a person is eligible

for Washington apple health expansion coverage, which may be reduced or terminated under WAC 182-525-0600.

(2) The certification period for apple health expansion coverage is 12 months, as long as the person remains eligible according to program rules.

(3) The certification period begins on the first day of the month the person is approved and continues through the end of the 12th month.

(4) If, during a person's certification period, apple health expansion funding is exhausted, as described in WAC 182-525-0300, the agency terminates enrollment for a person based on funding availability according to WAC 182-525-0600.

(5) The agency considers an enrollee's eligibility for all other Washington apple health programs, as well as qualified health plans, health insurance premium tax credits (as defined in WAC 182-500-0045), and cost sharing reductions (as defined in WAC 182-500-0020) before ending the enrollee's apple health expansion coverage.

(6) A person may be eligible for retroactive coverage through the medical assistance programs for noncitizens, as described in WAC 182-507-0110.

NEW SECTION

WAC 182-525-0900 General eligibility requirements. (1) A person must meet the following eligibility criteria for Washington apple health expansion coverage:

(a) Be age 19 or older (see WAC 182-503-0050);

(b) Be a resident of Washington state (see WAC 182-503-0520 and 182-503-0525);

(c) Have net countable income that is at or below 138 percent of the federal poverty level for a household of the applicable size;

(d) Is not entitled to or enrolled in medicare benefits under Part A or B of Title XVIII of the Social Security Act; and

(e) Is not eligible for another full scope medical assistance program.

(2) A person in a public institution, including a correctional facility, is not eligible for apple health expansion coverage until released, unless the person:

(a) Is age 21 or younger or age 65 or older and is a patient in an institution for mental disease (see WAC 182-513-1317(5)); or

(b) Receives inpatient hospital services outside of the public institution or correctional facility.

NEW SECTION

WAC 182-525-1000 Application processing times. Application processing times for Washington apple health expansion follow the application processing times described in WAC 182-503-0060.

NEW SECTION

WAC 182-525-1100 Billing an enrollee. (1) This section specifies the limited circumstances in which:

(a) Washington apple health expansion enrollees can choose to self-pay for health care services; and

(b) Providers, as defined in WAC 182-500-0085, have the authority to bill apple health expansion enrollees for health care services furnished to those enrollees.

(2) The provider is responsible for:

(a) Verifying whether a person is eligible to receive health care services on the date the services are provided;

(b) Verifying whether the person is enrolled with an agency-contracted health plan;

(c) Knowing the limitations of the services within the scope of apple health expansion coverage (see WAC 182-501-0050 (4) (a), 182-501-0060, 182-501-0065, and chapters 182-525, 182-525A, and 182-525B WAC);

(d) Informing the enrollee of those limitations;

(e) Exhausting all applicable agency or agency-contracted health plan processes necessary to obtain authorization for requested service(s);

(f) Ensuring that translation or interpretation is provided to enrollees with limited-English proficiency (LEP) who agree to be billed for services in accordance with this section; and

(g) Retaining all documentation which demonstrates compliance with this section.

(3) Unless otherwise specified in this section, providers must accept as payment in full the amount paid by either:

(a) The agency health plan, for health care services furnished to enrollees; or

(b) The agency, for services provided on a fee-for-service basis.

(4) (a) A provider must not bill an enrollee, or anyone on the enrollee's behalf, for any services until the provider has completed all requirements of this section, including the conditions of payment described in the agency's rules, the agency's fee-for-service billing instructions, and the requirements for billing the enrollee's health plan, and until the provider has then fully informed the enrollee of their coverage options.

(b) A provider must not bill an enrollee for:

(i) Any services for which the provider failed to satisfy the conditions of payment described in the agency's rules, the agency's fee-for-service billing instructions, and the requirements for billing the enrollee's health plan;

(ii) A covered service even if the provider has not received payment from the agency or the enrollee's health plan; or

(iii) A covered service when the agency or the enrollee's health plan denies an authorization request for the service because the required information was not received from the provider or the prescriber within 30 calendar days.

(5) If the requirements of this section are satisfied, then a provider may bill an enrollee for a covered service or a noncovered service. The enrollee and provider must sign and date the HCA form 13-879, Agreement to Pay for Healthcare Services, before the service is furnished. Form 13-879, including translated versions, is available to download at https://www.hca.wa.gov/assets/billers-and-providers/13_879.pdf. The requirements for this subsection are as follows:

(a) The agreement must:

(i) Indicate the anticipated date the service will be provided, which must be no later than 90 calendar days from the date of the signed agreement;

(ii) List each of the services that will be furnished;

(iii) List treatment alternatives that may have been covered by the agency or the enrollee's health plan;

(iv) Specify the total amount the enrollee must pay for the service;

(v) Specify what items or services are included in this amount (such as preoperative care and postoperative care). See WAC 182-501-0070(3) for payment of ancillary services for a noncovered service;

(vi) Indicate that the enrollee has been fully informed of all available medically appropriate treatment, including services that may be paid for by the agency or the enrollee's health plan, and that the enrollee chooses to get the specified service(s);

(vii) Specify that the enrollee may request an exception to rule (ETR) in accordance with WAC 182-501-0160 when the agency or the enrollee's health plan denies a request for a noncovered service and that the enrollee may choose not to do so;

(viii) Specify that the enrollee may request an administrative hearing in accordance with chapter 182-526 WAC to appeal the agency's denial of a request for prior authorization of a covered service and that the enrollee may choose not to do so;

(ix) Be completed only after the provider and the enrollee have exhausted all applicable agency or health plan processes necessary to obtain authorization of the requested service, except that the enrollee may choose not to request an ETR or an administrative hearing regarding agency or health plan denials of authorization for requested service(s); and

(x) Specify which reason in (b) of this subsection applies.

(b) The provider must select on the agreement form one of the following reasons (as applicable) why the enrollee agrees to be billed for the service(s). The service(s) is:

(i) Not covered by apple health expansion, the ETR process as described in WAC 182-501-0160 has been exhausted, and the service(s) is denied;

(ii) Not covered by apple health expansion and the enrollee has been informed of their right to an ETR and has chosen not to pursue an ETR as described in WAC 182-501-0160;

(iii) Covered by apple health expansion, requires authorization, and the provider completes all the necessary requirements; however, the agency or health plan denied the service as not medically necessary (this includes services denied as a limitation extension under WAC 182-501-0169); or

(iv) Covered by apple health expansion and does not require authorization, but the enrollee has requested a specific type of treatment, supply, or equipment based on personal preference which the agency or health plan does not pay for and the specific type is not medically necessary for the enrollee.

(c) For enrollees with limited-English proficiency, the agreement must be the version translated in the enrollee's primary language and interpreted if necessary. The translator or interpreter must sign the agreement regardless of whether the agreement is translated in writing or orally interpreted;

(d) The provider must give the enrollee a copy of the agreement and maintain the original and all documentation which supports compliance with this section in the enrollee's file for six years from the date of service. The agreement must be made available to the agency for review upon request; and

(e) If the service is not provided within 90 calendar days of the signed agreement, the provider must complete a new agreement, which must be signed by both the provider and the enrollee.

(6) The following are the limited circumstances in which a provider may bill an enrollee without executing form 13-879, Agreement to Pay for Healthcare Services, as specified in subsection (5) of this section:

(a) The enrollee, the enrollee's legal guardian, or the enrollee's legal representative:

(i) Was reimbursed for the service directly by a third party (see WAC 182-501-0200); or

(ii) Refused to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill the third-party insurance carrier for the service.

(b) The person represented that they were paying privately and not enrolled in apple health expansion when they were already enrolled in and receiving benefits under apple health expansion. In this circumstance, the provider must:

(i) Keep documentation of the enrollee's declaration of medical coverage. The declaration must be signed and dated by the enrollee, the enrollee's legal guardian, or the enrollee's legal representative; and

(ii) Give a copy of the document to the enrollee and maintain the original for six years from the date of service, for agency review upon request.

(c) The enrollee is placed in the agency's or a health plan's patient review and coordination (PRC) program and obtains nonemergency services from a nonpharmacy provider that is not an assigned or appropriately referred provider as described in WAC 182-501-0135;

(d) The service is within a service category excluded from the enrollee's benefits package. See WAC 182-501-0060;

(e) The services were noncovered ambulance services (see WAC 182-546-0250(2));

(f) An enrollee chooses to receive nonemergency services from a provider who is not contracted with the agency after being informed by the provider that they are not contracted with the agency and that the services offered will not be paid by apple health expansion; and

(g) An enrollee chooses to receive nonemergency services from providers outside of the health plan's network without authorization from the health plan, i.e., a nonparticipating provider.

(7) There are situations in which a provider must refund the full amount of a payment previously received from or on behalf of an enrollee and then bill the agency for the covered service that had been furnished. This occurs when the enrollee becomes eligible for a covered service that was already furnished. Providers must then accept as payment in full the amount paid by the agency or the enrollee's health plan for medical services furnished to enrollees. These situations include, but are not limited to, the following:

(a) The person was not enrolled in apple health expansion on the day the service was furnished. The person applies for apple health expansion later in the same month in which the service was provided and

the agency makes the person eligible for apple health expansion from the first day of that month;

(b) The enrollee receives a delayed certification for apple health expansion as defined in WAC 182-500-0025; or

(c) The enrollee receives apple health expansion certification for a retroactive period as defined in WAC 182-500-0095.

(8) Regardless of any written and signed agreement to pay, a provider may not bill, demand, collect, or accept payment or a deposit from an enrollee, anyone on the enrollee's behalf, or the agency for:

(a) Copying, printing, or otherwise transferring health care information, as the term health care information is defined in chapter 70.02 RCW, to another health care provider. This includes, but is not limited to:

(i) Medical/dental charts;

(ii) Radiological or imaging films; and

(iii) Laboratory or other diagnostic test results.

(b) Missed, canceled, or late appointments;

(c) Shipping and/or postage charges;

(d) "Boutique," "concierge," or enhanced service packages (e.g., newsletters, 24/7 access to provider, health seminars) as a condition for access to care; or

(e) The price differential between an authorized service or item and an "upgraded" service or item (e.g., a wheelchair with more features; brand name versus generic drugs).

OTS-5227.5

Chapter 182-525A WAC

WASHINGTON APPLE HEALTH EXPANSION—HEALTH PLAN ADMINISTRATION OF BENEFITS

NEW SECTION

WAC 182-525A-0100 Health plan rules—General. The rules in this chapter govern the administration of benefits under Washington apple health expansion by health plans, as defined in WAC 182-525-0400. Chapter 182-538 WAC is not applicable to apple health expansion, except for the definitions found in WAC 182-538-050, which are incorporated by reference into this chapter.

NEW SECTION

WAC 182-525A-0200 Health plan choice and assignment. The agency requires people enrolled in Washington apple health expansion to enroll in a health plan.

(1) To enroll with a health plan, a person may:

- (a) Enroll online via the Washington Healthplanfinder at <https://www.wahealthplanfinder.org>;
- (b) Call the agency's toll-free enrollment line at 800-562-3022;
- or
- (c) Go to the ProviderOne client portal at <https://www.waproviderone.org> and follow the instructions.
- (2) A person enrolled in apple health expansion must enroll with a health plan available in the regional service area where the person resides.
- (3) All family members must be enrolled with the same health plan if contracted to serve apple health expansion enrollees. However, family members of an apple health expansion enrollee placed in the patient review and coordination (PRC) program under WAC 182-501-0135 need not enroll in the same health plan as the family member placed in the PRC program.
- (4) An apple health expansion enrollee may be placed into the PRC program by the health plan or the agency. An enrollee placed in the PRC program must follow the enrollment requirements of the program as stated in WAC 182-501-0135.
- (5) When a person requests enrollment with a health plan, the agency enrolls them with the earliest possible effective date, based on the requirements of the agency's enrollment system.
- (6) The agency assigns a person who does not choose a health plan as follows:
- (a) If the person was enrolled with a health plan within the previous six months, the person is reenrolled with the same health plan if:
- (i) The agency identifies the prior health plan and the program is available; and
- (ii) The person does not have a family member enrolled with a health plan;
- (b) If (a) of this subsection does not apply and the person has a family member enrolled with a health plan, the person is enrolled with that health plan;
- (c) If the person has a break in eligibility of less than two months, that person will be automatically reenrolled with their previous health plan and no notice will be sent;
- (d) If the person cannot be assigned according to (a), (b), or (c) of this subsection, the agency:
- (i) Assigns the person based on agency policy, or this rule, or both;
- (ii) Does not assign people to any health plan that has a total statewide market share of 40 percent or more of people who are enrolled in apple health expansion coverage. On a quarterly basis, the agency reviews enrollment data to determine each health plan's statewide market share in apple health expansion coverage; and
- (iii) Applies performance measures associated with increasing or reducing assignment consistent with this rule and agency policy and its contracts with health plans; or
- (e) If the person cannot be assigned to a health plan under (a), (b), or (c) of this subsection, the agency assigns the person as follows:
- (i) If a person does not choose a health plan, the agency assigns the person to a health plan available in the regional service area where the person resides. The health plan is responsible for primary care provider (PCP) choice and assignment.

(ii) For people who are newly eligible or who have had a break in eligibility of more than six months, the agency sends a written notice to each household of one or more people who are assigned to a health plan. The assigned person has 10 calendar days to contact the agency, if desired, to change the health plan assignment before enrollment is effective. The notice includes the:

(A) Agency's toll-free number;

(B) Toll-free number and name of the health plan to which each person has been assigned;

(C) Effective date of enrollment; and

(D) Date by which the person must respond to change the assignment.

(7) An apple health expansion enrollee's selection of a PCP or assignment to a PCP occurs as follows:

(a) An apple health expansion enrollee may choose:

(i) A PCP or clinic that is in the enrollee's health plan and accepting new enrollees; and

(ii) A different PCP or clinic participating with the enrollee's health plan for different family members.

(b) If the enrollee does not choose a PCP or clinic, the health plan assigns a PCP or clinic that meets the access standards in the health plan contract.

(c) An apple health expansion enrollee may change from one PCP or clinic to a different PCP or clinic participating in the enrollee's health plan for any reason, with the change taking effect no later than the beginning of the month following the enrollee's request.

(d) An apple health expansion enrollee may file a grievance with the health plan if the health plan does not approve an enrollee's request to change PCPs or clinics.

(e) Apple health expansion enrollees required to participate in the agency's PRC program may be limited in their right to change PCPs. (See WAC 182-501-0135.)

NEW SECTION

WAC 182-525A-0300 Qualifications to become an agency-contracted health plan for Washington apple health expansion coverage. (1) To provide services under the Washington apple health expansion contract, a health plan must:

(a) Contract with the agency; and

(b) Contract with an agency-contracted behavioral health administrative service organization (BH-ASO) that maintains an adequate provider network to deliver services to enrollees in the apple health expansion regional service areas.

(2) A health plan must meet the following qualifications to be eligible to contract with the agency:

(a) Have a certificate of registration from the Washington state office of the insurance commissioner (OIC) that allows the health plan to provide health care services under a risk-based contract;

(b) Accept the terms and conditions of the agency's apple health expansion contract;

(c) Meet the network and quality standards established by the agency; and

(d) Pass a readiness review, including an on-site visit conducted by the agency.

(3) The agency may periodically conduct a procurement for new apple health expansion health plans or to reduce or expand the use of existing apple health expansion health plans.

(a) The agency may conduct a procurement when the agency determines in its sole discretion there is a need to:

- (i) Expand or reduce current health plan contracts;
- (ii) Enhance current health plan provider networks;
- (iii) Establish new contracts for apple health expansion coverage in one or more regional services areas; or
- (iv) Adjust the program to ensure adherence to state and federal law.

(b) The agency gives significant weight to the following factors in any procurement process:

- (i) Demonstrated commitment to, and experience in, serving low-income populations;
- (ii) Demonstrated commitment to, and experience in, serving people who have mental illness, substance use disorders, or co-occurring disorders;
- (iii) Demonstrated commitment to, and experience in, serving immigrant populations and populations with limited-English proficiency;
- (iv) Demonstrated commitment to, and experience with, partnerships with county and municipal criminal justice systems, housing services, and other critical support services necessary to achieve the outcomes established in RCW 70.320.020, 71.24.435, and 71.36.025;
- (v) Recognition that meeting apple health expansion enrollees' physical and behavioral health care needs is a shared responsibility of contracted behavioral health administrative services organizations, health plans, service providers, the state, and communities;
- (vi) Consideration of past and current performance and participation in other state or federal behavioral health programs as a contractor;
- (vii) Quality of services provided to enrollees under previous contracts with the state of Washington or other states;
- (viii) Accessibility, including appropriate utilization, of services offered to enrollees;
- (ix) Demonstrated capability to perform contracted services, including the ability to supply an adequate provider network; and
- (x) The ability to meet any other requirements established by the agency.

(c) The agency may define and consider additional factors as part of any procurement including, but not limited to:

- (i) Timely processing of, and payments to, providers in the health plan networks, including reconciliation of outstanding payments; and
- (ii) The optimal number of health plans per regional services area, based on population and in the manner that the agency determines most beneficial for the program, enrollees, and providers.

(4) The agency reserves the right not to contract with any otherwise qualified health plan.

NEW SECTION

WAC 182-525A-0400 Health plan payments, corrective action, and sanctions. (1) The agency pays Washington apple health expansion health plans monthly capitated premiums that:

(a) Were developed using generally accepted actuarial principles and practices;

(b) Are appropriate for the covered populations and the services to be furnished under the apple health expansion contract;

(c) Are certified by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board;

(d) Are based on analysis of historical cost, rate information, or both; and

(e) Are paid based on legislative allocations.

(2) Health plans are solely responsible for payment of apple health expansion-contracted health care services. The agency does not pay for a service that is the health plan's responsibility, even if the health plan has not paid the provider for the service.

(3) The agency pays health plans a service-based enhancement rate for wraparound with intensive services (WISE) administered by a certified WISE provider who holds a current behavioral health agency license issued by the department of health under chapter 246-341 WAC.

(4) For crisis services, the health plan must determine whether the person receiving the services is eligible for apple health expansion or if the person has other insurance coverage.

(5) The agency may require corrective action for:

(a) Substandard rates of clinical performance measures;

(b) Deficiencies found in audits and on-site visits; or

(c) Findings of noncompliance with any contractual, state, or federal requirements.

(6) The agency may:

(a) Impose sanctions for a health plan's noncompliance with any contractual or state requirement; and

(b) Apply a monthly penalty assessment associated with poor performance on selected behavioral health performance measures.

(7) If a health plan fails to meet any material obligation under the apple health expansion contract, the agency may impose the maximum allowable sanction on a per-occurrence, per-day basis until the agency determines the health plan has:

(a) Corrected the violation; and

(b) Remedied any harm caused by the noncompliance.

NEW SECTION

WAC 182-525A-0500 Scope of care. (1) A person enrolled in Washington apple health expansion is eligible only for the scope of services identified in WAC 182-501-0060, which may be modified by other agency rules pertinent to apple health expansion.

(2) The agency does not require the health plan to cover any services outside the scope of covered services in the agency's health plan contract. At its discretion, a health plan may cover services not required under the apple health expansion contract.

(3) Some services included in apple health expansion coverage may be provided on a fee-for-service basis rather than through a health plan.

(4) The health plan is not required to authorize or pay for covered services if services:

- (a) Are determined not to be medically necessary, as defined in WAC 182-500-0070, in accordance with the apple health expansion contract;
- (b) Are excluded from coverage under the apple health expansion contract;
- (c) Are received in a hospital emergency department for nonemergency medical conditions, except for a screening exam;
- (d) Are received from a participating provider that require prior authorization from the health plan; or
- (e) Are nonemergency services covered under the apple health expansion contract and received from nonparticipating providers that were not prior authorized by the health plan.

NEW SECTION

WAC 182-525A-0600 Health plan administration requirements. For covered services administered through the Washington apple health expansion contracts:

- (1) Health plans must subcontract with enough providers to deliver the scope of contracted services in a timely manner.
- (2) Health plans must provide new enrollees with written information about how enrollees may obtain covered services.
- (3) Health plans must provide covered services to enrollees through their participating providers unless an exception applies. A health plan covers services from a nonparticipating provider when an apple health expansion enrollee obtains:
 - (a) Emergency services; or
 - (b) Authorization from the health plan to receive services from a nonparticipating provider.
- (4) For nonemergency services, health plans may require:
 - (a) The enrollee to obtain a referral from the enrollee's primary care provider (PCP); or
 - (b) The provider to obtain authorization from the enrollee's health plan.
- (5) Health plans and their contracted providers must determine whether a requested service is medically necessary, as described in WAC 182-500-0070, given the enrollee's condition, according to the requirements included in the apple health expansion contract.
- (6) The health plan must coordinate benefits with other insurers in a manner that does not reduce benefits to the enrollee or result in costs to the enrollee.
- (7) A health plan enrollee does not need a PCP referral to receive reproductive health services, as described in chapter 182-532 WAC, from any reproductive health care provider participating with the health plan. Any covered services ordered or prescribed by a reproductive health care provider must meet the health plan's service authorization requirements for the specific service.
- (8) For enrollees outside their health plan service area, the health plan must cover enrollees for emergency care and medically necessary covered benefits that cannot wait until the enrollees return to their health plan service area.
- (9) A health plan enrollee may obtain specific services described in the apple health expansion contract from either a health plan-contracted provider or a provider with a separate agreement with the agency without a referral from the PCP or health plan.

(10) Health plans must provide new enrollees with written information about covered services. Additionally, the agency sends each enrollee written information about covered services when there is a change in covered services.

(11) An apple health expansion enrollee is entitled to timely access to covered services that are medically necessary as defined in WAC 182-500-0070.

(12) All nonemergency services covered under the apple health expansion contract and received from nonparticipating providers require prior authorization from the health plan.

(13) A provider may bill an apple health expansion enrollee for services only if the requirements of WAC 182-525-1100 are met.

NEW SECTION

WAC 182-525A-0700 Telemedicine and store and forward technology.

The agency's rules related to the authorized use of telemedicine and store and forward technology are found in WAC 182-501-0300 and are applicable to Washington apple health expansion benefits, including those administered by the health plan.

NEW SECTION

WAC 182-525A-0800 The grievance and appeal system and agency administrative hearings. (1) **Introduction.** This section contains information about the grievance and appeal system and the right to an agency administrative hearing for Washington apple health expansion health plan enrollees.

(2) **Statutory basis and framework.**

(a) Each health plan must have a grievance and appeal system in place for enrollees.

(b) Once a health plan enrollee has completed the health plan appeals process, the enrollee has the option of requesting an agency administrative hearing regarding any adverse benefit determination (as defined in WAC 182-538-050) upheld by the health plan. See chapter 182-526 WAC.

(3) **Health plan grievance and appeal system - General requirements.**

(a) The health plan grievance and appeal system must include:

(i) A process for addressing complaints about any matter that is not an adverse benefit determination, which is a grievance;

(ii) An appeal process to address enrollee requests for review of a health plan's adverse benefit determination; and

(iii) Access to the agency's administrative hearing process for review of a health plan's resolution of an appeal.

(b) Health plans must provide information describing the health plan's grievance and appeal system to all providers and subcontractors.

(c) A health plan must have agency approval for written materials sent to enrollees regarding the grievance and appeal system and the agency's administrative hearing process under chapter 182-526 WAC.

(d) Health plans must inform enrollees in writing within 15 calendar days of enrollment about enrollees' rights with instructions on

how to use the health plan's grievance and appeal system and the agency's administrative hearing process.

(e) A health plan must give enrollees any reasonable assistance in completing forms and other procedural steps for grievances and appeals (e.g., interpreter services and toll-free numbers).

(f) A health plan must allow enrollees and their authorized representatives to file grievances and appeals orally as well as in writing.

(g) Methods to file either a grievance or appeal include, but are not limited to, U.S. mail, commercial delivery services, hand delivery, fax, telephone, and email.

(h) Health plans may not require enrollees to provide written follow-up for a grievance the health plan received orally.

(i) The health plan must resolve each grievance and appeal and provide notice of the resolution as expeditiously as the enrollee's health condition requires and within the time frames identified in this section.

(j) The health plan must ensure that the people who make decisions on grievances and appeals:

(i) Were neither involved in any previous level of review or decision making nor a subordinate of any person who was so involved;

(ii) Are health care professionals with appropriate clinical expertise in treating the enrollee's condition or disease if deciding any of the following:

(A) An appeal of an adverse benefit determination concerning medical necessity;

(B) A grievance concerning denial of an expedited resolution of an appeal; or

(C) A grievance or appeal that involves any clinical issues; and

(iii) Consider all comments, documents, records, and other information submitted by the enrollee or the enrollee's representative without regard to whether the information was submitted or considered in the initial adverse benefit determination.

(4) The health plan grievance process.

(a) Only an enrollee or enrollee's authorized representative may file a grievance with the health plan. A provider may not file a grievance on behalf of an enrollee without the enrollee's written consent.

(b) The health plan must acknowledge receipt of each grievance within two business days. Acknowledgment may be orally or in writing.

(c) The health plan must complete the resolution of a grievance and provide notice to the affected parties as expeditiously as the enrollee's health condition requires, but no later than 45 calendar days after receiving the grievance.

(d) The health plan must notify enrollees of the resolution of grievances within five business days of determination.

(i) Notices of resolution of grievances not involving clinical issues can be oral or in writing.

(ii) Notices of resolution of grievances for clinical issues must be in writing.

(e) Enrollees do not have a right to an agency administrative hearing to dispute the resolution of a grievance unless the health plan fails to adhere to the notice and timing requirements for grievances.

(f) If the health plan fails to adhere to the notice and timing requirements for grievances, the enrollee is deemed to have completed

the health plan's appeals process and may initiate an agency administrative hearing.

(5) **Health plans' notice of adverse benefit determination.**

(a) **Language and format requirements.** The notice of adverse benefit determination must be in writing in the enrollee's primary language and in an easily understood format.

(b) **Content of notice.** The notice of health plan adverse benefit determination must explain:

(i) The adverse benefit determination the health plan has made or intends to make, and any pertinent effective date;

(ii) The reasons for the adverse benefit determination, including citation to legal authority and the health plan criteria that were the basis of the decision;

(iii) The enrollee's right to receive upon request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse benefit determination, including medical necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits;

(iv) The enrollee's right to file an appeal of the adverse benefit determination, including information on the health plan appeal process and the right to request an agency administrative hearing;

(v) The procedures for exercising the enrollee's rights;

(vi) The circumstances under which an appeal can be expedited and how to request it; and

(vii) The enrollee's right to have benefits continued pending resolution of an appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.

(c) **Timing of notice.** The health plan must mail the notice of adverse benefit determination within the following time frames:

(i) For termination, suspension, or reduction of previously authorized services, at least 10 calendar days prior to the effective date of the adverse benefit determination. This notice must be mailed by a method that certifies receipt and assures delivery within three calendar days.

(ii) For denial of payment, at the time of any adverse benefit determination affecting the claim. This applies only when the enrollee can be held liable for the costs associated with the adverse benefit determination.

(iii) For standard service authorization decisions that deny or limit services, as expeditiously as the enrollee's health condition requires, but not to exceed 14 calendar days following receipt of the request for service. An extension of up to 14 additional calendar days may be allowed if:

(A) The enrollee or enrollee's provider requests the extension.

(B) The health plan determines, and justifies to the agency upon request, a need for additional information and that the extension is in the enrollee's interest.

(iv) If the health plan extends the time frame for standard service authorization decisions, the health plan must:

(A) Give the enrollee written notice of the reason for the decision to extend and inform the enrollee of the right to file a grievance if the enrollee disagrees with that decision; and

(B) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

(v) For expedited authorization decisions:

(A) In cases involving mental health drug authorization decisions, or where the provider indicates or the health plan determines that following the standard time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the health plan must make an expedited authorization decision and provide notice no later than 72 hours after receipt of the request for service.

(B) The health plan may extend the 72-hour time frame up to 14 calendar days if:

(I) The enrollee requests the extension; or

(II) The health plan determines and justifies to the agency, upon request, there is a need for additional information and it is in the enrollee's interest.

(6) The health plan appeal process.

(a) **Authority to appeal.** An enrollee, the enrollee's authorized representative, or the provider acting with the enrollee's written consent may appeal an adverse benefit determination from the health plan.

(b) **Oral appeals.** A health plan must treat oral inquiries about appealing an adverse benefit determination as an appeal to establish the earliest possible filing date for the appeal.

(c) **Acknowledgment letter.** The health plan must acknowledge in writing receipt of each appeal to both the enrollee and the requesting provider within five calendar days of receiving the appeal request. The appeal acknowledgment letter sent by the health plan serves as written confirmation of an appeal filed orally by an enrollee.

(d) **Standard service authorization - 60-day deadline.** For appeals involving standard service authorization decisions, an enrollee must file an appeal within 60 calendar days of the date on the health plan's notice of adverse benefit determination. This time frame also applies to a request for an expedited appeal.

(e) **Previously authorized service - 10-day deadline.** For appeals of adverse benefit determinations involving termination, suspension, or reduction of a previously authorized service, and when the enrollee is requesting continuation of the service, the enrollee must file an appeal within 10 calendar days of the health plan mailing notice of the adverse benefit determination.

(f) **Untimely service authorization decisions.** When the health plan does not make a service authorization decision within required time frames, it is considered a denial. In this case, the health plan sends a formal notice of adverse benefit determination, including the enrollee's right to an appeal.

(g) **Appeal process requirements.** The health plan appeal process must:

(i) Provide the enrollee a reasonable opportunity to present evidence and allegations of fact or law, in person, by telephone, or in writing. The health plan must inform the enrollee of the limited time available for this in the case of expedited resolution;

(ii) Provide the enrollee and the enrollee's representative the opportunity before and during the appeal process to examine the enrollee's case file, including medical records, other relevant documents and records, and any new or additional evidence considered, relied upon, or generated by the health plan (or at health plan's direction) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution time frame for appeals as specified in this section; and

(iii) Include as parties to the appeal:

(A) The enrollee and the enrollee's representative; or

(B) The legal representative of the deceased enrollee's estate.

(h) **Level of appeal.** There is only one level of review in the health plan's appeals process.

(i) **Time frames for resolution of appeals and notice to the enrollee.** Health plans must resolve each appeal and provide notice as expeditiously as the enrollee's health condition requires, and within the following time frames:

(i) For standard resolution of appeals, including notice to the affected parties, no longer than 30 calendar days from the day the health plan receives the appeal. This includes appeals involving termination, suspension, or reduction of previously authorized services.

(ii) For expedited resolution of appeals, including notice to the affected parties, no longer than 72 hours after the health plan receives the appeal. The health plan may extend the 72-hour time frame up to 14 calendar days if:

(A) The enrollee requests the extension; or

(B) The health plan determines and shows to the satisfaction of the agency, upon request, there is a need for additional information and it is in the enrollee's interest.

(iii) If the health plan fails to adhere to the notice and timing requirements for appeals, the enrollee is deemed to have completed the health plan's appeals process and may request an agency administrative hearing.

(j) **Language and format requirements - Notice of resolution of appeal.**

(i) The notice of the resolution of the appeal must be in writing in the enrollee's primary language and in an easily understood format.

(ii) The notice of the resolution of the appeal must be sent to the enrollee and the requesting provider.

(iii) For notice of an expedited resolution, the health plan must also make reasonable efforts to provide oral notice.

(k) **Content of resolution of appeal.**

(i) The notice of resolution must include the results of the resolution process and the date it was completed.

(ii) For appeals not resolved wholly in favor of the enrollee, the notice of resolution must include:

(A) The right to request an agency administrative hearing under chapter 182-526 WAC, and how to request the hearing;

(B) The right to request and receive benefits while an agency administrative hearing is pending, and how to make the request in accordance with subsection (9) of this section and the agency's administrative hearing rules in chapter 182-526 WAC; and

(C) That the enrollee may be held liable for the cost of those benefits received for the first 60 calendar days after the agency or the office of administrative hearings (OAH) receives an agency administrative hearing request if the hearing decision upholds the health plan's adverse benefit determination.

(7) **Health plan expedited appeal process.**

(a) Each health plan must establish and maintain an expedited appeal process when the health plan determines or the provider indicates that taking the time for a standard resolution of an appeal could seriously jeopardize the enrollee's life, physical or behavioral health, or ability to attain, maintain, or regain maximum function.

(b) The enrollee may file an expedited appeal either orally, according to WAC 182-526-0095, or in writing. No additional follow-up is required of the enrollee.

(c) The health plan must make a decision on the enrollee's request for expedited appeal and provide written notice as expeditiously as the enrollee's health condition requires but no later than two calendar days after the health plan receives the appeal. The health plan must also make reasonable efforts to orally notify the enrollee of the decision.

(d) The health plan may extend the time frame for decision on the enrollee's request for an expedited appeal up to 14 calendar days if:

(i) The enrollee requests the extension; or

(ii) The health plan determines and shows to the satisfaction of the agency, upon its request, that there is a need for additional information and the delay is in the enrollee's interest.

(e) The health plan must make reasonable efforts to provide the enrollee prompt verbal notice and provide written notice for any extension not requested by the enrollee with the reason for the delay.

(f) If the health plan grants an expedited appeal, the health plan must issue a decision as expeditiously as the enrollee's physical or behavioral health condition requires, but not later than 72 hours after receiving the appeal. The health plan may extend the time frame for a decision and to provide notice to the enrollee for an expedited appeal, up to 14 days, if:

(i) The enrollee requests the extension; or

(ii) The health plan determines and shows to the satisfaction of the agency, upon its request, that there is a need for additional information and the delay is in the enrollee's interest.

(g) The health plan must provide written notice for any extension not requested by the enrollee within two calendar days of the decision and inform the enrollee of the reason for the delay and the enrollee's right to file a grievance.

(h) If the health plan denies a request for expedited resolution of an appeal, it must:

(i) Process the appeal based on the time frame for standard resolution;

(ii) Make reasonable efforts to give the enrollee prompt oral notice of the denial; and

(iii) Provide written notice within two calendar days.

(i) The health plan must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal.

(8) The right to an agency administrative hearing for health plan enrollees.

(a) **Authority to file.** Only an enrollee, the enrollee's authorized representative, or a provider with the enrollee's or authorized representative's written consent may request an administrative hearing. See WAC 182-526-0095 and 182-526-0155.

(b) **Right to agency administrative hearing.** If an enrollee has completed the health plan appeal process and does not agree with the health plan's resolution of the appeal, the enrollee may file a request for an agency administrative hearing based on the rules in this section and in chapter 182-526 WAC.

(c) **Deadline - 120 days.** An enrollee's request for an agency administrative hearing must be filed no later than 120 calendar days from the date of the written notice of resolution of appeal from the health plan.

(d) **Independent party.** The health plan is an independent party and responsible for its own representation in any agency administrative hearing, appeal to the board of appeals, and any subsequent judicial proceedings.

(e) **Applicable rules.** The agency's administrative hearing rules in chapter 182-526 WAC apply to agency administrative hearings requested by enrollees to review the resolution of an enrollee appeal of a health plan adverse benefit determination.

(9) **Continuation of previously authorized services.**

(a) The health plan must continue the enrollee's services if all of the following apply:

(i) The enrollee, or enrollee's authorized representative, or provider with written consent files the appeal on or before the later of the following:

(A) Within 10 calendar days of the health plan mailing the notice of adverse benefit determination; or

(B) The intended effective date of the health plan's proposed adverse benefit determination;

(ii) The appeal involves the termination, suspension, or reduction of previously authorized services;

(iii) The services were ordered by an authorized provider; and

(iv) The original period covered by the original authorization has not expired.

(b) If the health plan continues or reinstates the enrollee's services while the appeal is pending at the enrollee's request, the services must be continued until one of the following occurs:

(i) The enrollee withdraws the health plan appeal;

(ii) The enrollee fails to request an agency administrative hearing within 10 calendar days after the health plan sends the notice of an adverse resolution to the enrollee's appeal;

(iii) The enrollee withdraws the request for an agency administrative hearing; or

(iv) The office of administrative hearings (OAH) issues a hearing decision adverse to the enrollee.

(c) If the final resolution of the appeal upholds the health plan's adverse benefit determination, the health plan may recover from the enrollee the amount paid for the services provided to the enrollee for the first 60 calendar days after the agency or the office of administrative hearings (OAH) received a request for an agency administrative hearing, to the extent that services were provided solely because of the requirement for continuation of services.

(d) Expenditures for continued enrollee services under this section are subject to legislative funding provided specifically for apple health expansion coverage and the health plan's obligation to continue the services will terminate when available funding for apple health expansion is exhausted.

(10) **Effect of reversed resolutions of appeals.**

(a) **Services not furnished while an appeal is pending.** If the health plan or a final order entered by the agency's board of appeals, as defined in chapter 182-526 WAC, or an independent review organization (IRO) reverses a decision to deny, limit, or delay services that were not provided while the appeal was pending, the health plan must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires, but not later than 72 hours from the date it receives notice reversing the determination.

(b) **Services furnished while the appeal is pending.** If the health plan reverses a decision to deny authorization of services or the denial is reversed through an IRO or a final order of OAH or the board of appeals and the enrollee received the disputed services while the appeal was pending, the health plan must pay for those services.

(11) **Available resources exhausted.** Any appeals, independent review, or agency administrative hearing process related to a request to authorize or pay for a service will terminate when the available funding for apple health expansion coverage is exhausted, since services cannot be authorized or paid for without funding, regardless of medical necessity.

NEW SECTION

WAC 182-525A-0900 Enrollee request for a second medical opinion.

(1) A health plan enrollee has the right to a timely referral for a second opinion upon request when:

(a) The enrollee needs more information about treatment recommended by the provider or health plan; or

(b) The enrollee believes the health plan is not authorizing medically necessary care.

(2) A health plan enrollee has a right to a second opinion from a participating provider. At the health plan's discretion, a clinically appropriate nonparticipating provider who is agreed upon by the health plan and the enrollee may provide the second opinion.

NEW SECTION

WAC 182-525A-1000 Quality of care. To assure that health plan enrollees receive quality health care services, the agency requires health plans to comply with quality improvement standards detailed in the agency's health plan contract. Health plans must:

(1) Have a clearly defined quality organizational structure and operation, including a fully operational quality assessment, measurement, and improvement program;

(2) Have effective means to detect overutilization and underutilization of services;

(3) Maintain a system for provider and practitioner credentialing and recredentialing;

(4) Ensure that health plan subcontracts and the delegation of health plan responsibilities align with agency standards;

(5) Ensure health plan oversight of delegated entities responsible for any delegated activity to include:

(a) A delegation agreement with each entity describing the responsibilities of the health plan and the entity;

(b) Evaluation of the entity before delegation;

(c) An annual evaluation of the entity; and

(d) Evaluation or regular reports and follow-up on issues that are not compliant with the delegation agreement or the agency's health plan contract specifications;

(6) Cooperate with an agency-contracted, qualified independent external quality review organization (EQRO) conducting review activities;

- (7) Have an effective mechanism to assess the quality and appropriateness of care furnished to enrollees with special health care needs;
- (8) Assess and develop individualized treatment plans for enrollees with special health care needs which ensure integration of clinical and nonclinical disciplines and services in the overall plan of care;
- (9) Submit annual reports to the agency on performance measures as specified by the agency;
- (10) Maintain a health information system that:
- (a) Collects, analyzes, integrates, and reports data as requested by the agency;
 - (b) Provides information on utilization, grievances and appeals, and other areas as defined by the agency;
 - (c) Retains enrollee grievance and appeal records for a period of no less than 10 years;
 - (d) Collects data on enrollees, providers, and services provided to enrollees through an encounter data system, in a standardized format as specified by the agency; and
 - (e) Ensures data received from providers is adequate and complete by verifying the accuracy and timeliness of reported data and screening the data for completeness, logic, and consistency.
- (11) Conduct performance improvement projects designed to achieve significant improvement, sustained over time, in clinical care outcomes and services, and that involve the following:
- (a) Measuring performance using objective quality indicators;
 - (b) Implementing system changes to achieve improvement in service quality;
 - (c) Evaluating the effectiveness of system changes;
 - (d) Planning and initiating activities for increasing or sustaining performance improvement;
 - (e) Reporting each project status and the results as requested by the agency; and
 - (f) Completing each performance improvement project timely so as to generally allow aggregate information to produce new quality of care information every year;
- (12) Ensure enrollee access to health care services;
- (13) Ensure continuity and coordination of enrollee care; and
- (14) Maintain and monitor availability of health care services for enrollees.

NEW SECTION

WAC 182-525A-1100 Notice requirements. The notice requirements in chapter 182-518 WAC apply to Washington apple health expansion. However, when available funds are exhausted, benefits are terminated, and the agency sends notice to enrollees in accordance with WAC 182-518-0025 (1), (2), and (3). Continued coverage of apple health expansion benefits is not available.

NEW SECTION

WAC 182-525A-1200 Enrollee rights. Washington apple health expansion enrollees have the rights described in WAC 182-503-0100, as applicable, and WAC 182-538-180, as applicable.

OTS-5228.3

Chapter 182-525B WAC
WASHINGTON APPLE HEALTH EXPANSION OUTPATIENT DRUG PROGRAM

NEW SECTION

WAC 182-525B-0100 Introduction. The rules in this chapter are applicable to the Washington apple health expansion outpatient drug program. Chapter 182-530 WAC is not applicable to apple health expansion, except for the definitions from WAC 182-530-1050 that are incorporated by reference into this chapter as identified in WAC 182-525B-0300.

NEW SECTION

WAC 182-525B-0200 Overview. (1) The Washington apple health expansion outpatient drug program provides medically necessary outpatient drugs, drug-related supplies, and devices to apple health expansion enrollees based on agency rules.

(2) The agency determines the outpatient drugs, vitamins, minerals, drug-related supplies, and devices that are covered under apple health expansion.

(3) The apple health expansion outpatient drug program covers outpatient drugs, vitamins, minerals, drug-related supplies, and devices when:

(a) The items are designated as covered for apple health expansion on the agency's apple health expansion preferred drug list. For covered outpatient drugs, vitamins, minerals, drug-related supplies, and devices, refer to WAC 182-525B-0500. For noncovered outpatient drugs, vitamins, minerals, drug-related supplies, and devices, refer to WAC 182-525B-0600; or

(b) The items are prescribed by a practitioner with prescriptive authority (also known as "prescriber," as defined in WAC 182-525B-0300), unless covered without a prescription as described in WAC 182-525B-0500 for family planning and emergency contraception; and

(c) When the prescriber is a provider:

(i) With an approved core provider agreement;

(ii) Who is enrolled as a servicing provider on an approved core provider agreement; or

(iii) Who is enrolled as a nonbilling provider.

NEW SECTION

WAC 182-525B-0300 Definitions. In addition to the definitions and abbreviations found in chapter 182-500 WAC, the following definitions apply to this chapter:

"Apple health expansion preferred drug list (PDL)" - The list of all drugs in drug classes and each drug's preferred or nonpreferred status as approved by the agency director or designee.

"Compendia of drug information" - See WAC 182-530-1050.

"Drug-related supplies and devices" - See WAC 182-530-1050.

"Medically accepted indication" - See WAC 182-530-1050.

"National drug code (NDC)" - See WAC 182-530-1050.

"Nonpreferred drug" - A drug within a therapeutic class of drugs on the apple health expansion PDL that has not been selected as a preferred drug.

"Obsolete NDC" - See WAC 182-530-1050.

"Outpatient drug" - A prescription or OTC drug, vitamin, mineral, enzyme, or supplement. Covered outpatient drugs will be listed on the apple health expansion PDL.

"Over-the-counter (OTC) drugs" - Outpatient drugs that do not by any applicable federal or state law or regulation require a prescription before they can be sold or dispensed.

"Pharmacist" - See WAC 182-530-1050.

"Pharmacy" - See WAC 182-530-1050.

"Practice of pharmacy" - The practice of and responsibility for:

- (a) Accurately interpreting prescription orders;
- (b) Compounding drugs;
- (c) Dispensing, labeling, administering, and distributing drugs and devices;
- (d) Providing drug information to the enrollee that includes, but is not limited to, the advising of therapeutic values, hazards, and the uses of drugs and devices;
- (e) Monitoring of drug therapy and use;
- (f) Proper and safe storage of drugs and devices;
- (g) Documenting and maintaining records;
- (h) Initiating or modifying drug therapy in accordance with written guidelines or protocols previously established and approved for a pharmacist's practice by a practitioner authorized to prescribe drugs; and

(i) Participating in drug use reviews and drug product selection.

"Practitioner" - See WAC 182-530-1050.

"Preferred drug" - A drug within a therapeutic class of drugs on the apple health expansion PDL that has been selected as a preferred drug.

"Prescriber" - A physician, osteopathic physician/surgeon, dentist, nurse, physician assistant, optometrist, pharmacist, or other person authorized by law or rule to prescribe drugs. See WAC 246-945-350 for pharmacists' prescriptive authority.

"Prescription" - An order for drugs, vitamins, minerals, enzymes or devices issued by a prescriber, in the course of the prescriber's professional practice, for a legitimate medical purpose.

"Prescription drugs" - Drugs, vitamins, minerals, or enzymes required by any applicable federal or state law or regulation to be dispensed by prescription only or that are restricted to use by practitioners only.

"Terminated NDC" - See WAC 182-530-1050.

NEW SECTION

WAC 182-525B-0400 Requirements for prescribing and dispensing controlled substances—Prescription monitoring program (PMP). This section identifies the steps prescribers must take before prescribing a controlled substance. This includes the steps pharmacists must take when dispensing a controlled substance from an outpatient pharmacy to check a Washington apple health expansion enrollee's prescription drug history in the prescription monitoring program (PMP) described in chapter 246-470 WAC.

(1) **PMP review required.** Except as identified in subsection (4) of this section, a prescriber, before prescribing, and a pharmacist, when dispensing, must check all the apple health expansion enrollee's current prescriptions in the PMP, including any prescriptions not paid for under apple health expansion.

(2) **Retrieval by delegates allowed.** A prescriber or pharmacist may delegate the retrieval of the apple health expansion enrollee's PMP information to anyone in their practice setting with authorization to access the PMP, so long as the prescriber or pharmacist reviews all the enrollee's current prescriptions in the PMP before prescribing or when dispensing a controlled substance.

(3) **Documentation.** The prescriber and pharmacist must document in the apple health expansion enrollee's record the date and time of the:

(a) Retrieval of information from the PMP; and

(b) Review of information from the PMP.

(4) **Good faith effort exception.**

(a) If a prescriber, pharmacist, or their delegate is unable to access the apple health expansion enrollee's record in the PMP after a good faith effort, that attempt must be documented in the enrollee's record.

(b) A prescriber or pharmacist must document the reason or reasons they were unable to conduct the check in the apple health expansion enrollee's medical record.

NEW SECTION

WAC 182-525B-0500 Covered drugs, drug-related supplies, and devices. (1) The Washington apple health expansion outpatient drug program covers:

(a) Prescription and over-the-counter (OTC) drugs, vitamins, and minerals as defined in WAC 182-525B-0300, subject to the limitations and requirements in this chapter, when:

(i) The item is approved by the Food and Drug Administration (FDA);

(ii) The item is for a medically accepted indication as defined in WAC 182-525B-0300;

(iii) The manufacturer has a signed drug rebate agreement with the federal Department of Health and Human Services (DHHS) or the agency has exempted the drug from the rebate requirement based on a determination that the nonrebateable product is medically necessary and essential to the health of the enrollees; and

(iv) The item is not excluded from coverage under WAC 182-525B-0600.

(b) Drugs and drug-related supplies and devices used for family planning per chapter 182-532 WAC are as follows:

(i) OTC drugs, devices, and drug-related supplies used for family planning without a prescription when the agency determines it necessary for enrollee access and safety;

(ii) Contraceptive patches, contraceptive rings, and oral contraceptives, excluding emergency contraception, when dispensed in no less than a one-year supply, unless:

(A) A smaller supply is directed by the prescriber;

(B) A smaller supply is requested by the enrollee; or

(C) The pharmacy does not have adequate stock.

(iii) Family planning drugs that do not meet the federal drug rebate requirement in (a)(iii) of this subsection, on a case-by-case basis.

(c) Prescription or OTC vitamins, minerals, and enzymes listed as preferred on the apple health expansion preferred drug list (PDL) that are:

(i) Prenatal vitamins, iron replacement, or folic acid, when prescribed and dispensed to a pregnant person;

(ii) Recommended by the United States Preventive Services Task Force with an A or B rating;

(iii) Fluoride for enrollees under age 21; or

(iv) Taken for a clinically documented medical condition that causes vitamin, mineral, or enzyme deficiencies, and the deficiency cannot be treated through other dietary interventions.

(d) OTC drugs listed on the apple health expansion PDL that the agency determines to be the least costly therapeutic alternative for a medically accepted indication;

(e) Drug-related supplies and devices that are:

(i) Essential for the administration of an outpatient drug;

(ii) Not excluded from coverage under WAC 182-525B-0600; and

(iii) Medical equipment and supplies covered under chapter 182-543 WAC and available at retail pharmacies, when published on the apple health expansion PDL.

(f) Preservatives, flavoring, or coloring agents, only when used as a suspending agent in a compound;

(g) Prescription drugs and OTC drugs listed as preferred on the apple health expansion PDL to promote tobacco/nicotine cessation; and

(h) Drugs approved by the FDA under an emergency use authorization during a public health emergency.

(2) Apple health expansion does not cover or pay for any drug, vitamin, mineral, enzyme, or drug-related supply or device not meeting the coverage requirements under this section.

NEW SECTION

WAC 182-525B-0600 Noncovered outpatient drugs, drug-related supplies, and devices. (1) The agency does not cover a drug that is:

(a) Not approved by the Food and Drug Administration (FDA);

(b) Prescribed for a condition that is not a medically accepted indication, including a dose or dosage schedule that is not FDA-approved or supported in the Compendia;

(c) Prescribed for:

(i) Weight loss or gain;

(ii) Infertility, frigidity, or impotency;

- (iii) Cosmetic purposes or hair growth; or
- (iv) Sexual or erectile dysfunction, unless such drugs are used to treat a condition other than sexual or erectile dysfunction and approved by the FDA.
- (d) Designated by the FDA as a less-than-effective drug;
- (e) An outpatient drug for which the manufacturer requires as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or manufacturer's designee;
- (f) An outpatient drug, drug-related supply, or device:
- (i) With an obsolete National Drug Code (NDC) for more than two years;
- (ii) With a terminated NDC;
- (iii) Whose shelf life has expired; or
- (iv) Which does not have a valid NDC approved by the FDA.
- (g) A prescription or OTC drug, vitamin, mineral, or enzyme except as allowed under WAC 182-525B-0500 (1)(h);
- (h) A drug regularly supplied by other public agencies as an integral part of program activity (e.g., immunization vaccines for children);
- (i) Listed as not covered on the Washington apple health expansion preferred drug list (PDL); or
- (j) A free pharmaceutical sample.
- (2) A noncovered drug may be requested through the exception to rule process as described in WAC 182-501-0160.

NEW SECTION

- WAC 182-525B-0700 Washington apple health expansion preferred drug list (PDL).** (1) Outpatient drugs in a drug class on the Washington apple health expansion preferred drug list (PDL) may be designated as preferred, nonpreferred, or not covered drugs.
- (2) The agency director or designee makes the final selection of drugs or drug classes included on the apple health expansion PDL.
- (3) The agency determines the preferred, nonpreferred, and not covered status of outpatient drugs on the apple health expansion PDL.
- (4) A nonpreferred drug may:
- (a) Require trial and failure of one or more preferred drugs before the nonpreferred drug will be considered for authorization; or
 - (b) Require authorization for medical necessity as established by the agency or health plan criteria for the nonpreferred drug instead of the preferred drug.
- (5) Drugs in a drug class on the apple health expansion PDL may require authorization regardless of preferred or nonpreferred status.
- (6) When a preferred innovator drug or biological product on the apple health expansion PDL loses its patent, the agency may:
- (a) Designate an available, equally effective, generic equivalent, or biosimilar biological product as a preferred drug; and
 - (b) Make the innovator drug or biological product nonpreferred.

OTS-5180.3

AMENDATORY SECTION (Amending WSR 21-11-039, filed 5/12/21, effective 6/12/21)

WAC 182-526-0005 Purpose and scope. (1) This chapter:

(a) Describes the general hearing rules and procedures that apply to ~~((~~

~~(i))~~ the resolution of disputes between an appellant and the health care authority (HCA), an agency designee, or an HCA-contracted managed care organization (MCO) or health plan, or a dispute involving an assessed overpayment by HCA against an HCA-contracted MCO or health plan, involving:

(i) Medical services programs established under chapter 74.09 RCW including, but not limited to, Washington apple health fee-for-service, integrated managed care ((in)) (see chapters 182-538((~~7~~ 182-538A,)) and 182-538B WAC), and crisis and noncrisis services ((in)) (see chapter 182-538C WAC); ((and))

(ii) ((The resolution of disputes between an appellant and the health care authority (HCA) arising from)) Washington apple health expansion (see chapters 182-525, 182-525A, and 182-525B WAC); and

(iii) The prescription drug pricing transparency program in chapter 182-51 WAC and the all payer health care claims database rules in chapter 182-70 WAC.

(b) Supplements the Administrative Procedure Act (APA), chapter 34.05 RCW, and the model rules, chapter 10-08 WAC, adopted by the office of administrative hearings (OAH).

(c) Establishes rules encouraging informal dispute resolution between HCA, its authorized agents, or an HCA-contracted ~~((managed care organization ((MCO)))~~ or health plan, and people or entities who disagree with its actions.

~~((d))~~ (2) Unless specifically excluded by this chapter or program rules, this chapter regulates all hearings involving:

(a) Medical services programs established under chapter 74.09 RCW including, but not limited to, apple health fee-for-service, managed care in chapters 182-538((~~7~~ 182-538A,)) and 182-538B WAC((~~7~~)) and crisis and noncrisis services in chapter 182-538C WAC((~~7~~, unless specifically excluded by this chapter or program rules));

(b) Apple health expansion eligibility or services as described in chapters 182-525, 182-525A, and 182-525B WAC; and

(c) Prescription drug pricing transparency program in chapter 182-51 WAC and the all payer health care claims database rules in chapter 182-70 WAC.

~~((2))~~ (3) Nothing in this chapter is intended to affect the constitutional rights of any person or to limit or change additional requirements imposed by statute or other rule. Other laws or rules determine if a hearing right exists, including the APA and program rules or laws.

~~((3))~~ (4) If there is a conflict between this chapter and specific program rules, the specific program rules prevail. HCA's hearing rules and program rules prevail over the model hearing rules in chapter 10-08 WAC.

~~((4))~~ (5) The hearing rules in this chapter do not apply to the public employees benefits board or the school employees benefits board programs (see chapters 182-16 and 182-32 WAC).

WSR 25-05-019
EMERGENCY RULES
DEPARTMENT OF

SOCIAL AND HEALTH SERVICES

(Developmental Disabilities Administration)

[Filed February 7, 2025, 3:14 p.m., effective February 7, 2025, 3:14 p.m.]

Effective Date of Rule: Immediately upon filing.

Purpose: The developmental disabilities administration (DDA) is enacting these changes on an emergency basis to implement home and community-based services (HCBS) waivers as approved by the Centers for Medicare and Medicaid Services (CMS).

Primary waiver amendments:

- These amendments add: Waiver eligibility for children and youth age 20 and younger who are subject to a court dependency or a similar proceeding in a tribal court or are receiving extended foster care services from the department of children, youth, and families or from a tribe in Washington state; technical information about service plan collaboration; and teleservice delivery as a service delivery method for some services.
- These amendments adjust: Waiver enrollment limits; language about cross-agency collaboration; the service definition for transportation; provider qualifications for music therapists; and level-of-care and inter-rate reliability level of care evaluation processes.
- These amendments clarify: Teleservice language in all services where teleservice delivery is now available; and waiver service definitions and service limit language across all five waivers.

To read all other CMS-approved waiver amendments effective September 1, 2024, open a waiver under "Current Approved Waivers" on DDA's home and community-based waivers website.

This is a subsequent emergency filing on these sections and is necessary to keep the rules in effect until DDA completes the permanent rule-making process. DDA is preparing the rules for external review. We have filed a CR-101 preproposal under WSR 24-18-103. This filing supersedes the emergency filed as WSR 25-02-044.

Citation of Rules Affected by this Order: New WAC 388-842-0001, 388-842-0005, 388-842-0010, 388-842-0015, 388-842-0020, 388-842-0025, 388-842-0030, 388-842-0035, 388-842-0040, 388-842-0045, 388-842-0060, 388-842-0065, 388-842-0070, 388-842-0075, 388-842-0080, 388-842-0085, 388-842-0090, 388-842-0095, 388-842-0110, 388-842-0115, 388-842-0120, 388-842-0125, 388-842-0140, 388-842-0145, 388-842-0150, 388-842-0165, 388-842-0170, 388-842-0175, 388-842-0180, 388-842-0185, 388-842-0190, 388-842-0195, 388-842-0205, 388-842-0210, 388-842-0215, 388-842-0220, 388-842-0230, 388-842-0235, and 388-842-0250; repealing WAC 388-825-0571 and 388-845-2019; and amending WAC 388-825-020, 388-825-096, 388-825-120, 388-828-1020, 388-828-1340, 388-828-1540, 388-828-5120, 388-828-5140, 388-828-5160, 388-828-5180, 388-828-5920, 388-828-5940, 388-828-5980, 388-845-0001, 388-845-0030, 388-845-0045, 388-845-0055, 388-845-0060, 388-845-0100, 388-845-0110, 388-845-0111, 388-845-0760, 388-845-0955, 388-845-1515, 388-845-1607, 388-845-1620, 388-845-2000, 388-845-2010, 388-845-2200, 388-845-3015, and 388-845-3095.

Statutory Authority for Adoption: RCW 34.05.350.

Other Authority: RCW 71A.12.380(1); 42 C.F.R. 441.301.

Under RCW 34.05.350 the agency for good cause finds that state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.

Reasons for this Finding: Enacting these rules on an emergency basis is necessary in order to implement HCBS waivers as approved by CMS. Aligning rules with approved waiver amendments provides assurances required under 42 C.F.R. 441.301. This third filing is necessary to remove WAC 388-845-0113 and 388-845-0210 from the emergency filed under WSR 25-02-044 and file them under a separate emergency filing.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 39, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 39, Amended 31, Repealed 2.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: February 7, 2025.

Katherine I. Vasquez
Rules Coordinator

Reviser's note: The material contained in this filing exceeded the page-count limitations of WAC 1-21-040 for appearance in this issue of the Register. It will appear in the 25-07 issue of the Register.

WSR 25-05-020
EMERGENCY RULES
DEPARTMENT OF

SOCIAL AND HEALTH SERVICES

(Developmental Disabilities Administration)

[Filed February 7, 2025, 3:16 p.m., effective February 7, 2025, 3:16 p.m.]

Effective Date of Rule: Immediately upon filing.

Purpose: The developmental disabilities administration (DDA) is enacting these changes on an emergency basis to implement changes to DDA's home and community-based services (HCBS) waivers as approved by the Centers for Medicare and Medicaid Services (CMS).

Citation of Rules Affected by this Order: Amending WAC 388-845-0113, 388-845-0210, 388-845-0215, 388-845-0220, 388-845-0225, 388-845-0230, 388-845-0820, 388-845-1150, 388-845-1870, 388-845-1880, 388-845-1890, 388-845-2005, 388-845-2205, and 388-845-2210.

Statutory Authority for Adoption: RCW 34.05.350.

Other Authority: RCW 71A.12.380(1); 42 C.F.R. 441.301.

Under RCW 34.05.350 the agency for good cause finds that state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.

Reasons for this Finding: Enacting these rules on an emergency basis is necessary in order to implement HCBS waivers as approved by CMS. Aligning rules with approved waiver amendments provides assurances required under 42 C.F.R. 441.301.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 14, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 14, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: February 7, 2025.

Katherine I. Vasquez
Rules Coordinator

SHS-5073.2

AMENDATORY SECTION (Amending WSR 23-18-035, filed 8/29/23, effective 9/29/23)

WAC 388-845-0113 When may I receive waiver services through teleservice? (1) Teleservice is a remote service delivery method that uses a HIPAA-compliant technology system approved by DDA.

(2) The following services may be delivered through teleservice:

- (a) Assistive technology;
- (b) Community engagement;

- (c) Individual supported employment;
- ~~((e))~~ (d) Individualized technical assistance;
- (e) Life skills;
- ~~((d))~~ (f) Music therapy;
- ~~((e))~~ (g) Occupational therapy;
- ~~((f))~~ (h) Peer mentoring;
- ~~((g))~~ (i) Person-centered plan facilitation;
- ~~((h))~~ (j) Physical therapy;
- ~~((i) Positive behavior support and consultation until August 31, 2023,)~~
- (k) Residential habilitation;
- ~~((j))~~ (l) Specialized evaluation and consultation;
- ~~((k) Specialized habilitation,)~~
- ~~((l))~~ (m) Speech, hearing, and language services;
- ~~((m) Supported employment;~~
- ~~(n) Supported parenting; and)~~
- (n) Stabilization - crisis diversion bed;
- (o) Stabilization - life skills;
- (p) Stabilization - staff and family consultation;
- ~~((o))~~ (q) Staff and family consultation((-)); and
- (r) Supported parenting.

(3) A waiver service may be delivered through teleservice if:

(a) The waiver participant chooses that service delivery method and acknowledges the teleservice agreement through signature on the person-centered service plan;

(b) DDA determines through the person-centered planning process that the waiver service can be adequately provided remotely based on the reason for the service request;

(c) There is no risk to the waiver participant's health or safety as a result of the waiver service being provided remotely; and

(d) The waiver participant's person-centered service plan indicates each waiver service that will be provided through teleservice.

(4) For each waiver service that occurs regularly over the course of the plan year and is being delivered remotely, the service must be delivered in-person at least one time per plan year.

AMENDATORY SECTION (Amending WSR 23-18-035, filed 8/29/23, effective 9/29/23)

WAC 388-845-0210 What services are available under the basic plus waiver? The following services are available under the basic plus waiver:

SERVICE	YEARLY LIMIT
AGGREGATE SERVICES:	Total costs must not exceed \$6,192 per year per participant
<u>Assistive technology</u>	
((Assistive technology)) Extermination of cimex lectularius (bedbugs)	
Community engagement	
Environmental adaptations	
<u>Life skills</u>	

SERVICE	YEARLY LIMIT
Occupational therapy Physical therapy Remote support Skilled nursing Specialized equipment and supplies ((Specialized habilitation)) Speech, hearing, and language services Staff and family consultation Transportation Wellness education	
Therapeutic adaptations	Limited to a single one-time authorization every five years and limited to funds available in the client's aggregate and emergency funding
EMPLOYMENT SERVICES: Individual technical assistance Supported employment Community inclusion	Limits determined by DDA assessment and employment status
	Limits determined by the person-centered service plan
STABILIZATION SERVICES: Crisis diversion bed ((Specialized habilitation)) <u>Life skills</u> Staff and family consultation	Limits determined by the person-centered service plan
Respite care	Limits determined by DDA assessment
Risk assessment	Limits determined by DDA
Community engagement Environmental adaptations Occupational therapy Physical therapy <u>Remote support</u> Specialized equipment and supplies Speech, hearing, and language services Skilled nursing Staff and family consultation Therapeutic adaptations Transportation	\$6,000 per year for emergency assistance funding

AMENDATORY SECTION (Amending WSR 23-18-035, filed 8/29/23, effective 9/29/23)

WAC 388-845-0215 What services are available under the core waiver? (1) The following services are available under the core waiver:

SERVICE	YEARLY LIMIT
Assistive technology Extermination of cimex lectularius (bedbugs) Community engagement Community transition Environmental adaptations <u>Life skills</u> Occupational therapy Physical therapy Remote support Residential habilitation Risk assessment Skilled nursing Specialized equipment and supplies ((Specialized habilitation)) Speech, hearing, and language services Staff and family consultation Supported parenting Transportation Wellness education	Determined by the person-centered service plan
EMPLOYMENT SERVICES: Individualized technical assistance Supported employment	Limits determined by DDA assessment and employment status
Community inclusion	Limits determined by the person-centered service plan
STABILIZATION SERVICES: Crisis diversion bed ((Specialized habilitation)) <u>Life skills</u> Staff and family consultation	Limits determined by the person-centered service plan
Respite care	Limits determined by DDA assessment

(2) A participant's core waiver services are subject to additional limits under this chapter.

(3) The total cost of a participant's core waiver services must not exceed the average cost of care at an intermediate care facility for individuals with intellectual disabilities (ICF/IID).

AMENDATORY SECTION (Amending WSR 23-18-035, filed 8/29/23, effective 9/29/23)

WAC 388-845-0220 What services are available under the community protection waiver? (1) The following services are available under the community protection waiver:

SERVICE	YEARLY LIMIT
Assistive technology Extermination of cimex lectularius (bedbugs) Community transition Environmental adaptations Occupational therapy Physical therapy ((Positive behavior support and consultation)) Residential habilitation Risk assessment Skilled nursing Specialized equipment and supplies Specialized evaluation and consultation Speech, hearing, and language services Staff and family consultation Transportation	Determined by the person-centered service plan
EMPLOYMENT SERVICES: Individual technical assistance Supported employment	Limits determined by DDA assessment and employment status
STABILIZATION SERVICES: Crisis diversion bed ((Specialized habilitation)) <u>Life skills</u> Staff and family consultation	Limits determined by the person-centered service plan

(2) A participant's community protection waiver services are subject to additional limits under this chapter.

(3) The total cost of a participant's community protection waiver services must not exceed the average cost of care at an intermediate care facility for individuals with intellectual disabilities (ICF/IID).

AMENDATORY SECTION (Amending WSR 23-18-035, filed 8/29/23, effective 9/29/23)

WAC 388-845-0225 What services are available under the children's intensive in-home behavioral support (CIIBS) waiver? (1) The following services are available under the children's intensive in-home behavioral support (CIIBS) waiver:

SERVICE	YEARLY LIMIT
Assistive technology Environmental adaptations <u>Life skills</u> Nurse delegation Specialized clothing Specialized equipment and supplies ((Specialized habilitation)) Staff and family consultation Transportation Vehicle modifications	\$15,000 per year for any combination of services
Respite care	Limits determined by the DDA assessment.
STABILIZATION SERVICES: Crisis diversion bed ((Specialized habilitation)) <u>Life skills</u> Staff and family consultation	Limits determined by the person-centered service plan
Risk assessment	Limits determined by DDA
Environmental adaptations (Accessibility and repairs) ((Specialized habilitation)) <u>Life skills</u> Staff and family consultation Vehicle modifications	\$6,000 per year for emergency assistance funding
Equine therapy Music therapy Peer mentoring Person-centered plan facilitation	\$5,000 per year for any combination of services
Therapeutic adaptations	Limited to a single, one-time authorization not to exceed \$15,000 every five waiver years

(2) A participant's CIIBS waiver services are subject to additional limits under this chapter.

AMENDATORY SECTION (Amending WSR 23-18-035, filed 8/29/23, effective 9/29/23)

WAC 388-845-0230 What services are available under the individual and family services (IFS) waiver? (1) The following services are available under the individual and family services (IFS) waiver:

SERVICE	YEARLY LIMIT
Assistive technology Community engagement Environmental adaptations <u>Life skills</u> Nurse delegation Occupational therapy Peer mentoring Person-centered plan facilitation Physical therapy Remote support Respite care Skilled nursing Specialized clothing Specialized equipment and supplies ((Specialized habilitation)) Speech, hearing, and language services Staff and family consultation Supported parenting services Transportation Vehicle modifications Wellness education	Total cost of waiver services must not exceed annual allocation determined by the person-centered service plan
Therapeutic adaptations	Limited to a one-time authorization every five years and limited to funds available in the client's annual allocation
Risk assessment	Limits determined by the person-centered service plan. Costs are excluded from the annual allocation.
STABILIZATION SERVICES: Crisis diversion bed ((Specialized habilitation)) <u>Life skills</u> Staff and family consultation	Limits determined by the person-centered service plan. Costs are excluded from the annual allocation.

(2) Your IFS waiver services annual allocation is based upon the DDA assessment under chapter 388-828 WAC. The DDA assessment deter-

mines your service level and annual allocation based on your assessed need. Annual allocations are as follows:

- (a) Level 1 = \$1,560;
- (b) Level 2 = \$2,340;
- (c) Level 3 = \$3,120; or
- (d) Level 4 = \$4,680.

AMENDATORY SECTION (Amending WSR 23-18-035, filed 8/29/23, effective 9/29/23)

WAC 388-845-0820 Are there limits to your use of emergency assistance funding? All of the following limits apply to the emergency assistance funding you may receive.

(1) Prior approval by the DDA regional administrator or designee is required based on a reassessment of your person-centered service plan to determine the need for emergency assistance.

(2) Payment authorizations are reviewed every 30 days and must not exceed \$6,000 per 12 months based on the effective date of your current person-centered service plan.

(3) Emergency assistance funding is limited to the following aggregate services when on the basic plus waiver:

- (a) Community engagement;
- (b) Environmental adaptations;
- (c) Occupational therapy;
- (d) Physical therapy;
- (e) Remote support;
- (f) Skilled nursing;
- (g) Specialized equipment and supplies;
- (h) Speech, hearing, and language services;
- (i) Staff and family consultation, which excludes individual and family counseling;
- (j) Transportation; and
- (k) Therapeutic adaptations.

(4) Emergency assistance funding is limited to the following services when on the CIIBS waiver:

- (a) Environmental adaptations;
- (b) (~~Specialized habilitation~~) Life skills;
- (c) Staff and family consultation; and
- (d) Vehicle modifications.

(5) Emergency assistance funding may be used for interim services until:

- (a) The emergency situation has been resolved;
- (b) You are transferred to alternative supports that meet your assessed needs; or
- (c) You are transferred to an alternate waiver that provides the service you need.

AMENDATORY SECTION (Amending WSR 21-19-108, filed 9/20/21, effective 10/21/21)

WAC 388-845-1150 What are stabilization services? (1) Stabilization services assist persons who are experiencing a crisis.

- (2) Stabilization services are available in the basic plus, core, children's intensive in-home behavior support (CIIBS), individual and family services (IFS), and community protection waivers.
- (3) A participant may be eligible for stabilization services if:
- (a) A behavioral health professional and DDA has determined the participant is at risk of institutionalization or hospitalization; and
 - (b) The participant needs short-term:
 - (i) ~~((Specialized habilitation))~~ Life skills;
 - (ii) Staff and family consultation; or
 - (iii) Crisis diversion beds.

AMENDATORY SECTION (Amending WSR 23-18-035, filed 8/29/23, effective 9/29/23)

- WAC 388-845-1870 What are ~~((specialized habilitation))~~ life skills services?** (1) ~~((Specialized habilitation))~~ Life skills services provide community-based and individualized support with the intent of reaching an identified habilitative goal in the person-centered service plan.
- (2) Service must assist a client to learn or maintain skills in categories of:
- (a) Self-empowerment;
 - (b) Safety awareness and self-advocacy;
 - (c) Interpersonal effectiveness and effective social communication;
 - (d) Coping strategies for everyday life changes; and
 - (e) Managing daily tasks and acquiring adaptive skills.
- (3) ~~((Specialized habilitation))~~ Life skills services must promote inclusion in the community.
- (4) ~~((Specialized habilitation))~~ Life skills services are available on the basic plus, IFS, core, and CIIBS waivers.
- (5) ~~((Specialized habilitation))~~ Life skills services, when authorized as a stabilization service, is available on all five HCBS waivers.

AMENDATORY SECTION (Amending WSR 23-18-035, filed 8/29/23, effective 9/29/23)

- WAC 388-845-1880 Who are qualified providers of ~~((specialized habilitation))~~ life skills services?** To provide ~~((specialized habilitation))~~ life skills services, a provider must be contracted with DDA for this service, have one year of experience working with people with a developmental or intellectual disability, and be one of the following:
- (1) A certified life skills coach;
 - (2) An individual with a bachelor's, master's, or doctoral degree in social work, sociology, psychology, education, child development, gerontology, nursing, or other related field; or
 - (3) An individual enrolled and supervised in a university internship program for social work, sociology, psychology, education, child development, gerontology, sociology, or nursing.

AMENDATORY SECTION (Amending WSR 23-18-035, filed 8/29/23, effective 9/29/23)

WAC 388-845-1890 Are there limits to the (~~specialized habilitation~~) life skills I may receive? The following limits apply to your receipt of (~~specialized habilitation~~) life skills:

(1) (~~Specialized habilitation~~) Life skills is limited to address a maximum of three goals at a time.

(2) (~~Specialized habilitation~~) Life skills support needs must be identified in your DDA assessment and (~~specialized habilitation~~) life skills must be documented in your person-centered service plan.

(3) (~~Specialized habilitation~~) Life skills must not exceed:

(a) \$6,192 within your total basic plus aggregate budget;

(b) Your IFS annual allocation in combination with other waiver services; or

(c) \$15,000 within your total CIIBS aggregate budget and \$6,000 emergency assistance funding when eligible per WAC 388-845-0800 and 388-845-0820.

(4) (~~Specialized habilitation~~) Life skills does not cover education, vocational, skills acquisition training through community first choice, behavioral health, ABA, skilled nursing, occupational therapy, physical therapy, or speech, language, and hearing services that are covered benefits through the medicaid state plan, including early and periodic screening, diagnosis, and treatment, and part B special education services.

(5) Life skills may be provided in a small group up to four if the clients have the same person-centered goal, and the group work addresses each client's current goal.

(6) (~~Specialized habilitation~~) Life skills must not be authorized for a client receiving residential habilitation, unless the client is receiving the service from a companion home provider.

(~~(6)~~) (7) Habilitation plans must be documented as formal plans as outlined in the provider's contract.

(~~(7) Specialized habilitation~~) (8) Life skills, not provided as a stabilization service, requires prior approval by the DDA regional administrator or designee.

AMENDATORY SECTION (Amending WSR 23-18-035, filed 8/29/23, effective 9/29/23)

WAC 388-845-2005 Who is a qualified provider of staff and family consultation? To provide staff and family consultation, a provider must be contracted with DDA and be one of the following licensed, registered, or certified professionals:

- (1) Audiologist;
- (2) Licensed practical nurse;
- (3) Marriage and family therapist;
- (4) Mental health counselor;
- (5) Occupational therapist;
- (6) Physical therapist;
- (7) Registered nurse;
- (8) Sex offender treatment provider;
- (9) Speech-language pathologist;
- (10) Social worker;
- (11) Psychologist;

- (12) Certified American Sign Language instructor;
- (13) Nutritionist;
- (14) Counselors registered or certified in accordance with chapter 18.19 RCW;
- (15) Certified dietician;
- (16) Recreation therapist registered in Washington and certified by the national council for therapeutic recreation;
- (17) Certified music therapist (for CIIBS only);
- (18) Psychiatrist;
- (19) Professional advocacy organization;
- (20) DDA-contracted (~~(specialized habilitation)~~) life skills provider; or
- (21) Teacher certified under chapter 181-79A WAC.

AMENDATORY SECTION (Amending WSR 23-18-035, filed 8/29/23, effective 9/29/23)

WAC 388-845-2205 Who is qualified to provide transportation services? The provider of transportation (~~(services can be an individual or agency)~~) must be an entity contracted with DDA (~~(whose contract includes)~~) to provide transportation (~~(in the statement of work)~~).

AMENDATORY SECTION (Amending WSR 23-18-035, filed 8/29/23, effective 9/29/23)

WAC 388-845-2210 Are there ~~((limitations))~~ limits to the transportation services you can receive? The following (~~(limitations)~~) limits apply to transportation services:

(1) Support needs for transportation services are limited to those identified in your DDA assessment and documented in your person-centered service plan.

(2) (~~(Transportation is limited to travel to and from a waiver service. When the waiver service is supported employment, transportation is limited to days when you receive employment support services.~~

~~(3) Transportation does not include the purchase of a bus pass.~~

~~(4))~~ Reimbursement for provider mileage requires prior authorization by DDA and is paid according to contract.

~~((5))~~ (3) This service does not cover the purchase or lease of vehicles.

~~((6))~~ (4) Reimbursement for provider travel time is (~~(not)~~) included (~~(in this service)~~) for nonmedical transportation from a transportation company only.

~~((7))~~ (5) Reimbursement to the provider is limited to transportation that occurs when you are with the provider.

~~((8))~~ (6) You are not eligible for transportation services if the cost and responsibility for transportation is already included in your provider's contract and payment.

~~((9))~~ (7) The dollar limitations for aggregate services in your basic plus waiver or the dollar amount of your annual allocation in the IFS waiver limit the amount of service you may receive.

WSR 25-05-027
EMERGENCY RULES
DEPARTMENT OF
FISH AND WILDLIFE

[Order 25-20—Filed February 10, 2025, 4:21 p.m., effective February 11, 2025]

Effective Date of Rule: February 11, 2025.

Purpose: The purpose of this rule making is to provide for treaty Indian fishing opportunity in the Columbia River while protecting salmon listed as threatened or endangered under the Endangered Species Act (ESA). This rule making implements federal court orders governing Washington's relationship with treaty Indian tribes and federal law governing Washington's relationship with Oregon.

Citation of Rules Affected by this Order: Repealing WAC 220-359-02000N; and amending WAC 220-359-020.

Statutory Authority for Adoption: RCW 77.04.012, 77.04.020, 77.04.130, 77.12.045, and 77.12.047.

Other Authority: *United States v. Oregon*, Civil No. 68-513-KI (D. Or.), Order Adopting 2018-2027 *United States v. Oregon* Management Agreement (February 26, 2018) (Doc. No. 2607-1). *Northwest Gillnetters Ass'n v. Sandison*, 95 Wn.2d 638, 628 P.2d 800 (1981); Washington fish and wildlife commission policies concerning Columbia River fisheries; 40 Stat. 515 (Columbia River compact).

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: This rule sets treaty commercial sales for nontreaty buyers in the 2025 Columbia River mainstem Zone 6 winter sturgeon setline fisheries above Bonneville Dam. This rule is consistent with actions of the Columbia River compact on January 8, January 16, January 30, and February 10, 2025. Conforms state rules with tribal rules. The general public welfare is protected with the immediate opening of nontreaty buyers purchasing fish from treaty fisheries. This harvest opportunity allows for the tribal use and public access to the resource as well as the maintenance of sustainable fish populations. There is insufficient time to adopt permanent regulations.

The Yakama, Warm Springs, Umatilla, and Nez Perce Indian tribes have treaty fishing rights in the Columbia River and inherent sovereign authority to regulate their fisheries. Washington and Oregon also have some authority to regulate fishing by treaty Indians in the Columbia River, authority that the states exercise jointly under the congressionally ratified Columbia River compact. *Sohappy v. Smith*, 302 F. Supp. 899 (D. Or. 1969). The tribes and the states adopt parallel regulations for treaty Indian fisheries under the supervision of the federal courts. A court order sets the current parameters. *United States v. Oregon*, Civil No. 68-513-KI (D. Or.), Order Adopting 2018-2027 *United States v. Oregon* Management Agreement (February 26, 2018) (Doc. No. 2607-1). Some salmon and steelhead stocks in the Columbia River are listed as threatened or endangered under ESA. On February 23, 2018, the National Marine Fisheries Service issued a biological opinion under 16 U.S.C. § 1536 that allows for some incidental take of these species in the fisheries as described in the 2018-2027 *U.S. v. Oregon* Management Agreement.

Columbia River fisheries are monitored very closely to ensure consistency with court orders and ESA guidelines. Because conditions change rapidly, the fisheries are managed almost exclusively by emergency rule. As required by court order, the Washington (WDFW) and Oregon (ODFW) departments of fish and wildlife convene public hearings and invite tribal participation when considering proposals for new emergency rules affecting treaty fishing rights. *Sohappy*, 302 F. Supp. at 912. WDFW and ODFW then adopt regulations reflecting agreements reached.

Number of Sections Adopted in Order to Comply with Federal Statute: New 1, Amended 0, Repealed 1; Federal Rules or Standards: New 1, Amended 0, Repealed 1; or Recently Enacted State Statutes: New 1, Amended 0, Repealed 1.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 1, Amended 0, Repealed 1.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: February 10, 2025.

Kelly Susewind
Director

NEW SECTION

WAC 220-359-02000P Columbia River salmon seasons above Bonneville Dam. Notwithstanding the provisions of WAC 220-359-010, WAC 220-359-020, WAC 220-359-030, and WAC 220-359-090, effective February 1 through March 21, 2025, it is unlawful for a person to take or possess salmon, steelhead, sturgeon, shad, carp, catfish, walleye, bass, or yellow perch taken for commercial purposes in Columbia River Salmon Management and Catch Reporting Areas (SMRCA) 1F, 1G, and 1H. However, those individuals possessing treaty fishing rights under the Yakima, Warm Springs, Umatilla, and Nez Perce treaties may fish for salmon, steelhead, sturgeon, shad, carp, catfish, walleye, bass, or yellow perch under the following provisions:

(1) Open Areas: SMCRA 1G (The Dalles Pool)

(a) Season: 6 AM Tuesday, February 11, 2025, until 6 PM Thursday, February 13, 2025.

(b) Gear: Setline gear only.

(c) Allowable sales: Sturgeon from 43 to 54 inches fork length caught in the The Dalles Pool, may be sold or kept for subsistence purposes.

(d) Standard river mouth and dam sanctuary closures remain in place for this gear.

(2) Open Areas: SMCRA 1H (John Day Pool)

(a) Season: Immediately, until 6 PM Saturday, February 15, 2025.

(b) Gear: Setline gear only.

(c) Allowable sales: Sturgeon from 43 to 54 inches fork length caught in John Day Pool, may be sold or kept for subsistence purposes.

(d) Standard river mouth and dam sanctuary closures remain in place for this gear.

(3) Open Areas: SMCRA 1F, 1G, 1H (Zone 6)

(a) Season: Immediately, until 6 PM Friday, March 21, 2025.

(b) Gear: Hoop nets/bag nets, dip nets, and rod and reel with hook and line.

(c) Allowable sales: Sturgeon from 38 to 54 inches fork length in the Bonneville Pool and from 43 to 54 inches fork length in The Dalles and John Day pools may be kept for subsistence purposes. Sturgeon within the legal-size limits and caught in the platform and hook and line fishery may only be sold if caught during the open period and open Pool of an open setline fishery. Fish landed during the open periods are allowed to be sold after the period concludes.

(d) Standard river mouth and dam sanctuary closures remain in place for this gear.

(4) 24-hour quick reporting is required for Washington wholesale dealers for all areas as provided in WAC 220-352-315, except that all landings from treaty fisheries described above must be reported within 24-hours of completing the fish ticket (not 24-hours after the period concludes).

(5) Fish caught during the open period may be sold after the period concludes.

REPEALER

The following section of the Washington Administration Code is repealed, effective February 11, 2025:

WAC 220-359-02000N Columbia River salmon seasons above
Bonneville Dam. (25-16)

WSR 25-05-028
EMERGENCY RULES
DEPARTMENT OF
FISH AND WILDLIFE

[Order 25-22—Filed February 10, 2025, 4:32 p.m., effective February 13, 2025]

Effective Date of Rule: February 13, 2025.

Purpose: This emergency rule will allow nontreaty commercial fishing opportunities in the Columbia River while protecting fish listed as threatened or endangered under the Endangered Species Act (ESA). This rule implements federal court orders governing Washington's relationship with treaty Indian tribes, federal law governing Washington's relationship with Oregon, and Washington fish and wildlife commission (commission) policy guidance for Columbia River fisheries.

Citation of Rules Affected by this Order: Amending WAC 220-358-030.

Statutory Authority for Adoption: RCW 77.04.012, 77.04.020, 77.12.045, and 77.12.047.

Other Authority: *United States v. Oregon*, Civil No. 68-513-KI (D. Or.), Order Adopting 2018-2027 *United States v. Oregon* Management Agreement (February 26, 2018) (Doc. No. 2607-1). *Northwest Gillnetters Ass'n v. Sandison*, 95 Wn.2d 638, 628 P.2d 800 (1981); Washington fish and wildlife commission policies concerning Columbia River fisheries; 40 Stat. 515 (Columbia River Compact).

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: Sets 2025 winter, spring, and summer select area commercial seasons. Impacts to nonlocal stocks are expected to be minimal and local Chinook stocks reared for the select area sites are available for harvest. Preseason modeling results in a select area commercial fisheries allocation of ≤392 upriver spring Chinook. The fishery is consistent with the *U.S. v. Oregon* Management Agreement and the associated biological opinion. Conforms Washington state rules with Oregon state rules. Regulation is consistent with compact action of February 10, 2025. The general public welfare is protected with the immediate opening of nontreaty select area fisheries. This harvest opportunity allows for public access to the resource as well as the maintenance of sustainable fish populations. There is insufficient time to promulgate permanent rules.

Washington and Oregon jointly regulate Columbia River fisheries under the congressionally ratified Columbia River Compact. Four Indian tribes have treaty fishing rights in the Columbia River. The treaties preempt state regulations that fail to allow the tribes an opportunity to take a fair share of the available fish, and the states must manage other fisheries accordingly. *Sohappy v. Smith*, 302 F. Supp. 899 (D. Or. 1969). A court order sets the current parameters. *United States v. Oregon*, Civil No. 68-513-KI (D. Or.), Order Adopting 2018-2027 *United States v. Oregon* Management Agreement (February 26, 2018) (Doc. No. 2607-1). Some salmon and steelhead stocks in the Columbia River are listed as threatened or endangered under ESA. On February 23, 2018, the National Marine Fisheries Service issued a biological opinion under 16 U.S.C. § 1536 that allows for some incidental take of these

species in the fisheries as described in the 2018-2027 *U.S. v. Oregon* Management Agreement.

Some Columbia River Basin salmon and steelhead stocks are listed as threatened or endangered under the ESA. The Washington and Oregon fish and wildlife commissions have developed policies to guide the implementation of such biological opinions in the states' regulation of nontreaty fisheries.

Columbia River nontreaty fisheries are monitored very closely to ensure compliance with federal court orders, ESA, and commission guidelines. Because conditions change rapidly, the fisheries are managed almost exclusively by emergency rule. Representatives from the Washington (WDFW) and Oregon (ODFW) departments of fish and wildlife convene public hearings and take public testimony when considering proposals for new emergency rules. WDFW and ODFW then adopt regulations reflecting agreements reached.

Number of Sections Adopted in Order to Comply with Federal Statute: New 1, Amended 0, Repealed 0; Federal Rules or Standards: New 1, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 1, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 1, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: February 10, 2025.

Kelly Susewind
Director

NEW SECTION

WAC 220-358-03000M Columbia River seasons below Bonneville.

Notwithstanding the provisions of WAC 220-358-030, WAC 220-358-040, and WAC 220-335-050, it is unlawful for a person to take or possess salmon, sturgeon, and shad for commercial purposes from Columbia River Salmon Management and Catch Reporting Areas 1A, 1B, 1C, 1D, 1E and Select Areas, except during the times and conditions listed below:

(1) Tongue Point and South Channel areas:

Open Dates	Open Days	Open Time	Open Duration
Feb 13 - Mar 14	Sun, Tue, Thu (nights)	7:00 pm - 7:00 am	13 nights
Apr 24 - May 2	Mon, Wed, Thu (nights)	7:00 pm - 7:00 am	4 nights
May 5 - Until further notice	Mon, Tue, Wed, Thu (nights)	7:00 pm - 7:00 am	24 nights

Tongue Point Area only:

Open Dates	Open Days	Open Time	Open Duration
Mar 16 - Mar 17	Sun (night)	9:00 pm - 1:00 am	4 hrs
Mar 18 - Mar 19	Tue (night)	9:30 pm - 1:30 am	4 hrs
Mar 20 - Mar 21	Thu (night)	11:00 pm - 3:00 am	4 hrs

April 22	Tue (morning)	2:30 am - 6:30 am	4 hrs
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South Channel Area only:

Open Dates	Open Days	Open Time	Open Duration
Mar 16 - Mar 21	Sun, Tue, Thu (nights)	7:00 pm - 7:00 am	3 nights
Mar 24 - April 15	Mon, Thu (nights)	7:00 pm - 7:00 am	7 nights
Apr 17 - Apr 18	Thu (night)	7:00 pm - 7:00 am	1 night
Apr 21 - Apr 22	Mon (night)	7:00 pm - 7:00 am	1 night

(a) Area definitions: Effective February 13, 2025, until further notice:

(i) Tongue Point: Waters of the Columbia River bounded by a line from the end of the southern-most pier (#1) at the Tongue Point Job Corps facility projecting in a straight line through flashing red USCG light "6" to the shore of Mott Island, a line from a regulatory marker at the southeast end of Mott Island northeasterly to a regulatory marker on the northwest shore of Lois Island, and a line from a regulatory marker located on the Oregon shore approximately 300 yards northwest of the railroad bridge crossing the John Day River projecting easterly to a regulatory marker on the southwest shore of Lois Island. If the marker on the Oregon shore is not in place, the upper boundary is defined by a line projecting easterly from a point (46°10'57.7"N latitude 123°44'35.3"W longitude) on the Oregon shore approximately 300 yards northwest of the railroad bridge crossing the John Day River to a regulatory marker on the southwest shore of Lois Island.

(ii) South Channel: Defined as waters of the Columbia River bounded by a line from a regulatory marker on the Oregon shore at John Day Point projecting northeasterly to a regulatory marker on the southwest shore of Lois Island, and a line from a regulatory marker on Settler Point projecting northwesterly to the flashing red USCG light "10" then projecting westerly to the eastern tip of Burnside Island.

(b) Gear: Gillnets:

(i) February 13 through April 15, 2025: 7-inch minimum mesh size.

(ii) April 17, 2025, until further notice: 9 3/4-inch maximum mesh size.

(iii) The maximum net length is 1,500 feet (250 fathoms).

(iv) In the Tongue Point Area, the lead line weight may not exceed two pounds per any one fathom.

(v) In the South Channel Area, there is no lead line weight limit and attachment of additional weight and anchors directly to the lead line is permitted.

(2) Blind Slough and Knappa Slough areas:

Open Dates	Open Days	Open Time	Open Duration
Feb 13 - Mar 21	Sun, Tue, Thu (nights)	7:00 pm - 7:00 am	16 nights
Mar 24 - April 15	Mon, Thu (nights)	7:00 pm - 7:00 am	7 nights
Apr 17 - Apr 25	Mon, Thu (nights)	7:00 pm - 7:00 am	3 nights
April 28 - May 2	Mon, Wed, Thu (nights)	7:00 pm - 7:00 am	3 nights
May 5 - Until further notice	Mon, Tue, Wed, Thu (nights)	7:00 pm - 7:00 am	24 nights

(a) Area definitions:

(i) The Blind Slough Select Area is defined as waters of Blind Slough and Gnat Creek from a north-south line represented by regulatory markers at the mouth of Blind Slough upstream to a regulatory mark-

er in Gnat Creek located approximately 0.5 miles southeasterly (upstream) of the Barendse Road Bridge.

(ii) The Knappa Slough Select Area is defined as waters of Knappa Slough, Calendar Slough, and Big Creek Slough bounded to the north (upstream) by a line projecting from a regulatory marker on the eastern shore of Karlson Island to the northernmost regulatory marker at the mouth of Blind Slough and bounded to the west (downstream) by a line projecting southerly from a regulatory marker on the southwestern tip of Karlson Island through regulatory markers on the western tips of Minaker Island to a marker on the Oregon shore.

The waters of Knappa Slough within a 100-foot radius of the railroad bridge crossing Big Creek are closed.

Through May 2 the downstream (western) boundary in Knappa Slough is a north-south line projecting through the easternmost tip of Minaker Island and regulatory markers on Karlson Island and the Oregon shore.

(b) Gear: Gillnets:

(i) February 13 through April 15, 2025: 7-inch minimum mesh size.

(ii) April 17, 2025, until further notice: 9 3/4-inch maximum mesh size.

(iii) The maximum net length is 600 feet (100 fathoms).

(iv) There is no lead line weight limit and attachment of additional weight or anchors directly to the lead line is permitted.

(c) Miscellaneous: Permanent transportation rules in effect.

(3) Deep River Select Area:

Open Dates	Open Days	Open Time	Open Duration
Feb 13 - Mar 21	Sun, Tue, Thu (nights)	7:00 pm - 9:00 am	16 nights
Mar 24 - Apr 15	Mon, Thu (nights)	7:00 pm - 9:00 am	7 nights
Apr 17 - Apr 25	Mon, Thu (nights)	7:00 pm - 9:00 am	3 nights
Apr 28 - May 2	Mon, Wed, Thu (nights)	7:00 pm - 9:00 am	3 nights
May 5 - Until further notice	Mon, Tue, Wed, Thu (nights)	7:00 pm - 9:00 am	24 nights

(a) Area definition: From the mouth of Deep River defined as a line from USCG navigation marker #16 southwest to a marker on the Washington shore, upstream to the Highway 4 Bridge.

(b) Gear: Gillnets:

(i) February 13 through April 15, 2025: 7-inch minimum mesh size.

(ii) April 17, 2025, until further notice: 9 3/4-inch maximum mesh size.

(iii) The maximum net length is 600 feet (100 fathoms).

(iv) There is no lead line weight limit and attachment of additional weight or anchors directly to the lead line is permitted.

(v) Nets may not fully cross navigation channel. It is unlawful to operate in any river, stream or channel any gill net longer than three-fourths the width of the stream (WAC 220-354-010). It shall be unlawful in any area to use, operate, or carry aboard a commercial fishing vessel a licensed net or combination of such nets, whether fished singly or separately, in excess of the maximum lawful size or length prescribed for a single net in that area, except as otherwise provided for in the rules and regulations of the department rule (WAC 220-353-060).

(c) Miscellaneous:

(i) Transportation or possession of fish outside the fishing area (except to the sampling station) is unlawful until WDFW staff has bio-

logically sampled individual catches. After sampling, fishers will be issued a transportation permit by WDFW staff.

(ii) February 15, 2025, until further notice: fishers are required to call 360-846-5268 to confirm the place and time of sampling.

(4) Allowable Sales: Salmon (except Chum) and shad.

(5) 24-hour quick reporting is in effect for Washington buyers (WAC 220-352-315). Permanent transportation rules in effect. Oregon buyers are required to submit fish receiving tickets electronically pursuant to OAR 635-006-0210.

(6) Multi-Net Rule: Nets not specifically authorized for use in these areas may be onboard a vessel if properly stored. A properly stored net is defined as a net on a drum that is fully covered by a tarp (canvas or plastic) and bound with a minimum of ten revolutions of rope with a diameter of 3/8 (0.375) inches or greater (WAC 220-358-030(2)).

(7) Lighted Buoys: Nets that are fished at any time between official sunset and official sunrise must have lighted buoys on both ends of the net unless the net is attached to the boat. If the net is attached to the boat, then one lighted buoy on the opposite end of the net from the boat is required.

WSR 25-05-030
EMERGENCY RULES
DEPARTMENT OF
FISH AND WILDLIFE

[Order 25-21—Filed February 10, 2025, 4:55 p.m., effective February 15, 2025]

Effective Date of Rule: February 15, 2025.

Purpose: This emergency rule opens one day of recreational white sturgeon retention from The Dalles Dam to John Day Dam on the Columbia River.

Citation of Rules Affected by this Order: Repealing WAC 220-312-06000D; and amending WAC 220-312-060.

Statutory Authority for Adoption: RCW 77.04.012, 77.04.020, 77.12.045, and 77.12.047.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: This rule opens recreational sturgeon retention day in The Dalles Pool and maintains the previously adopted Bonneville Pool recreational sturgeon retention closure. There are 134 fish remaining on the harvest guideline and projections indicate this fishery can support an additional day of retention. These populations are managed under sustainable harvest guidelines. This action is consistent with decisions made by the states of Washington and Oregon during the Columbia River compact hearing on February 10, 2025. There is insufficient time to adopt permanent rules.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 1, Amended 0, Repealed 1.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: February 10, 2025.

Kelly Susewind
Director

NEW SECTION

WAC 220-312-06000E Freshwater exceptions to statewide rules—Columbia River. Effective February 15 through April 30, 2025, the provisions of WAC 220-312-060, WAC 220-312-030, and WAC 220-316-010 regarding white sturgeon retention seasons from Bonneville Dam to John Day Dam are as follows. All other provisions of WAC 220-312-060, WAC

220-316-010, and WAC 220-312-030 not addressed herein remain in effect unless otherwise amended by emergency rule:

(1) From Bonneville Dam upstream to The Dalles Dam, including adjacent tributaries:

White sturgeon: Closed to retention. Catch and release fishing only.

(2) From The Dalles Dam upstream to John Day Dam, including adjacent tributaries:

(a) February 15, 2025: It is permissible to retain white sturgeon: Daily limit 1. Minimum fork length 43 inches. Maximum fork length 54 inches.

(b) February 16 through April 30, 2025: White sturgeon: Closed to retention. Catch and release fishing only.

REPEALER

The following section of Washington Administrative code is repealed, effective February 15, 2025:

WAC 220-312-06000D Freshwater exceptions to statewide rules—Columbia River. (25-01)

WSR 25-05-051

EMERGENCY RULES

BUILDING CODE COUNCIL

[Filed February 13, 2025, 11:53 a.m., effective February 13, 2025, 11:53 a.m.]

Effective Date of Rule: Immediately upon filing.

Purpose: Amending chapter 51-52 WAC, the adoption of the 2021 International Mechanical Code with Washington state amendments, to clarify requirements for A2L refrigerants. The changes coordinate the adopted code with the most recent ASHRAE 15, ASHRAE 15.2, ASHRAE 34, and UL 60335-2-40 standards. The majority of the changes are in chapter 11, with updates to the referenced standards in chapter 15 and coordinating changes to the definitions and the location of exhaust outlets.

Citation of Rules Affected by this Order: New WAC 51-52-1103, 51-52-1104, 51-52-1109, and 51-52-1110; and amending WAC 51-52-0202, 51-52-0501, 51-52-1101, 51-52-1105, 51-52-1106, 51-52-1107, and 51-52-1500.

Statutory Authority for Adoption: RCW 19.27.031 and 19.27.074.

Other Authority: Chapter 19.27 RCW.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: The changes proposed help coordinate with the hydrofluorocarbon rules adopted by the department of ecology that went into effect January 1, 2024, and provides clearer guidance on the use of A2L refrigerants. These changes will help ensure a safe and consistent application of the latest safety standards for A2L and other refrigerants that are now the only option available for some HVAC equipment. The rules will eliminate the need for owners, developers, architects, contractors, and other engineers from pursuing the more costly route of code compliance through the use of alternate means and methods to use the necessary standards for the safe use of these refrigerants. On January 24, 2025, the state building code council voted that an emergency basis exists, pursuant to RCW 19.27.032 (1)(c)(iii), based on the cost and complexity of meeting both the mechanical code requirements and the refrigeration standards for the refrigerants with lower global warming potential required by chapter 173-443 WAC.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 4, Amended 7, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 4, Amended 7, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 4, Amended 7, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: January 24, 2025.

Todd Beyreuther

RDS-6147.3

AMENDATORY SECTION (Amending WSR 23-02-055, 23-12-106, and 23-20-025, filed 1/3/23, 6/7/23, and 9/25/23, effective 3/15/24)

WAC 51-52-0202 Section 202—General definitions.

BALANCED WHOLE HOUSE VENTILATION. Any combination of concurrently operating residential dwelling or sleeping unit mechanical exhaust and mechanical supply whereby the total mechanical exhaust airflow rate is within 10 percent or 5 cfm, whichever is greater, of the total mechanical supply airflow rate.

NOT BALANCED WHOLE HOUSE VENTILATION. A whole house ventilation system serving a dwelling or sleeping unit that is not considered balanced in accordance with the definition in this code for *balanced whole house ventilation system*. Only other than Group R-2 dwelling and sleeping units are allowed in accordance with Section 403.4.4.1 to have *not balanced whole house ventilation systems*.

DISTRIBUTED WHOLE HOUSE VENTILATION. A whole house ventilation system shall be considered distributed when it supplies outdoor air directly (not transfer air) to each dwelling or sleeping unit habitable space, (living room, den, office, *interior adjacent room*, interior adjoining spaces or bedroom), and exhausts air from all kitchens and bathrooms directly outside.

NOT DISTRIBUTED WHOLE HOUSE VENTILATION. A whole house ventilation system shall be considered not distributed when either the supply system or the exhaust system is not distributed. Supply systems are not distributed when a habitable space is supplied with outdoor air to ventilate an *interior adjacent room* or an *interior adjoining space*. Exhaust systems are not distributed when all bathrooms and kitchens are not exhausted by the whole house ventilation system. If either the supply system or the exhaust system is not distributed, then the ventilation quality adjustment system coefficient adjustment is required in accordance with Section C403.4.3.

EFFECTIVE DISPERSAL VOLUME. The volume of a space or connected spaces in which leaked refrigerant will disperse.

EFFECTIVE DISPERSAL VOLUME CHARGE (EDVC). The maximum refrigerant charge permitted for an effective dispersal volume.

ENCLOSED KITCHEN. A kitchen whose permanent openings to interior adjacent spaces do not exceed a total of 60 square feet (6 m²).

INTERIOR ADJACENT ROOM. An enclosed room without exterior windows or openings to the outdoors located within a dwelling or sleeping unit that does not have interior unobstructed openings required for an *interior adjoining space*.

INTERIOR ADJOINING SPACE. A room or space without openings to the outdoors that is naturally ventilated from another habitable space by unobstructed fixed openings size in accordance with Section 402.3.

LOCAL EXHAUST. An exhaust system that uses one or more fans to exhaust air from a specific room or rooms within a residential dwelling or sleeping unit.

MACHINERY ROOM. A designated space meeting the requirements of Sections 1105 and 1106 that contains one or more refrigerating systems or portions thereof.

PERMANENT CONSTRUCTION. Construction that, if removed, would disturb the structural integrity of the building or the fire-resistance rating of a building assembly.

RELIEF AIR. Exhausted return air from a system that provides ventilation for human usage.

REPLACEMENT AIR. Outdoor air that is used to replace air removed from a building through an exhaust system. Replacement air may be derived from one or more of the following: Makeup air, supply air, transfer air, and infiltration. However, the ultimate source of all replacement air is outdoor air. When replacement air exceeds exhaust, the result is exfiltration.

WHOLE HOUSE VENTILATION SYSTEM. A mechanical ventilation system, including fans, controls, and ducts, which replaces, by direct means, air from the habitable rooms with *outdoor air*.

VENTILATION ZONE. Any indoor area that requires ventilation and comprises one or more spaces with the same occupancy category (see Table 403.3.1.1), occupant density, zone air distribution effectiveness (see Section 403.3.1.1.1.2), and design zone primary airflow per unit area.

AMENDATORY SECTION (Amending WSR 23-23-105, filed 11/15/23, effective 3/16/24)

WAC 51-52-0501 Section 501—General.

501.3.1 Location of exhaust outlets. The termination point of exhaust outlets and ducts discharging to the outdoors shall be located with the following minimum distances:

1. **For ducts conveying explosive or flammable vapors, fumes or dusts:** 30 feet (9144 mm) from the property line; 10 feet (3048 mm) from operable openings into the building; 6 feet (1829 mm) from exterior walls and roofs; 30 feet (9144 mm) from combustible walls and operable openings into the building which are in the direction of the exhaust discharge; 10 feet (3048 mm) above adjoining grade.

2. **For other product-conveying outlets:** 10 feet (3048 mm) from property lines; 3 feet (914 mm) from exterior walls and roofs; 10 feet (3048 mm) from operable openings into the building; 10 feet (3048 mm) above adjoining grade.

3. **For environmental air exhaust other than enclosed parking garage and transformer vault exhaust:** 3 feet (914 mm) from property lines, 3 feet (914 mm) from operable openings into buildings for all occupancies other than Group U, and 10 feet (3048 mm) from mechanical air intakes. Such exhaust shall not be considered hazardous or noxious. Separation is not required between intake air openings and living space *exhaust air* openings of an individual *dwelling unit* or *sleeping unit* where an approved factory-built intake/exhaust combination termi-

nation fitting is used to separate the air streams in accordance with the manufacturer's instructions.

EXCEPTIONS:

1. The separation between an air intake and exhaust outlet on a single listed package HVAC unit.
2. Exhaust from environmental air systems other than garages may be discharged into an open parking garage.
3. Except for Group I occupancies, where ventilation system design circumstances require building HVAC air to be relieved, such as during economizer operation, such air may be relieved into an open or enclosed parking garage within the same building.

4. Exhaust outlets serving structures in flood hazard areas shall be installed at or above the elevation required by Section 1612 of the *International Building Code* for utilities and attendant equipment.

5. For enclosed parking garage exhaust system outlets and transformer vault exhaust system outlets: 10 feet (3048 mm) from property lines which separate one lot from another; 10 feet (3048 mm) from operable openings into buildings; 3 feet (914 mm) horizontally from, 10 feet above, or 10 feet below adjoining finished walkways.

6. For transformer vault exhaust system outlets, subject to the requirements of NFPA 70 Section 450.45: Ten feet (3048 mm) from fire escapes, required means of egress at the exterior of the building, elements of exit discharge, exterior combustible materials, and openings that are not protected in accordance with Section 705.8 of the *International Building Code*; 10 feet (3048 mm) from property lines which separate one lot from another; 10 feet (3048 mm) from operable openings into buildings; 10 feet (3048 mm) above walkways.

7. For elevator machinery rooms in enclosed or open parking garages: Exhaust outlets may discharge air directly into the parking garage.

8. For specific systems see the following sections:

8.1. Clothes dryer exhaust, Section 504.4.

8.2. Kitchen hoods and other kitchen exhaust equipment, Sections 506.3.13, 506.4 and 506.5.

8.3. Dust stock and refuse conveying systems, Section 511.2.

8.4. Subslab soil exhaust systems, Section 512.4.

8.5. Smoke control systems, Section 513.10.3.

8.6. Refrigerant discharge for relief devices, Section 1105.7.

8.7. Machinery room discharge, Section 1105.6.1.

8.8. Natural ventilation and mechanical exhaust discharge for A2L and B2L refrigerant piping shafts, Sections 1105.7 and 1109.3.2.

8.9. Mechanical exhaust discharge for A2, B2, A3, and B3 refrigerant piping shafts, Sections 1105.7 and 1109.3.2.

501.4 Pressure equalization. Mechanical exhaust systems shall be sized to remove the quantity of air required by this chapter to be exhausted. The system shall operate when air is required to be exhausted. Where mechanical exhaust is required in a room or space, such space shall be maintained with a neutral or negative pressure. If a greater quantity of air is supplied by a mechanical ventilating supply system than is removed by a mechanical exhaust for a room, adequate means shall be provided for the natural or mechanical exhaust of the excess air supplied. If only a mechanical exhaust system is installed for a room or if a greater quantity of air is removed by a mechanical exhaust system than is supplied by a mechanical ventilating supply system for a room, adequate makeup air consisting of supply air, transfer air or outdoor air shall be provided to satisfy the deficiency. The calculated building infiltration rate shall not be used to satisfy the requirements of this section.

EXCEPTION:

Intermittent kitchen exhaust, intermittent domestic dryer exhaust, and intermittent local exhaust systems in R-3 occupancies and dwelling units in R-2 occupancies are excluded from the pressure equalization requirement unless required by Section 504 or Section 505.

AMENDATORY SECTION (Amending WSR 23-02-055, 23-12-106, and 23-20-025, filed 1/3/23, 6/7/23, and 9/25/23, effective 3/15/24)

WAC 51-52-1101 ((Reserved.)) General.

1101.1.1 Refrigerants other than ammonia. Refrigeration systems using a refrigerant other than ammonia shall comply with this chapter, the *International Fire Code*, and either ASHRAE 15 or ASHRAE 15.2, as applicable. Refrigeration systems containing carbon dioxide as the refrigerant shall also comply with IIAR CO2 or be part of *listed and labeled equipment*.

NEW SECTION

WAC 51-52-1103 Section 1103—Refrigeration system classification.

1103.1 Refrigerant classification. Refrigerants shall be classified in accordance with ASHRAE 34 as listed in Table 1103.1. Refrigerants without a refrigerant number designation or without a safety group classification in the referenced edition of ASHRAE 34 shall be classified in accordance with the criteria in ASHRAE 34 as a single-compound refrigerant blend of two or more compounds. Such safety classifications not assigned by ASHRAE 34 shall be submitted for approval to the *code official*. Compliance with the requirements of this code is contingent upon use of *approved* safety classifications where not assigned by the referenced edition of ASHRAE 34.

NEW SECTION

WAC 51-52-1104 Section 1104—Refrigeration system application requirements.

1104.2 Machinery room. Except as provided in Sections 1104.2.1 and 1104.2.2, all components containing the refrigerant shall be located either outdoors or in a *machinery room* where the quantity of refrigerant in an independent circuit of a *refrigeration* system exceeds both of the following:

1. The amounts shown in Table 1103.1; and
2. The effective *dispersal volume charge* as calculated in accordance with ASHRAE 15.

For refrigerant blends not listed in Table 1103.1, the same requirement shall apply for that component. These requirements shall also apply where the combined amount of the blend components exceeds a limit of 69,100 parts per million (ppm) by volume. *Machinery rooms* required by this section and containing only Group A1 or B1 refrigerants shall be constructed and maintained in accordance with Section 1105. *Machinery rooms* required by this section and containing any Group A2, B2, A3, or B3 flammable refrigerants shall be constructed and maintained in accordance with Sections 1105 and 1106. *Machinery rooms* required by this section and containing any Group A2L or B2L flammable refrigerants and containing no Group A2, B2, A3, or B3 flammable refrigerants shall be constructed and maintained in accordance with Section 1105 and Sections 1106.4.1 through 1106.4.3.

- Exceptions:**
1. *Machinery rooms* are not required for *listed equipment* and *appliances* containing not more than 6.6 pounds (3 kg) of refrigerant, regardless of the refrigerant's safety classification, where installed in accordance with the *equipment's* or *appliance's* listing and the *equipment* or *appliance* manufacturer's installation instructions.
 2. Piping in compliance with Section 1107 is allowed in other locations to connect components installed in a *machinery room* with those installed outdoors.

1104.3.1 High-probability air conditioners, heat pumps, and dehumidifiers. High-probability air conditioners, heat pumps, and dehumidifiers shall use Group A1 or A2L refrigerant.

- Exceptions:**
1. Equipment *listed* for and used in residential *occupancies* containing a maximum of 6.6 pounds (3 kg) of refrigerant.
 2. Equipment *listed* for and used in commercial *occupancies* containing a maximum of 22 pounds (10 kg) of refrigerant.
 3. Industrial *occupancies*.

1104.3.2 Group A2, A3, B2, and B3 refrigerants. Group A2 and B2 refrigerants shall not be used in high-probability systems. Group A3 and B3 refrigerants shall not be used except where *approved*.

- Exceptions:**
1. Laboratories where the floor area per occupant is not less than 100 square feet (9.3 m²).
 2. *Listed* self-contained systems having a maximum of 0.331 pounds (150 g) of Group A3 refrigerant.
 3. Industrial *occupancies*.
 4. Equipment *listed* for and used in residential *occupancies* containing a maximum of 6.6 pounds (3 kg) of Group A2 or B2 refrigerant.
 5. Equipment *listed* for and used in commercial *occupancies* containing a maximum of 22 pounds (10 kg) of Group A2 or B2 refrigerant.
 6. Self-contained equipment using Groups A3 and B3 refrigerants that are *listed* to UL 60335-2-89 and installed in accordance with the listing, the manufacturer's installation instructions, and ASHRAE 15.
 7. Self-contained equipment using Groups A3 and B3 refrigerants that are *listed* to UL 60335-2-40 and installed in accordance with the listing, the manufacturer's installation instructions, and ASHRAE 15.

TABLE 1104.3.2

MAXIMUM PERMISSIBLE QUANTITIES OF REFRIGERANTS

This table is not adopted.

1104.3.5 Corridors and lobbies. Refrigerating systems in a public corridor or lobby shall comply with ASHRAE 15 Section 7.5.1.2.

AMENDATORY SECTION (Amending WSR 23-02-055, 23-12-106, and 23-20-025, filed 1/3/23, 6/7/23, and 9/25/23, effective 3/15/24)

WAC 51-52-1105 ((Reserved.)) Section 1105—Machinery room, general requirements.

1105.7 Termination of relief devices and refrigerant piping shaft ventilation discharge air outlets. Pressure relief devices, fusible plugs, and purge systems located within the machinery room and refrigerant piping shaft natural and mechanical ventilation discharge air shall terminate outside of the building and comply with all of the following:

1. The point of vent discharge shall be at a location not less than 15 feet (4572 mm) above the adjoining grade level.
2. The point of vent discharge shall be not less than 20 feet (6096 mm) from any window, ventilation opening or exit.
3. For heavier-than-air refrigerants, the point of vent discharge shall be located not less than 20 feet (6096 mm) horizontally from below-grade walkways, entrances, pits, or ramps if a release of the entire system charge into such a space would yield a concentration of refrigerant in excess of the refrigerant concentration limit (RLC). The direct discharge of a relief vent into enclosed outdoor spaces, such as a courtyard with walls on all sides, shall not be permitted if a release of the entire system charge into such a space would yield a concentration of refrigerant in excess of the RLC. The volume for the refrigerant concentration calculation shall be determined using the

gross area of the space and a height of 8.2 feet (2500 mm), regardless of the actual height of the enclosed space.

4. The termination point of a vent discharge line shall be made in a manner that prevents discharged refrigerant from spraying directly onto personnel that might be in the vicinity.

5. The termination point of vent discharge lines shall be made in a manner that prevents foreign material or debris from entering the discharge outlet.

6. Relief vent lines that terminate vertically upward and are subject to moisture entry shall be provided with a drip pocket having a minimum of 24 inches (610 mm) in length and having the size of the vent discharge pipe. The drip pocket shall be installed to extend below the first change in vent pipe direction and shall be fitted with a valve or drain plug to permit removal of accumulated moisture.

AMENDATORY SECTION (Amending WSR 23-23-105, filed 11/15/23, effective 3/16/24)

WAC 51-52-1106 Section 1106—Machinery room, special requirements.

1106.3 Class 2 and 3 refrigerants. Where any flammable refrigerants of Groups A2, A3, B2, and B3 are used, the machinery room shall conform to the Class I, Division 2, hazardous location classification requirements of NFPA 70.

1106.4 Group A2L and B2L refrigerants. Machinery rooms containing any Group A2L or B2L refrigerants and containing no refrigerants of Group A2, A3, B2 or B3 shall comply with Sections 1106.4.1 through 1106.4.3.

1106.4.1 Elevated temperatures. Open flame-producing devices or continuously operating hot surfaces over 1290°F (700°C) shall not be permanently installed in the room.

1106.4.2 ((Emergency ventilation system. An emergency ventilation system shall be provided at the minimum exhaust rate specified in ASHRAE 15 or Table 1106.4.2. Shutdown of the emergency ventilation system shall be by manual means.)) **Refrigerant detector.** In addition to the requirements of Section 1105.3, refrigerant detectors shall signal an alarm and activate the ventilation system in accordance with the response time specified in Table 1106.4.2.

Table 1106.4.2
((MINIMUM EXHAUST RATES

Refrigerant	Q(m/sec)	Q(cfm)
R32	15.4	32,600
R143A	13.6	28,700
R444A	6.46	13,700
R444B	10.6	22,400
R445A	7.83	16,600
R446A	23.9	50,700
R447A	23.8	50,400
R451A	7.04	15,000
R451B	7.05	15,000
R1234yf	7.80	16,600

Refrigerant	Q(m/sec)	Q(efm)
R1234ze(E)	5.92	(2,600)

GROUP A2L AND B2L DETECTOR ACTIVATION

ACTIVATION LEVEL	MAXIMUM RESPONSE TIME (seconds)	ASHRAE 15 VENTILATION (seconds)	ALARM RESET	ALARM TYPE
Less than or equal to the OEL in Table 1103.1	300	1	Automatic	Trouble
Less than or equal to the refrigerant concentration level in Table 1103.1	15	2	Manual	Emergency

1106.4.3 Mechanical ventilation. The machinery room shall have a mechanical ventilation system complying with ASHRAE 15.

AMENDATORY SECTION (Amending WSR 20-03-041, filed 1/8/20, effective 7/1/20)

WAC 51-52-1107 Section 1107—((Reserved)) Piping material.

1107.4 Piping materials standards. Refrigerant pipe shall conform to one or more of the standards listed in Table 1107.4. For refrigeration systems complying with ASHRAE 15.2 used in residential occupancies serving only a single dwelling unit or sleeping unit, refrigerant piping and tubing shall be limited to aluminum, copper, and copper alloy. The exterior of the pipe shall be protected from corrosion and degradation.

1107.5 Pipe fittings. Refrigerant pipe fittings shall be approved for installation with the piping materials to be installed, and shall conform to one or more of the standards listed in Table 1107.5 or shall be listed and labeled as complying with UL 207. For refrigeration systems complying with ASHRAE 15.2 used in residential occupancies serving only a single dwelling unit or sleeping unit, refrigerant fittings shall be limited to aluminum, copper, copper alloys, stainless steel, and steel.

NEW SECTION

WAC 51-52-1109 Section 1109—Refrigerant pipe installation.

1109.2.2 Refrigerant pipe enclosure. Refrigerant piping shall be protected by locating it within the *building* elements or within protective enclosures.

- Exception:**
- Piping protection within the *building* elements or protective enclosure shall not be required in any of the following locations:
 1. Where installed without *ready access* or located more than 7 feet 3 inches (2210 mm) above the finished floor.
 2. Where located within 6 feet (1829 mm) of the refrigerant unit or *appliance*.
 3. Where located in a *machinery room* complying with Section 1105.
 4. Outside the *building*:
 - 4.1. Where protected from damage from the weather including, but not limited to, hail, ice, and snow loads.
 - 4.2. Where protected from damage within the expected foot or traffic path.
 - 4.3. Where installed underground not less than 8 inches (200 mm) below finished grade and protected against corrosion.

1109.2.5 Refrigerant pipe shafts. Refrigerant piping that penetrates two or more floor/ceiling assemblies shall be enclosed in a fire-resistance-rated shaft enclosure. The fire-resistance-rated shaft enclosure shall comply with Section 713 of the *International Building Code*.

Refrigerant pipe shafts that are naturally or mechanically ventilated shall be constructed as exterior building envelope walls with thermal insulation and air barrier construction required by the *Washington State Energy Code*.

Exceptions:

1. Refrigeration systems using R-718 refrigerant (water).
2. Piping in a direct refrigeration system where the refrigerant quantity does not exceed the limits of Table 1103.1 for the smallest occupied space through which the piping passes.
3. Piping located on the exterior of the *building* where vented to the outdoors. Natural ventilation openings shall be distributed vertically along the enclosure to prevent containment of refrigerant piping leaks and be located a minimum of 3 feet (914 mm) from operable openings into the building. Mechanical ventilation of exterior enclosures to comply with Section 1109.3.2.

1109.2.7 Pipe identification. Refrigerant pipe located in areas other than the room or space where the refrigerating *equipment* is located shall be identified. The pipe identification shall be located at intervals not exceeding 20 feet (6096 mm) on the refrigerant piping or pipe insulation. The minimum height of lettering of the identification label shall be 1/2 inch (12.7 mm). The identification shall indicate the *refrigerant designation* and safety group classification of the refrigerant used in the piping system. For Group A2L and B2L refrigerants, the identification shall also include the following statement: "WARNING-Risk of Fire. Flammable Refrigerant." For Group A2, A3, B2 and B3 refrigerants, the identification shall also include the following statement: "DANGER-Risk of Fire or Explosion. Flammable Refrigerant." For any Group B refrigerant, the identification shall also include the following statement: "DANGER-Toxic Refrigerant."

Exception:

For refrigeration systems complying with ASHRAE 15.2 used in residential occupancies serving only a single *dwelling unit* or *sleeping unit*, pipe identification shall not be required.

1109.3.2 Shaft ventilation. Refrigerant pipe shafts with systems using Group A2L or B2L refrigerant shall be naturally or mechanically ventilated. The shaft natural ventilation discharge outlet and mechanical ventilation discharge exhaust outlet shall comply with Sections 501.3.1 and 1105.7. Naturally ventilated shafts shall have a pipe, duct or conduit not less than 4 inches (102 mm) in diameter that connects to the lowest point of the shaft and extends to the outdoors. The pipe, duct or conduit shall be level or pitched downward to the outdoors. A *makeup air* opening shall be provided at the top of the shaft. Mechanically ventilated shafts shall have a minimum airflow velocity in accordance with Table 1109.3.2. The mechanical ventilation shall be continuously operated or activated by a refrigerant detector. *Makeup air* shall be provided at the inlet to the shaft for mechanically ventilated shafts. Systems utilizing a refrigerant detector shall activate the mechanical ventilation at a maximum refrigerant concentration of 25 percent of the lower flammable limit of the refrigerant. The detector, or a sampling tube that draws air to the detector, shall be located in an area where refrigerant from a leak will concentrate.

Exceptions:

1. The shaft shall not be required to be ventilated for double-wall refrigerant pipe where the interstitial space of the double-wall pipe is vented to the outdoors.
2. For refrigeration systems complying with ASHRAE 15.2 used in residential occupancies serving only a single *dwelling unit* or *sleeping unit*, shaft ventilation shall not be required where the pipe or tube is continuous without fittings in the shaft.

1109.4.2 Shaft ventilation. Refrigerant pipe shafts with one or more systems using any Group A2, A3, B2 or B3 refrigerant shall be continuously mechanically ventilated and shall include a refrigerant detector. The shaft ventilation exhaust outlet shall comply with Sections 501.3.1 and 1105.7. Mechanically ventilated shafts shall have a minimum airflow velocity as specified in Table 1109.3.2. *Makeup air* shall be provided at the inlet to the shaft for mechanically ventilated shafts. The shaft shall not be required to be ventilated for double-

wall refrigerant pipe where the interstitial space of the double-wall pipe is vented to the outdoors.

NEW SECTION

WAC 51-52-1110 Section 1110—Refrigerant piping system test.

1110.2 Exposure of refrigerant piping system. Refrigerant pipe and joints installed in the field shall be exposed for visual inspection and testing prior to being covered or enclosed.

Exception: Factory-insulated refrigerant piping line-sets are exempt from exposing the piping material for visual inspection.

AMENDATORY SECTION (Amending WSR 23-02-055, 23-12-106, and 23-20-025, filed 1/3/23, 6/7/23, and 9/25/23, effective 3/15/24)

WAC 51-52-1500 Chapter 15—Referenced standards. The following referenced standards are amended or added to Chapter 15.

AHAM

Association of Home Appliance Manufacturers
1111 19th St. N.W., #402
Washington D.C. 20036

AHAM-Certified Range Hood
Directory. 403.4.7.3.1
HRH-2 Household Range Hoods 403.4.7.3.1

ANCE

UL/CSA/ANCE 60335-2-40—((2019)) 2022 Household and Similar Electrical Appliances - Safety - Part 2-40: Particular Requirements for Electrical Heat Pumps, Air Conditioners and Dehumidifiers 1101.2

ASHRAE

15-2022 Safety Standard for Refrigeration Systems. 1101.6, 1104.3.5, 1105.8, 1106.4.2, 1108.1

15.2-2022 Safety Standard for Refrigeration Systems in Residential Applications. 1101.1.1, 1107.4, 1107.5, 1109.2.7, 1109.3.2

34-2022 Designation and Safety Classification of Refrigerants. 202, 1102.2.1, 1103.1

62.2-2019 Ventilation and Acceptable Indoor Air Quality in Low-Rise Residential Buildings. 401.4, 403.4, 403.4.7.3.3, 403.4.11

ASTM

E3087—18: Standard Test Method for Measuring Capture Efficiency of Domestic Range Hoods. 403.4.7.3.2, Table 403.4.7.3.2

CSA

UL/CSA/ANCE 60335-2-40—((2019)) 2022 Household and Similar Electrical Appliances - Safety - Part 2-40: Particular Requirements for Electrical Heat Pumps, Air Conditioners and

Dehumidifiers. 1101.2

HVI address:

Home Ventilating Institute
1740 Dell Range Blvd., Suite H, PMB 450
Cheyenne, WY 82009

HVI Publication 911 Certified Home Ventilating Product

Directory. 403.4.7.3.4

HVI 915-2020 Procedure for Loudness Testing of Residential Fan Products. 403.4.6.1, 403.4.6.2, 403.4.7.2

HVI 916-2020 Air Flow Test Procedure. 403.4.6.1, 403.4.6.2, 403.4.7.2

HVI 920-2020 Product Performance Certification Procedure Including Verification and Challenge. 403.4.6.1, 403.4.6.2, 403.4.7.2

NFPA

110-22 Standard for Emergency and Standby Power Systems. 915.3, 915.3.1, 915.3.2

111-22 Standard on Stored Electrical Energy Emergency and Standby Power Systems. 915.3, 915.4

UL

864-2014 Control Units and Accessories for Fire Alarm Systems with revisions through October 2018. 606.2.2

UL/CSA/ANCE ((60335-2-40-2019)) 60335-2-40-2022 Household and Similar Electrical Appliances - Safety - Part 2-40: Particular Requirements for Electrical Heat Pumps, Air Conditioners and Dehumidifiers. 1101.2

WSR 25-05-052
EMERGENCY RULES
DEPARTMENT OF
FISH AND WILDLIFE

[Order 25-23—Filed February 13, 2025, 1:04 p.m., effective March 16, 2025]

Effective Date of Rule: Thirty-one days after filing.

Purpose: This emergency rule sets March and April recreational salmon seasons in Marine Areas 5, 10, and 11.

Citation of Rules Affected by this Order: Amending WAC 220-313-060.

Statutory Authority for Adoption: RCW 77.04.012, 77.04.020, 77.12.045, and 77.12.047.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: Marine Area 10 preseason guidelines are 4,787 total encounters, 735 total unmarked encounters, and 4,055 total sublegal encounters. Marine Area 11 preseason guidelines are 1,196 total encounters, 209 total unmarked encounters, and 840 total sublegal encounters. Marine Area 5 sublegal encounter guideline is 2,168.

The Washington department of fish and wildlife fishery managers have considered these preseason guidelines along with recommendations from Puget Sound recreational anglers and the Puget Sound sport fishing advisory group in an effort to extend available quota late into the winter season.

This rule is needed to avoid early season closures and is intended to extend the available winter salmon quota later into the season.

There is insufficient time to adopt permanent rules.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 1, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: February 13, 2025.

Kelly Susewind
Director

NEW SECTION

WAC 220-313-06000J Puget Sound salmon—Saltwater seasons and daily limits. Effective March 16 through April 30, 2025, salmon rules for Catch Record Card areas 5, 10 and 11 shall be modified as descri-

bed in this section. All other provisions of WAC 220-313-060 not addressed in this section, or unless otherwise amended by emergency rule, remain in effect:

(1) Catch Record Card Area 5: Salmon;

(a) March 16 through April 13, 2025: Closed.

(b) April 14 through April 30: Daily limit 1. Release all salmon other than hatchery Chinook.

(2) Catch Record Card Area 10, except Agate Pass (waters west of a line from Point Monroe to Indianola and east of a line from Point Bolin to Battle Point), and year-round piers (Seacrest Pier, Waterman Pier, Bremerton Boardwalk, and Illahee State Park Pier): Salmon;

(a) March 16 through April 1, 2025: Closed.

(b) April 2 through April 30: Open Wednesday through Saturday only, each week; daily limit 2 including no more than 1 hatchery Chinook. Release wild Chinook and chum. Closed Sunday through Tuesday, each week.

(3) Catch Record Card Area 11, except year-round piers (Des Moines Pier, Les Davis Pier, and Point Defiance Boathouse Dock):

(a) March 16 through April 1, 2025: Closed.

(b) April 2 through April 30:

(i) Open Wednesday through Saturday only, each week; daily limit 2 including no more than 1 hatchery Chinook. Release wild Chinook and chum. Closed Sunday through Tuesday, each week.

(ii) Commencement Bay (east of a line from Cliff House Restaurant to Sperry Ocean Dock): Closed to fishing for or retention of salmon.

WSR 25-05-063

EMERGENCY RULES

HEALTH CARE AUTHORITY

[Filed February 14, 2025, 8:30 a.m., effective February 14, 2025, 8:30 a.m.]

Effective Date of Rule: Immediately upon filing.

Purpose: The health care authority (agency) is providing continuous eligibility for children ages zero to six covered through the apple health children's health insurance program.

Citation of Rules Affected by this Order: Amending WAC 182-504-0015, 182-504-0035, and 182-505-0210.

Statutory Authority for Adoption: RCW 41.05.021 and 41.05.160.

Other Authority: Section 211(87), chapter 376, Laws of 2024.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: The legislature directed the agency to pursue a 1115 medicaid waiver to provide continuous eligibility for children ages zero to six covered through the Washington apple health children's health insurance program (section 211(87), chapter 376, Laws of 2024 (ESSB 5950)). The agency received federal government waiver approval, effective January 8, 2025, to provide continuous eligibility. This emergency filing is necessary to ensure eligible children ages zero to six do not lose their coverage. The agency began the permanent rule-making process by filing WSR 25-05-048 on February 13, 2025.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 3, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 3, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 3, Repealed 0.

Date Adopted: February 14, 2025.

Wendy Barcus
Rules Coordinator

RDS-6180.1

AMENDATORY SECTION (Amending WSR 24-20-052, filed 9/25/24, effective 10/26/24)

WAC 182-504-0015 Washington apple health—Certification periods for categorically needy programs. (1) A certification period is the

period of time we determine that you are eligible for a categorically needy (CN) Washington apple health program. Unless otherwise stated in this section, the certification period begins on the first day of the month of application and continues through the end of the last month of the certification period.

(2) Newborn coverage begins on the child's date of birth and continues through the end of the month of the child's first birthday.

(3) If you are eligible for apple health based on pregnancy, the certification period continues through the last day of the month the pregnancy ends. After-pregnancy coverage begins the first day of the month, following the end of the pregnancy, and ends the last day of the 12th month from the time after-pregnancy coverage began.

(4) If you are newly eligible for apple health coverage and had a pregnancy end within the last 12 months, your certification period for after-pregnancy coverage:

(a) Begins the first day of the month you are eligible; and

(b) Ends the last day of the 12th month following the end of your pregnancy.

(5) If you are eligible for the refugee program, the certification period ends at the end of the 12th month following your date of entry to the United States.

(6) If you are a child under age six receiving apple health for kids without a premium or apple health for kids with premiums, your certification period ends the last day of the month of your sixth birthday.

(7) If you are eligible for newborn coverage, your coverage continues through the last day of the month of your first birthday. Apple health for kids coverage begins automatically on the first day of the month after your newborn coverage ends and the certification period ends the last day of the month of your sixth birthday.

(8) For all other CN coverage, the certification period is 12 months.

(9) If you are a child, eligibility is continuous throughout the certification period regardless of a change in circumstances, unless you:

(a) Turn age 19;

(b) Move out-of-state; or

(c) Die.

(10) When you turn 19, the certification period ends after the redetermination process described in WAC 182-504-0125 is completed, even if the 12-month period is not over, unless:

(a) You are receiving inpatient services (described in WAC 182-514-0230) on the last day of the month you turn 19;

(b) The inpatient stay continues into the following month or months; and

(c) You remain eligible except for turning age 19.

(11) A retroactive certification period is described in WAC 182-504-0005.

(12) Coverage under premium-based programs included in apple health for kids as described in chapter 182-505 WAC begins no sooner than the month after creditable coverage ends.

AMENDATORY SECTION (Amending WSR 23-23-057, filed 11/8/23, effective 12/9/23)

WAC 182-504-0035 Washington apple health—Renewals. (1) For all Washington apple health (~~((WAH))~~) programs, the following applies:

(a) You are required to complete a renewal of eligibility at least every 12 months with the following exceptions:

(i) If you are eligible for (~~((WAH))~~) apple health medically needy with spenddown, then you must complete a new application at the end of each three- or six-month base period;

(ii) If you are eligible for (~~((WAH))~~) apple health alien emergency medical, then you are certified for a specific period of time to cover emergency inpatient hospitalization costs only (see WAC 182-507-0115(8));

(iii) If you are eligible for (~~((WAH))~~) apple health refugee coverage, you must complete a renewal of eligibility after 12 months; or

(iv) If you are a child on apple health for kids without premiums or apple health for kids with premiums, your first renewal is due the month of your sixth birthday.

(b) You may complete renewals online, by phone, or by paper application that you mail or fax to us (the agency or its designee).

(c) If your (~~((WAH))~~) apple health is renewed, we decide the certification period according to WAC 182-504-0015.

(d) We review all eligibility factors subject to change during the renewal process.

(e) We redetermine eligibility as described in WAC 182-504-0125 and send you written notice as described in WAC 182-518-0005 before (~~((WAH))~~) apple health is terminated.

(f) If you need help meeting the requirements of this section, we provide equal access services as described in WAC 182-503-0120.

(2) For programs based on modified adjusted gross income (MAGI) as described in WAC 182-503-0510:

(a) Sixty days prior to the end of the certification period:

(i) When information from electronic sources shows income is reasonably compatible (as defined in WAC 182-500-0095), we administratively renew your coverage (as defined in WAC 182-500-0010) for a new certification period and send you a notice of renewal with the information used. You are required to inform us if any of the information we used is wrong.

(ii) If we are unable to complete an administrative renewal (as defined in WAC 182-500-0010), you must give us a signed renewal in order for us to decide if you will continue to get (~~((WAH))~~) apple health coverage beyond the current certification period.

(iii) We follow the requirements described in WAC 182-518-0015 to request any additional information needed to complete the renewal process or to terminate coverage for failure to renew.

(b) If your (~~((WAH))~~) apple health coverage is terminated because you did not renew, you have 90 days from the termination date to give us a completed renewal. If we decide you are still eligible to get (~~((WAH))~~) apple health coverage, we will restore your (~~((WAH))~~) apple health without a gap in coverage.

(3) For non-MAGI based programs (as described in WAC 182-503-0510):

(a) Forty-five days prior to the end of the certification period, we send notice with a renewal form. You must renew before the end of the certification period by either calling the department of social

and health services at the number listed on the form to renew by telephone, renew online at www.washingtonconnection.org, or mailing or delivering to the department of social and health services a signed renewal form with the information required by WAC 182-503-0005.

(b) We follow the requirements in WAC 182-518-0015 to request any additional information needed to complete the renewal process or to terminate coverage for failure to renew.

(c) To complete your renewal, you must give us all the other information requested on the application that is needed to determine your eligibility.

(d) If you are terminated for failure to renew, you have 30 days from the termination date to submit a completed renewal. If still eligible, we will restore your ((WAH)) apple health without a gap in coverage.

(4) If we determine that you are not eligible for renewal of your ((WAH)) apple health coverage, we:

(a) Consider your eligibility for all other ((WAH)) apple health programs before ending your ((WAH)) apple health coverage; and

(b) Coordinate with the health benefit exchange any request for information that is necessary to determine your eligibility for:

(i) Other ((WAH)) apple health programs; and

(ii) With respect to qualified health plans, health insurance premium tax credits (as defined in WAC 182-500-0045) and cost-sharing reductions (as defined in WAC 182-500-0020).

(5) We reconsider our decision that you are not eligible for ((WAH)) apple health coverage without a new application from you when:

(a) We receive the information that we need to decide if you are eligible within 30 days of the date on the termination notice; or

(b) You request a hearing within 90 days of the date on the renewal denial letter and an administrative law judge (ALJ) or HCA review judge decides our decision was wrong (per chapter 182-526 WAC).

(6) If you disagree with our decision, you can ask for a hearing. If we decided that you are not eligible for renewal because we do not have enough information, the ALJ will consider the information we already have and anymore information you give us. The ALJ does not consider the previous absence of information or failure to respond in determining if you are eligible.

RDS-6181.2

AMENDATORY SECTION (Amending WSR 23-23-057, filed 11/8/23, effective 12/9/23)

WAC 182-505-0210 Eligibility for children. (1) **General eligibility.** For purposes of this section, a child must:

(a) Be a Washington state resident under WAC 182-503-0520 and 182-503-0525;

(b) Provide a Social Security number under WAC 182-503-0515, unless exempt; and

(c) Meet program-specific requirements.

(2) **Deemed eligibility groups.** A child is automatically eligible for coverage without an application if the child meets the program-specific requirements in (a) through (c) of this subsection.

(a) **Newborn coverage.** A child (~~(under)~~) younger than age one is eligible for categorically needy (CN) coverage if the birth parent was eligible for Washington apple health on the date of delivery:

- (i) Including a retroactive eligibility determination; or
- (ii) By meeting a medically needy (MN) spenddown liability with expenses incurred by the date of the newborn's birth:

(b) **Washington apple health for supplemental security income (SSI) recipients.** A child who is eligible for SSI is automatically eligible for CN coverage under WAC 182-510-0001.

(c) **Foster care coverage.** A child age 20 (~~(and)~~) or younger is eligible for CN coverage under WAC 182-505-0211 when the child is in foster care or receives subsidized adoption services. For children who age out of the foster care program, see WAC 182-505-0211(3).

(3) **Continuous eligibility for children under age six.** (~~(Children are)~~) A child is eligible for Washington apple health continuous eligibility for children under age six when they:

- (a) Have household income at or below (~~(215)~~) 210 percent of the federal poverty level at the time of application; or
- (b) On or after January 8, 2025, have household income greater than 210 percent but equal to or less than 312 percent of the federal poverty level at the time of application; or

(c) Received coverage under subsection (5) of this section and are no longer eligible for deemed coverage under subsection (5)(b) or (c) of this section.

(4) **MAGI-based eligibility groups.** A child age 18 (~~(and)~~) or younger is eligible for CN coverage based on modified adjusted gross income (MAGI):

- (a) At no cost when the child's countable income does not exceed the standard in WAC 182-505-0100 (6)(a);
- (b) With payment of a premium when the child's countable income does not exceed the standard in WAC 182-505-0100 (6)(b), and the child meets additional eligibility criteria in WAC 182-505-0215;
- (c) Under chapter 182-514 WAC, if the child needs long-term care services because the child resides or is expected to reside in an institution, as defined in WAC 182-500-0050, for 30 days or longer. An institutionalized child is eligible for coverage under the medically needy (MN) program if income exceeds the CN income standard for a person in an institution (special income level);
- (d) Under WAC 182-505-0117, if a child is pregnant.

(5) **Non-MAGI-based children's programs.** The agency determines eligibility for the:

(a) (~~(Medically needy (MN))~~) MN program according to WAC (~~(182-510-0001(6) and)~~) 182-519-0100. A child age 18 (~~(and)~~) or younger is eligible if the child:

- (i) Is not eligible for MAGI-based coverage under subsection (4) of this section;
- (ii) Meets citizenship or immigration requirements under WAC 182-503-0535 (2)(a), (b), (c), or (d); and
- (iii) Meets any spenddown liability required under WAC 182-519-0110.

(b) **SSI-related program.** A child age 18 (~~(and)~~) or younger is eligible for CN or MN SSI-related coverage if the child meets:

- (i) SSI-related eligibility under chapter 182-512 WAC;
- (ii) Citizenship or immigration requirements under WAC 182-503-0535 (2)(a), (b), (c), or (d); and
- (iii) Any MN spenddown liability under WAC 182-519-0110.

(c) **SSI-related long-term care program.**

(i) A child age 18 (~~and~~) or younger is eligible for home and community based (HCB) waiver programs under chapter 182-515 WAC if the child meets:

(A) SSI-related eligibility under chapter 182-512 WAC;

(B) Citizenship or immigration requirements under WAC 182-503-0535 (2) (a), (b), (c), or (d); and

(C) Program-specific age and functional requirements under chapters 388-106 and 388-845 WAC.

(ii) A child age 18 (~~and~~) or younger who resides or is expected to reside in a medical institution as defined in WAC 182-500-0050 is eligible for institutional medical under chapter 182-513 WAC if the child meets:

(A) Citizenship or immigration requirements under WAC 182-503-0535 (2) (a), (b), (c), or (d);

(B) Blindness or disability criteria under WAC 182-512-0050; and

(C) Nursing facility level of care under chapter 388-106 WAC.

(6) **Alien emergency medical program.** A child age 20 (~~and~~) or younger who does not meet the eligibility requirements for a program described under subsections (2) through (5) of this section is eligible for the alien emergency medical (AEM) program if the child meets:

(a) The eligibility requirements of WAC 182-507-0110; and

(b) MN spenddown liability, if any, under WAC 182-519-0110.

(7) **Other provisions.**

(a) A child residing in an institution for mental disease (IMD) as defined in WAC 182-500-0050(~~(4)~~) is not eligible for inpatient hospital services, unless the child is unconditionally discharged from the IMD before receiving the services.

(b) A child incarcerated in a public institution as defined in WAC 182-500-0050(~~(4)~~) is only eligible for inpatient hospital services.

WSR 25-05-069
EMERGENCY RULES
DEPARTMENT OF
FISH AND WILDLIFE

[Order 25-24—Filed February 14, 2025, 2:21 p.m., effective February 14, 2025, 2:21 p.m.]

Effective Date of Rule: Immediately upon filing.

Purpose: The purpose of this emergency rule is to amend commercial crab fishing regulations in Puget Sound:

WAC 220-340-45500W closes Region 1 on February 17, 2025; and
WAC 220-340-47000T eliminates pot limits in closed areas and maintains pot limits in open areas.

Citation of Rules Affected by this Order: Repealing WAC 220-340-45500V and 220-340-47000S; and amending WAC 220-340-455 and 220-340-470.

Statutory Authority for Adoption: RCW 77.04.012, 77.04.020, 77.12.045, and 77.12.047.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: This emergency rule extends commercial harvest in Region 1 through February 16, 2025, to allow additional flexibility for gear retrieval and to ensure the safety of commercial harvesters due to deteriorating weather conditions. There is sufficient allocation remaining to allow continued harvest in Puget Sound commercial crab fisheries in Regions 1, 3-2, and 3-3, until further notice. These provisions are in conformity with agreed management plans with applicable tribes. Comanagement plans are entered into as required by court order. The Puget Sound commercial season is structured to meet harvest allocation objectives negotiated with applicable treaty tribes and outlined in the management plans. Further adjustments of the season structure may be made pending updated harvest data.

There is insufficient time to adopt permanent rules.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 2, Amended 0, Repealed 2.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: February 14, 2025.

Kelly Susewind
Director

NEW SECTION

WAC 220-340-45500W Commercial crab fishery—Seasons and areas—Puget Sound. Notwithstanding the provisions of WAC 220-340-455, effective immediately, until further notice:

Harvest of Dungeness crab in Puget Sound is permitted during the "Open period" indicated in the following table. On the opening date, harvest will be permitted starting at 8:00 a.m. Harvest for these areas after the opening date is permitted starting one hour before official sunrise until further notice. Any closures will take effect one hour after official sunset unless otherwise indicated.

Geographical Management Unit (WAC 220-320-110)	Open Period
Region 1, MFSF Catch Areas 21A, 21B, and 22B	Immediately, through February 17, 2025.
Region 1, Marine Fish-Shellfish Catch Areas 22A, 20A, and 20B	Immediately, through February 17, 2025.
Region 2E, excluding Everett Flats CSMA (WAC 220-320-120(3))	Closed, until further notice.
Region 2E, Everett Flats CSMA (WAC 220-320-120(3))	Closed, until further notice.
Region 2W, not including Port Townsend Bay CSMA (WAC 220-320-120(5))	Closed.
Region 2W, Port Townsend Bay CSMA (WAC 220-320-120(5))	Closed.
Subregion 3-1	Closed, until further notice.
Subregion 3-2, not including Discovery Bay CSMA (WAC 220-230-120 (1)(a)), Sequim Bay CSMA (WAC 220-320-120(6)), or the Port Angeles Harbor CSMA (WAC 220-320-120(4)).	Immediately, until further notice.
Subregion 3-2, Discovery Bay CSMA (WAC 220-320-120 (1)(a))	Immediately, until further notice.
Subregion 3-2, Sequim Bay CSMA (WAC 220-320-120(6))	Immediately, until further notice.
Subregion 3-2, the Port Angeles Harbor CSMA (WAC 220-320-120(4)).	Closed, due to ongoing public health concerns.
Subregion 3-3	Immediately, until further notice.
Subregion 3-4	Closed, until further notice.

Reviser's note: The typographical error in the above section occurred in the copy filed by the agency and appears in the Register pursuant to the requirements of RCW 34.08.040.

NEW SECTION

WAC 220-340-47000T Commercial crab fishery—Gear limits—Puget Sound and Marine Fish-Shellfish Management and Catch Reporting Areas Notwithstanding the provisions of 220-340-470, effective immediately, until further notice:

Effective during the "Open period" listed in WAC 220-340-45500W it is unlawful for any person to harvest crabs with more than the "Pot limit" per license per buoy tag number indicated within each "geographical management unit".

Geographical Management Unit (WAC 220-320-110)	Pot limit
Region 1, MFSF Catch Areas 21A, 21B, and 22B	60
Region 1, Marine Fish-Shellfish Catch Areas 22A, 20A, and 20B	60
Region 2E, excluding Everett Flats CSMA (WAC 220-320-120(3))	0
Region 2E, Everett Flats CSMA (WAC 220-320-120(3))	0
Region 2W, not including Port Townsend Bay CSMA (WAC 220-320-120(5))	0

Region 2W, Port Townsend Bay CSMA (WAC 220-320-120(5))	0
Subregion 3-1	0
Subregion 3-2, not including Discovery Bay CSMA (WAC 220-230-120 (1)(a)), Sequim Bay CSMA (WAC 220-320-120(6)), or the Port Angeles Harbor CSMA (WAC 220-320-120(4)).	60
Subregion 3-2, Discovery Bay CSMA (WAC 220-320-120 (1)(a))	20
Subregion 3-2, Sequim Bay CSMA (WAC 220-320-120(6))	20
Subregion 3-2, the Port Angeles Harbor CSMA (WAC 220-320-120(4)).	0
Subregion 3-3	50
Subregion 3-4	0

Reviser's note: The typographical error in the above section occurred in the copy filed by the agency and appears in the Register pursuant to the requirements of RCW 34.08.040.

REPEALER

The following sections of Washington Administrative Code are repealed, effective immediately:

- WAC 220-340-45500V Commercial crab fishery—Seasons and areas—Puget Sound. (25-19)
- WAC 220-340-47000S Commercial crab fishery—Gear limits—Puget Sound and Marine Fish-Shellfish Management and Catch Reporting Areas. (25-19)

WSR 25-05-075

RESCISSION OF EMERGENCY RULES

PIERCE COLLEGE

[Filed February 12, 2025, 10:01 a.m., effective February 14, 2025]

WSR 24-24-051, CR-103E, is rescinded effective February 14, 2025. This filing was in reference to chapter 132K-135 WAC which was submitted on November 26, 2024. This is due to changes to Title IX which require institutions of education to revert to previous versions of federal requirements.

Julie A. White, Ph.D.
Chancellor and CEO

WSR 25-05-095

EMERGENCY RULES

STATE BOARD OF HEALTH

[Filed February 19, 2025, 8:49 a.m., effective February 19, 2025, 8:49 a.m.]

Effective Date of Rule: Immediately upon filing.

Purpose: Testing of drinking water contaminants; state action levels (SALs) and state maximum contaminant levels (MCLs) in WAC 246-290-315.

The state board of health (board) has authority under RCW 43.20.050 to adopt rules for group A public water systems that are necessary to ensure safe and reliable public drinking water and to protect the public health. Chapter 246-290 WAC, Group A public water supplies, establishes standards and requirements for these water systems. The department of health (department) administers the rules.

To ensure safe drinking water, water must be tested for contaminants. The board establishes SALs and MCLs to ensure contaminate levels are below a certain threshold. The board sets criteria for the adoption of SALs and MCLs in WAC 246-290-315 and includes criteria that would apply upon federal adoption of MCLs. WAC 246-290-315(8) states that upon federal adoption of an MCL, the MCL will supersede a less stringent SAL and associated requirements, including monitoring and public notice.

The Environmental Protection Agency published new federal standards for per- and polyfluoroalkyl substances (PFAS) on April 10, 2024, with an adoption date of June 25, 2024. These new standards include MCLs. This affects the board's rule and triggers the provision in WAC 246-290-315(8). The federal standards, however, have delayed effective dates for criteria and public health protections that are currently in place for Washington. According to the Washington state rules associated with the SALs, public water systems must notify customers of detections of PFAS above the SAL within 30 days of that detection. This is necessary to allow people the opportunity to protect themselves by using bottled water, securing a filter, or taking other measures. Thirty-day public notification is not effective for MCLs in the federal standard until April 2029. Without this amendment to WAC 246-290-315, customers served by group A public water systems will no longer be notified of dangerous levels of PFAS in their drinking water, which is a significant reduction in protections.

The board adopted an emergency rule on June 12, 2024, to amend WAC 246-290-315 such that the criteria would apply on the effective date of an MCL as set in the federal standard, not the adoption date, in order to maintain vital public health protections for drinking water safety. Along with the emergency rule making, the board initiated a permanent rule making to amend the rule language to align with the emergency provision and explore other protections. The CR-101 preproposal statement of inquiry for the permanent rule making was filed as WSR 24-20-093 on September 30, 2024. This third emergency rule continues the emergency rule originally filed on June 24, 2024, as WSR 24-14-016; and extended on October 22, 2024, as WSR 24-21-138, without change.

Citation of Rules Affected by this Order: Amending WAC 246-290-315.

Statutory Authority for Adoption: RCW 43.20.050 (2)(a).

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and

that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: The federal adoption date of the standards was June 25, 2024, at which point the MCLs and relative protections would have superseded the SALs. Because of the delayed effective date, currently active public health protections would have ended on that date. The board finds that emergency adoption of this rule is necessary to preserve public health.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 1, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 1, Repealed 0.

Date Adopted: February 19, 2025.

Michelle A. Davis, MPA
Executive Director

OTS-5531.1

AMENDATORY SECTION (Amending WSR 21-23-097, filed 11/17/21, effective 1/1/22)

WAC 246-290-315 State action levels (SALs) and state maximum contaminant levels (MCLs). (1) The department shall consider the following criteria to select a contaminant for developing a SAL:

(a) Drinking water contributes to human exposure to the contaminant.

(b) The contaminant is known or likely to occur in public water systems at levels of public health concern. Sources of occurrence information include, but are not limited to:

(i) Washington state department of agriculture;

(ii) Washington state department of ecology; and

(iii) Monitoring results reported in accordance with 40 C.F.R. 141.35.

(c) The contaminant has a possible adverse effect on the health of persons exposed based on peer-reviewed scientific literature or government publications, such as:

(i) An EPA health assessment such as an Integrated Risk Information System assessment;

(ii) Agency for Toxic Substances and Disease Registry toxicological profiles;

(iii) State government science assessment; and

(iv) EPA guidelines for exposure assessment such as the EPA exposure factors handbook.

(d) A certified drinking water lab can accurately and precisely measure the concentration of the contaminant in drinking water at and below the level of public health concern using EPA-approved analytical methods.

(2) After consideration of the criteria in subsection (1) of this section, the department may develop a SAL based on the following:

(a) Evaluation of available peer-reviewed scientific literature and government publications on fate, transport, exposure, toxicity and health impacts of the contaminant and relevant metabolites;

(b) An assessment based on the most sensitive adverse effect deemed relevant to humans and considering susceptibility and unique exposures of the most sensitive subgroup such as pregnant women, fetuses, young children, or overburdened and underserved communities; and

(c) Technical limitations to achieving the SAL such as insufficient analytical detection limit achievable at certified drinking water laboratories.

(3) The state board of health shall consider the department's findings under subsections (1) and (2) of this section when considering adopting a SAL under this chapter.

(4) Contaminants with a SAL.

(a) If a SAL under Table 9 of this section is exceeded, the purveyor shall take follow-up action as required under WAC 246-290-320. For contaminants where the SAL exceedance is determined based upon an RAA, the RAA will be calculated consistent with other organic contaminants per WAC 246-290-320(6) or other inorganic contaminants per WAC 246-290-320(3).

TABLE 9
STATE ACTION LEVELS

Contaminant or Group of Contaminants	SAL	SAL Exceedance Based On:
Per- and polyfluoroalkyl substances (PFAS)		
PFOA	10 ng/L	Confirmed detection
PFOS	15 ng/L	Confirmed detection
PFHxS	65 ng/L	Confirmed detection
PFNA	9 ng/L	Confirmed detection
PFBS	345 ng/L	Confirmed detection

(b) If a system fails to collect and submit a confirmation sample to a certified lab within ten business days of notification of the sample results, or as required by the department, the results of the original sample will be used to determine compliance with the SAL.

(5) The department shall consider the following when developing a state MCL:

(a) The criteria in subsection (1) of this section;

(b) Whether regulating the contaminant presents a meaningful opportunity to reduce exposures of public health concern for persons served by public water systems;

(c) The need for an enforceable limit to achieve uniform public health protection in Group A public water systems; and

(d) The need for an enforceable limit to support source water investigation and clean-up of a contaminant in drinking water supplies by responsible parties.

(6) In addition to the requirements in subsection (5) of this section, the department shall:

(a) Meet the requirements of subsection (2) of this section;

(b) Comply with the requirements in RCW 70A.130.010 to establish standards for chemical contaminants in drinking water;

(c) Consider the best available treatment technologies and affordability taking into consideration the costs to small water systems; and

(d) Determine that the probable benefits of the rule are greater than its probable costs, taking into account both the qualitative and quantitative benefits and costs.

(7) The state board of health shall consider the department's findings under subsections (5) and (6) of this section and follow the requirements under chapters 34.05 and 19.85 RCW when adopting a state MCL under this chapter.

(8) (~~Upon federal adoption of an MCL~~) When a federal MCL takes effect, the federal MCL will supersede a SAL or a less stringent state MCL, and the associated requirements, including for monitoring and public notice. If the federally adopted MCL is less stringent than a SAL or state MCL, the board may take one of the following actions:

(a) Adopt the federal MCL; or

(b) Adopt a state MCL, at least as stringent as the federal MCL, using the process in subsections (6) and (7) of this section.